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PASTORAL COUNSELLING

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THE MINISTER AS COUNSELLOR

"Jugglers, that's what we are expected to be", said one minister to another, with a mixture of complaint and awe. "Jugglers, expected to keep three or four balls in the air and never drop one of them. There's the three 'Ps'—Preaching, Praying and Pastoral—then you can add Reading, Admin and any number of extra specialities we are supposed to be able to take in our stride these days."

How right he is and it is both our burden and our blessing. The blessing comes from the refreshment of variety and the burden from long hours and the impossibility of doing all the things as well as we would like. This burden we have to take to the Lord and let Him carry it with us.

Now here is another ball to be kept in the air: Counselling. Though this is not a new ball but merely a restatement of aspects of our pastoral work.

I think that the different parts of our work are complementary. There are some who specialise in one branch. I once heard that the late Robert McCracken, of Riverside fame, spent all Tuesday morning in his study working on the first paragraph of his next Sunday sermon! And there are those who specialise in pastoral work and do no preaching. I want to address myself to the majority of ministers who, working through the local church, seek to fulfil a reasonably competent ministry in all the varied aspects that are usually associated with the task.

Jesus himself preached to the crowds, counselled the individual, prayed far longer than I ever have, organised his work with care in a very small country and a handful of centres.

There are times when preaching is the instrument God uses, as He did through Peter at Pentecost. At other times it is the one-to-one relationship that is effective, as Ananias with Saul and Philip with the Ethiopian.

People are all individuals and must be treated graciously. They have individual needs that may never be specifically dealt with in a sermon, however loyal the person may be to the diet of worship and however wide ranging and practical the preacher may be. Nicodemus, the Samaritan woman, Zacchaeus and many more who appear on the NT stage all had personal problems that needed the help of Jesus the Counsellor.

It is all the more true to-day, when preaching is out of favour, that many needy people can only be helped through the private, personal interview. Some part of our work programme should be set aside for this. Not too little, not too much.

How can we go about this work effectively?

1. **Set aside time and place for this work**

Ideally this should be in a room at the church. However open house the minister and his wife may be at The Manse, this kind of work is best done in a room on the church premises. This room should be easily accessible, preferably on the front of the building, best of all straight off the footpath, with its own front door and knocker. People coming for a confidential interview with the minister don't want everybody to know. If the room is "round the back" see that it is well signed so that the visitor can find it easily without having to make enquiries. The minister's name put up on the door when he is in session helps. (Make sure this sign is well done and not scribbled on a piece of card torn from a cornflakes packet).

A waiting room is useful too. It is helpful and wise to have a trusted member of the church on duty to act as courteous, tactful and confidential receptionist. Such a person's presence nearby can also safeguard the minister's good name. (I shall have more to say about this under a paragraph on ethics).

If there is no receptionist then a simple notice saying "Please Knock and Wait" tells the minister that there is someone else waiting. This is better than a complicated system of lights and signs saying "Engaged" or "Free". This may look more professional but does not give the clue that there is someone waiting. The receptionist should use the same method: knock and wait. The minister may be in prayer with the person he is counselling. Or the interview may be at a very important point, when interruption would be most unhelpful.

For the same reasons the telephone must not be allowed to interrupt. Don't have a phone in the interviewing room. It is no good saying to the visitor: "Don't worry about that, I'm not going to answer it." Those are the occasions when the person the other end seems determined to hang on and hang on. And if the phone is not in the room, beware of being called to the phone whilst you are having an interview. A receptionist should be trained to say that you will ring back.

The interviewing room and the waiting room should be as pleasant as possible. Warm in the winter. With useful reading material available. The chairs should be comfortable, the carpet good and the flowers carefully arranged. If one of your members tells you that they are doing some refurnishing, so would you like their old easy chairs/occasional table/curtains/etc., for "your room" have the sense to say "No thank you." You may add that you too had your eye on some Parker Knoll—cheaper in the long run, especially if you can get them at trade—and if they would care to keep their furnishings another year or two and give the church the money they were going to spend so that the room and the waiting room at the church could be properly furnished, so much the better, especially if they rise to the bait.

It is useful to vary the style of the chairs in the interview room, some low and some high. People need to be comfortably seated at such times. I don't like to have a desk in the room, behind which I sit! Can you imagine Jesus setting up such a barrier? Let people choose to sit where they like. It helps to have a focal point. The light from an electric fire giving "artificial" flame helps.

There is much to be said for having an appointments system, but also there are advantages in being "in the room"

available for anyone at certain set hours. These can be advertised in the weekly order of service, or announced in the notices. It is difficult to tie oneself down to the same time every week of the year. And it's useful to vary the times for the convenience of people. Sessions during the morning, afternoon and evening all prove to be useful.

2. **Encourage people to use your counselling service**

Invite them to make an appointment. Make it known that you are willing and eager to help people through counselling. "Why not come and have a chat in my room with me about this matter?" Get out your diary there and then.

Don't be put off when people say: "Oh! I know you are far too busy to give me much of your precious time; could you just spare a word now." If this is said at the door after a service, remember that instant counselling is of little use, especially when given by a mind which is neither fresh nor undivided. Their plea that you are too busy for them to trouble you is a defence against your not being willing to spend time with them (although they know that you do with other people). Or it may be a sign that they are finding it hard to face up to their trouble and would like a "reason" for not talking about it to their minister.

Such counselling does not end visiting folk in their own homes. Indeed it frequently arises from such a visit, especially when, as so often happens, they begin to speak about some matter that really is worrying them, just as you are about to leave. That is the time to make an appointment for them to come to your room so that the matter can be shared. And let it be soon. They may be far more scared than we would ever dream.

Sometimes our own church members will find it easier to seek help from another minister, who is a comparative stranger. This should not perturb us; there will be times when we are called on to help a sheep from another flock. Mutual trust and respect between ministers is important. I do not think it necessary for me to have even a confidential report from another minister when he is helping one of my people. Permission should always be obtained from the person before any information is passed on. This holds true for contacts with all the people who may be involved in helping the person.

I have never found information of any help unless it is freely given to me by the person I am counselling. And they should be sure that all they say to me is strictly confidential. For this reason too I do not find the taking of notes during an interview to be a good thing. Perhaps afterwards it may be useful to put a few things down on paper to help with the next meeting. Any such notes must be kept under tight security.

The length of a visit must be varied, but it seems that an hour is about the best time. Twice a week to begin with and then once a week seems to be a useful pattern, guarding against a state of dependence. (More on that below).

The minister must always remember that he is a minister, not a psychiatrist, nor a psychologist, nor a social worker, nor a doctor. People should be referred to other helpers

when ever it is right. This is not passing the buck, but simply taking a sober account of ourselves and recognising that God has many servants.

3. **What can we do as ministers?**

a) **Listen.** Preachers and teachers are not good at listening. We have so much to say, and are good at saying it! We have had so much experience and sometimes even some extra courses to make us more effective! We long for the "client" to stop talking and listen to us. We are tempted to feel that we are wasting our time, even God's time, if we don't get a chance to speak, and at length or at depth.

Taylor Caldwell in her book "The Man Who Listens" reminds us that "man's real need, his most terrible need, is for someone to listen to him, not as a 'patient', but as a human soul."

People need to know that we care, that we are really listening, that they are important to us. We haven't all the answers at a drop of the hat, or after a five-minute chat. Even if we have an "outside" solution, the person must come to the solution from "within". He must find the truth about himself and his situation for himself. He must desire to know the truth, search for it, recognise it and finally accept it. He is helped in this task by talking to someone he can trust, whom he believes cares, in whose confidentiality he can feel safe and who will give the time.

b) **The minister must keep the law.** "You shall love the Lord your God . . . and your neighbour". He listens therefore without shock, judgment, superiority or inquisitiveness. He will not demand a confession to humiliate the person or to satisfy his own curiosity. He listens as a sinner listening to a sinner.

The love of God flowing through the minister is the all-important catalyst. It breaks down the barriers, it brings release, it removes fears that have been standing guard over the subconscious for years, it shows guilt a place where forgiveness may be found.

God loves the person we are listening to. This is the one thing we can be sure of. As His love flows through us to him, he is touched by Him. This is the heart of the matter where Christian Counselling is concerned. This is the beginning and end of it. Nothing can be done without this love. With this love all things are possible.

This love keeps us humble and therefore usable. It keeps us peaceful and peaceable. It removes from us the temptation to play at being God. It helps us to do our small part as his errand boys rather than calling Him in as a consultant when we are temporarily stuck for a solution!

God's love also keeps the minister "safe" ethically. In this, as in other things, he must be as wise as a serpent and harmless as a dove. But if the minister is not willing to be involved, he is very unlikely to be able to help much in this kind of work. The love of God protects him from the wrong kind of involvement, from succumbing to temptations and from keeping himself so aloof that he does not give counsel at all.

The love of God also protects the minister from the time-consuming person who develops a dependence on the counsellor.

The keeping of the law of love reminds the minister that he is always working in the presence of the Triune God, that it is God who does the work, that the minister is merely His servant. In remembering this the minister is not drained by the work, but rather blessed and refreshed through it.

People desperately need to be introduced not merely to a loving God but to the God who is love, who has revealed Himself in His Son. Once people can be assured that nothing can separate them from the love of God they can face all things and bear all things. This takes them so much further than statements about having a cross to bear, or that God's ways are mysterious and we must just accept them.

God loves. Therefore He is the law giver, the judge, the forgiver, the saviour, the healer, the restorer.

c) **Teach people to relax.**

"Slow me down, Lord . . .
Slow them down, Lord . . ."

I teach people to relax, not by telling them to do it, but by doing it myself, in their presence, and saying aloud, with my eyes shut, what I am doing. I invite them to tag along, if they wish. This is a great help to me. I need to be still. People greatly appreciate the practical instruction. Very few people know how to relax, although many have been told to do so by someone else. Everyone can be taught to relax and all need to.

d) **Teach people to meditate.** This is a way of prayer by which the conscious mind dwells on some spiritual truth and thereby directs this thought to the subconscious mind. Thus after practice and repetition for a few weeks the subconscious mind accepts this truth and passes it on to the sympathetic nervous system. This in turn translates the message to the nervous system and the organs of the body. To take a statement like that of Jesus: "My peace I give to you" and meditate on it "three times a day after meals", varying it with the response: "You, Lord, are giving me your peace" is a way to receive the gift of God's peace.

e) **Help people to make their confession.** Confession is in part the recognising of the true situation and the acceptance of a portion of the blame. It is the end of blaming others, the end of self-pity, the end of blaming God. It is the end of trying the short cuts, the evasion, the pretence, the wishful thinking. When a person can say, with King David: "Against Thee, Thee only have I sinned and done this great wrong", he has come to that willing submission to the soul surgery that only God can perform.

Ministers can be of great help at this point. We are sinners saved by grace. We have sat where they are sitting. We have known times of shame. We have had to confess to God. More, we know the wonder of God's forgiveness, and that it is true that our God forgives and, as Charles Wesley wrote, breaks the power of cancelled sin, He sets the prisoner free.

It is not our job to provide what Bonhoeffer called "cheap grace". There is no easy forgiveness. Sin killed Jesus. He gave his life to do something effective about sin. The person who honestly confesses needs our help. He needs to be assured that his sin is not too bad for God to forgive. Here our own unshockableness helps, as does our lack of condemnation.

We must try to make the experience of confession and forgiveness so real to them that it is effective. Quotations from the Bible help. So do imaginative acts or ideas. It might help for a confession actually to be written out, read by the minister, offered to God and then burnt as a sign that the forgiveness has been accepted.

Or the idea that there is a film of our lives which needs God's editing in His "cutting" room. We cannot forget, but God can and does. When we remember our forgiven sins, we immediately recall that God has forgiven and forgotten them, and we concentrate upon the wonder of that and not upon our past sin.

If confession and apology should be made to someone who has been hurt by our sin, then this too must be faced up to. If further mischief were done by such a confession it should not be indulged in.

f) **Father . . . forgive us . . . as we forgive.** Forgiven people must be forgiving. All resentment, bitterness and feelings of being hurt must be given up. These are poisons that destroy wholeness.

g) **Guide people into effective prayer for themselves and for others.** Ours is a living God, who loves people. "My Father is still at work", said Jesus. And Paul wrote to the church at Philippi: "Have no anxiety, but in everything make your requests known to God in prayer and petition with thanksgiving." Our people need God's help, not ours. We need His help too, with their problems. Only God has the power to save people and they need to be saved. Only He has the power to change people and they need to be changed. They come to us asking, in effect, for the circumstances to be changed, or for other people to be changed. Their first need is to be changed themselves. This is not our work but the work of the Holy Spirit. The search for victory in the situation as it is is the starting point. The recognition that all our troubles are within the framework of God's love, expressed in the gift of freedom to us, and to others, is the beginning of the journey to wholeness. Prayer is not trying to change God's will, but rather seeking to align ourselves with His. "Thy kingdom come, Thy will be done" is the basis of our praying. One of the besetting sins is egocentricity. We even hope to use God for the fulfilment of our will! He must be seen to be at the centre.

4. **Our own church has a part in this.**

There is much that we cannot share with our church concerning this work. We must guard against using counselling experience as sermon illustration. This should never be done with a situation in which the minister is currently involved. And even after time has elapsed some

camouflage or "scrambling" should be used to prevent any confidential material from leaking out.

But our people help by being a worshipping, believing and caring fellowship. Their prayer support of the minister and of any names he feels able to bring to them can play an important part. The vitality of worship and the experience of the sacraments can be a powerful backcloth to the minister's counselling work. Trained prayer groups too can be of great assistance. And there may be a few people in the membership who, after training, would be able to take on a counselling role.

In conclusion we must remember that a minister is a servant. A servant of God and a servant of people. (If we want our vocation to serve us then we are in need of counselling!) Like our Lord we must do the things we see our Father doing. Our work must be done according to the terms of the Gospel, by the direction of the Holy Spirit.

Like us, all people wear an invisible label which says "Fragile. Please handle with care". God's love therefore is the only instrument we are allowed to use. We only see through a glass darkly. We do not know all the answers. There are successes and failures in this work. We should seek to learn from them both. And there is mystery. We have to say with the Apostle Paul, baffled as he was that, whilst the Gentiles had come into the kingdom, his beloved Jews had not: "O depth of wealth, wisdom and knowledge in God! How unsearchable are his judgments, how untraceable his ways! Who knows the mind of the Lord? Who has been his counsellor? Who has ever made a gift to him to receive a gift in return? Source, Guide and Goal of all that is—to him be glory for ever! Amen."

NORMAN J. RENSHAW

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THE MINISTER AS COUNSELLOR:

A Psychologist's View

This article consists of a theme with three variations. The central issue is individual freedom and the place of counselling in the process of enabling people to become as free as possible within the broad constraints of the society in which they live. Realistically speaking, no one is completely free, yet there still exists a large range of behaviour over which the individual must, for the sake of his own identity,

and can, with the development of judgement, exercise uninterfered-with decisions based on choices which are appropriate to him, and perhaps to him only. All the while we should realise that the most exquisite kind of power and control of one person over others is to be able to determine not only to what extent they may exercise relatively independent decisions about their own actions, but also when. This can be seen, for example, when one country is in a position to set the exact date when another country is to begin self-government.

First, we must be willing to recognise that counselling (and psychotherapy, for that matter) involves giving advice or counsel to someone. This is relatively easy to accept for the lay person, since he expects to be guided if not told what to do in connection with a certain problem, yet many of my professional colleagues still resist acceptancy of the fact that the counsellor intrudes upon the client's life and directs him, sometimes quite unintentionally.

One type of counselling can be done in a relatively simple, direct manner where an individual seeks out a competent person, and after consultation is presented with recommendations to deal with a problem in a particular manner. This is generally the practice with a lawyer and, although the process can be exceedingly complex the guidelines remain clear: the client states his case, the lawyer analyses the situation and makes recommendations. The important thing is that both the client and counsellor operate in a relatively open system where the client may refuse the advice offered to him.

Counselling, however, may take a different form in that advice-giving becomes more implicit, more subtle, hence less visible, and this is frequently the case in situations involving counselling a person about personal problems. The point here is that unless the counsellor has an unusual degree of self-knowledge, he may unintentionally, direct the client to behave in a particular manner; and further, the client may follow this direction due to the fact that he is both in a vulnerable position and not presented with clearly stated alternative courses of action. The most common ways of accomplishing this are through selective agreement or disagreement with solutions proposed by the client and by the counsellor providing a model for the client to imitate. Let us leave aside the issue of the knowledgeable manipulator of persons who uses these techniques unscrupulously to gain his own ends. The major concern is this: to what extent is the client's behaviour directed, while both counsellor and client think that the client is making relatively independent choices?

There is one additional point here. The question may be raised, "What is wrong with giving advice to another?" The answer is this: If a counsellor is to provide advice, he must be competent so to do, and in the business of living, competence is extremely difficult to assess.

Second, many counsellors fall prey to over-treatment based largely on an overestimation of the problem. This is true of

the inexperienced and especially true of the pastoral counsellor who considers it his duty not only to seek out and listen to his parishioners but to provide counsel to them. The line here is thin and difficult to draw; it hinges on the issue of whether the pastoral counsellor can accept the fact that in some cases it may be better for the client **not** to be counselled. This relates, of course, to the extent to which any counsellor thinks that the client, almost by definition, needs the counsellor and, if it is any consolation, this is true of the psychiatrist, psychologist and social worker as well. Rapid diagnosis or analysis of the situation is critical here, but equally important is a willingness on the part of the counsellor to opt out. Also, the pastoral counsellor must recognise that there are strong influences on him by society, the church **and** the client to do something to or for the person who presents the problem. To resist these influences and to allow the person time to work out his own solutions is asking a great deal. Yet the majority of people are surprisingly resilient if given the chance. Of course, we are not dealing here with cases which demand immediate referral and treatment by professionals, and yet, even in these cases it must be said that there is increasing concern that the rush to treat can inhibit the person's ability to function as an individual unit of society.

Remember that the Good Samaritan rapidly assessed the predicament of the wounded man, saw that without help he would perish, provided only necessary aid, and then left the man to fend again for himself.

Third, the pastor occupies a somewhat unusual position in many respects. He frequently sees the people he counsels in other everyday activities. At the least he may see the person in church or church-related activities and this shift in role can place a special strain on the counselling relationship, even where the roles are kept as separate and clearly defined as possible. Confidences, even willingly given by the client often change the relationship of the pastor and the person involved, and this is to be expected.

Also, the pastoral counsellor, as a function of his position in contrast to the lay counsellor, can involve a third party in the counsellor-client interaction. Indeed, it may be that the only way of ensuring maximum individual freedom for the client is for both counsellor and client to recognise their limitations in comparison with a supreme being of some sort. There is no need to "play God" when the real thing is readily available.

WILLIAM A. DRAPER

MINISTERING TO THOSE WHO HARM THEMSELVES

If we limit ourselves in our definition of "those who harm themselves" to those who come to the attention of the hospital services following a self injury episode then we are talking about a surprisingly large number of people. In one electoral ward of Bristol, which is largely made up of old Victorian houses divided into bed sitters, 1 in 200 of the

population attempts to harm themselves each year. If we add to this number those who either do something to harm themselves and do not come to the notice of the hospital authorities and those who think about harming themselves then we would have to multiply this number many times. There are many ways of harming one's self, but for our purposes we shall limit our discussion to those methods which, by and large, result in, or may result in some harm which promptly carries with it a real risk to health or life.

Despite the prevalence of these events in our society clergymen are only rarely in touch with these people and hence when they do meet this problem they are often at a loss for how they may best intervene. The reasons why the clergyman is only infrequently acquainted with the problem will become clear later but because of the very nature of the event the clergyman should and does have a role to play. The psychiatrist in one sense compares markedly with the clergyman in that he is likely to spend a proportion of each week trying to help this group after they have tried to harm themselves.

We have in the stories of Elijah in 1 Kings and of Judas around the time of the crucifixion, examples which we can use to make some general points about this problem. We can ask ourselves what would we have done and said if we had been the angel who met Elijah in the wilderness, or if by chance we had met Judas as he was on his way to hang himself? We should ask this question because it is clear that a sizeable proportion of those who do eventually kill themselves have sought help from one source or another in the preceding few days.

Elijah was a strange, perhaps solitary man whose beliefs led him into conflict with Ahab. In the setting of the confrontation with the prophets of Baal he was the instrument of a most incredible triumph. Within a short time, despite this triumph, he felt his life to be at risk, to have no-one of similar belief and outlook to turn to, to be estranged from his own people and to be in urgent need of a hiding place. It was in the wilderness, after he had left his servant behind that he came to the point of requesting his own death. He was preoccupied with himself, his own failure, and the way in which he was not appreciated. Partly as a result of his own actions and of the reactions of others he was alienated from society. We could describe him as despondent and desolate. It was while he was sitting in this state contemplating his death that he was visited by the angel. The angel did not attempt to deal with the many complex needs of Elijah but rather he recognised his immediate needs and dealt with them, when these were met he provided Elijah with a definite way forward. When Elijah had begun to progress he had to face the question "What are you doing here?" This deceptively simple question focused quite accurately on Elijah's existential problem. The question was asked as he reviewed his situation. Although he tries to avoid the implications of the question as he attempts to justify himself he is eventually forced to answer it.

It is difficult to know what motivated Judas in his betrayal of Jesus but whatever he had thought would have been the consequences it seems most unlikely that he had anticipated the actual result. Having once embarked on his course he lost control and the consequences followed in a seemingly inevitable sequence. His attempts to reverse the procession only served to point up his own failure to realise the awful result. In his mounting distress he retains sufficient clarity of vision and sense of purpose in order to be able to take the necessary steps to hang himself.

These two examples are familiar to us all and can serve as the focus for us as we consider the contemporary evidence about those who attempt to harm themselves.

Despite the very high incidence in our society of self harm there are very few examples of those who do this "out of the blue" in a manner which on investigation does not seem to have any rhyme or reason to it. The vast majority of those who we can study do not do as Judas did and attempt to use a method which has a high chance of succeeding, rather, most are like Elijah who put himself at risk by going out into the wilderness and failing initially to take the appropriate steps to care for himself.

If we look at the psychosociological characteristics of people who attempt to harm themselves in Great Britain then we find that they are very similar to those which Elijah and Judas had. In the first place they were people who were in some sense different from most of their contemporaries. In the case of Elijah and Judas they were and had been for some years in a special relationship to someone which effectively set them apart. With this separateness went a burden or constraint which necessitated some kind of adaptation or sacrifice on their part. In our contemporary examples the thing which people have which sets them apart we would usually talk of in terms more specifically, indicating problematic or distorting features such as a physical deformity or being a member of a broken family. We could call this their life problem.

The life problem is compounded by the way in which the individual reacts to the problem, that is to say the kind of life style which is developed by the individual in response to the problem. Elijah initially responded to the problem presented to him by his calling by behaving in a certain way which in turn brought him into conflict with the King and Queen of his day. Judas having been selected by Jesus and having spent three years of his life following him and developing his own ideas about the course of the cause which Jesus led, took an initiative which dramatically altered the direction of events.

In the vast majority of those who harm themselves it is possible to identify a break in some significant relationship in the days preceding the harming attempt. In one series which was studied, the break in the relationship occurred almost entirely in the preceding twenty-four hours. That Elijah was alienated and felt he had no-one to turn to is clear, and he made things even more difficult for himself

by leaving his servant behind as he made off into the wilderness. This left him without the essential companionship which is a vital part of any return to a sense of proportion or hope. By contrast the events which surrounded the suicide of Judas were heaped tightly together and once the alienation had occurred he had little time left in which to find a way back. It is interesting to see that for Elijah he was able to see a way back and to end the alienation.

We have covered in passing the reason why clergymen are only infrequently involved with those who harm themselves. Most ministers are preoccupied with the affairs of their churches and their church members. In particular the people at the centre of the church affairs rather than those at the periphery. It is fairly typical of the case histories of our contemporaries who harm themselves that as part of their adaptation to their life problem they withdraw from the kind of situation in which they are likely to be "involved" in a wholehearted or absorbing way. The converse of this is that if a person is a member of a community which cares for the individuals which make it up, then this mitigates against any break in relationships being too damaging.

The angel who ministered to Elijah demonstrated the kind of caring which is effective. In the first instant he seemed to perceive that Elijah had some very simple but important needs which had to be met, and, in his meeting of these needs he indicated that he cared for Elijah. Although it is probably reading more into the account than is really warranted it seems that this was an unconditional caring. The unconditional caring and the perception of the needs of the individual go a long way towards allowing the person to establish an identity which is not too distorted by the recent events and which therefore might make more likely the consideration of those events which contribute to the current disorder. It is as if the person is able to feel that they are acceptable as a person in their own right. Having established the relationship it became necessary to move on to Horeb. Horeb was the place where Elijah came face to face with the reality of his condition that he was alienated from the people he had left behind. He also discovered that despite the problems that had led him to long for his own death there was still a very important role for him to play back in the place from which he had come. He had to take the road back.

There are other aspects of this exchange which Elijah had with his ministers which we should note. Unlike some present day counselling these exchanges were based as firmly as possible on the reality which could be shared rather than just the reality which Elijah perceived. Having been treated as a worthwhile person they had then to get on and deal with the problems which led to Elijah's becoming depressed. Despite his repeated claim that he knew—he alone knew—what the problem was, the short comings of his view were discovered. We can say of Elijah's helpers that they were remarkably perceptive of his state and needs and treated him directly and honestly without any charade or pretence.

Finally the plan for Elijah was worked out. Most of this plan for Elijah could probably have been executed quite easily by others but it was his, and he was expected to follow the plan but more importantly he was allowed to decide for himself whether he would follow it or not. So often we wreck our attempts to help people by doing for them what they should and could do for themselves. We deny them the dignity of making their own choice and following their own way.

It is probably as a result of their training that many ministers seem to develop a technique for preaching while failing to understand and develop any skill in talking with people. They can talk to but not with people. This is very sad because, valuable as the preaching may be in attracting the person in need to the minister as a person who might be able to help, the pulpit technique in the study or sitting room is of no value, and what is worse, may indeed be a form of rejection.

One of the characteristics of the effective helper is the way in which they confirm the person in need as being a worthwhile and real individual whose complaints are acknowledged as important by the very way in which they are listened to. The person in need requires a chance to share the problem as they see it and the helpers contribution is to make this possible. It is of no value for the helper to interpose their own experience as an illustration of how well they understand when all they have heard of the other's needs are a few hesitant sentences.

For many in need the chance to be listened to enables them at an early stage to get their problem straight. Before they have talked about it, it may have seemed bewilderingly complex and overwhelming to the extent that they felt quite defeated. Having set it out for another person brings a clarity to the problem which begins to show that there might be a way forward. If the helper has listened sympathetically then it is at this stage that he can make a contribution to the problem by talking about some of the next tentative steps which might be taken. In the story of Elijah the angel did not preach a sermon outlining a three-point plan but rather pointed to simple practical things that needed to be done immediately: eat drink and sleep. In our situation the power of the simple and practical first steps in part lies in their immediate effects of meeting those needs which if neglected would only enhance the overall problem, and also in that in so doing we can indicate our intention to stick with the problem until it is worked out in a way which would make it possible for the person to survive without our help.

Another aspect of this characteristic of the effective helper is the ability to drop the protective facade of the professional role and to allow the relationship to develop as one real person to another. This is not to say that the minister must stop being a minister but rather that he should not use his minister's role to keep those who consult him at arm's length. In other words the minister has to be a genuine person whose integrity as an individual breaks through the

protective armoury of his title and status. In order to do this it is necessary for the minister to be honest. Frequently ministers will attempt to hide behind "white lies" on "medical grounds" or some other grounds, as if there is some higher principle than truth by which we can be guided. If we do other than keep truth as our touch stone then we devalue ourselves and those whom we serve. This does not mean, for example, that we should march into the sick rooms of those who are dying and formally announce the fact perhaps on the grounds that this might give us some kind of spiritual purchase to lever someone into the Kingdom. Rather we should be prepared to share the pain of directly answering a direct inquiry in which this kind of information is sought.

The experience of pain in the helper goes hand in hand with the sharing of distress. Some times the helper feels the bewilderment and defeat of the person who seeks help and it is important not to pretend that we feel other than like this. It requires a peculiar sort of honesty to be able to say "I can't see the solution either", and then to persist in an attempt to find those simple practical next few steps. One technique which some ministers use when they feel overwhelmed is to resort to "a time of prayer" as a means of stopping the other person talking and thus preventing the distress getting even more acute. If you feel that this is justified then it is important to be certain that in doing this you are not treating the person in need as less than an equal in the relationship.

There is another trap which the clergyman needs to avoid particularly when he tries to help someone over a period of time, and that is to use the emotional bond which develops in the relationship to blackmail the individual into doing something which the clergyman believes it is right for him to do. In its extreme form a declaration of faith is extracted under this pressure. If we really want to be effective then our offering of concern has to be unconditional and we must never say however implicity, "I will love you if you please me".

Like others in distress the person who harms himself is effectively aided by the helper being able to comprehend the nature and even the cause of his distress and by then having this shown to him in a quite unmistakeable manner. As the distressed person struggles to talk with us we need to, as it were, open ourselves to the pain in a truly emphatic way. There may be some value in doing this alone but the real value to the sufferer comes from knowing that the other person understands. It is often sensible to preface our message to him with an expression like, "Let me see if I have really understood what you are saying. You feel that . . ."

Practically all that has been said above could have been said in almost the same words to a group of psychiatrists or general practitioners. The clergyman is different in a number of ways, in terms of the resources available to him, to both the psychiatrist and the general practitioner. Quite apart

from his faith and his belief in meaning and purpose, which would distinguish him from many medical people, he has the support of and access to a caring community. If this community—the church—is properly mobilised then he can invoke its aid so that the processes which the minister starts can be enhanced as they become involved. Hopefully, the individual who harms himself could be helped to discover meaning and purpose for a life time.

F. J. ROBERTS

PSYCHIATRIC CARE AND PASTORAL CONCERNS

Pastoral Objectives

I have been asked to write briefly about the pastoral objectives or aims which underlie the chaplain's ministry to the psychiatric patient. You will readily appreciate that there are differences of emphasis, of theology and of church tradition which are bound to colour the approach of any one chaplain's approach to his specific task.

For example; in a survey which I made some years ago into the chaplaincy services existing at the time in hospitals within the area of the Sheffield Regional Hospital Board, I gave the chaplains an opportunity to define in their own words the nature of their ministry in hospital. Here is a sample of some of their replies:—

1. "The chaplain is concerned with the total health of the hospital community and its internal relationships in relation to the area it serves."
2. The chaplain "has to interpret the love of God and reveal his special concern for the sufferers, both by his teaching and by his approach to people. This requires saintliness."
3. The chaplain seeks "to link patients to Jesus Christ so that they find in him a power beyond themselves for complete health and fulfilment."
4. "His main task is to save souls. When he helps to establish a right relationship between a patient and God, it brings about a great relief of conscience which is bound to prove helpful to the doctor."

These comments reflect not only the whole range of Christian tradition, but also, within their wider contexts, the emphases and theology of those who wrote them. Yet when one looks beneath the outer layer of words, not only of these samples but of the hundred or so other replies which were also offered, one dominant concept seems to emerge. A concept which to my mind appears to crystallise if you like both the role of religion and the chaplain's overall objectives, within the hospital, particularly the psychiatric hospital. It is the concept of relationships. You may wish to question this assumption, but I believe that underlying all religious philosophies or customs, including our own, is the idea of relationship. The inadequacy of so many attempts to define the nature of religion lies in their failure to appreciate or to do justice to the idea of relationship. It was Matthew

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To the Readers of the "Fraternal"

Dear Friends,

"If the average rugby man showed the same amount of devotion to this game as the average Christian does to his religion, most sides would be lucky to field six men on a Saturday afternoon."

Alan Gibson, The Times.

True or false?

I think this is the over-generalisation of over-generalisations! Nevertheless the uninitiated might accept Alan Gibson's comment as fair when you and I know that it is probably simply ill-informed. I am sure it is presented as an honest statement of opinion but I am equally sure the facts have been misunderstood.

I sometimes experience something of this situation in my own line of country. For instance a Baptist Church Liability Policy relates to the ordinary activities of Church Services, children's church, B.B. and G.B. meetings, Youth Club, Women's Meetings, Men's Contact Club and so on.

Recently a tractor/digger owned by the father of a deacon was borrowed by deacons who arranged for a young man aged 21 to use this heavy equipment to remove surplus soil from the church graveyard. The tractor/digger was licensed and insured by the owner only for his purposes including road use, but not for the Baptist Church graveyard work. An accident to a fence and gateway off the road occurred and it was then that we first heard of the use of the tractor/digger. The deacons in subsequent correspondence said "We presumed the policy would cover this."

An honest statement of opinion but it is essential to discuss this type of risk and indeed any unusual type of enterprise not already within the knowledge of the Insurance Company with the Company *before* work is carried out.

If your diaconate says "We think it's alright" then make sure before an enterprise is carried through that the "think" is changed to "know" by referring to us in good time.

Occasionally deacons will seek the advice of someone in the Church who "is something in Insurance." That "something" might be a job in the Accountants' Department, a Stationery Controller, on the Computer and so on. None of these avenues helps in connection with pure insurance. The Company underwriting a risk should be the source from which you take your advice.

If you want a Shakespearean quotation what about the cobbler in Julius Caesar:

"I meddle with no tradesmen's matters . . . but with awl."

Get matters affecting liability sewn up before trouble; do not try patching up afterwards!

Let the cobbler stick to his last!

Yours sincerely,

C. J. L. COLVIN
General Manager

Arnold who spoke of religion as "emotion tinged with morality" and Spencer who saw it as an "hypothesis supposed to render the universe intelligible". While perhaps the most unsatisfactory of all was Whitehead's "What a man does with his solitariness".

Religion, I believe, is the way in which a person expresses his attitude to life, and the relationship of his own life to other lives or to another life which he sees fuller or more complete than his own. From the Christian standpoint, this concept of relationship is best summed up in the words of our Lord who said to the young lawyer, "You shall love the Lord your God, with all your heart and with all your soul and with all your strength and with all your mind; and your neighbour as yourself" (Luke 10.27).

I think it is important to recognise this when considering the aims and objectives of the chaplain's ministry within hospital and particularly the psychiatric hospital. The specific contribution of our Christian faith towards the total healing ministry of the hospital needs to be seen in terms of relationships. It is not another form of treatment that is used when everything else has failed, but is primarily a way of life that is based upon a live relationship between God and man, and man and his fellows. When the young lawyer asked Jesus for the secret of life in God, He made it quite clear that the important thing was not only in "doing", that is, complying with a set of rules; but in "being", that is in realising one's purpose in life as found within a particular pattern of relationships. It is out of this pattern of **"being"** that true **"doing"** is made possible.

The mentally sick person is one who suffers amongst other things from a breakdown in the normal pattern of personal and social relationships. It is possible that in some instances the breakdown is itself a precipitating factor in the onset of the illness. What may be said with some certainty is that, whatever the ultimate cause or causes may be, the mental disorder itself profoundly affects the relationships which the patient has with his family and the community of which he is a part.

The chaplain, as a minister, is already committed to a "ministry of reconciliation", to use a Pauline phrase, and as such is, or should be, concerned in the healing and mending of damaged or broken relationships, whether they are the experience of people in or outside hospital. Within hospital his healing role, if I may use this phrase, lies not in doing something clinical or physical; lies not in his understanding of normal or abnormal psychology, though these may be of great assistance in his understanding of the human situation; lies not, in the outward forms at any rate, of his specifically religious expertise. It lies in sharing with others, with the doctor, the nurse, the social worker and others concerned with the patients' welfare, the burden and hurt of the latter's disorder. The sharing of this burden may involve the chaplain in a variety of roles. He will be a listener, a counsellor, perhaps, not only to the patient, but to his relatives and family as well. He may even be asked to give

advice on the ethics or morality of decisions made concerning the patients' treatment, and may well be manipulated into making judgments in matters that really lie outside his province. But over and above all the various things he is asked to **"do"** is the more important aspect of who and what he "is".

Michael Wilson in a recent study has suggested the futility of looking for **The role** most appropriate to the hospital chaplain, (Cf. **The Hospital—A Place of Truth—** p. 142). He suggests that though the chaplain has a multiplicity of roles, he is prophet, priest, counsellor, and so on; he must be able to step from one to another with ease. However, as he steps from one to the other, he must remain the same person. He must **be** himself. The question of his being gives foundation, meaning, purpose and credibility to everything he **does.**

I think that we touch upon a problem here that involves not only the task of the chaplain in hospital, but is very pertinent to the task of every minister working in the community to-day. What is it that we do or are supposed to be doing? And how does it contribute to the wellbeing of society in general? What do we do that others cannot? If this problem is not an acute one for some ministers and clergy, there are many who feel it to be pressing, and for a great many ordinary people it presents questions and comments. Indeed, I would imagine that the need to define and to communicate to others the specific "role" of the hospital chaplain, the theme of so many day conferences and articles is itself an indication of the uncertainty on the part of many people as to what is distinctive about that task.

I suspect that a great many tasks that the chaplain does or may emphasise, or has thrust upon him, may well satisfy a desire to be seen to be doing something specific. The doctor does something; the nurse does something; the pharmacist and the laboratory technician do something; the electrician and the administrator do something; and the things that they do are largely measurable and evidential. But what does the chaplain do that is at once measurable in terms of total effect upon the life of a particular patient or hospital community and yet peculiar to his task? The chaplain in a psychiatric hospital undoubtedly fulfils a variety of different tasks. He is in some respects a "Minister without Portfolio". He is a member of Cabinet, but is free to be involved in a variety of responsibilities. The point I am trying to make is this; because of the variety of his roles, he is able to establish within the hospital as a whole a great many useful, creative, healing relationships that are denied to most of the members of staff. He is bound up in the intricate web of interpersonal relationships within the hospital and as such is in a unique position to be of help to all. Patient to patient, patient to staff, staff to hospital, hospital to community; he is found somewhere within them all. Of course, he will be seen as standing for a particular attitude to life. The specifically religious—or ritual—services he conducts will mark him off from others, as the operation separates the surgeon from

the chemist or the catering officer. But what he does in the chapel or on the ward in worship, should give meaning and purpose to what he does in the hospital as a whole, and conversely, what he does in hospital should make his worship helpful and full of meaning to those who share in it.

Thus the chaplain in a psychiatric hospital needs to be able to find in all the relationships which he fosters or maintains within the hospital religious meaning and consequence and, because of this, to view these relationships as a means of communicating the love of God for men to men.

Pastoral Care

But how does this theoretical basis work out in practice? How may the chaplain's ministry to the psychiatric patient heal or restore damaged or severed social, domestic and spiritual relationships?

The Local Church

To begin with, the chaplain has often to minister to the church fellowships in the locality of the hospital. In spite of the wider knowledge which many people have of sickness and disease and the lip service which is paid to an enlightened attitude towards the mentally ill, I find a great deal of ignorance and misunderstanding still characteristic of many people in our churches towards such people and the hospitals which care for them. I find I have to explain the difference between mental illness and subnormality when a question such as "Can you hold an intelligent conversation with them?" is asked. Or perhaps I find myself outlining nurse training and explaining the new attitudes to hospital care when someone asks "How can one become an attendant?". But the gulf that still exists is shown in the sometimes shy approach by an older member who asks do I know Miss A. or Mr B. Further conversation reveals that she or he was once a member of the church before entering hospital some 20 to 30 years ago. The fellowship had lost touch with them and were not to know that their illness had long since been controlled and they were just part of a great number of people who would welcome the interest of old friends and associates to cheer their loneliness and sense of forgottenness. Encouraging patients to go out to church in the community can only be successful if the community churches are willing to accept them and make them feel at home.

The Sheffield Council of Churches has a Social Responsibility scheme operating in different parts of the city and it is possible to call on Churches to offer various forms of assistance in a variety of situations. For example, an old lady of 80 living alone on a new housing estate was ready for discharge from hospital. She had come in originally mentally confused and suffering from malnutrition. Hospital care soon put her back to normal again. But was it fair to allow her to return to an environment that might soon reduce her to helplessness again? She was quite capable of looking after herself, but lonely. Again a phone call and letter to the Director of Social Responsibility scheme and arrangements were made for someone to call in regularly to make sure the old lady was looking after herself.

The

Baptist Missionary Society

has been able to appoint

Rev. Edward Burrows

of Limbury, Luton,

for service at Serampore College, India,

and

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of the Baptist Theological College of Scotland for service in Sri Lanka.

These appointments were made in response to invitations from India and Sri Lanka.
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Patients' Relatives

Another aspect of the chaplain's ministry is bound up with relatives and the problems arising out of their own relationships with the patient. One so often finds that the patient being treated in hospital represents the tip of an iceberg of disturbed personal relationships. Staff have often said to me "We're treating the wrong person here", meaning that the real problems lie within families and human relationships outside. With the best will in the world, statutory agencies often have their hands tied when it comes to dealing with such matters, but the chaplain may well be able to step in and tackle a situation successfully because of his genuine concern and impartiality.

A woman was admitted to hospital suffering from the effects of an overdose following a brief extra-marital affair. The symptoms of depression and anxiety were soon dealt with, but the real causes had still to be tackled. It was evident, however, that the doctors had not time to deal with a tangle of human relationships that they felt lay outside their professional concern. As I had established a relationship of trust with the patient, I was allowed to enter into the situation where conversations with the husband, the other man as well as the woman, enabled in time a happy and so far permanent solution to be found.

Again, a woman was referred to me by a Consultant. Her problem was one of loneliness and guilt. She had an illegitimate and unfortunately subnormal boy who had to come into hospital for treatment. The woman had always kept herself to herself and had no close friends. Could we find somewhere where she could meet people without questions being asked? The answer was to introduce her to our after-care club. But this isn't a success story. The woman is very shy and although expressing interest, has made all kinds of excuses why she has not been able to attend the club, even though transport has been offered. The only thing to do is to try and keep in touch by occasional visits and hope that one day the ice will be broken.

Sometimes a man's worst enemies are to be found amongst kith and kin, and counselling these people when they themselves are unaware of the harm their attitudes cause is by no means easy or pleasant, but it has to be done and often the chaplain may be the man for the task.

I had to interview the parents of a patient. They were pleasant, hardworking, respectable people who were deeply disturbed by their daughter's illness and broken marriage. It was evident, however, from what they said and the way they behaved in their daughter's presence, that they were completely swamping her personality and, although a woman of thirty, she was becoming utterly dependent upon her mother. The girl realised this and once protested "But, mother, you won't allow me to live my own life". The reply was "Don't be silly, dear, you know that your father and I have always done our best for you. We only want you to be happy, etc., etc.".

It was by no means easy to get them to see that certain

aspects of their concern were not conducive to the girl's recovery. But they did see a little light eventually, and things have improved. The daughter has since made a good recovery. She has managed to leave home and live independently. She visits her parents from time to time and her relationships with them are no longer strained as before. Her own faith in God has been re-awakened and she finds help and encouragement in Christian friends.

I believe that local church fellowships have an important part to play in this caring ministry. Unfortunately, as I have already mentioned, there is still a great deal of misunderstanding and Christians need to be educated. It appears to me, as one who can look from the outside at the local churches' activities, that they are still largely bound up with themselves and with their own domestic affairs. Some do occasionally conduct ward services and there are a few churches which maintain a regular ministry in this respect, but there, it seems, their active interest stops. The new Health Service envisages a greater emphasis on community care, especially of the psychiatric services, so it behoves us to create some kind of concern and to contemplate some sort of practical action. What about some of those large church halls which remain empty for most of the week, at least during the day? Could they be used for day centres for the mentally handicapped or the mentally ill? What about our men's and women's meetings devoting one or two of their monthly meetings to some form of practical caring, either within the community or hospital? Pastoral concern is not the responsibility of one man, but of the Church as a whole. Though a great many of us pay lip service to this belief, it would appear that a few people are carrying quite a heavy burden.

H. W. TRENT

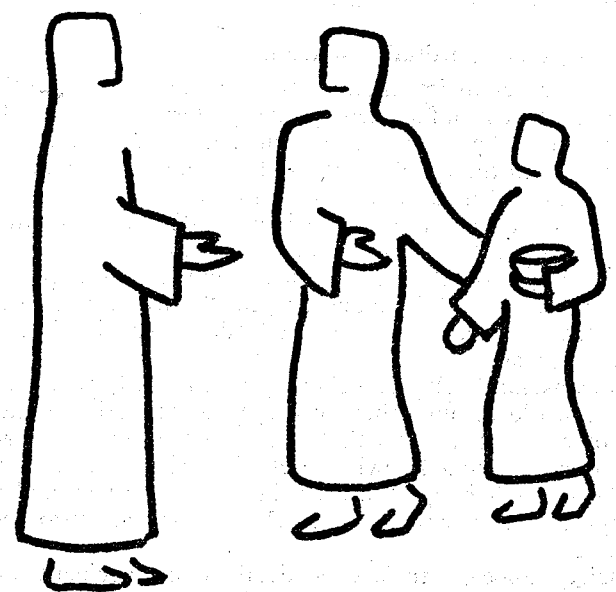
UNDERSTANDING AND CARING FOR THE DYING:

A DOCTOR'S VIEW

Death is something each one of us experiences in turn—and something we all wish to postpone as long as possible. In talking to the dying the objective is to build a relationship between two people—the patient and counsellor—which enables a patient to come to terms with his impending death and to provide him with reassurance and support during this very difficult phase of his life. This relationship should be widened to include the relatives of the dying patient for they will require help before and after the patient has died. Relatives appear to be able to accept a death in the family far more readily when they and the patient have received adequate support during the final illness—and of course the converse is true when people don't receive the help that is needed.

One of the difficulties in counselling the dying is that no living person has himself experienced death. It is easy to misunderstand the needs of a dying man or to ignore or misinterpret his cries for help—but the more experience that is

"There is a lad here" . . .



. . . who has a need

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gained, the more confidence and skill the counsellor develops in caring for the very ill. The purpose of this article is to pass on some of the lessons I have learnt over fifteen years in general practice. My teachers have been many patients who have been prepared to share their thoughts and feelings with me as they approach their death.

Factors affecting attitudes to death

People react to impending death in themselves or others in different ways, influenced by their philosophy of life. Their belief in a God and a life after death may help them to come to terms with the problem. It would be understandable if all those who had a faith were able to cope with death while those who had no faith found it more difficult—but this is not always so. The people who have absolutely no fears or worries about death must be in a minority for even Jesus when he was in Gethsemane prayed "O my father, if it be possible let this cup pass from me"—demonstrating just how human he was.

Subconsciously all men believe they will live for ever. They see the world through their own eyes and experience and so cannot envisage a world that functions without them. Men go mountaineering knowing there is a risk of death, convinced it won't happen to them but only to others and it is always the other person who develops a coronary thrombosis or cancer.

Society appears to accept death from accident more readily than from illness. I view all illness as accidents of life which may lead to death and some patients seem to be helped from having this pointed out to them. More horror and sympathy is evoked for the patient who is dying from cancer than any other type of illness. The man who has a sudden coronary and dies without suffering can be seen to be fortunate although it may be extremely difficult for his relatives to cope with their grief and shock when they have had no warning.

All accept that the elderly are nearing the end of their lives. They can be philosophical about the fact that they may not be alive in one or two years—yet take great care of themselves to remain on earth as long as possible. Children who are mortally ill evoke most sympathy—for why should a child miss so much. When a person who is dying is one's contemporary it is easy to become deeply involved emotionally in the problem for people imagine how they would feel if they were dying in place of the patient and almost punish themselves for *not* being the patient. This can be taken to such lengths that they may require medical treatment to cope with the situation—yet nothing is achieved by this attitude.

Society's attitude to dying

Society's attitude to the dying is frequently one of embarrassment. People, frequently including doctors and ministers, don't know how to deal with the terminally ill for they don't know what attitude to take or what information to impart to them. They won't tell the patient how ill he is and often

forbid the relatives to tell him either, because of the difficulties that may have to be coped with in facing a dying patient who knows he is dying. So often the attitude towards a helpless dying patient, lying in a bed, is like that of a parent towards his child. The child must be protected at all costs and should only be given good news and not bad as he probably won't cope with the bad. The seriously ill resent being treated as children as many, while physically unable to cope, continue to have clear and active minds and are still capable of assessing problems and contributing to their family situation.

I am fully convinced that most people who are dying are aware of the fact or at least that their condition is deteriorating, yet many members of the medical profession are not prepared to talk honestly to their patients. When patients express their fears to their doctors and nurses they are usually reassured forcibly that all is well, until they withdraw into their shell unable to communicate with the outside world. Such a patient then can't even express his fears of pain, of death, of letting himself down, as those who care for him may abruptly terminate the conversation in embarrassment.

This strain between the patient and his doctors and nurses becomes even greater when he can't communicate with his relatives either as they have been told not to tell. The burden of caring for a dying relative can be intolerable under these circumstances and I believe many patients are admitted to hospital to die because the relatives can't stand this strain.

Mrs X came to see me in tears as her husband was dying of carcinoma of the stomach and she had been told by the hospital not to tell him. This would be the first time in her life she had ever lied to him. I talked to her about my views on sharing the problem with him and including him in discussions on his care, but in her distress she wasn't sure whether to accept my advice. She eventually asked my partner (his own doctor) to tell him. Three weeks later I was called to the house to administer treatment. I was struck by the happy relaxed atmosphere between everyone in this situation where the patient was obviously dying, but it wasn't until the wife pointed it out to me that I remembered my previous conversation with her. She told me what a happy time they had had since the truth had been shared between them, feeling closer together than at any time in their 40 years of marriage.

Patient's reaction to impending death

Elizabeth Kobler Ross in her book "On death and dying" (Tavistock Publications), described five stages that the patient may pass through as he comes to terms with his condition.

The first stage when he becomes aware of the serious nature of his illness is denial and isolation "No not me, it cannot be true". This is a natural reaction to the shock of the news and may lead to the isolation of the patient as "nobody understands". Anger is the second stage replacing the first when denial is no longer possible "Why me?". The anger

may be directed in any direction—relatives, doctors and nurses, pastor—or even God Himself.

Bargaining is the third stage. If he gives the rest of his life to God will he be allowed to live? This may be associated with guilt for omissions in the past. Stage 4 is depression when the patient can no longer deny his illness and feels progressively weaker and this can lead to the final stage of acceptance where the patient can fight no longer and is ready to withdraw from the world.

The patient's reaction to his illness will also depend on his views on the purpose of life and whether he feels he has wasted it or not. It will also be affected by the way others are treating him. Is the nature of his illness known and discussed openly? Do people still consult him about problems as before and is he still allowed to make a valid contribution to those round about him?

Relative's reaction to impending death

The relatives often have great difficulty in accepting that the patient is dying. The saddest thing about a happy marriage is that one day it comes to an end and one partner will be left. The relatives may well blame themselves for not ensuring the patient went to the doctor earlier. They resent their friends who appear to be well and happy and they have anxiety for the future when they will be left alone to carry the problems of life themselves.

So often it is a wife who is only too ready to accept help and support at this stage, but easily feels let down if the support doesn't come up to her needs and expectations. When the patient is being nursed at home the wife will frequently have disturbed nights and go short of sleep making it increasingly difficult to cope with the situation.

How do I deal with a dying patient?

I find it almost impossible not to tell the truth to my patients when they ask me questions—in fact I have consciously tried to build up a reputation of being able to talk honestly with patients. I often say if they really want true answers to their medical problems they can come and ask me and I will tell as much as I know.

Before talking to a patient I usually see the relatives and inform them what I intend to do. Sometimes the relatives are completely opposed to the patient being told anything and if that is the case, I will usually express my opinions on this point of view, the result often being that they will leave it to me to decide. It is important to remember the patient himself has rights and that his doctor should be prepared to answer his questions if he insists. One great advantage a general practitioner has over his hospital colleague is that he has probably known the patient and his relatives over many years and they are very ready to accept guidance from him.

If I am going to build an honest relationship with a dying patient, I have also to be more prepared to support him. Although off duty, I will, when possible, go and see him

myself when help is needed, for only I know what has been said between us. It is so easy for a colleague unfamiliar with the situation to say just the wrong thing.

It is important to be perceptive to the patient's needs at this time and make time to talk when *he* wants to talk. Once the patient indicates he wants to talk—either from what he says spontaneously or from encouragement from me, I try to put out of my mind completely all the other problems I have to deal with that day and concentrate entirely on him. I avoid looking at my watch and try to relax completely as he asks questions. I usually sit on the side of the bed or on a chair from which the patient can see me easily without having to strain for it is far more difficult to talk to someone who stands at the end of the bed, apparently ready to leave as soon as possible.

The patient usually wants to know what is wrong with him and what the chances of recovery are. Will treatment help and what do I honestly think are the chances? I try to answer these questions as truthfully as possible always with an element of hope. The question "How long have I got?" is the most difficult to answer and one which I may well hedge round a little because I honestly don't know. My impression is that patients often live longer than expected when they know what they are up against.

Having been open with my patients, I am then able to talk to them of their worries. They are frequently worried about the process of dying, will it be painful or undignified? I assure them that as far as I am concerned pain should be unnecessary and I will do all in my power to help them avoid it. Most people like the thought of being able to die in their own surroundings and ask if it is possible to stay at home. I promise that I will certainly keep them there if at all possible but the final decision on this must be left to me as so much depends on the way the relatives stand up to the strain.

How will their relatives cope without them when they have been together so long is a question frequently asked. I point out to them how fortunate they are to have some warning of their death for it will enable them to put their affairs in order and teach their husband or wife how to cope without them.

Mrs Y. was a lady of about 50 who was dying of cancer. The boys had left home but her main worry was her 12-year-old daughter. The patient and I talked very openly about her condition and prognosis. She knew what was going to happen to her and I suggested she spent some of her time giving to her daughter advice she would under normal circumstances give as she continued to grow up. This she did and was also able to make arrangements for friends to keep an eye on the daughter and to discuss with her husband how she felt he should run the household. Although she didn't want to die she did so happily, knowing she had made arrangements for the family as far as possible.

It is a source of constant surprise to me that patients who have always been very concerned about themselves in the

WEST HAM CENTRAL MISSION

409 Barking Road, Plaistow, London, E13 8AL

My dear Brother Minister,

Let me start on a note of thanksgiving. I am writing these notes just before Christmas, in the middle of the response to our Christmas Appeal, and I am delighted to be able to report that the money has come flooding in so that it looks as if we may have broken all records.

The response, both from private individuals and from Churches, is heavier than ever, and I cannot let this opportunity go by without thanking those responsible. I am very conscious that our Ministers are key people in situations like this, and I thank everyone of you who said a good word for us.

You will not need me to tell you that we shall need every penny of the money that has been sent. I am neither a prophet nor the son of a prophet, but I think I know when the east wind is blowing, and I am anticipating that 1975 will prove a very difficult year for all Charities, and to particularize, a very difficult year for the West Ham Central Mission. Nevertheless, I am persuaded that we shall weather the storm, and all I am asking from you at the moment is that you would ask your people to put the work of the Mission on their prayer lists, for public and private prayer, so that we may be remembered at the place where it matters most.

I am delighted to tell you that the work of the Mission is being blessed of God in all kinds of ways, at Greenwoods, and Orchard House, and Rest-a-While, and Marnham House Settlement, and we thank all our friends who support us by giving us the opportunity of sponsoring the work we do.

May God's blessing be on you and your own Church throughout 1975 and may you see the signs following.

Yours very sincerely,

STANLEY TURL

Superintendent of the West Ham Central Mission

past, frequently accept fatal disease in a very relaxed and calm way. Mrs Z. was over 70 and had suffered from chest disease. She demanded a lot from her daughter and frequently called the doctor. She developed a carcinoma and one day asked me for an honest assessment of herself. I spent some time discussing her illness and that she wouldn't get better; following that discussion she became a pleasure to look after. The nurse commented on her improvement in attitude as did her relatives. She was a Christian and although she often felt quite ill would attend church and did as many other things as possible to within a few days of her death.

Doctors and Ministers in the care of the dying

There are large areas in common between the work of doctors and ministers. When caring for people we both do so on a one to one basis, and where those people are dying, develop a very deep relationship with them.

When I talk to a dying patient as a doctor, I do so with a tremendous amount of background information the minister doesn't have. The subject can be broched by the minister with an open-ended question such as "How ill are you?" It is important to be normal and relaxed with the patient. Often the patient in hospital complains that the Chaplain is too flippant when he wants to talk seriously—or that he is too glum. All the patient asks is to be taken seriously and treated like a normal person.

Conclusions:

In this article I have purposely avoided discussing the patient's spiritual problems for in practice when they are mentioned I usually suggest a minister is called in. As a Christian I am obviously prepared to listen to them and assure them that God hasn't let them down neither is He punishing them. So many Christians appear to feel they should have indemnity from sickness and suffering and their Christian faith appears to be more of an insurance policy.

I don't claim to be an expert in the care of the dying but feel that as I continue to look after seriously ill patients I am developing more skill in talking to them. One of the greatest privileges I have in my work is to help people at the end of their lives to die as happily and contentedly as possible. This I find enables the relatives to accept death more easily and to come to terms with their grief more readily.

My understanding of the worries of patients has developed as a result of talking to—and more important—listening to dying patients. They have been and will continue to be, my teachers.

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C. B. FLOYD

INNER AND OUTER CITY

Bill grew up in a rough street. He knew what it was to come home from school and find all the family's possessions piled in the front garden because they had been evicted. Many of his pals were the same, and some have found themselves in and out of jail.

Somehow the local Baptist Church got hold of him in their Boys' Brigade company. Any time he failed to turn up, his B.B. captain went to look for him. In time he was baptized, and soon became a leader among the church's young people. His daily work was in a wood-working firm; being honest and reliable, he became a foreman. The church had made something of him.

The girl he married was in the Girls' Brigade. She too came from a very poor street, though not from such a rough background. She became an infants' teacher. After they married, they lived for a while in such rented accommodation as they could find, but they were determined to give their children a better start in life than they had had themselves. In time they managed to get a mortgage on a small house in a very pleasant suburb, out along the radial road from the area where they grew up.

Looked at from one point of view, once again the Church has taken people out of the working class and made them middle-class. But that surely is nothing to be ashamed of. The Christian Church has taken someone who would have become one of the failures of life, and given him self-respect and worth and dignity. It has been the making of Bill and his wife.

David Sheppard has rightly reminded those who are middle-class to respect the working class: "It is a testimony to the toughness and adaptability of the human spirit that we can list endurance, expressiveness, humour, openness, solidarity, compassion, along with the bad things that confront us in working class life in the big city".* But when the Church has enabled people to surmount that bad things, and enter into better things, this is good. It does not always happen, but when it does it is a natural effect of the Gospel.

What does this imply for the resources of the inner city churches? There is a steady process whereby these churches remain chronically short of leaders. As fast as they discover or raise up people with initiative and leadership potential, they tend to lose them to the outer suburbs, "To those that have shall be given . . ."

Are these resources lost inescapably from the inner churches? Are these Churches always going to be supplying resources to thriving suburban churches? According to some current thinking, the answer is "Yes". I quote from the 1972 report of the Birmingham Baptist Strategy Commission:

> "It would seem that there is a vast challenge for the affluent suburban churches. It would be easy to ask for financial commitment by suburban churches to those in the 'inner ring' or to ask for a redirection of stewardship of time and talents, but both these smack of condescension. It is no good to appear to condescend—and it is in flat contradiction of the Gospel. Any effective Christian presence must be one which shares the ills and pressures of the area."

*"Built as a City" p. 34 (Hodder and Stoughton, 1974).

Of course there is warning here of a real danger—but it is also a very specious rationalisation whereby the suburban churches escape an inconvenient challenge.

It is argued again, quite rightly, that the style of life of suburban churches is unsuited to the 'inner ring' churches. Suburban life is too tidy; the good organiser is one who gets his agendas out, and his meetings over, in good time, and sees that everything runs smoothly. The natural style in the inner ring is different.

Again, there is important truth in this—but one crucial question is begged. Do the suburban churches try to learn from all this *how* to help, or do they take this as carte blanche for *not* helping? Are we not dangerously near saying to the inner ring areas, "Whether or not you are already ghettoes, you ought to be—it is better for you, it is no good trying to bridge the gulf from the suburban areas?"

One suggestion is that a few from the outer suburbs should make a *total* break. The Birmingham Strategy Report says:

> "One wonders whether more Christian families and individuals would respond to the need if the Churches were to ask and encourage them to move in to the 'inner ring', to set up house there, and to join with those Christians already there deliberately to seek to strengthen the Christian community and to seek ways in which to set forth the love of Christ, both by a caring relationship to their neighbours and by concerted action on some of the problems".

This is fine, but it cannot be the main life-line of the inner churches. It is the kind of sacrifice which will be the vocation of a few only. It would be comparatively easy for, say, young married couples (and would make it easier for them to save money for a few years!) but for families with children it would mean an educational sacrifice harder than that faced by many missionaries. Only a few would feel this to be right. In the main, the inner churches would continue to feel victims of neglect.

There are other things which are resented by inner ring areas beside condescension. They resent the unshared affluence of manpower and money in the outer areas. Resources in the suburban churches may be fully committed in their own work—but work tends to expand to utilise the available resources anyway.

The Girls' Brigade in Birmingham illustrates the processes at work. Companies are divided into Districts, and my own church's company belongs to a largely inner-ring District. They share similar problems; they also share their scanty resources. When the company from a neighbouring Baptist

church could find no officers, one of my key members became captain—this in addition to being the only lieutenant in our own company, and leader of the Primary Dept. of our Family Church. This inner-ring District of the G.B. has recently disbanded itself; the member companies are joining other Districts in the hope that better-off suburban Districts will thereby realise the need to share some of their resources.

In fact, in so many ways our inner churches *do* rely on "commuters". There is a natural mobility in the city; it may be hard to move home, but it is not hard to move around. Possibly London is so vast as to be an exception (I have no experience of living there) but in a city of even a million inhabitants the journey from inner ring to outer suburb takes only a few minutes. The very life of a city is based on personal mobility.

Two of the most devoted, hard-working and best-loved members of my own church grew up in its neighbourhood but moved to a house in an outer suburb as soon as they married. For thirty-five years they have commuted faithfully (just as the husband does daily to work), throwing themselves wholeheartedly into the life of the church. No one ever thinks of them as condescending. Condescension is an attitude of mind that does not simply depend on where you live, or how far you travel to church.

Often those who have grown up in an area, like these, are indeed the ones best able to make a contribution—and this is the most natural answer to the problem with which this article began. But others may do the same. A young medical student, living in a comfortable part of the city, has this last year thrown in her lot with my neighbouring parish church. She has rapidly become at home there, they feel she is "one of them", she shares in their work.

This does not need some very special personality—only someone who is humble and not stuck-up, someone who is out-going and warm-hearted, someone who is willing to say, "This is going to be *my* church".

I would say to ministers of suburban churches: Send us more people like this, and the ordinary members of our inner churches will be deeply grateful to you. They will not feel that aliens are coming to them, only that they have fellow Christians who care.

If we are concerned at the weakness of Christian witness in some of the most needy areas of our great cities, here is one immediate and practical way of helping. It will not be easy, because no church wants to give up members who are humble, out-going, warm-hearted and whole-hearted. But let this be encouraged, as well as the more drastic vocation of physically moving house as well.

There is a very good scriptural principle here:

> "I am not trying to relieve others by putting a burden on you; but since you have plenty at this time, it is only fair that you should help those who are in need."

E. H. B. WILLIAMS