

The Journal of  
HEALTH CARE  
CHAPLAINCY

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# The Journal of HEALTH CARE CHAPLAINCY

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Vol. 11 No. 2 Winter 2011

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## Editorial

### Meg Burton

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One of the delights of being the editor of the *Journal of Health Care Chaplaincy* is to read the articles as they come in. Some are in response to an article in the previous issue; others come 'out of the blue', as it were.

This issue is no exception. Almost immediately after I had received my copy, it became apparent that the discussion around supervision was going to continue. John Foskett wrote a letter for the last issue and has followed this up with an article entitled 'Pastoral Supervision: Who Is It For?', a question that must be in our minds if supervision is to be of value, for ourselves, of course, but also for those to whom we minister. To me, supervision is worthless if it doesn't lead to better practice. Guy Harrison has also been involved in supervision for some time, and his article, 'Towards a Collaborative Model of Pastoral Supervision', gives us more food for thought on a different way of supervising and being supervised.

It is very good to be able to publish the first part of Debbie Hodge's research, which she has called 'Chaplains – How Are They Known?' The story of how a group of chaplains in the South West Midlands Collaborative have explored who they are, what they do and how chaplains bring something 'other' to encounters, is fascinating and so relevant to how we are perceived and how we see and fulfil our role.

Debbie's work also fits very well with John Detain and Paul Salter's article, 'Meeting the Spiritual and Pastoral Needs of Patients and their Families at the End of Life'. They have outlined what started out as a pilot scheme whereby all the patients who went on the End of Life pathway for a six-month period were notified to the chaplains. The chaplains then made a visit, assessed the spiritual needs and followed up as was needed. In the references you will notice one for the *Nursing Times*, and I recommend you to get hold of the issue in which it was published as it explains from a different perspective, that of the palliative care consultant, how the initiative was received by families and staff. I was intrigued when I saw a reference in the NT article to one that was published in Volume 9 of the *Journal of Health Care Chaplaincy*, 'Using the Liverpool Care Pathway to Enhance Spiritual Care in an Acute Hospital Setting', written by our Trust's then IPOC nurse, Faye Witton.

Armed with all these articles, I spoke about John and Paul's initiative at our Trust's End of Life Strategy Group and we have set up our own pilot, which will run from November 2011 to the end of February 2012. John and Paul have been immensely helpful to us and, as they say in the article, this is something that can easily be adapted in other settings. I think this could be an immensely important way forward for us all, that has the potential to further improve the quality of spiritual care that we give to patients as they approach the ends of their lives and also to raise the awareness of practitioners in other disciplines of the value that chaplains bring to the patient journey and also to them as carers.

The way staff care for their own well-being is crucial, and Kathryn Darby has written about the various ways the chaplaincy team at Birmingham Children's Hospital have enabled staff to think about themselves, thus helping them better care for their patients in what must be a sometimes very stressful place. Bob Whorton, as well as having a book reviewed, has written about the boundaries of which, as we go about our everyday work, it is helpful to be aware. Finally, Susthama Kim is a Buddhist priest working in the East Midlands and she has written a very interesting article about one part of Buddhism and how this enhances her work as a chaplain.

I am disappointed that there are no letters this time. They are a good way to continue a discussion begun by an article so I hope that something in this issue sparks some thoughts that can be included in the next one.

This issue will be my fourth as editor and included in your envelope should be a short questionnaire. Please share your thoughts on what you think about the *Journal of Health Care Chaplaincy*, as it will help our planning for the future.

**Meg Burton**  
*Workshop*  
 October 2011

## Meeting the Spiritual and Pastoral Needs of Patients and their Families at the End of Life

**Revd John Detain** and **Revd Paul Salter** are Chaplains at North Tees and Hartlepool NHS Foundation Trust, Stockton-on-Tees and Hartlepool, Teesside, UK.

### Abstract

Spiritual care can be a neglected aspect of the Liverpool Care Pathway for patients approaching the end of life. Chaplains in an acute Trust, in cooperation with colleagues in the palliative care team, have implemented a model to try to ensure patients' needs are addressed at the end of life. This model has been successful and is transferable to other Trusts.

### Key Words

End of life care; Liverpool Care Pathway; Palliative care; Chaplains; Assessment; Spiritual needs; Patients and their families; Consent; Added value; Death and dying

## Main Article

### Introduction

What we have to recognize is that in healthcare there are two goods: cherishing life, and accepting death ... Both matter and neither need or should be done at the expense of the other. The problem is, as I see it, that we have not yet done enough particularly in training of staff and in the deployment of resources to recognize that dying is not a failure but a human reality that we can and should honour and fully respect in the way people are cared for. (Murphy-O'Connor 2008)

The Department of Health's *End of Life Care Strategy* (2008) has attempted to address the so-called last taboo of death, including the recognition of the need

for education in primary and secondary schools to normalize death as part of life. However, it will probably be many years hence before this strategic approach begins to bear fruit. Cicely Saunders, widely viewed as the founder of the modern hospice movement, asserted that 'the last stages of life should not be seen as a defeat, but rather as life's fulfilment' (Corr and Corr 1983). Although the hospice movement has had a significant effect on the way that death and dying are viewed in this country and further afield, even hospices promote themselves to try to ensure that they are not viewed only as places where people go to die, whereas in fact they often are just that. There is some tension here between a positive view of death as life's fulfilment, and the reality of the anxiety in many people's lives about death and dying.

The hospice movement, however, has certainly had a very beneficial effect on the way death is treated in the NHS, even if there is still much to absorb, to learn and to put into practice. In particular, the Liverpool Care Pathway (LCP) (Marie Curie PCI 2010) has attempted to ensure that imminent death is recognized and diagnosed appropriately, and that this is fully explained to a patient and/or the patient's family. At that point, the patient's needs – physical, psychological, emotional and *spiritual* – should be assessed and met as far as is practical. It is, it seems to us, a genuine attempt to 'honour and fully respect' (Murphy-O'Connor 2008) the reality of death, to normalize it within health care as a reality, but also to ensure that death is humanized and not simply reduced to a clinical process.

In an (unpublished) survey undertaken at North Tees and Hartlepool NHS Trust in 2008, it was found that, of those patients placed on the LCP (about 40 per cent of the average 1,600 deaths per annum), in only 4 per cent was there any documented evidence to suggest that there had been an attempt to assess patients' spiritual needs. We suspect that this statistic is not untypical of other acute hospital trusts in England and Wales. Small wonder that the National Council for Palliative Care referred to spiritual care as 'the missing piece' (NCPC 2010).

Now this in itself is not surprising. The NHS is a secular organization, operating in an increasingly secular society. Many people, including professionals working in the NHS, equate 'spirituality' with 'religion' and, as they have little experience of religion, have an understandable tendency to shy away from the unknown (Pugh *et al.* 2010: 19). Others perhaps find this whole area fraught with danger and are fearful of causing further upset at such a difficult time by raising what they perceive as a sensitive, possibly

even contentious, issue such as a patient's spiritual needs. Others, again, may perhaps be spiritually or even religiously inclined but are wary of raising the subject with others, especially in the emotionally fraught context of impending death, in case they are viewed as imposing their beliefs on others.

Despite all these difficulties, the need is clear – as death approaches, a person's spiritual needs should be addressed: the Liverpool Care Pathway is explicit on this, as is the Department of Health's *End of Life Care Strategy* (DH 2008). The *Patients' Charter* (DH 1991) acknowledged that 'health services should make provision so that proper personal consideration is shown by ensuring that privacy, dignity and religious and cultural beliefs are respected'. Even without the encouragement given by these sources, human experience demonstrates that spiritual need comes into clearer focus with the possibility or certainty of life coming to the end. Bruce Rumbold (2007) observes that a person's spiritual needs are constantly changing, and are subject to frequent revision in the face of life-changing events.

### Devising a Model to Address Spiritual Need

In order to ensure that the spiritual needs of patients on the LCP are in fact addressed within our Trust, the palliative care multidisciplinary team (MDT), in partnership with the chaplains, proposed the following model:

When a patient is placed on the LCP, the chaplaincy team would be informed as a matter of course. One of the chaplains would make a timely and sensitive visit to the patient and/or carers to ascertain what, if any, spiritual needs there may be and, if required, address that need. The chaplain would leave a contact card, and make further visits to the patient if required. The outcome of the visit will be recorded in the LCP documentation which is kept on the ward.

This proposal was a radical but logical departure from existing practice. Radical because how could chaplains be involved in this way if they were not part of the multidisciplinary team? (A chaplain may well be fully integrated into the MDT in a hospice, but not usually in an acute hospital trust.) Each ward in the trust has a key worker for palliative care – how would these workers view the chaplains' involvement? Indeed, how would patients and their families view it? However, the proposal was logical in the sense that the

NHS employs chaplains to provide expertise and care in spiritual matters, so surely they would be the obvious people to help address spiritual need?

A great deal of work and consultation was undertaken about the proposal (Pugh *et al.* 2010), and certain misgivings from some key workers and some members of the palliative care MDT were acknowledged. It was agreed that the proposal should be piloted over a six-month period from July to December 2009, and evaluated at that point. At Trust Board level it was agreed that the chaplains should be designated as members of the palliative care MDT so that they could access and contribute to a patient's LCP documentation, etc.

## Implementing the Model

At the end of the pilot period, the chaplains had visited 223 patients on the LCP, on average 37 per month. Fewer than 8 per cent of those visited declined the support of the chaplain, and 63 per cent of these patients received more than one visit. The pilot has been fully discussed elsewhere (Pugh *et al.* 2010). Suffice to say that no complaints were received from patients or carers but there were many compliments. Any misgivings on the part of professionals about the involvement of chaplains had dissipated. Indeed, staff recognized that the support offered by chaplains was not only of benefit to patients, but also to staff on the wards as well.

The model is now firmly rooted in practice in the Trust. To date (May 2011), we have visited over 1,000 patients and, on average, we see 45 to 50 patients each month on the LCP. Fewer than 3 per cent of those patients or their carers now decline input. In other words, 97 per cent of patients on the LCP accept spiritual and pastoral support in those last few hours and days before they die. There is anecdotal evidence that complaints around care at the time of death are declining. Staff feel better supported in themselves and they know that dying patients on their wards are receiving regular supportive input. They also feel more confident in chaplains and are more likely to refer other patients for support and spiritual care than they were previously.

## What Kind of Spiritual Assessment?

The LCP requires an assessment of a patient's holistic needs – physical, psychological, emotional and spiritual. How do chaplains, using this model, set about assessing spiritual need? We would not like to give the impression

that we meet the patient with a checklist of questions about their beliefs, feelings, etc. The meeting with the patient (or more usually family or carers as the patient, by this time, is very often not responsive) is as relaxed as it can be in the circumstances. The chaplain introduces him/herself and will usually ask family members to identify themselves as well; further questions, etc., can then be addressed to the nearest relatives.

The chaplain will leave a contact card which of itself can lead to further dialogue. The specially printed card states:

At this most important time, you may need someone to talk to

- To ask questions
- To help with problems
- You might like prayers, or some other kind of support or comfort
- You may just want to be on your own

If there is any way you feel we can help, or we can obtain help for you from someone else, please contact a member of the hospital's chaplaincy team.

There are dedicated phone lines printed on the card for this contact to be made or, of course, a member of the ward staff will make contact on behalf of the patient.



Figure 1 The contact card



We usually ask if there is anything the patient/carers need, or do they have any questions. This may lead to questions about the LCP process – why is no more treatment being given, no fluids or food, etc.? We are careful not to overstep boundaries and impinge on clinical issues; nevertheless, sometimes we can help allay fears, e.g. that their loved one is not being helped to die, or we can act as advocate and ask a consultant to visit and clarify issues with the patient. Even so, some patients or their family rightly view chaplains as competent to give guidance on ethical issues and need our reassurance that the process of the LCP does not equate with euthanasia. As Anne Aldridge has observed, this is entirely in keeping with the role of the chaplain ‘to be the conscience of the Trust in such areas – ensuring that issues are adequately debated and agreed’ (Aldridge 2006).

If the patient is conscious, sometimes they will ask to speak to us alone in order to discuss issues, but this is a rare occurrence. There may be family tensions that surface at a time like this and chaplains can help absorb, deflect or even resolve some of these difficulties. If the patient is not close to death (relatively speaking), we may visit the family a few times and have established a relationship over a few days in which they gain more confidence in our support and expertise. Not infrequently, someone will ask, what is it like when someone dies? Or what do I do when they’ve died? How do I arrange a funeral? We can give basic advice and/or direct them to the Trust’s bereavement officers.

These are broadly pastoral issues, and sometimes this is all the input that a patient/family requires. The first meeting with the patient/family is key and it may be that we pick up signals, or uncertainty about what we can offer. In most encounters, unless there are obvious counter-indicators, we will ask if they think their loved one would have wanted a prayer. This evokes a variety of responses – ‘Oh yes, she said her prayers every night’, ‘She used to go to church when she was younger’, ‘He loved Psalm 23’, etc., or sometimes, ‘We’re not very religious, but a prayer wouldn’t do any harm ...’ or ‘No thank you, he didn’t like that kind of thing’.

Of course, we will respect the wishes of the patient/family as expressed. Sometimes a family will change their mind and, as death approaches, ask for prayers when previously they had declined. Anecdotally (as this is not information we actively audit), we have observed that the majority of patients/families do at some point ask for some overt spiritual input, i.e. a prayer, and they will often join with a familiar prayer like the Lord’s prayer.

Also, the ‘formality’ of a prayer, including the recognition that these are the last hours, will evoke tears in the dawning recognition that this is going to be the fulfilment of a loved one’s life in death.

Part of the respect we offer is the recognition of different religious traditions. A Roman Catholic may ask for a priest for the last rites, and we can arrange this. A Muslim family may wish to be put in touch with an Imam; someone of Jewish faith with a Rabbi, etc. We also recognize and respect those who have no religious faith but may still have broadly spiritual needs.

‘The chaplain visited Mary and Don as Don was on the LCP. Immediately they made it clear that they were humanists and Don had planned his own funeral, but they were happy for supportive pastoral visits from the chaplain, especially as they had no immediate family to visit them. Within 24 hours Don had become unresponsive, but Mary stayed with him. She met the chaplain in the corridor when she was taking a break and clearly needed to talk. In the chaplain’s office she began to cry, saying she was relieved to do so as she did not want to express her tears in the same room as Don for fear of distressing him. She spoke of her sadness as Don’s death approached, about her own mortality and what she would do without him. She visited the chaplain on at least one other occasion before Don died two days later. Although Mary had no expressed religious faith, she clearly had spiritual needs that might not otherwise have been met.’

## Consent

Because the LCP directs that a patient’s spiritual needs should be assessed, and includes a section in the LCP documentation to record this assessment, some professionals, rightly protective of their patients, may ask a patient or family, ‘Would you like to see the chaplain?’ Some will answer this question by saying: ‘We’re not very religious, so, no thank you.’ Chaplains will then be informed that the family does not wish to see them, whereas in fact they have not been given an opportunity to have their true spiritual or pastoral needs addressed. As a consequence, that patient will not benefit from our involvement, including the continuing support that we can offer over the hours and days before a patient dies.



In fact, a protocol exists within the Trust, agreed at Board level, that it is *the chaplain who offers this choice*. When we enter a room with a patient and his/her family, our first statement is to introduce ourselves and couple this with 'Is it OK if I come in for a chat?' At that point, the patient/family can give or (rarely) withhold consent. We must emphasize that this model is not about imposing religion, but it is about offering choices.

We are trying to educate staff, largely successfully, to allow us to do our work and carry out the spiritual assessment. Consequently, we discourage them from asking this somewhat limiting question: 'Do you want to see the chaplain?'

### How Do Chaplains Bring Added Value to End of Life Care?

#### 1 The patient benefits.

- The opportunity to have their spiritual/religious needs met.
- To talk in confidence to someone outside their own family.
- To find peace and reconciliation.
- To help resolve issues that may be of concern.

#### 2 The patient's family/carers benefit.

- They receive direct support at a very difficult time.
- They have the chance to ask questions, seek answers.
- They can advocate for their loved one.
- They can have chosen religious rites fulfilled.

#### 3 Benefits for staff.

- They know that a patient's spiritual needs are addressed and recorded.
- They know that someone is able to spend time with their patient.
- They can themselves receive support directly from the chaplain if required.
- There is a saving of clinical nurse time.

#### 4 Benefits for the Trust.

- Ensuring that spiritual needs are assessed as part of LCP = best practice.
- Chaplains available to mentor staff and be involved in training.
- Some evidence of a reduction in complaints.

#### 5 Benefits for chaplains.

- Staff become more aware of our role.
- Staff are more confident to refer in non-LCP circumstances.
- New and clearer focus for ministry.
- Sense of personal fulfilment in the role.

### Is This Model Transferable?

We are convinced that it is, and we would be happy to advise colleagues from other Trusts who might like to consider replicating the model. However, certain preconditions are required to make it work effectively.

- *Support of the palliative care MDT*, especially the consultant. As with so much in the NHS, the consultant is key and can help make things happen.
- *Support of the Trust Board*. Again, the influence of the consultant is key here, e.g. to have chaplains accepted as part of the MDT.
- *Support of the staff on the wards, especially*. Staff took a little time to be convinced, but the successful pilot ensured that the model was accepted. The fact that the model continues to work effectively, and benefits patients and families, ensures continuing support from staff.
- *Support of the chaplains*. Unless we were all committed to this role in the Trust, it would be ineffective. There was some concern that this work would overwhelm our workload. This has not proved to be the case; in fact, it enhances what we do.

## Angels of Death?

Chaplains have long held a fear that they are always perceived as angels of death – if the chaplain is on the ward, someone must have died! Much as we might like to escape this, and emphasize that the majority of our work is with the living, we do nevertheless have a vital role to play in end of life care. If we cannot signify some hope at such a time, then what is our faith about?

We have found that our work in end of life care, emotionally demanding though it may be at times, has been immensely fulfilling. Other than birth, there is surely no bigger moment in anyone's life than their death. To be present and to have such a significant role at this time is, we believe, a privilege.

The role does demand emotional and psychological stability and integrity, including an unshakeable sense of humour. So much depends on our God-given personalities, formed and moulded through our life experiences. As one of the palliative care key-workers commented:

'The success of this project is in no small measure attributable to you chaplains' approachability and warmth of personality.'

This ministry is very rewarding for someone of resilience and faith, and, among so much else, witnesses to the fact that, in death, life is changed not ended.

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## Pastoral Supervision: Who Is It For?

**John Foskett** is an Adviser in Religion and Spirituality to Somerset Partnership Mental Health NHS Foundation Trust.

### Abstract

The question, who is supervision for?, is explored from the perspectives of the supervisor and supervisee. It is shown that the point of view of the parishioner, patient, client or service user is often assumed and then lost in the practice of pastoral supervision. A learning theory provides a connection to the Christian Trinitarian God, the well-being of the recipients of ministry and the importance of immanence, transcendence and inspiration in the work of care and counsel and the pastoral supervision which supports it.

### Key Words

Parishioner; Patient; Client; Service user; Pastoral supervision; Immanence; Transcendence; Inspiration

## Main Article

### Introduction

Pastoral supervision has been around for at least two millennia in the Pastoral Epistles, the gospels and the letters of Paul. All include stories and pictures of the relationship between pastors/disciples and their fellow pastors who wish to learn from them to pastor as effectively as they can. This ministry/vocation is now in the recovery position for pastors, among whom health care chaplains, in particular, are very engaged. The writings of Martin Kerry (2010; 2011) and Jane Leach and Michael Paterson (2010) are good examples of the current interest in, and significance of, pastoral/clinical supervision. They provide a comprehensive collection of the diverse sources of the theory and the practice of supervision from many allied caring and

therapeutic professions, and from their own considerable experience as pastoral supervisors and supervisees themselves. They do this by examining the activity of supervision and its importance in the professional care and development of pastors and in the ministries they perform. Latterly, the training and development of pastoral supervisors has also been addressed by Leach and Paterson (2010: 204 f.) and as lifelong learning by Frances Ward (2005). Kerry in his articles provides us with a more concise picture of pastoral supervision with health care chaplains in mind.

Reflecting on my own experience of being supervised, supervising and training supervisors, I am heartened that what was once a peripheral interest has moved nearer to the centre of ministry, and is more acceptable and more expected of those who minister in a number of faith and spiritual traditions. I hope the profession of supervision will grow and blossom even more abundantly, as I see it helping us embrace the presence of our Trinitarian God's strategy for salvation.

### Who Is Pastoral Supervision For?

Ultimately I believe pastoral supervision, like all ministry, is for the glory of God, the universe and humanity, in the context of life here and hereafter – here, most typically in environments which obscure that glory. For many millions of people, signs of the Kingdom of God are hard to come by, and yet the essence of pastoral supervision is to engage with whatever glimpses of the Kingdom there are. It does this with a bias towards the sufferings and passions of the coming Kingdom and life in the meantime. This can make it and us sound morbidly obsessive in our preoccupation with the negative. But at its best, like great art, our task is to reveal the jewels in the mess and pain of life, the treasures buried in its shadows. To reach the Kingdom we do have to bear our cross like our saviour bore his.

Given this necessary emphasis on the painful and the discordant in our experience, it is not surprising that we would approach supervision with caution. Will such exploration and navel-gazing make matters seem worse than they really are? Will it undermine what little confidence I have about my ministry to explore the things which hurt and undermine me? These questions, familiar to me as I approach my supervisor, go some way to explain how long it has taken for modern ministry to embrace this practice. 'Why don't some chaplains receive supervision?' (Kerry 2011). From our earliest

memories, a message to us Christians (and other faiths too) has been to look on the bright side of life, celebrating an Easter and Pentecostal faith and passing over the Cross and the Tomb, which have been vanquished by the miracle of resurrection and the gift of God's spirit.

### Supervision for the Supervisor and Supervisee

So who, apart from God, is supervision for? From my own experience, and the much that I have read and tried to apply, the impression I have formed is that supervision is for the supervisor and the supervisee(s). 'To look together at the supervisee's practice' is the first definition of pastoral supervision of the Association of Pastoral Supervisors and Educators (APSE 2008) and it goes on to define the activity as 'a relationship, spiritually and theologically rich, psychologically informed, contextually sensitive, practice based, attentive to fitness to practice' and a way of growing in a modern list of the fruits of the spirit.

Thus the focus is essentially upon the supervisor and supervisee and his/her activity in caring or counselling those with whom s/he ministers. It is to help develop the pastoral skills and abilities of the supervisee and to contain their ministry within realistic ethical and professional boundaries. This is a considerable task in any context, historical or contemporary, and is sometimes beyond both supervisors and supervisees to achieve, given the scale and seriousness of the sufferings, traumas and crises that confront us in ministry. Health care chaplains, like others in the NHS, are especially vulnerable to the overwhelming emotions of life-threatening illnesses and death (Menzies Lyth 1988). The burgeoning of studies and writings about supervision, and the expanding practice of it, suggests a realization of the personal and professional costs – burnout and breakdown – involved in such uncertain times. Maybe the very word *super-vision* is a clue to an optimistic hope that something or someone has a better vision than we do and can help us catch it and make some headway in the oceans of need and distress before us.

This concentration upon, and development of, the profession of pastoral supervision is also illustrative of what happened in other disciplines confronted by these adverse conditions. Professions concentrate upon the areas in which they can make a difference, and in health and social care much is done to value the contribution and skill of each profession, while

maximizing their effectiveness by working in harmony with each other. Inevitably, this is an ideal, and the survival instincts of each profession can undermine the ideal in a competitive world with limited resources, as in our national health service. However, there is a saviour of a kind to inspire and protect us from the prospect of disintegration.

### Parishioner, Patient, Client, Service User<sup>1</sup>

Successive governments and their leaders tell us continually to put the *patient* first. He or she is to be the anchor and object of our efforts, even though the sceptical among us deduce that economic goals often supplant the *patient* in most services of care. Who is pastoral supervision for? Yes, it is for the supervisor and their livelihood and for the supervisee and their professional development, as health care chaplains fearing for their employment know only too well. But ultimately it must be for the benefit of the *patient* that pastoral supervision is practised and developed. Should it, like any other profession or service, become absorbed with and be an end in itself, existing only for those who do it, then it is vulnerable to confusing means with ends and so to the sin of idolatry. Pastoral supervision, like all activities which exist for others, must be called to account for its effectiveness or otherwise in contributing to the well-being of the *patient*, etc.

In establishing itself, the profession has to identify best practice, codes of conduct and ethical guidelines, and it is easy to assume that the *patient* is central to these. In practice, our hubris, which is really our idolatry, is more pernicious than our ideals and, as the books referred to above and many others reveal, the *patient* is assumed rather than mentioned when compared with the references to the 'supervisor' and the 'supervisee'.<sup>2</sup> I remember the matron in the hospital where I first worked always prefaced and concluded discussions by asking about the *patient(s)* and their point of view. So it is incumbent upon us to ask ourselves, at least at the beginning and ending of pastoral supervision, about the patient in order to assure ourselves that we have not been diverted by the mysteries and wonders of the supervision itself. To help himself and his clients, a colleague family therapist, when supervising other therapists, would film the supervision and then play it back to the client family for their reactions and guidance with the supervisees present.

As such facilities are rarely, if ever, available to pastors and their supervisors, we need to develop other ways to keep the *patient* in the centre of our ministry and our supervision of that ministry. Somehow we need to identify and confirm the difference which any pastoral supervision makes to the well-being of the *patient* who receives care affected by that supervision. As it is idolatry that we need to avoid, it is likely that theology will give us the best chance to maintain our focus upon God's dealings with the *patient* and how the supervisee's ministry helps or hinders that.

### A Theology of Pastoral Supervision

There is nothing better than the practice and experience of pastoral supervision to help us discern what God is about in the lives and passions of God's people. That was why David Lyall and I (Foskett and Lyall 1988) chose to begin our book with the experience of pastoral supervision and its contribution to the well-being of *patients* and only then go on to explore the theory and practice of supervision more theologically. As working pastors ourselves, the majority of our ministry was with *patients*, and only a small part was in receiving and giving pastoral supervision. Since leaving full-time ministry, and yet doing and receiving supervision, I am aware of the disadvantage of no longer practising ministry as those who I supervise do. However, poor health, in making me a *patient*, has strengthened my perspective on the effect of pastoral care that chaplaincy, therapy and its supervision has given me. Being a *patient* is a very good, if painful, place to be in order to assess the value of care. It is now the task of pastoral ministry and pastoral supervision to enlist *patients* to help evaluate the efficacy of pastoral ministry and its supervision, as they have done with mental health services practice and research (Copsey 1997; Foskett *et al.* 2004; Lawrence and Head 2009).

### Learning Theory as the Ground for Theological Meaning

Adult learning theory from Kolb *et al.* (1974) helped me begin to make connections between my experience of supervision and my theology with *patients* in mind. It was a gradual process beginning with the recognition that the four elements of the theory, beginning with the *experience* – what happened, what was said or shown – puts the *patient* firmly in the centre of

the picture. This can be reinforced if the supervisee is invited to take the part of the *patient*, and with the use of a verbatim to speak the *patient's* words, feel his or her feelings and hear their own responses spoken by the supervisor. The *reflection* phase provides a rich mixture of the feelings and experience of the *patient*, the supervisee and the supervisor in the role of the supervisee as minister, carer or counsellor. If the emotions are especially powerful, the time given to reflection is very important in order not to lose this opportunity to embrace the feelings and thoughts of the patient, mediated through the supervisee and the action of the role-play. When done as thoroughly as possible, the ground is laid for the *understanding* phase which, rather than generalize meanings and theories, focuses upon what seems most relevant to this *patient* in this context and how the supervisee will best provide it. The *experimenting* phase draws this out, allowing the supervisee to reclaim their place as minister, carer or counsellor and to take from the supervision whatever is most useful. The experiment becomes the next experience, which in turn will provide material for the next supervision.

### The Trinitarian God

In using Kolb's (Foskett and Lyall 1988) method over time, I have come to see in it a reflection of the Trinity, not so much as a doctrine as an icon of God's strategy for salvation. I identify the immanence of God, the Son, in the *reflective* phase and its incarnate association of entering into the experience of the *patient*, whose words and actions are given flesh through imaginative reflection. All ministry offers opportunities to incarnate ourselves in the lives and experience of those we minister to and for, using our experience to stand in their shoes, feeling their feelings as closely as we can. The *understanding* phase has us looking from their point of view towards the detached 'authorities' of theology and the human sciences, most fully to be found in our transcendent God, the Father. The Holy Spirit is often envisaged as coming from the relationship of Father and Son, the love that each has for the other. So the *experimenting* phase gathers the fruits of the interaction between immanence and transcendence, Father and Son, to inspire our future ministry, care and counsel. It has been my experience that I can enter most fully into the passion and suffering of the *patient* because I know supervision will recall me to myself, my thinking and my resources, to help me make sense of what I entered into so completely. One process in



particular reminds me of the work of the Holy Spirit through its unconscious and inspirational flavour. This is generally known as the parallel, reflection or mirroring process (Searles 1965). Janet Mattinson (1975: 11) stumbled across this phenomenon in her supervision of students at the Institute of Marital Studies and the Tavistock Clinic. She writes:

The processes at work currently in the *relationship between* client and worker (therapist, chaplain) are often reflected in the *relationship between* worker and supervisor. (her italics)

The reflection process obviously works two ways, from the work to the supervision and from the supervision to the work. The common factor in the two situations, and the link between them, is the student ... For me the excitement, after being muddled, came with the idea of the behaviour of the student in the interactive situation with the supervisor, in front of the supervisor's own eyes, giving a clue, not just to their own inadequacies, but to the difficulties of the client (1975: 13).

In her examples, and in my own experience, supervision groups often replicate and act out the unconscious and especially the most troublesome conflicts of the *patient* and of his or her family/friends, and indeed of the conflicts of the staff team caring for the *patient*. Often this happens because we are attracted to one phase of Kolb's model and can overlook the others. The same, of course, is true of our favouring one person of the Trinity more than the others. God's strategy for salvation is recognized by the church in the form of the Trinity and the whole of God and God's being for us is reflected in Kolb's four phases, all of which contribute to ministry and its supervision.

### Acknowledgements

I am most grateful to the health care chaplains – Fay Wilson Rudd, Ken Coles and John Rothwell in Somerset, and Jane Lloyd, Nigel Tooth and Declan McConville in Dorset – for reminding me and themselves to keep the *patient* central in our supervision together.

### Notes

- 1 It was very difficult to find a satisfyingly generic word for those who receive ministry – parishioner (RC and Anglican), patient (hospital), client

(therapy), service user (mental health). As this article is for health care chaplains, I decided to use the word 'patient' to stand for any individual or group who receives supervised ministry. I hope readers can, if they wish, replace it in their minds with their preferred word.

- 2 In Kerry's article the key words are *supervision*, *professional standards* and *supervisors*. In Leach and Paterson's book there is no mention in the index or the glossary of the *patient*, *client* or *user*. I have to own up to the fact that in *Helping the Helpers*, the index includes no mention either.

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## Towards a Collaborative Model of Pastoral Supervision

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### Abstract

This article explores one of the issues Martin Kerry raises in his article 'Taking Supervision Forward: An Agenda for Chaplains and Chaplaincy' in the previous issue of this journal. A response is given to the question: who should provide supervision? The case for line management-provided professional supervision is made. It is argued that by focusing on the relationship between supervisor and supervisee, collaborative learning and meaning-making may be enhanced and integrated into theological reflection.

### Key Words

Collaboration; Process; Relationship; Reflection-in-action; Person-centred; Theological perspective

### Context

The West London Mental Health Trust provides a full range of mental health services for children, adults and older people living in the boroughs of Ealing, Hammersmith and Fulham, and Hounslow. It also provides specialist and forensic mental health services, including high secure services at Broadmoor Hospital. The Trust aims to meet the diverse needs of a local population of nearly 700,000 people and employs around 4,000 staff across 32 sites. As Lead Chaplain I currently supervise three full-time and two part-time members of the team. I also provide external supervision to a chaplain from another NHS Trust.

## An Overview

My understanding of pastoral supervision is that it incorporates a number of dimensions which interrelate with each other. The ultimate focus or 'outcome' is the quality of service to the client or, in my present context as a mental health chaplain, the service user. In my view this quality should have as its guiding principle the building up of a community of faith, hope and love, in which we are all enabled to attain our full potential as human beings. For me this is the focus and ultimate goal of the supervision process. The highest quality of service is also dependent on the nature of ongoing learning, development, skill-building and theological commitment to reflection which takes place in the context of the supervisory relationship, whether in a one-to-one or group setting.

I find it helpful to use the Gestalt concepts of 'figure' and 'ground', the learning relationship being figure and the various functions and contextual factors within a given supervision framework becoming the ground. In terms of the relationship itself, two particular dimensions are for me key to the issue of quality: first, the supervisory relationship and, second, a set of collaborative principles and behaviours that operate within, and which support, this relationship and which in turn support the quality of service to the service user. My experience is that the dimensions of relationship and collaborative process interrelate over time within the supervision process as a whole.

## The Supervisory Relationship

My view is that within the context of pastoral care with service users it is the quality and form of the relationship which underpins the effectiveness of the process of pastoral care. Although several writers, for example Hawkins and Shohet (1989), Hunt (1986), and Foskett and Lyall (1988), make reference to the importance of the supervisory relationship and outline some of the key aspects of the supervisory process between supervisor and supervisee, the relationship is never clearly presented as the overriding framework for potential learning and exploration. My core model for working depends upon collaboration as a key principle in terms of developing the supervisory relationship and the potential for learning that takes place within that

relationship. In my opinion such a joint learning venture is dependent upon what is meant by the learning process.

## The Learning Process

Psychological theory and research suggests that learning is enhanced and outcomes maximized when the learner is involved in the process. This way the learner's motivation is engaged, they have an opportunity to co-create the structure of meaning inherent in the learning process, and are most likely to develop a commitment to achieving a set of learning goals.

For me, to truly collaborate on a joint learning venture is sometimes risky, especially so as a manager. It requires that the patterns which have existed within my chaplaincy team are laid open for perusal in order that new assumptions may be taken on and worked with. In my experience this process is both exciting and uncomfortable. It is the kind of learning, however, that ensures freshness and openness to new experience and changed awareness, rather than sitting with what we already know and with what is often more comfortable.

My model of pastoral supervision challenges me as a supervisor to move away from any fixed roles and responsibility in a way which makes me as fully available as possible for a relationship characterized by transparency and by the principle of collaboration and a commitment to learning. According to Donald Schon's (1983) formulation, this requires of us a willingness to move beyond our 'technical rationality' – that is, beyond being passive receivers of knowledge and skill, and towards becoming active in the development of our own creativity. To work in this way requires in me, as supervisor, a willingness to move out from behind a potentially more comfortable professional façade, towards a 'reflection-in-action' mode of being, where responsibility and accountability are more equally shared.

## Attitudes, Behaviours and Skills

I would describe these as the following:

- non-judgemental stance
- holistic presence

- descriptive phenomenology
- attention to power and transference/counter-transference issues
- naming of difficult emotions (e.g. anxiety)
- willingness to name relevant factors present in 'the field'

Broadly speaking, I am talking about a phenomenological attitude, where both supervisor and supervisee are willing to bracket their prejudices, attend to the description of what is available to the senses in the present moment, name 'unsaid' as well as other factors which might have a bearing on the relationship and on the work of supervision, and attend to the ebb and flow of energy as the process unfolds.

Thinking about the evolution of the supervisory role within the chaplaincy setting, and the many aspects of this which are reflected in the literature as well as in my own experience of the process, I have come across the idea of focusing on 'size' within the supervisory relationship. In doing so, it is possible to take a literal approach to any number of factors, which can include power relations, felt age or regressed states, lack of confidence and anxiety, or the different experiential states of 'judging' or 'feeling judged'. Under each of these conditions, if we tune into our physical sensations, we will find that our experience of our own size will generally vary. Under certain conditions my supervisees may feel small or, if my supervisees don't seem to respect me, they might feel 'big' and I might feel 'small'. Where I as the supervisor feel that I am directly responsible for the supervisees' 'clinical' work and that I am 'in charge' of the ethics of the matter, then I might feel 'big'. If all this 'responsibility' sits like concrete on my shoulders, making me feel very anxious or 'worn down', then I would be more likely to feel 'small'. So, by utilizing the dimension of 'size', it makes it possible very rapidly to tune into a range of important issues, some of which are likely to be outside our conscious experience at the time. Through the development of my awareness in this way I can bring new aspects of experience into focus, make them transparent, and figure out how to deal with them in creative ways. Importantly, I can do this figuring out overtly in the context of the supervisory relationship. Working in this way also raises more general issues which may, moreover, be more personal. These include the perceived 'risk' involved in being willing to stand at the edge of my own vulnerability,

with a willingness to have my own anxiety or personal struggles made more visible.

At the broader level, it also raises the issue of potential difference with supervisees with different levels of training and experience. It is my experience that with new chaplains it is sometimes more appropriate for me to be 'big' in the relationship. As to whether 'big' means 'more supportive' or whether this is a rationalization of my need to keep control under conditions of uncertainty is always an open question.

## Finding Meaning

Sitting alongside attitudes, behaviours and skills is the whole area of meaning-making – in other words, how supervisor and supervisee understand the experience and its effect and then discover something of its meaning. In my context as a chaplain, my hope is that in supervision it is possible to discover something about the mutuality of ministry and pastoral care, how our own experience of suffering, pain and sometimes our own sense of helplessness may in turn become the very tools by which pastoral care is often mysteriously given. Here, then, lies the quality of God-given revelation where light and understanding replace a sense of fear and sometimes of failure.

## Line-management-provided Professional Supervision

As a management supervisor I have responsibility to ensure that the organization's duty of care to its service users is carried out, and the organization therefore has a specific responsibility to ensure that employees are enabled to fulfil this responsibility. This gives the organization a right and a responsibility to review the practice of their team members. I realize that this can be problematic. I am aware that many within, for example, the profession of counselling and psychotherapy argue that supervision should be independent of management. However, for my Trust to create a second, mandatory supervisory relationship for chaplains, social workers, clinical psychologists and others would create a further demand on already stretched resources. I therefore offer management supervision.

My approach to management supervision is, where possible, to utilize the person-centred approach. Carl Rogers' (1959) early work on encounter

groups, used to train counsellors, quickly evolved to train managers, and he collaborated closely with Thomas Gordon (1951), who developed a group-centred approach to leadership and administration. Gordon summarizes his approach as follows:

The group-centred leader believes in the work of the members of the group and respects them as individuals different from himself. They are not persons to be used, influenced or directed in order to accomplish the leader's aims. They are not people to be 'led' by someone who has 'superior' qualities or more important values. The group-centred leader sees the group as existing for the individuals who compose it. (1951: 338)

This collaborative concept has been refined by writers such as Peter Block (1993), who proposed that the concepts of management and leadership be replaced with those of governance and stewardship. Governance is a concept that is increasingly important to chaplains, who are increasingly required to evidence and standardize the care they must give. However, Block argues that the traditional command and control concepts of patriarchal management, which are essentially parental and infantilizing, be replaced by the concept of partnership. Block identifies four key requirements for creation of real partnership:

- *Exchange of purpose*, whereby every stakeholder has a voice in what kind of institution we are creating. (Having facilitated local staff and patient focus groups in one NHS Trust for the creation of a local strategy, I have seen this in action in the NHS.)
- *The right to say no*. Block recognizes that there may always be an imbalance of power between manager and managed, but suggests that this can be a 51:49 split, and that, even so, partners always retain the right to have their voices heard.
- *Joint accountability*. The price of freedom and adulthood is that each and every employee takes an individual and collective responsibility for the outcomes and quality of cooperation within a unit and/or organization.
- *Absolute honesty*. Block recognizes that this is difficult and frightening in practice, but argues that 'not telling the truth to each other is an act of betrayal' (1993: 30 f.).

When it comes to the supervision of chaplains, this sharing of power, responsibility and purpose in a respectful, adult relationship is central to my person-centred approach. The sharing of 'purpose' creates the conditions for a mutual empathic understanding, whilst the 'absolute honesty' and 'right to say no' acknowledge the importance of congruence in an effective relationship. Furthermore, my supervision has to encompass clinical practice, an understanding of the context in which the practice takes place, as well as thoughtful theological reflection. This knowledge enables me to congruently offer an empathic understanding of a supervisee's work and context, and to make available to both of us the necessary theological resources by which each member of the team can improve their practice through the development of new therapeutic and theological insights and strategies.

## Theological Reflection

Finally, I turn to the 'space' which underpins all that we do as chaplains. In her book *Lifelong Learning*, Frances Ward (2005), drawing on Christian Trinitarian theology, reflects on the 'space' of supervision:

I want ... to use the metaphor of 'space' ... to carry forward a way of thinking about supervision. The 'space of supervision' then becomes a space in which mutual learning occurs, a space of interaction and dialogue, a space where identities are formed and transformed, a space of interplay, of experimentation. This space will be employed differently if it is called supervision, or mentoring, or consultancy or even spiritual direction, but basically, what is provided is time and 'space' where both supervisor and reflective practitioner can experience safety and challenge so that growth and learning occurs. (2005: 87 f.)

It is all too easy to become so immersed in the experience that we fail to acknowledge the joint enterprise that is making space and quietness for reflection and meditation upon what God is doing or suffering within the situation we are analysing in the context of what is, after all, *pastoral* supervision. The theological perspective is essential and sets pastoral supervision apart from all other types of supervision.

My theology, practice and, therefore, my spirituality is Christian and, in particular, incarnational by nature. I meet God in the often marginalized and

stigmatized members of society – in the day-to-day work of mental health care. David Lyall (Foskett and Lyall 1988) points out that in the parable of the sheep and goats, Christ locates himself in the body of the oppressed. He does not simply enjoin us to be of service to the marginalized as a moral outcome of following a just God, but he states that it is in them that he himself is to be met. 'In as much as you did it to one of these, you did it to me' (Matthew 25:40). Time and again, in my experience, service users will say that they know God to be there among them, although they may not be exactly sure when or where he can be found. This sense of presence is echoed in my relationship with my supervisees. In the context of a chaplaincy service, whether that be acute care, mental health care or palliative care (I have worked in all three), a chaplain's theological reflections enable him or her to engage with some of the harsh issues of life in God's presence, where together we become aware of how inadequate we would be without God's grace. My hope is that within supervision we also become aware of how a truer appreciation of what is really happening in the service user, carer or staff encounter allows us to know more fully that God is with us.

Within the community I seek to serve, within each and every pastoral supervision, the issues I encounter begin to be perceived aright as 'spiritual' issues, and therefore become the focus of our prayer, meditation and sacramental action. In this way, if it is placed within the context of worship and prayer, pastoral supervision becomes a wrestling with an awareness of God's suffering and joyful presence in the world.

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## Chaplains – How Are They Known?

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### Abstract

Chaplains in the Health Service need to be able to describe what they do and the contribution their work makes to health outcomes. This article brings together the work of a group of chaplains who have described their work and structured a 'model of chaplaincy' that relates to other working models in the NHS. The work of the group is ongoing and the effect on health outcomes continues to be explored.

### Key Words

Chaplain; Chaplaincy; Spiritual care; Nursing process

### Main Article

In the modern NHS the role of the chaplain is under scrutiny. Questions over evidence-based practice, the efficacy of the service offered, along with budget revisions mean that chaplains in all areas of the NHS have to account for their place in the health care system.

Over the past five years there has been a gradual realization that chaplains need to say how they spend their time (e.g. utilizing the minimum data set), what contribution they make to the patient experience, their development through reflective practice and research, evidence to support chaplaincy practice, and the endorsement from chaplaincy bodies and faith communities of the Competencies and Capabilities document developed in Scotland (2007), which provides criteria with which to measure practice and practice development.

Yet there is no model or picture of the work of the chaplain by which members of the multidisciplinary team (MDT) can begin to understand

the method, process or outcomes of the spiritual (and where applicable religious) care.

So how are chaplains known? For some the clues come from the job description, for others it relates to being from 'the church' and doing 'godly' stuff. For many staff the chaplain is 'the last resort'.

If chaplains are to be known for the key work they do with patients, enabling effective spiritual care that has an impact on overall outcomes, they need to be able to describe their ways of working. To explore this, a group of chaplains – the South West Midlands Collaborative – have spent two years reflecting on their everyday practice and discerning a pathway that begins to paint a picture of activity and *outcome*.

Using the outline of theory development that enabled nursing to explore its roots and role (Fitzpatrick and Whall 1989), the initial task of the group was to discuss and explore the key building blocks of theological and philosophical understandings that shape the view of patient, health, chaplaincy and environment. The results of that first exploration brought out both theological and philosophical roots, as can be seen below.

### Person

- unique human being made in God's image, connected to family, friends, community and God
- sum of body, mind and spirit
- 'personhood'
- needing love and belongingness

### Health

- not about cure
- the integration of body, mind and spirit
- death is the ultimate healing
- being whole, wholeness
- healing achievable by all



- 'whose view is the right view?'<sup>1</sup>
- 'well staff' means 'well patients'

#### *Chaplaincy*

- holistic
- compassion
- vulnerability
- acceptance, forgiveness, empathy
- stillness and silence
- 'soaking up' or 'holding' situations, emotions and spiritual distress
- presence – being present
- a 'representative' of something 'other', making the 'other' visible
- bridge builder, safety net

#### *Environment*

- sacred space, holy ground
- illness had made the familiar landscape that was the patient into an alien one
- fear of the environment
- context
- who owns the 'environment'?
- alienation
- welcoming the stranger, radical hospitality
- asylum

It became apparent that these descriptions, while at the heart of their every-day work, were linked to the deeply held and sustaining narrative of their faith and personal spirituality, which was the meta narrative of the Christian

gospel (the group was for the most part Christian, with occasional attendance by the Muslim chaplain). The responses also gave credence to the motivation or drivers for the work chaplains do – a calling or vocation from God, rooted in God's love and grace (Ephesians 5:15–17).

They also acknowledged that they worked in three paradigms (pastoral, spiritual and religious), among three sets of people (patients, staff, and friends/relatives).<sup>2</sup>

Having set some key building blocks in place and explored where the care is rooted, the group moved on to discuss what they do – the intricacies of what happens at the bedside, in the ward, in a conversation with staff or a relative.

The process described moved through various stages, the first being 'encounter' with the person who has asked to see or has sought out the chaplain.

This initial 'encounter' phase was described as the testing out of the situation and the people involved:

'Extending my 'proboscis' and sensing – like a butterfly.'

'Sensing the situation – soaking up the atmosphere.'

'Making sense of the situation.'

'Asking myself – why am I here, what's the story?'

'Involves a greeting – and the look on your face and the look in your eyes.'

This initial encounter provides the bedrock of the chaplain's work and leads to 'relationship'. It is in the relationship phase that the work on discerning dis-ease is centred, or (using the language of the NHS) where an assessment is made of spiritual and religious needs.

From the group came such descriptors as:

'We work in a world of mystery, approach things through allegory and metaphor – able to say hard things and ask hard questions.'

'We pick up on language – word and symbol – touching on a common language.'

‘reaching out on a human basis.’

‘involves advocacy.’

‘Spiritual distress – in all its forms – but what is behind it?’

The relationship can be built in five minutes and can be as short as that – or can last for months – but in that relationship many issues are explored and questions raised for and in the chaplain as well as the ‘patient’:

- guilt
- anger
- tears
- loneliness
- fragile hope
- compassion – is this the outworkings of theological integration and pastoral expedient?

Two stories serve to elucidate the building of relationship:

#### Story 1: Loneliness

After a few moments, the patient said, ‘My daughter hasn’t spoken to me since I had the diagnosis of cancer.’

#### Story 2: On the edge

A lady with longstanding depression and low self-esteem struggles with her faith – God being distant and not hearing her cries. She has been experiencing herself as on the margins, an outcast – which is a totally negative image.

During guided meditation we explore life on the margins and are brought to reflect upon the margins of the fields left uncultivated for the poor to eat – spoken of in Leviticus and by Jesus. In the margins there is rubbish, excrement, vermin and pests, and wild animals, yet also food to be shared with the poor, outcast and lost.

If this lady finds herself placed in the margins, then it can be seen as positive, as a God-given role, living with the s\*\*t yet being able to give life through food and company to the poor and the outcast.

She found it a profoundly helpful picture and it has been a key part of her recovery – finding God in her experience of depression and being an outcast – perhaps finding meaning in a place with no meaning.

It is in the relationship phase that not only are spiritual, pastoral and religious needs discerned – but where the planning and intervention to meet those needs are formulated. To put that in the language of chaplaincy, this is where the ‘being’ comes into play – for often the only intervention needed is to be there – in body, mind and spirit.

Yet every chaplain comes to the patient with a tool box – a box that contains their knowledge and skills, developed and extended through experience and reflection. Skills that have been fashioned in the crucible of patient encounter, competence that has been honed in the fire of supervision and support, and the lifetime of prayer and formation that supports the use of all that has been learnt and experienced. That tool box may have varied contents (see box 1).

Faith	Bible
Hope	Prayer
Love	Reflection
Openness	Language
Vulnerability	Symbolic action
Self-awareness	Priestly role
Presence	Sacrament
Humility	Commissioned by God
Compassion	Self
Discernment	

**Box 1 Tool box contents**

The contents described by the group members once again link back to their personal faith and the meta narrative of the Christian gospel – yet much would reflect the tool boxes of those of faiths and beliefs other than Christian.

There is, however, another tool box – that of the patient – again built over time and containing the resources and learning that they have gathered, developed and lived through. When both boxes are opened and the sharing begins there can be those moments of deep connection that enhance the experience and provide a reconnection for the patient that mediates their spiritual or religious distress.

What happens when there is that ‘connection’ is that something is transacted. There is a shift in thinking, feeling, being, that has effects on the patient and the chaplain. Transaction occurs because the process is not one-way working with patients and has an effect also on the chaplain. This is perhaps the hardest part of the process to discern, for in it all there are greater forces at work than we can know or describe. The fruit of this work, however, is seen in the outcomes.

The outcomes need describing and translating. They may be described in religious language, or in spiritual or pastoral language – but that may not be understood by the patient or the MDT.

What the group discovered was that while they had made a note that the patient said ‘they were more peaceful’ or that it was ‘good to talk things through’, the chaplain had not been going back to see whether the peace lasted (e.g. did the patient sleep better), or if the talking had reduced anxiety (e.g. was the patient happier to talk about what had brought them to hospital with the other members of the caring team).

The identification of the outcomes of pastoral, spiritual and religious care are of little consequence in the wider picture of health if they are not evaluated and communicated. Once identified, the ‘outcomes’ are reflected on and their impact established for both patient and chaplain.

In reviewing the process of chaplaincy the main components are:

- encounter
- relationship
- transaction
- outcome and reflection

In relating that to the problem-solving cycle and the nursing process it can be seen that there is correlation with what chaplains do and with what other health care professionals do.

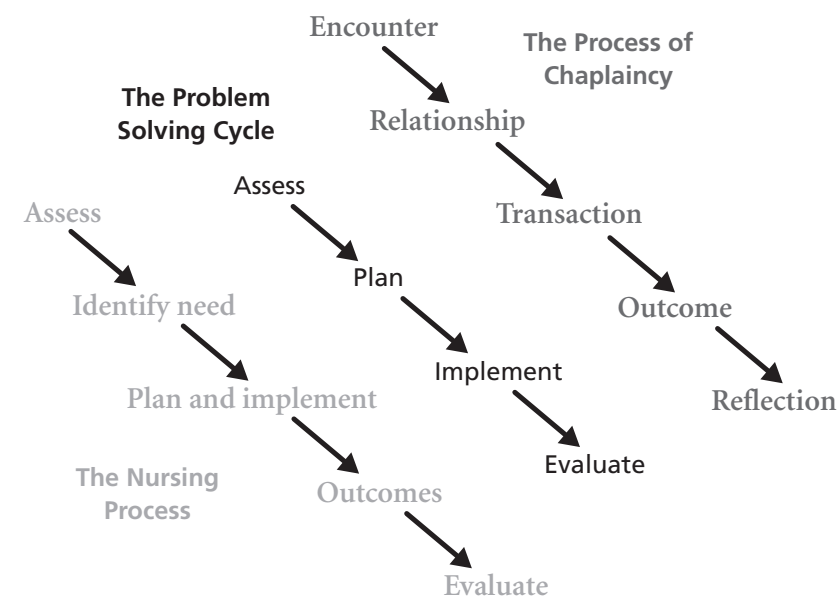


Figure 1 Chaplaincy in the context of the nursing process

Figure 1 is a linear representation, but when it is worked out in practice it is spiral in nature – in that the aspects of the process may be revisited over time, and the outcome/reflection will always lead to further encounters with the same or a different patient.

## Conclusion

This article gives only a snapshot of two years' worth of conversations that have taken place every 4–6 months. There is much that underpins the process in terms of theology and philosophy, much that motivates individuals to become chaplains, and much that sustains them day by day.

What is provided is a way of describing what the chaplain does, and how, while language and aims may be different, chaplains have a vital role to play in providing the pastoral, spiritual and religious context for that individual patient that can lead to identified outcomes that have a significant effect on the overall health of the patient.

Further work is needed to test these thoughts and ideas in different settings, along with discussions with members of the multidisciplinary team to continue the dialogue that exposes the contribution that spiritual and religious care contributes to overall outcomes.

### Acknowledgement

This work is ongoing and immense thanks are due to the Collaborative chaplains and volunteers who have shared their stories and, through patient reflection, have discerned a way of describing how they work.

### Notes

- 1 Moltmann (1985) cautioned that 'the ideas of "health" may not be necessarily "healthy"', supporting comments that the person's view of health for them may not be 'healthy'. This leads to questions like: whose health is it?
- 2 Throughout this essay the word 'patient' is used for ease of writing but could refer to staff, relative/friend.

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## How Does the Bombu Paradigm Fit into the Professionalization of Health Care Chaplaincy?

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### Abstract

The challenges that chaplains face when working in hospital settings are numerous. They include entering a patient's space, building a trusting relationship with someone that they've never met before, and providing care that is spiritually healing without setting oneself up as a super-human, capable of handling any situation. This article addresses some of the problems found in the professionalization of the NHS and, at the same time, offers a different kind of health care chaplaincy model which draws heavily on concepts and doctrines found in Pureland Buddhism.

### Key Words

Pureland Buddhism; Health care chaplaincy model; Grace; Relationships

### Main Article

#### Introduction

The concept of bombu nature and the associated principle of Amida are among the most significant differences between Pureland Buddhist and most Western and other Buddhist approaches to spiritual and pastoral care in the West. The bombu (ordinary, deluded being), embodying human frailty, is located in relationship to, and dependent upon, Amida Buddha (source of infinite benevolence). The implications of these concepts might lead to interesting theological reflections and study; however, in this article I am

interested in them as practical working concepts. How do these ideas fit into the professionalization of health care chaplaincy? And, furthermore, how can this paradigm help guide me as a Buddhist chaplain working in a hospital setting?

## The Two Paths of Liberation

In Buddhism, one approach to practice is to emulate the Buddha, and to declare only that which is beneficial because it belongs to the holy life and leads to liberation (Bhikku and Bhikku 1995: 63:9–10). Another approach is to be inspired and guided by the wisdom and compassion that permeates the Buddha's teachings (Urakami 1996). Both approaches begin with recognizing our limitations:

We are vulnerable; we are fallible; we are dependent; we are mortal; and we suffer. Furthermore, we do not like these facts. We flee from them. We hide them. We try to live as though they were not true. We want to look masterful, wise, independent, and to act as though our actions will go on forever. The approach of death cuts through all that. It offends our most cherished fantasies. It is a shock. How we respond to such a rupture of the fabric of our ordinary attitude is an indication of our faith. (Brazier D 2007: 27)

This understanding of the human condition has many implications. In accepting that we are limited and fragile beings we may find that we gain insight into the nature of all phenomena. Wisdom and faith are two ways in Buddhism that lead to the development of spiritual attainment but, depending on the approach that one takes, they will be called different things. In note 273 of the *Majjhima Nikaya* (MN) it says that there are two classes of individuals standing on the path of stream-entry:

'Dhamma-followers' (dhammanusarin) are disciples in whom the faculty of wisdom (pannindriya) is predominant and who develop the noble path with wisdom in the lead; when they attain the fruit they are called 'attained-to-view' (ditthipatta). 'Faith-followers' (saddhanusarin) are disciples in whom the faculty of faith (saddhindriya) is predominant

and who develop the noble path with faith in the lead; when they attain the fruit they are called 'liberated-by-faith' (saddhvimutta). (Bhikku and Bhikku 1995: 1212)

The attainment of liberation by faith was favoured and articulated as the superior path by early Indian and Chinese Buddhist masters, and then came into dominance in Japan during the twelfth century due to a monk called Honen Shonen. Influenced by the writings of Shan-tao, a sixth-century Chinese Buddhist monk, he began to teach a form of Buddhism that centred on devotion and faith in the saving power of Amida's vow – *I will not accept perfect enlightenment, unless when I attain Buddhahood, people of the ten directions who hear my name ... are able to fulfil their wish of being born into my land* (Urakami 1996: 29). In doing so, he founded the first independent Pureland school. In looking more closely at the historical development of Buddhism in Japan, we see this new paradigm beginning to take hold and gain popularity in the dawn of the Kamakura period (1185–1333):

while the traditional schools reassert the viability of the traditional path to enlightenment, Pure Land Buddhist thought presents a reversal of viewpoint wherein Buddhism is instead considered from the ground of the unenlightened person. That is, Japanese Pure Land Buddhism after Honen is not concerned with the kinds of issues that would traditionally have formed the core of a monastic program, such as rigorous meditation to identify and rid oneself of the mental afflictions that the Buddhist teachings define as the fundamental impediment to liberation, or study of the metaphysical implications of emptiness in terms of self and one's knowledge of the world. Instead, Pure Land movement at this time is directed to the refinement of a new orthodoxy of practice centred on the Nembutsu invocation ... But before this can be effective, each individual must attain a realisation of the fundamental truth that he/she is so steeped in karmic limitations that attaining complete enlightenment 'on one's own' is an existential impossibility. In other words, Honen's new paradigm begins with the premise that each believer has accepted their status as an 'ordinary person' Bombu, a term inclusive of lay and monastic, commoner and aristocrat, female and male. (Blum 2002)



Given the pessimistic aspect presented, it is understandable to ask the following questions:

- Is this a useful concept?
- How can such a hopeless view of the human condition be insightful?
- How can one provide professional care when one's own knowledge and capacity is limited?

Taking a glance at the current NHS model of health care from this perspective, one can ask whether the NHS paradigm is realistic. The standards that doctors and nurses have set often go unmet and, ironically, the motivation to achieve aims and objectives runs the risk of taking one further and further away from the actual purpose. Even when great effort is made to collect and measure the level of performance, it is often incomplete and imperfect. The National Institute for Clinical Excellence (NICE 2002: 33–8) recognizes that the registers can be incomplete; that clinical records are often incomplete; and that, in reality, data are often held in several databases, on paper or electronically, in different departments, even different organizations, or may not be collected at all. Is it possible for the NHS to provide accurate statistics to the public when so much relies on fallible humans? And, taken even further, if one accepts the impossibility of a complete and perfect model, then how much of the motivation for an infallible medical model is to give human beings a sense of control and security?

### Modern NHS Culture

In the West, professional health care chaplaincy and other disciplines have changed as the conditions in the UK, and the rest of the world, have changed throughout history. Cobb gives a brief historical overview of hospitals in Britain through to the development of the National Health Service:

Healthcare was increasingly a public matter that became subject to more regulation and control. The epidemic diseases of industrial society led not only to social reform but also to a greater state responsibility, particularly for the 'sick poor'. Alongside these political and demographic changes, medicine was developing more reliable

scientific knowledge and clinical treatments based upon research. (Cobb 2005: 3)

He explains that hospitals were originally set up by a religious spirit and ethos to care for the sick and then became increasingly secularized and professionalized to the point where social, economic and political factors, plus scientific methods, seemed to dominate most professional disciplines in the NHS (NICE 2002).

In the current climate, emphasis is placed on providing better service and improving the quality of care. The route to achieve this is by setting high standards, followed by the collection of data and measuring levels of performance to check and ensure that these standards are being met. Desirable outcomes are replicated, while clinical audits are done regularly in an attempt to assure the public of quality control. All these activities are seen as valid and effective in professional practice. This pervasive attitude has crossed over into the pastoral care arena and some health care chaplains like Peter Speck recognize this to be a good reason for chaplains to align themselves with this approach:

Some might argue that we should not align ourselves with the 'measure of everything' culture of the NHS. However, if some chaplains do not engage in this work other professionals will continue to examine this aspect of care, and may not be as conversant as healthcare chaplains are with the intricacies and sensitivities required in providing good, effective pastoral care. (Speck 2008: 11)

Others who work in professional health care chaplaincy, on the other hand, question the validity of these methods because many experiences in life that are unique and meaningful cannot be measured or replicated – like bringing life into this world at one end of the spectrum, with death and the dying process at the other. Furthermore, spiritual and religious practices that may be used to heal or support a person's recovery (such as mystical healing, prayer, invocations, expressions of love and gratitude, and many others) fall outside the category of reliable and valid data.

This raises even more questions:

- Does chaplaincy fit into a health care model whose framework is mainly to diagnose and treat?



- Is spiritual and pastoral care healing, without setting a target for a cure? Should chaplains be observing and measuring something that is different from other professional disciplines?
- Can chaplains be guided by the secular institution's governing body and remain true to their own faith tradition, beliefs and values?

The process and method of collecting and measuring data is often long and daunting. Nolan argues that not all chaplains have signed up for evidence-based research and practice, adding that this is just one more in an expanding set of increasingly professional demands that conspire to take them away from the real work, which is 'being' with patients (Nolan 2008).

The directives of the current professional health care community, if taken to the extreme, may lead chaplains to perform a narrow scientific exercise. Moreover, they may lead to specialized areas of work which exclude important features of real human contact and spiritual relationships. Dick makes a point in saying that religion has always been an anti-specialistic force (Cabot and Dicks 1936: 3), and Campbell stresses the danger of disconnection from religion as well as creating elitism out of expertise (Campbell 1985). If the minister is to counteract the evils of extreme specialism he must not become another specialist like the doctor or the social worker. His job is to focus attention on two points: the patient as a whole and the ground of his being in God (Cabot and Dicks 1936: 9).

## Healing Power of Amida's Grace

The bombu concept acknowledges the flaws and corrupt nature, not just of individuals, but of anything created and organized by humans – even professional disciplines are limited, imperfect and dependent. Who are we to look to if we know ourselves to be fallible and corrupt? Shan-tao and Honen answered these questions using scriptures and Buddhist doctrines:

Amida Buddha had made his vow out of his compassionate desire to save precisely these people. Shan-tao further emphasised that those who recognised themselves as ordinary, deluded persons could *especially* enter Amida Buddha's Pure Land. As he states in his *Commentary on the Meditation Sutra*:

'The Buddha extends his great compassion toward those who are suffering most. Amida Buddha pities and cherishes especially those who are bound by delusion. Therefore he welcomes such people to his Pure Land. If he will not save one who is actually drowning, why should he save one who is relaxing on the river bank?' (T. 1753, 37:248b; JZ. 2:6)

Thus Shan-tao regarded deluded, helpless persons as the special objects of Amida Buddha's compassion and the proper recipients of his teaching. (Jodo Shu Research Institute 2005)

The universal or the limitless is something that is beyond reckoning:

The name of Amida means 'without measure'. Amida Buddha is the infinite Buddha; the archetypal Buddha, the experience of Buddha that is always available to us. The *-mida* part of Amida's name is related etymologically with the word metre, and the *a-* prefix denotes a negative. *Buddha* means awakened or enlightened, the state in which the clouding of perception that self-preoccupation creates has dropped away ... Amida Buddha is thus an embodiment of the universal or the limitless. (Brazier C 2007)

The act of calling out to something that is wholesome and loving will be the same whether the object is called God, Allah or Buddha. If we recognize the longing to call out for help to something greater than oneself as a spiritual need, can we predict how this spiritual need will be met?

## Case Studies

To illustrate the effective power of this paradigm in the work that I do as a health care chaplain, I have used two different case studies.

### Case Study 1

John and Mary are two members of a Buddhist community. After trying for a baby for several years she finally became pregnant with twins. They were delighted at the prospect of having not just one baby but two. At twenty-seven weeks, Mary's waters broke and she was rushed into hospital. The babies were born three months early, the boy was 2 lbs 4 oz and the girl was 1 lb 15 oz. They needed 24-hour care, plus the medical expertise to keep them alive. Full of fear, Mary called on her Buddhist community for support.

As soon as I received the request, I went to see Mary at the hospital. She talked about many things including an account of her journey in the ambulance. Through the window of the ambulance she could see the moon and was reminded of the Bodhisattva (awakened being) of compassion who is represented by the full moon and whose Chinese name *Quan Shi Yin* means 'the one who hears the cries of the world'. Then she took me to see the twins who were in individual incubators.

From when their twins were born John and Mary requested a Buddhist blessing. The blessing service that we did together gave John and Mary permission to see their babies as they were. We started the blessing by invoking the Bodhisattvas, and chanting the Buddha's name. I welcomed the babies into this world, and then gave room for the parents to say some words to them. All three of us were full of feeling as we brought the blessing to a close by chanting *Namo Quan Shi Yin Bosat* or 'I call on the all compassionate one'. In blessing them, we acknowledged the preciousness of their birth into this world as well as wishing them protection, and salvation, when their lives come to an end.

In this incident, the health care model that chaplains are offering is a healing and supportive one that works alongside vital medical care but is open to any possible outcome. It might include assessment, diagnosis and evidence-based research; however, the chaplaincy model doesn't require these. What it requires is faith in a gracious universe, and the ability to be bombu in the presence of another bombu.

The bombu paradigm in this context is useful for the following reasons:

- 1 It places Amida as something that one can call out to, and rely upon during times of crisis and emergency.
- 2 It strengthens faith and trust in universal, unconditional love.
- 3 It recognizes and supports a spiritual practice that fosters people's courage to express their faith.
- 4 It allows the chaplain to be human and feel the emotions that come naturally and spontaneously with every situation.
- 5 In the chaplain's ability to trust Amida, one can then openly show that one is moved and touched.

- 6 It accepts one's limitations, but rather than fleeing from a situation, it allows one to remain steadfast in acting sincerely and compassionately.
- 7 In acknowledging one's own fragility and dependency on conditions that are out of one's control, we can appreciate the preciousness of the situation.

## Case Study 2

On one of my visits to a mental health unit, I saw a group of patients sitting together in silence and so sat with them and introduced myself to them. One of the patients then turned to the others and asked if they were interested in the spiritual space that I was offering. Everyone looked down as I waited. Then, after a long pause, two other patients started to nod and so the four of us rose to find a room that we could use.

They suggested we make use of the smoking room off the lounge. When the initial chitchat came to a natural pause, I asked one of the women how she was doing. She opened up and said that she wasn't very well. She had been feeling very low and explained that one of the patients on the ward, just 19 years old, had taken her life the day before.

The second woman thanked her for her opening up and sharing how she was feeling because she, too, was feeling low and anxious. She was worried that she might take an overdose in order to numb her pain, but without intending to, killing herself as a result. The third woman kept her head down as she asked me to pray for them. They explained that they weren't church-goers but had been brought up in the Church of England, and as all three opened up more and more, I found myself facilitating a group-sharing, which included some stories from their past, and fears about their current situation. I then read a prayer that my Christian colleague had given me to use. There was a moment of silence followed by all of us sharing stories and memories of the young woman.

After the session, they expressed their gratitude and became more animated than when I first saw them. They all said how important and good it felt to do something for the young woman.

All three women had a different story to tell, yet what united us was the need to share and to pray. We (I include myself as I also worked with this patient) came together in a meaningful way to collectively remember and pray for the woman who had died, as well as for ourselves.

Here the role of faith and concept of Amida was useful for the following reasons:

- 1 It enables the chaplain to enter a space without knowing what will happen.
- 2 In trusting that Amida is supporting everyone unconditionally, the chaplain can then reach out and fulfil a role for the patient (or patients) in an appropriate manner.
- 3 One can use prayer and other spiritual practices to assist healing.
- 4 It can help patients who feel vulnerable and isolated to connect with others who feel the same.
- 5 This paradigm can provide conditions where human beings can feel their way into a trusting and respectful relationship.
- 6 It creates a strong sense of love between two strangers that can go beyond most medical interventions.
- 7 It acknowledges death and the complex reactions that we have when we encounter it in our lives.
- 8 In trusting the process and entering without knowing all the factors, the chaplain can avoid acting in pre-programmed or formulaic patterns.

Marion Carson writes that part of good pastoral care is to be able to recognize one's limitations and gifts and to act accordingly (2008: xxiv). In these two examples, we see how the concept of bombu is about recognizing our limitations and how the associated principle of Amida helps the chaplain to act appropriately and confidently despite our predicament. The trust in Amida, from one who recognizes his or her own fallibility, can bring much more than merely caring qualities such as compassion and acceptance. It can also give the chaplain strength to make encounters with another person, and to be with them as real human beings, the objective of pastoral care.

When compassion is present and we are able to really listen to the other person, often the experience is of feeling moved. With permission to be affected by another person's story, both lives are transformed in a way that is mutual and loving. The questions that arise from this paradigm are:

- How possible is it to provide this sort of compassion if we too are bombu?
- Is there an element of the chaplain playing the role of Amida Buddha for the patient, even if she knows herself to be bombu?
- Can a bombu really hear and feel empathy, or experience fellow feeling towards another bombu?

Hanada-Lee stresses the importance of acknowledging one's own pain:

Hearing of another person's pain evokes sympathy. We hear of someone's mother dying, and our affinity and association to their loss and grief develops. If death has touched our home, and it probably has, we begin to remember our own experiences. Hearing another person share the pain evokes even stronger emotions. We not only remember the facts of our own experience, we begin to remember how we felt, and we hurt all over again. The relationship between two people can be healing and transformative especially when we can open our own hearts and listen to our own grief. (Hanada-Lee 2006)

## A Bombu Health Care Model

The reality for patients and staff is that they are suffering from many things, whether it is from birth, old age, sickness, death, being in hospital away from the comforts of their home, being separated from their friends and family, being unwell, or feeling vulnerable and fragile. Through the task of listening, the chaplain needs to go beyond empathy into understanding the universality of the fundamental existential suffering of the other, in order to truly provide genuine, spiritual support.

The bombu paradigm offers a different kind of health care model for chaplains. It is a framework that operates on many levels and rests on a supportive foundation. On one level, one feels accepted just as one is, and so is able to look at oneself and one's actions honestly. David Brazier writes that our ability to do this eliminates any tendency towards judgementalism. When we have done some inward reflection it is apparent to us that we ourselves are imperfect in many ways and we are then disinclined to stand in judgement, even in subtle ways (Brazier D 2007).

On another level, it meets a religious need in us to call out to that which

is immeasurable and to continuously look beyond ourselves for love, acceptance, and support. And on an analytical level, it can be used as a theory to analyse and understand any given situation.

The bombu paradigm can influence the orientation and objectives of the Buddhist chaplain within professional health care chaplaincy. This paradigm starts with the recognition that human beings are limited and vulnerable, and asserts that the practitioner is accepted and supported by Amida Buddha. This trust or faith in an infinitely wise and unconditionally loving Buddha creates a system of thought that sees compassion, transformation and healing as available to ordinary people.

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## Supporting Staff at the Birmingham Children's Hospital

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### Abstract

Working in an acute care setting, and in particular in paediatric care, can be draining on every level. Chaplaincy can provide a lead in offering support to staff, encouraging them to look after their own needs as well as those of the people around them. A grant of money for one year allowed us at Birmingham Children's Hospital Chaplaincy to develop what we are doing in the area of staff support: guided meditations, art sessions, retreat days, a Christian retreat to Holy Island, developing a staff choir, as well as ongoing one-to-one support.

### Key Words

Self-care; Well-being; Meditation; Retreat

### Main Article

Working at the Birmingham Children's Hospital (BCH) is often described by staff as rewarding and fulfilling, more than just a job – a vocation. However, attending to the needs of children and young people who are sick, and at times critically ill, and to the needs of their families, can be demanding and emotionally draining work. Our spirits can become depleted. Spiritual needs become related to physical needs as overstretched bodies show the signs of wear and tear.

It becomes crucial to understand self-care and self-awareness as intrinsic to the professional care that we give. To use a simple analogy – we're good at pouring out tea for others, who is filling up our cup? We cannot give out to others endlessly unless we are being filled up. Do we know what we might be asking for? Are we aware of our own needs? Can we reflect on the essentially

spiritual question: what restores my natural connection with the wonder and energy of life?

Often those who are compassionate and caring – whether it be in a faith arena or in a more secular environment – struggle to prioritize care for themselves. Within a Christian culture, we may have to re-examine our understanding of such texts as 'If any want to become my followers, let them deny themselves and take up their cross and follow me' (Matthew 16:24) and ideas we might harbour that giving oneself attention and care is selfish, self-indulgent or sinful. Loving God, loving our neighbour and loving *ourselves* are closely linked by Jesus (Luke 10:27–8) and bound up with one another. The ascetic Antony of Egypt (c.251–c.356), wrote:

He who knows himself, knows everyone.

He who can love himself, loves everyone.

Caring professionals from all faiths or none can neglect or undervalue themselves as people deserving care. And yet, unless we develop our means of restoration and rejuvenation, there is a real danger of stress-related illness and burn-out, made evident to me in one-to-one pastoral conversations that I have had.

The Boorman Report (Boorman 2009) recommends that 'all NHS organisations provide staff health and well-being services that are centred on prevention (of both work-related and lifestyle-influenced ill-health)' and that training in health and well-being are essential to leadership development. Chaplaincy can offer a lead in the important aspect of supporting staff and helping them to support themselves. In my role as one of the chaplains at BCH, a grant of money allowed me an extra six hours a week to develop this work over a 12-month period.

### Meditations

Within an acute hospital, staff often operate at an unrelenting pace, but they do theoretically have a lunch break! Within chaplaincy we decided to advertise a series of 'meditations for relaxation' and invite people to the Chapel for a lunchtime session. There were mixed feelings about using this venue, as some felt that the Chapel should be used solely for prayer and Christian reflection, and some wondered if the Chapel was an environment suitable for

welcoming people of different faiths or none. The benefits were that the Chapel holds its own peace which aids meditation, and is entirely different from clinical spaces in which staff are normally working. On balance, we decided to offer further meditation sessions in the Education Centre, creating an atmosphere of peace and tranquillity by dimming the lights and placing a visual focus of flowers or coloured fabric in the centre of the circle of chairs. In small ways, we tried to offer a welcoming and supportive space for people. They were invited to withdraw from their usual duties and activities over their lunchtime break and become resourced through the meditations. Practising mindfulness leads people to value being and not doing or striving all the time and to become attuned to the signals and sensations of their own bodies. Some people were anxious that interrupting the rush and pressure of an ordinary working day with meditation practice might bring them to a crashing halt and they might not be able to get up again! However, those taking part in the sessions found that bringing their awareness into the present moment refreshed and renewed them for the remaining tasks of the day.

I have led these sessions alternately with the volunteer Buddhist Chaplain, Kelsang Leksang. We offered distinctive but complementary approaches, using stilling and centring exercise and visualizations. Mindfulness meditation provides an approach to spirituality irrespective of religious affiliation and has been shown to reduce stress (Greeson *et al.* 2011). We have organized three series of meditations running for six weeks over the course of the year.

The question, 'Did you find the sessions helpful and, if so, how do you feel you have benefited?' received the following responses:

'I found the sessions very helpful. They provided an opportunity to relax in an otherwise stressful job.'

'Yes – lowered stress levels – able to focus my mind and then go on to have a productive afternoon.'

'More able to work through day, with other people in a relaxed, understanding way.'

'Relaxation and energy or inspiration for the day ahead.'

At the close of our most recent series, members of staff said that they would like to attend sessions every week, and also commented on how a room which was a restful space within the hospital would be a great aid to well-being.

## Art Sessions

Working closely with the hospital Art Department, we also offered an art for relaxation series for staff, running for six weeks during the noon hour. Members of staff were invited to attend one or all of the sessions. During each session we offered a simple craft idea which enabled people to relax and allow their creativity to flow freely. With their hands and minds occupied in this gentle way, the conversation and spirit of mutual support and care quickly developed within the group.

## Retreat Days

The receptiveness of staff to the meditation sessions led us to build on what we were doing and offer five individual retreat days organized between September 2010 and May 2011. Having been successful in our bid for money with the Department of Health Paediatric Palliative Care Fund, three of these retreat days were aimed at a wider network of staff working in palliative care; two of the retreats were open to BCH staff only. The Woodbrooke Quaker Study Centre in Birmingham provided an ideal setting for the retreats, being within easy reach of the hospital, but offering a beautiful, tranquil and green space for us to withdraw into from the pressures of urban life. The days were advertised as non-religious, and open to any member of staff, to consider ways of managing stress, to explore spiritual and personal development, to think about approaches to life and work, and to promote well-being. The beautiful surroundings of the Woodbrooke Study Centre and the excellent food contributed to the overall aims of the day. Most of the participants gained study leave from work in order to attend (and were not required to take holiday time) and were financed by their departments. The places were subsidized by the Trust and the Palliative Care Fund.

Exercises in meditation, mindfulness and relaxation were incorporated into each day. Input was given which led people into periods of quiet and individual space, to try exercises in self-reflection and to consider their



patterns of living. Each day held its own particular focus, with leaders contributing from the areas of music therapy, art therapy, psychotherapy, and reflective practice.

The following comments are some of the responses to the evaluation question: What would you consider the most useful part of the course?

‘Time to reflect and to be able to take this back with me.’

‘Relaxing and learning about yourself and allowing to relate to inner self.’

‘People affirming, life affirming approach and atmosphere, whole emphasis on creativity.’

‘It made me slow down and think about how things are. It made me remember some things I used to enjoy doing that I don’t find time for any more, including some aspects of nursing. The approach of being able to take part in a session or listen at the side doing art work was good.’

There was general agreement, as people reflected on the days, that their teams and departments would benefit from this kind of input and they hoped that opportunities would become more widespread in the Trust.

### Holy Island of Lindisfarne

The Chaplaincy also offered our first extended retreat in June 2011. The senior chaplain, Revd Paul Nash, and I led a Christian retreat for four days at the site of the Holy Island of Lindisfarne. Seven people travelled up to Holy Island in a hospital minibus to the retreat house of the St Aidan and Hilda Community of Lindisfarne. Under the banner of ‘Finding Space to Be’, we offered some guided sessions and some free time to enter into the history and beauty of the island and explore themes around being sustained in work, prayer and self-development. We had opportunity to enter into the broader rhythms of worship on the island, and to make space to listen to ourselves and to God. The Celtic understanding of the Spirit weaving in and through the ordinary patterns of life offered us a foundation for exploring the balance between work and play, activity and leisure, doing and being. The success of our trip has given us confidence to think more concretely about a multi-faith pilgrimage to Jerusalem.

### Choir

In the early part of my ministry at BCH I gave a Trust-wide invitation for staff to join a choir, no auditions necessary, but to gather simply to share the joy of singing and to prepare for the Chaplaincy Christmas Service. We have since sung at the annual Memorial Service, and at other events around the hospital. Members of the choir enjoy the rehearsal time leading up to these events as an opportunity to meet with others in a relaxed and informal way and to share our own form of music therapy. A half-hour break in the usual hectic routines of the day is manageable for most people and provides a welcome and refreshing change.

The choir does not run every week of the year. Offering rehearsals leading up to key appointments allows us to take breaks from the singing and to return enthused for another project. Some staff members have felt free to join the choir for one event and then take time away from the choir, depending on their work schedule.

Coming together for a group-focused activity builds relationships and often leads to a deeper sharing of personal and work issues with staff members. The one-to-one pastoral support of staff continues to be an important strand of our work as a multi-faith team.

### Final Reflections

Promoting well-being and self-care can be an essential part of what chaplaincy offers within a hospital setting. Meditations and retreats, a staff choir and lunchtime art sessions, as well as one-to-one support, are some of the ways in which we have tried to create space for people’s spirits to breathe and even dance and to find restoration in the midst of the demanding work undertaken at the Birmingham Children’s Hospital. One of the principles we have followed is that it is better to try things and be willing to abandon them if they do not catch people’s imagination. We have also worked with the model of offering sessions in blocks, in order to take breaks and to refresh ourselves for something new or to return again at another time. Offering a lead in staff support and spirituality inevitably brings us back to our own self-reflection and an examination of our personal patterns of working, resting and recharging. Our words and services will become hollow if they do not flow out of a life lived differently.

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## Boundaries and Health Care Chaplaincy

**Revd Bob Whorton** is chaplain at Sir Michael Sobell House Hospice, Oxford.

### Abstract

Understanding boundaries in chaplaincy work means attending to soul in addition to psychological theories. This soul work is part of our professional identity. Four 'relationship positions' are outlined – merged, separated, ambivalent and connected. We need the courage to reflect on the movements of our soul with regard to our boundaries in order to be effective and safe practitioners.

### Key Words

Boundary; Child-self; Circle; God; Professional; Reflection; Soul

### Main Article

As chaplaincy embraces a true professionalism, the question of boundaries in our work calls for our imaginative exploration. We simply cannot do the work we do without an appreciation of our power, our vulnerabilities and our limits. Our boundary is an invisible edge around us, like the frame which contains a painting, or a large circular wall which keeps the city safe. What happens when the circle of our self comes into contact with the circle of another person? This obviously takes place constantly in our work, but in our day-to-day busy-ness we do not normally question what is happening. Only when we give time to reflection are we aware of the often powerful forces at work. This reflective time is not 'navel-gazing'; by attending to soul (and boundaries have much to do with soul, as I hope to demonstrate), we become more effective practitioners.

I have come to realize that my relationship with my child-self has a direct impact on my work as a hospice chaplain. In imagination, a while back now, I glimpsed a powerful picture in which I was pulling my child-self behind me

in a box, which was rather like a coffin. He was not too keen on this. When I can allow this self to come out of the box, so that he can speak to me and so that I can put my arms around him, something is freed up in my work with patients, relatives and staff. There is a release of energy. I believe that this relationship with the child-self, or perhaps even the baby-self, has an important bearing on boundaries in the here and now.

We need the courage to explore with one another some of the reasons why our boundaries may either slip or become too strong. How do we hold on to our 'calmly held boundaries' (Rohr 2003: 23) when we are under immense pressure? This investigation may well involve touching our earliest experiences, because this is when some of the basic structures of our being were formed. And it will also mean a soul-full and religious approach, because this is part of our identity as chaplains.

Most of us in chaplaincy learn about the theory of boundaries from the worlds of psychology and psychotherapy, and in what follows you may find yourself thinking about the attachment theory developed by John Bowlby, or the object relations theory of Melanie Klein. In fact, the springboard for my thinking on boundaries was a book written by a voice coach, Patsy Rodenburg, who noticed how certain actors could engage an audience powerfully and effectively while others were not able to connect at all. In her inspirational book *Presence* (2007) she describes three very different 'circles of energy'. Having read this book, I found myself musing about different 'boundary positions'. I suggest there are four fundamental ones. In what follows I invite you to identify with the 'I' in the narrative and reflect on what resonates or does not resonate with you.

### Position One: Merged

The first position is one in which there is actually no boundary. It is represented by one circle placed over another so that there is simply one circle. It is a place of blind unconsciousness. I cannot see myself clearly in relation to the other person because there is no objective 'I' with which to see myself. I am completely merged with the other. I am you and you are me. This is how the world appears to the baby and very young child.

Position one is a state of dependency. I cannot exist unless you hold me in life. If you go away I will certainly die. You will meet all of my needs, and I will meet all of your needs, and we will put up our barricades against the

world. We do not need *them* for *we* are more than enough. In this position I need love. I need to know that I am OK, and that I am good. I cannot believe these things on my own. You must tell me and show me, and even sacrifice your life for me so that I can know I am loved.

Here there is no awareness of a bigger circle, the circle of God's love, because in effect the other person is God.

When we listen to another person, some of us will feel the pull back to this position. I certainly do at times. There is in us a yearning to be perfectly loved, to belong, and to be united with a wholly loving other. Unconsciously, we may see the person we are caring for as someone who can meet that need. We wish to merge with the other person – to be their friend, lover or mate, with absolutely no distance between us. This pull can come from different places – from within ourselves or from within the other person (and most powerfully, of course, from within both of us). There is a desire for differentiation to be overcome. If we allow ourselves to be led by this desire we will not be helpful to the other person. Objectivity and perspective will be eroded, and ultimately we will become two drowning people who cling to each other.

Some clues that we are in position one might be:

- I feel special in your presence.
- I spend longer than I intend with you.
- I want to rescue you.
- You powerfully enter my inner being and fantasy life.

### Position Two: Separated

The second boundary position is represented by separate circles. I see myself as completely independent and understand this to be the natural state of adult being. I can look after myself, and I certainly do not need you to make my world complete. But behind this self-sufficiency may be an experience of rejection. I retreat from you in my fear and you retreat from me in your fear. I have been hurt by you and may be hurt again, so I keep myself safe. I look at you from my isolated vantage point and communication consists in shouting over a wall. I do not really see you any more. If I do look at you I see difference and this makes me even more afraid. Instead of strangers I see enemies.

I may also feel very lonely, because I cannot touch or be touched. This position is the exact opposite of the first. It is the experience of the young child who is not fully attached to the ones who care for her or him.

In this position I need safety and space. I am bombarded by the concerns and needs of other people. I just want to escape and to be left alone. I may feel that others are trying to change me, manipulate me, or threaten the very core of my being, so I run from them into the safety of my own world. At times I may come close to you and look over the separating wall. I may try to communicate, but if I sense any threat at all I will scuttle back into the safety of my shell.

In this position there is little sense of the encircling presence of God, because fear is all-pervasive. God and fear don't mix well.

When we listen to another person we may retreat into this position. We may be physically present to them, but in reality there is a gulf between us. We cannot truly meet this person. We cannot be with them. The powerful desire is to distance ourselves from the other person because they threaten us in some way or are different from us. We hurriedly build a wall between us. Silences are not pregnant or potentially wholesome, but rather defensive and barren. Communication is uneasy and stilted. The process of talking and listening simply does not flow. The desire for distance may originate in ourselves, the other person, or in both of us.

Some signs that we are in this position may be:

- I *really* do not want to visit you.
- I am not listening to you.
- I experience fear when I think about you.
- I think you hold negative thoughts about me.

### Position Three: Ambivalent

This position is represented by connecting circles, but where the circles intersect, the lines are dotted. This is a place of profound uncertainty and inner confusion. I simply do not know where I am. At one moment I seem to be very close to you, and the next I have been discarded. I do not know what to feel. At first I was able to trust you, but now I am not so sure. I do not know the rules which operate here. If I try to be 'good', that does not seem to

change anything. And if I try being 'bad', that makes no difference either. Sometimes I am close to despair.

This is the state of the baby and young child who cannot trust the care which is offered because that care is experienced as being inconsistent. And so, when all strategies to find consistent love have been exhausted I retreat within myself. It's not worth it. I will never be able to win.

This is a state of mistrust. At least in the separated position I know where I am. I know who the enemy is! In this state I do not know who are the 'goodies' and who are the 'baddies'. Consequently, I trust nobody. In this position I desire the truth. I want you to stop the ambiguity, the sickening swings of behaviour. Just let me know where I am and what is true.

Some days God shines on me and I know the warmth of his love and power. Other days God is distant or I'm not sure that there is someone I can describe as God.

When we listen to someone from this position we will be drawn to someone and repelled by them in equal measure. At one moment we will feel trusted with intimate secrets, and the next moment we strike a defensive wall. I find myself wanting to offer a precious insight of my own, and then the next moment I want the conversation to be over and I never want to see the person again. Or one day I will find everyone is wanting to see the chaplain and the next day I find only closed doors. I will forever wonder whether I am 'in' the organization or 'out' of it. This may well sum up the position of a chaplain working in a health care organization.

Signs we are in this position may be:

- I am not sure I can trust you.
- My thoughts and feelings change rapidly.
- I am confused when I think about you.
- I love you and hate you at the same time.

### Position Four: Connected

The fourth boundary position is represented by overlapping circles. This is the state of adult consciousness. I am defining myself as a human being in relationship with other human beings. Through playing with different roles in life and working at relationships, I slowly find the ground on which I can

stand. This can be quite a revelation. I did not think I could feel as safe as this or as confident as this. I enjoy talking to you and listening to you. I reveal myself to you and you reveal yourself to me. There is a mutual vulnerability which paradoxically feels very strong. In this position I learn to hold the tension between intimacy and distance and find to my surprise that I can hold these contradictions. I can move towards you and share the most beautiful heights and depths, but I can also be separate from you and, to my amazement, this does not feel like abandonment or rejection. I know that I am loved even when I am at a distance from you.

This position is a demanding one to stay in, and it requires trust. I trust you not to overwhelm me or reject me. I trust that this connection, which seems fragile at times, is able to hold us. I trust that what you give me, imperfect though it is, is enough for me and what I give you is enough for you. There is joy and pain because our lives touch.

Position four is a state of connection, and in our chaplaincy work the circles will intersect at different points. When I am gently challenging a theological student on placement in the hospice, the overlap may be quite small; and when I am listening to a dying patient, who honestly and painfully tells me the story of their life, the overlap will be much larger. We learn to connect differently according to the situations we are in.

And we discover that we are held in a Love that is bigger than us. The connected circles are contained within a larger circle which we call God. We know ourselves to be held in something bigger, deeper, beyond ... In addition to the primary boundary of the self we discover a secondary boundary, which is the circle of God's love. Then the text 'in him we live and move and have our being' (Acts 17:28) is more than rather nice words; the words become lived experience.

Signs of being in this position are:

- I do not have to please you or prove anything to you.
- I am empty of expectations.
- I do not have to fix you.
- I do not need you to meet my needs.
- I know I am held in the circle of God's love.

## Conclusion

We know from our experience as health care chaplains that we must aim to stay connected in position four – which is the place of balance, wholeness and spiritual vitality. We believe this is the place we 'ought' to inhabit. And when we become aware that we are being pulled towards the merged position or the separated position, or stuck in ambivalence, we may become worried. Instead of thinking to ourselves, 'this feeling of attraction (or repulsion) is *interesting*', we may be tempted to say 'this feeling of attraction (or repulsion) is bad'. This immediately closes down the inner conversation. To feel these inner movements of the soul is neither good nor bad. I believe that what we are experiencing is frequently our child-self talking to us. S/he is inviting us to take this 'evidence of the soul' seriously, and to work with it. What am I experiencing which comes from my inner world, what is emerging from the soul of the person I am listening to, and what is an amalgam of both? Awareness is the key to everything in the listening relationship – truly seeing what is happening on the surface and under the surface. And when we take our reactions into our own playful, imaginative reflection (Whorton 2011) and into our supervision, we increase that awareness.

Finally, let me underline again the importance of attending to our boundaries in terms of our professional development. The UK Board of Healthcare Chaplaincy contains the following statement about boundaries in its Code of Conduct:

Boundaries enable the effective functioning of caring and supportive relationships in which healthcare chaplains can respond to the spiritual and religious needs of those in their care. Boundaries frame behaviour and practice so that pastoral relationships are consistent and their limitations clear to all parties involved. (4.1)

The Association of Pastoral Supervisors and Educators offers a definition of Pastoral Supervision (Leach and Paterson 2010: 205). It contains the following:

Pastoral Supervision is ... attentive to issues of fitness to practice, skill development, management of boundaries, professional identity and the impact of the work upon all concerned parties.



By reflecting imaginatively, non-judgementally and playfully with our boundary positions we will grow in our work.

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## Book Reviews

### Spiritual Care for Healthcare Professionals: Reflecting on Clinical Practice

By TOM GORDON, EWAN KELLY and DAVID MITCHELL

Radcliffe Publishing, London, 2011

Paperback, 162 pages. ISBN 978-1846194559. £24.99

This is a well structured and engaging book, and will be a boon to those chaplains wanting to offer their colleagues a way to widen their understanding of spiritual care. Its authors, all well-known figures in UK chaplaincy, have set out to fill a gap between the tidy statements of health care policy documents and the realities of practice. Through a logical progression of self-awareness, consideration of context and theoretical unpacking, the book takes the reader on an enlightening journey. Along the way case studies and reflective exercises draw the health care professional into an active examination of the part they play in spiritual care. It is a book that manages the difficult task of addressing the twin audiences of chaplains and other staff involved in patient care.

The second part of the book builds a comprehensive picture of how spiritual care can be done effectively in practice. The chapter on assessment is a clear and helpful summary of the key issues and provides a useful review of some existing tools. Wisely, the authors do not advocate a slavish use of assessment templates but encourage the development of informed and skilful approaches that draw on models as resources and are matched to each unique situation. As they do throughout the volume, the writers draw on their extensive experience to combine professional insight, case-study reflection and poetry to enable the reader to see the potential for a varied and creative spiritual care. This is chiefly what makes the book so valuable for those working alongside chaplains in health care. Reading this, we glimpse in greater detail the difference that touch, attentive listening and formal rites can make to those who are ill.

The chapter on loss, grief and bereavement captures the breadth and

impact of an experience which transforms the lives of people. Seeing 'loss' in broad terms, the chapter invites the reader to reflect on the consequences of absence. The consideration of professional uselessness in this situation is astute and important. We all know how safe it can feel to have new hope to give – fresh treatments to do, or novel procedures to start. Sticking with loss can be one of the most terrifying things we are ever asked to do. The decision to place the chapter entitled 'Nurturing our spiritual selves' immediately after the chapter on loss enables the book to model the kind of thoughtful spiritual care it so effectively advocates. The volume ends with two chapters focusing on staff and institutional support and the chaplain's place within both topics.

My only quibble with the book came in the central chapter entitled 'Disentangling spiritual and religious care'. This is an unavoidable discussion for a book like this, and the chapter deals directly with a question of classification which often perplexes those working in health care. Recognizing the difficulty of the task, and the need to frame this in an accessible way for health professionals, the authors have opted for a clarity that cannot be wholly justified by experience or wider literature. For example, the statement that religious people will have 'relationships, activities and connections other than faith-related ones' appears to assume an unreasonably narrow definition of what it means to be a person of faith. There is the risk, too, that the chapter succumbs to the popular pull of 'spirituality good, religion bad'. Perhaps this chapter teaches us that disentangling religion and spirituality is too ambitious a goal: we may simply need to have a better grasp of their entanglement.

I enjoyed reading this book, and shall include it as essential reading for students studying chaplaincy and also draw on it to support staff education. Only today I have recommended it to a manager who has just taken on the responsibility for chaplaincy services in a local Trust. It offers a rounded introduction to spiritual care and will be invaluable for anyone wishing to gain a rounded insight into the place of spirituality in contemporary health care.

**Revd Dr Chris Swift**

*Head of Chaplaincy Service, Leeds Teaching Hospitals NHS Trust*

## **Supporting Dying Children and Their Families: A Handbook for Christian Ministry**

By **PAUL NASH**

SPCK, London, 2011

Paperback, 192 pages. ISBN 978-0281060054. £14.99

In the Birmingham Children's Hospital about four children die each week. Paul Nash is senior chaplain there and it is out of this immense pastoral responsibility that he has written his very moving book.

All ministers, and many lay people, are experienced in supporting the dying and the bereaved, but the death of a child (often after a period of increasing illness) requires remarkable pastoral strength and skill, qualities which shine through the writing of this difficult and harrowing book.

Nash looks at the experiences of children who know they are dying, and parents who watch as their child dies. He sets out stages in a care pathway such as end-of-life rituals, funerals, literature, continuing support and invitations to annual events. His theological reflections on death and dying are important and helpful, but I found occasionally that they did not plumb the depths that I would have appreciated. In particular, a section on biblical reflections was sometimes in danger of skating over issues. But I could not fault his pastoral sensitivity and reflective insights.

In a helpful chapter, 'Preparing to care', Nash looks at skills, attitudes, knowledge and ethics, and it is a model for anyone preparing for pastoral ministry. I have not seen more clearly set out some of the temptations in caring, such as pat answers, an unhealthy exercise of power, and fear.

One of the strengths of the book is that it is filled with responses by parents to their experience of bereavement and of the care (or lack of it) that they received. The stories are deeply moving both for the profound anguish and grief they eloquently express and for the shining courage the parents are at times able to express. If I had found myself in the situation that they had experienced I am not sure I could have written as they have willingly done.

There is a useful section on spiritual resources, in particular some outside traditional liturgical practices, such as the distribution of heart-shaped pieces of confetti. I would have to say that, while I would not feel drawn to using this, Nash makes an appealing case for the practice in the right context.

The author commends the quality of the Methodist service for miscarriages and neonatal deaths, but unfortunately he refers to them as being in the 'Methodist Service Book' instead of the 'Methodist Worship Book'. I would have appreciated a deeper engagement with the ways in which the traditional liturgies and prayers of the Church can be best used.

If I have an irritation with the book it is that too often the layout and style look more like a PowerPoint display and lecture notes than a book. There are endless bullet points – all valid – but the layout, and some of the diagrams, made it a fussy read.

This criticism in no way detracts from the overall quality and strength of the book. I wish I had read it when, early in my ministry, I received a telephone call the day after I had baptized a baby, telling me that it had died that night in a cot death. Nothing can prepare you, but at least you can be helped in your preparation. Nash's book does this powerfully and sensitively and I warmly commend it.

#### Note

This review was first published in the *Methodist Recorder*, 14 April 2011.

**Revd John Lampard**

*Methodist representative on the Churches Funeral Group*

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### Being a Chaplain

By **MIRANDA THRELFALL-HOLMES and MARK NEWITT**

SPCK, London, 2011

Paperback, 160 pages. ISBN 978-0281063857. £10.99

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Archbishop William Temple said: 'The Church is the only society that exists for the benefit of those who are not its members.' It is not a concept that the Church, either its hierarchy or its members, has eagerly embraced. Self-preservation, as well as limited resources, has often limited the extent of its mission to the un-churched. The appointment of chaplains, commissioned by the churches to serve in places such as the armed forces, prisons, hospitals, universities and colleges, has been one of the established ways of making this concept a reality. Yet there has been a suspicion that chaplaincy is for those looking for a soft option – 'a place for those who have sold out, can't hack church ministry'.

*Being a Chaplain*, by Miranda Threlfall-Holmes and Mark Newitt, argues that chaplaincies are a major part of the mission and ministry of Christian Churches and are increasingly being entered into by other faith communities. Further, there needs to be theological reflection about what chaplaincy is, what a chaplain might be expected to do and whether and why it is important.

The authors invited 22 chaplains working in diverse contexts and from different church backgrounds to share their stories and then reflected theologically on the issues raised by working in a multi-faith context, the skills required, different models of chaplaincy, the tensions experienced in working in secular institutions.

There is within the life of the Church an increased focus on mission and outreach and on fresh expressions. Chaplaincy, being embedded in prisons, hospitals, educational establishments, the forces and the workplace, has its contribution to make to this debate. In its many forms, chaplaincy attempts to articulate religious faith both within and beyond the Church, going to where people are rather than waiting for them to move in the direction of the Church. This was the essence of Jesus's ministry, not in the synagogue or temple, but in the home, where people worked.

I recall the late Cardinal Basil Hume saying at the commissioning service

for my colleague as principal Roman Catholic Chaplain to the Prison Service, how he envied the work in which we were engaged: 'You could hardly be involved', he said, 'in a ministry more deeply rooted in the Gospel.'

Many today feel that our society is becoming increasingly secular and that the response of the Church must be to stand up for what it believes and fight. The experiences related in this book suggest there is another way. For decades chaplains have been working creatively and productively in institutions where contracts, policy documents and performance targets have provided the guidelines. The insights gained can be of considerable value in showing how faith and ministry can flourish in an explicitly secular, even on occasions hostile, environment.

Some chaplains perform the more normal duties of a priest or minister, leading worship celebrating the sacraments and rites of passage, as in prisons or the armed services. Others have a role less well defined, as on a college campus or in the workplace.

Many speak of the ministry as 'incarnational', emphasizing the theological and practical importance of presence and relationships. Others see their ministry as 'sacramental' in the sense of taking the everyday stuff of life and making it a sign of God's presence and love.

Still others speak of an 'expecting' ministry, waiting for opportunities to present themselves and expecting these opportunities to come.

No one reading these stories, whether they be of chaplains working on the battlefields of Afghanistan or on the landings at Wakefield Prison, the wards of an NHS hospital or a Cambridge college, Luton Airport or Manchester United Football Club, can believe chaplains are marginal to the missions of the Church. This is a book, as the cover states, which will provide an invaluable resource not only for those engaged in chaplaincy work but also for the wider Church.

#### Note

This review was first published in the *Methodist Recorder*, 28 July 2011.

**Revd William J Davies**

*Former Superintendent Minister and Chaplain of Prisons*

## Reflective Caring: Imaginative Listening to Pastoral Experience

By **BOB WHORTON**

London, SPCK, 2011

Paperback, 160 pages. ISBN 978-0281064137. £10.99

Bob writes in a gentle, easy style at a steady pace. The chapters are nicely sectioned with short passages containing various themes focusing on both the practical and metaphorical. Though Bob draws on the nature of the hospice for the majority of his reflections, he manages to communicate a deeper message that reaches beyond the confines of the hospice setting.

Much of the book is firmly rooted in the Christian Scriptures. Bob rightly acknowledges that he is writing from a Christian perspective and suggests those from other, non-Christian traditions find corresponding texts in other sacred writings. However, perhaps, as there are a growing number of multi-faith chaplains, it may have been helpful to include such related texts in the appendix.

Imaginatively, Bob takes on some of the big Johannine narratives, such as the Woman at the Well and the Raising of Lazarus, and weaves them into everyday experiences for us. He interprets his own personal experiences into practical situations, which reflect these powerful themes that we can all relate to. For example, in the chapter on 'Depth' (ch. 4, pp. 32 ff.), Bob looks at the encounter between Jesus and the woman at the well as a conversation between himself (as a chaplain) and the woman (as a patient in the hospice). So when the woman and Jesus start talking about water, Jesus invites the woman to go deeper and to talk about 'living water'. So, too, with such an encounter in the hospice, there is the opportunity to offer a deeper, more open and honest look at one's own heart. Bob, who sees the hospice setting for patients who are 'thirsty' for this 'deeper, living water', expresses this well.

I think that Bob's section on 'Fear' (ch. 6, 'Afraid', pp. 52 ff.) is tackled well and he relates this to the sufferings of Jesus, particularly around the agony in the garden, his betrayal and crucifixion. The emotional, physical and psychological pain that goes on within the hospice opens the way to discover acceptance, faith, courage and freedom.

Though Bob never explicitly expresses it, he certainly alludes to the fact

that the whole concept of the modern-day hospice is very much like that of the church. The hospice invites the patient, family and carers to face the reality of life, and to let go of all the unnecessary baggage that is often carried over the years: externally, as in the material possessions, practical achievements, skills and talents that have been acquired over the years; but also internally, in coming to terms with apparent failures, unresolved guilt, broken relationships, the acceptance of one's own mortality. The Church's true mission, as it was for Jesus himself, is to bring the message of opening more fully the Kingdom of God to people, offering them an invitation to grow to true freedom.

I once heard about a part-time hospice chaplain who, on Good Friday, after the 3.00 p.m. Celebration of the Lord's Passion, said to his co-pastor, 'I'm just going off to the hospice for an hour or so!' His colleague answered, 'Surely you do not have to go there today after doing all those heavy services?' He replied, 'Yes, I need cheering up!' He had told me that one of the happiest places he has ever been to was the hospice. So, the Church, ideally, not only prepares us for life and death, it leads us to a freedom that reaches beyond the limits this world can give and encourages immense happiness on the journey.

Bob's excellent little book gives us an opportunity to reflect on these powerful issues, not only for those working in pastoral settings, but also for those who want to reflect caringly on life itself.

**Fr Andy Graydon**

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## Endpiece

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### The Sacramentality of Objects

A recent study of bedside objects in a hospice in the United Kingdom conducted by Kellehear *et al.* (2009) revealed two principal findings. First, patients wished to recreate some semblance of 'home' in their institutional settings. Second, despite a great diversity of objects, most of which were used for distraction or entertainment, almost every individual patient harboured at least one personally unique possession.

This got me thinking about the symbolic meaning that unique personal objects can hold for us. Moreover, I was reminded of Leonardo Boff's (1989) sacramental theology by which everything is, or can become, a sacrament – even the most mundane objects, like a cigarette butt.

'Who would have said that a cigarette butt could become a sacrament?' Boff reflected. 'But there it is [in a flask] in the back of my drawer. Now and then I open the flask. An aroma escapes. The color and texture of a living past take shape. In my mind's eye I see my father alive, rendered present in the cigarette butt: cutting the straw, parceling out the tobacco, igniting the lighter, taking long drags of his cigarette, giving lessons, reading the newspaper, burning holes in his shirts with the sparks, plunging into arduous office work at night, smoking ... smoking. His last cigarette went out with his own mortal life. But something continues to remain lit, because of the sacrament, (p. 19).

This reminded me also of a palliative care patient I came to know well a couple of years ago. Among all of the objects Olga kept at her bedside there was one most special one – her rosary. This was not just any rosary, but one that she received from a priest in a refugee camp in Poland after the war more than sixty years ago. Moreover, every time she picked it up to show it to me, which she did often, she would marvel at how it had never broken in all the time she had had it. I took this to be a symbol of her strong faith.

In contrast to Olga's unbreakable rosary, I thought about how many times I have had to repair my own rosary. Perhaps they don't make rosaries like they used to, I thought to myself. However, thinking symbolically, I doubted whether my own faith was as strong as Olga's. Most of all, I just appreciated how much nurturing repair work my own faith requires from time to time.



What objects do you keep closest to you? What awe and wonder do they evoke in you? What other realities do they call forth into being for you? As Boff said, 'The more deeply human beings relate to the world and to the things of *their own world*, the more clearly sacramentality shows up' (p. 18).

### References

Boff L (1987). *Sacraments of Life, Life of the Sacraments: Story theology* (trans. John Drury). Washington: Pastoral Press.

Kellehear A, Pugh E and Atter L (2009). A home away from home? A case study of bedside objects in a hospice. *International Journal of Palliative Nursing* 15(3): 148–52.

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*Revd Jim Dobson is the Chaplain, University of Dovedale, Hodness Hospital, Worcester, UK.*

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