Chaplaincy in Queensland Health, and private hospitals in South East Queensland: a study in the re-articulation of pastoral care within a framework of plurality and difference.

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Abstract.

Pastoral care in our day has its origins in the Christian church and the religious (Soul) care of members. Pastoral care in the hospital has been, and continues to be articulated in the traditional terminology of religious care. This thesis argues that in our multicultural and multifaith society re-articulation of pastoral care is now required; taking account of the nature of belief, genuine valuing of story, and focused presence. Such benchmarks create authentic engagement through which pastoral care becomes capable of crossing religious boundaries to foster spiritual comfort.

This thesis maps these factors – belief, story and presence - within the literature review, drawing on the experience of many researchers in pastoral care, and of those who in various ways have engaged with others in sharing their own lives, experiences and reflections. The review sources engage with pluralism, the differences between spiritual and religious care, the importance of authenticity and the way this might be discerned through a brief study of belief, story, and presence. The research strategy employed questionnaires and interviews with chaplains and representatives of their denomination using qualitative narrative procedures. The responses of a select group of chaplains to a number of questions about their understanding of, and involvement in pastoral care were obtained. A selection of these was chosen for engagement in an interview process drawing out additional meanings. A number of people who, as representatives of their denominational body, have responsibility for appointing chaplains were then asked to answer questions in relation to their responsibilities and their views about the programme and procedures.

It was found that understanding of chaplaincy was circumscribed by belief, and the limited understanding of professionalism in its practise. A tendency to engage in religious care did not allow for adequate interfaith engagement. Participants were hesitant about the value of story and presence and there was some evidence of non-understanding. Training and supervision clearly need greater consideration in order for chaplains to develop a truly authentic approach to pastoral care in general and spiritual care in particular.
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Walter Blair Stratford.
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Abbreviations used

ACCM. Academy for Chaplaincy and Community Ministries.
CEM. Continuing Education for Ministry.
Cert. IV. Certificate IV in Pastoral Care.
CPE. Clinical Pastoral Education.
EHCC. Ecumenical Hospital Chaplaincy Course. (a course of training used prior to its re-development as HMPCC)
HCCVi. Hospital Chaplaincy Council of Victoria Inc.
HMPCC. Hospital Ministry and Pastoral Care Course.
ITIM. Interchurch Trades and Industry Mission
NHS. National Health Service (United Kingdom).
NLM. New Life Ministries.
NRSV. New Revised Standard Version of the Bible
OP. Overall Position tertiary entrance rank.
Pilgrim Learning Community. “UCA (Queensland Synod) Christian Education and Lay Training Organization”
RTO. Registered Training Officer.
SCA. Spiritual Care Australia Inc.
UCA. Uniting Church in Australia.
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Definitions.

Christian.
  a. Christian church: an organized and structured expression of the faith stance of members.
  b. A person who commits to and is recognized by the church (usually a denomination) as a member.
  c. Christian faith: The tenets of belief developed and acknowledged by the church as the expression of its faith.

Religion
  a. A formal or institutionalized, socially organized, and structured expression of belief
  b. Religious –the attitude and feeling of one who believes in a transcendent power or powers.

Spiritual
  Gary Bouma, in his Australian Soul: Religion and Spirituality in the 21st Century, puts forward a useful definition of spiritual which I find helpful, and which is acceptable to me as a definition in this thesis.
    a. ‘the spiritual refers to an experiential journey of encounter and relationship with otherness, with powers, forces and beings beyond the scope of everyday life’ (2006, p.12).
    b. ‘To be spiritual is to be open to this “more than” in life, to expect to encounter it and to expect to relate to it’ (2006, p.12).

Multifaith
  a. An expression of recognition of the large numbers of faith standpoints that can be found in the world.

Interfaith
  a. Title applied to any interaction between different faiths. For example: Christian v Muslim. Buddhist v Jewish.
  b. Distinct from "Interchurch" which describes interaction between Christian denominations.
Introduction.

Australia in this 21st century is a multi-layered society. The layers embrace ethnicity, culture, religious belief, and much more. Christianity is by far the dominant religion, but is diminishing in importance because of the increasing variability of other faith groups and also the rise of secularism. Within this amalgam of difference however, pastoral care continues to have an important function. Pastoral care is expressed in many ways depending on the context. These contexts include at least, educational facilities, prisons, sporting bodies, industry, health care, and aged care.

My specific application for pastoral care is within private and public health care hospitals in South East Queensland. Pastoral care stems from pre-Christian times; Hebrew Scriptures portray shepherding as a model of God’s action towards God’s people. This has been refined in the Christian church, and through the centuries has been considered to have a primary benefit in the care of souls.

The history of religion demonstrates the range and variability of religious faiths and their associated systems of belief. Faith groups are made up of people, and as people vary so also do the beliefs they espouse. The purpose of this thesis however, is not to ascertain the views of those who are undertaking a chaplaincy role on behalf of non-Christian faith groups, but to identify the difficulties present in current Queensland hospital chaplaincy arrangements. Highlighting misunderstanding in our multifaith society is a pathway to improving spiritual care.

Denominationalism in the Christian church clearly shows the variety of beliefs in the church and, when we extrapolate from Christianity to other faiths, a similar pattern emerges. Belief therefore has the potential to be a unifier and bring people, who differ in their personalities, together into community. At the
same time however, there is the potential for, and in many instances the actuality of, suspicion directed towards those whose beliefs differ.

The purpose of all this is to demonstrate that in all belief systems, personal belief impacts strongly on relations with others. Those who take on the task of chaplaincy, as presented in this thesis, do not come with a pure belief. They come with their own history of engagement with Christianity, and other faiths, through the veil of their denomination.

A central question in this thesis is; how do those engaging in pastoral care from a Christian perspective in which God is clearly named, provide appropriately and with integrity for those whose lives are constructed differently. In order to do this, three core features must be taken into account. In this thesis they are delineated as belief, story, and presence, and each one will be explored more widely in the body of the thesis.

Listening carefully to people’s stories opens pathways into their lives and the potential for the chaplain to be a travelling companion for a time. Being clearly present in the encounter allows for trust to develop and grow with mutuality in understanding. The reason why belief is so important is its potential to both engage and repel. Belief that engages recognizes difference and understands that belief, even within one faith standpoint, has a dynamic quality. Belief that repels can be portrayed as a room with locked doors. Others can be locked out and particular belief stances held fast.

Both of these are possibilities and both of these have the potential to affect pastoral encounters. Elements of both possibilities will be recognized in the profiles presented in Chapter 5. Inasmuch as belief, story and presence affect each other and the progress of authentic pastoral care, the links must be forged with care. This thesis seeks to explore the extent to which this occurs within the parameters established for this study.
Chapter 1. Literature Review.

Pluralism: Acknowledging difference.

Daniel Schipani writing of interfaith pastoral care says:

The growing presence of a plurality of faith expressions (as well as non-religious) in our culture is indeed a major dimension of the social reality. Christian pastoral care specialists, both as practitioners and as pastoral theologians, need to work within, and reflect upon such a reality in the light of normative claims of the Christian faith tradition [...]. (2007, p.407)

While the parameters of this thesis are set within Christianity, it is not my intention to deny or minimize the faith standpoints of any other faith group; my parameters have to be limited by space and topic. The Christian church however, is not unified in its exposition of the Christian faith. The reality is that there are many variations embraced across all cultures and races. Within Christianity, despite "normative claims" there has been, and still is, a plurality in which denominations claim a variety of belief standpoints. It is also true to say that within Christianity, spread through the world, there are many cultural differences. My focus however, is on the plurality of world religions in which Christianity becomes one of many. While those engaging in pastoral care will be well aware of denominational differences, awareness of faith differences is less clear.

Plurality is one aspect of multiculturism and globalization, and needs to be taken into account as we attempt to live appropriately in one world. Samuel Lee (2001), a Methodist theologian, makes the comment that: 'multiculturalism and globalization are not matters of faddism. They describe the reality of the society to which we belong. We cannot simply close our eyes to the reality of the society to which we belong' (p.390). The difficulty with chaplaincy, from a Christian standpoint, is that while multiculturalism and globalization are acceptable, if hard for some, attaching the sense of these to religion is a stumbling block that proves at times, almost insurmountable in pastoral care.
It is however, important to develop awareness because public health systems provide services for all, irrespective of cultural or faith differences. Anderson’s (2004) claim that ‘chaplains are constantly challenged to weigh and evaluate what is out of the range of previous life experience’ (p.3), is a timely reminder for all engaging in pastoral care. This is particularly so for those whose personal faith stance contains a conviction that the faith stance of others is not as efficacious as their own.

Understanding, however, is fundamental to appropriate recognition of differing values [and faiths] that hold people’s attention. Sir Isaiah Berlin renowned philosopher claims, and I think correctly, that understanding at times requires imagination. He expresses his claim in this way:

If I am a man or a woman with sufficient imagination (and this I do need), I can enter into a value system which is not my own, but which is nevertheless something I can conceive of men pursuing while remaining human, while remaining creatures with whom I can communicate, with whom I have some common values – for all human beings must have some common values or they cease to be human, and also some different values else they cease to differ, as in fact they do (2000, p.12).

Opening minds and acknowledging the essential humanity of each other, will cut across exclusivism, and open the way to a more caring and accepting community.

Religious belief is considered to be very personal, and among those who have grown up in the Christian Church, specific beliefs prevail. The church as interpreter of belief, has through the years clearly established the centrality of Jesus as the Way, Truth, and Life. This has become pivotal in Christian faith standpoints. Such boundaries have enabled many believers to retreat behind their religious barriers and feel secure. In the practice of pastoral care, however, as interactions occur with a variety of people, the boundaries may be blurred and security breached.
In learning the art of pastoral care, much needs to be unlearned; in particular the sense, where this is the case, of the absolute rightness of one’s own religious belief. This is not an easy process and Mary Fukuyama (2004) reminds us that: ‘unlearning racism, confronting internalized oppression, truly valuing differences, and taking risks to build alliances are formidable and painful tasks’ (p.31). Anderson offers two case studies and in his discussion makes the telling point that: ‘the cases describe the complexity and challenge of multi-spiritual and cultural competency development, a continuous learning process essential to professional practice in a globalized and diverse health care context’ (2004, p.20). We will become aware in chapter six (p.198) of this Thesis, in the answers to question eleven, of a reference to a training module which allows for an engagement with interfaith contexts. (p.198)

Hauerwas writes of community and diversity, with particular reference to living with mentally disabled people. There is in his words, however, a clear application for us in our approach to the diversity of faith standpoints, with the differences that chaplains must face:

There should be no mistake about it; a community of diversity that enhances differences is indeed a hard enterprise to sustain. We are creatures that fear difference. […] If we are to be a good community we must be one that has convictions substantive enough not to fear our differences, and indeed to see that we would not be whole without the other being different from us (Hauerwas in Swinton 2004, p.40).

Pastoral care clearly has a place among mentally disabled people. It is an area of care however, in which difference may be very confronting. The naivety and frank openness of many of those mentally disabled may challenge chaplains to the depths of their being. It is an aspect of diversity that crosses all boundaries of culture and faith.

Diversity is with us, and always has been. In the Christian church denominations abound. In the Australian context denominationalism is now accepted as normal; this has not always been the case. Diversity is more
clearly focused in interactions that disrupt our established and comfortable life patterns. Culture and faith belong together; in some areas tightly bound and impacting strongly on the nation. The mix of cultures and faiths that are now present, for example, in the United Kingdom with subsequent disruption of that nation’s life are the catalysts that inspired Anne-Marie Fortier to research the difficulty in that country. Introducing her work *Multicultural Horizons* she writes:

Taking seriously the question about how we could conceive of multiculture in ways that address the intensity of feelings it ignites, this volume examines the ways in which contemporary Britain is (re)imagined as a multicultural nation and how those imaginings are invested with idea(l)s of mixing loving thy neighbour, and feelings for the nation (2008, p.2).

Multicultural and multifaith belong together and “intensity of feeling” has, throughout the world, impacted not only on national attachment, but also on faith groups and beliefs that are held dear. History is witness to interfaith and intrafaith rivalry and the results of intense feeling. The immediate parallel challenge for chaplains lies in the chaplains’ Christian belief and the learned attitudes to “non-believers”; terminology traditionally applied to people of different faith.

Sherlon Pack-Brown & Carmen Braun Williams claim in *Ethics in a Multicultural Context* that:

It is common knowledge that to engage in ethical behaviour one needs to develop multicultural and diversity “lenses” in order to accurately see differences and similarities reflective of race, ethnicity, culture, gender, and so on. Of equal importance is the development of multicultural and diversity “hearing aids” that facilitate hearing values as having cultural foundations (2003, p.82).

It could be said with equal emphasis that within an ethical framework of pastoral care, one needs to develop faith lenses and hearing aids so as to more adequately provide care for those whose faith standpoint differs. Seeing, hearing and reflecting are fundamental skills for chaplains and need to be core subjects in training programmes.
David Belgum, describing in some detail the cultural mix in which America was born and developed, provides the reader with a reminder that:

Cultural diversity is not a new thing, and it will always be with us. How can we live with it creatively and constructively? Even when not agreeing with each other, we may still be able to learn from each other, remain in dialogue, and keep an open mind. (1999, p.181)

While Australia’s experience differs from the American experience, nevertheless diversity has always been with us but limited by official government policies which kept unwanted races at bay. The demise of the “White Australia Policy” and a more open stance, made room for acceptance of people from Asia and India, and their incorporation into the nation. A more recent phenomenon is the influx of refugees from Middle Eastern countries. The increase in the number of adherents of Islam has disturbed many, and for chaplains, changed the dynamic of the care they seek to offer patients in hospitals.

The Australian experience of diversity is not an isolated event. Engagement in pastoral care in this country parallels the same activity elsewhere. Christians cannot assume that pastoral care must hold to its Christian base. The world has changed. Anke Flohr, a Lutheran Minister, in Schipani and Bueckert, *Interfaith Spiritual Care (2009)*, highlights this for us. She writes from her experience of pastoral care in Hawaii and says, ‘Hawaii has many cultures and ethnic groups living closely together with as many languages spoken as there are different ethnic groups’ (p.145). Approximately 50% of the population is Christian she says, and there are many denominational groupings. In this diversity, ‘being able to engage in “interfaith dialogue” is a necessity for chaplains’ (p.145).

Leah Bueckert (2009) recognized her multifaith encounters as a chaplain as stepping into the borderlands (p.29-49), acknowledging that ‘extending
welcome to care receivers of faiths different than ours may generate feelings of insecurity and anxiety’ (p.30).

We can discern in Kristen Johnson’s (2007) work on theology, political theory and pluralism, the directions that might be indicated by insecurity and anxiety. She writes of differences in identity formation and the necessity for understanding:

While difference is essential to the formation of identity, it is all too easy for difference to be translated into otherness or evil, while established identities come to seem as if they reflect the immutable, true order of reality […] Instead of treating difference as a complementary or contending identity with which one should be engaged and to which one should give respect, belief in the truth of one’s own identity leads one to treat difference as otherness. The latter results in scapegoating and oppression […] (2007, p.103).

History bears witness to scapegoating and oppression within and beyond the Christian church.

We need to note, however, that the formulation of a theology as Christianity developed, based its understanding on the message discerned in the gospels, along with a presumed authority of the Apostles as witnesses to Jesus’ life and work. Taking the words ascribed to Jesus, “Go into the world and baptize all in the name of Father, Son, and Holy Spirit”, as a command, Christians moved into the world with determination to carry out the command. Hick reminds us of the aggressive way Christian exclusiveness spread into the world:

It was a virtually unchallenged assumption that Christianity was to spread throughout the world, replacing the non-Christian traditions. Thus as late as 1913 Julius Richter defined his subject of missiology as “that branch of theology which in opposition to the non-Christian religions, shows the Christian religion to be the Way, the Truth, and the Life; which seeks to dispossess the non-Christian religions and to plant in their stead in the soil of heathen national life the evangelic faith and the Christian life” (1987, p.21).
Christianity’s exclusivist attitude sowed the seeds of scapegoating, and oppressing of the other. Kenneth Pargament, (2007) Jewish psychologist and researcher, observes that: ‘what marks exclusivism at its most extreme is the failure to respect the diversity of pathways that may lead to the sacred’ (p.189).

Sir Isaiah Berlin claims that while there is a plurality of values, in which values differ one from the other, it is nevertheless possible to understand the differences:

I do believe that there is a plurality of values which men can and do seek, and that these values differ. There is not an infinity of them: the number of human values, of values which I can pursue while maintaining my human semblance, my human character, is finite – let us say 74, or perhaps 122, or 26, but finite, whatever it may be. And the difference this makes is that if a man pursues one of these values, I, who do not, am able to understand why he pursues it or what it would be like, in his circumstances, for me to be induced to pursue it. Hence the possibility of human understanding (2000, p.12). ¹

Chaplains, who seek to understand the validity of faith stances in the lives of people, will in the offering of care, give respect to the one with whom they are engaging. Mackenzie et al (2011) write of ‘becoming available for the evolution of human being’ (p.161).

The key words in this first section are “multifaith and multicultural lenses”. Our entry into the re-articulation of pastoral care has taken us headlong into difference; in particular faith difference and the intensity of feeling attached to it. The literature is clear about the all pervading presence of diversity, but also about the need to live creatively and ethically within that diversity. The challenge for all engaging in pastoral care, is in the recognition that we are all bound together as human beings.

¹ This of course needs now to be inclusive. Him, and his should also appear alongside her, and hers. This should be understood as my intent whenever such quotations are used.
Care Models.
Pastoral care has its roots in the church’s history and stems from the image of the shepherd which arises in the Hebrew Scriptures long before the advent of Christianity. Shepherding was a common occupation, and in the biblical prophetic literature God is depicted as the good shepherd, caring for his sheep. It is used as a metaphor for the gathering of the Israelites into a common faith community. In Ezekiel, God says, ‘I will seek out my sheep. I will rescue them [...]’ (34:12). The Psalmist sings, ‘The Lord is my shepherd, I shall not want’ (Ps23). In the New Testament, the shepherds are given news of the birth of Jesus (Luke 2:10-11), and in John’s Gospel (10:11) Jesus says, “I am the good shepherd.”

In the church, considered to be the embodiment of the risen Christ, shepherding became an important model for ministry. The work of Jesus, in seeking out and rescuing, became the pastoral work of the church. Pastoral care has been for centuries, care of the religious life of individuals within the church as the faith community. McNeil (1977) writes of Pope Gregory the Great (540-604) who, in his treatise on the ‘Cure of Souls’, established a model that continued for centuries. Schillebeeckx (1985) comments that, ‘this book was to determine the whole of mediaeval spirituality of the ministry of proclamation and pastoral care’ (p.175). The necessity for the cure of souls established in the church led to a major undertaking of mission to gather all into Mother Church. The church established in Europe, carried all before it as the protector and guardian of religious life.

Even with the advent of the Reformation, resulting in many changes in the church, the practice of pastoral care continued as before. Conrad Cordatus provides us with an historical expression of this shepherding image and its application in the church, when he writes of Martin Luther’s approach to the sick:
When he [Luther] approaches a sick man he converses with him in a very friendly way, bends down as close to him as he can with his whole body, and first inquires about his illness, what his ailment is, how long he has been sick, what physician he has called, and what kind of medicine he has been using. Then he asks whether the sick man has been patient before God. When he has now assured himself that the sick man's will is inclined towards God, that he acknowledges that the illness, sent upon him by the will of God, is to be borne with patience, and that he is prepared to die in God's name, if this be his will, Luther highly praises this disposition of his as a work wrought to him by the Holy Ghost himself (Cordatus in Tappert 1955, p.36).

Luther seeks assurance of the correct disposition of the patient towards God. The assurance is that there is congruence between the faith of the patient and the will of God. The will of God, of course, was determined by the church.

A determination of God’s will by the church, does not take pluralism into account, nor did it need to in the days of Luther. Much of the church history to which we subscribe today has its roots in Europe which, in Luther’s day, was relatively homogenous. Those, whom we might consider were people of another faith, were recognized only as heathens needing to be converted. After the conversion, pastoral care assisted in maintaining the faith. Woodward and Pattison (2000), researchers in practical theology, comment on the historical links between pastoral care and the church’s life: ‘pastoral care, together with the pastoral theology that has accompanied and supported it, has been an important part of the life of the Christian church since its earliest origins’ (p.23).

This can be illustrated in Richard Baxter’s (1655) classic work which addresses the faith life of pastors, and then considers the nature of the work of pastors in overseeing the religious life of ‘the flock’:

The ultimate end of our pastoral oversight, is that which is the ultimate end of our whole lives; even the pleasing and glorifying of God and the glorifying of His Church. And the nearer ends of our office, are the sanctification and holy obedience of the people of our charge, their unity, order, beauty,
strength, preservation and increase; and the right worshipping of God, especially in the solemn assemblies (Baxter in Martin, H. 1956, p.48).

Carrie Doehring’s model of pastoral care is also helpful in the process of rearticulation of pastoral care. She writes of using trifocal lenses as the most effective way of providing pastoral care. She spells this out as follows:

Using a premodern lens, pastors assume for the moment that God or that which is sacred can be glimpsed and apprehended to some degree through sacred texts, religious rituals and traditions, and religious and spiritual experiences – the way transcendent realities seemed to be known within the ancient and medieval church […]. Using a modern lens, pastoral caregivers draw upon rational and empirical methods, like biblical critical methods, medical knowledge, and the social sciences in offering pastoral care. A postmodern lens brings into focus the contextual and provisional nature of knowledge, including knowledge of God (2006, p.2).

Spiritual care in particular awakens the contextual and provisional nature of knowledge, and this is mirrored in Speck’s claim that spiritual care “depends on patient and care giver being willing to explore without quite knowing where it will lead” (2004, p.21) Together they reinforce the need for changes in the delineation and practice of pastoral care. Doehring’s claim points to the premodern lens focusing on pastoral care as religious care. While this may be helpful for many, it excludes the wider ranging vision of the additional lenses. Spiritual care, at its best takes on the nature of trifocal focusing. Answers and comments from our respondents suggest a strong trend towards a single lens focus in care.

This thesis argues that in a modern multicultural context, pastoral care needs now to be considered as a generic term, in which we find religious care and spiritual care. Analysis of these however, reveals some significant differences along with some ambivalence in their practice. The differences can be located in a comparison between Dayringer (1998) with his determination that pastoral care and the Christian church are indissolubly linked, and Speck (2004) who articulates the importance of provider and receiver of pastoral care, exploring the experience together with all its uncertainties. Re-
articulation, however, is not about establishing an “either/or” or “better than” claim. Rather it is seeking to reclaim integrity in care which will honour and validate the faith stances of all care receivers.

Recognition that pastoral care has its roots in the Christian church, reveals a model of care that evolved with the church and sought always to maintain believers in their faith. Such a model however, cannot be used outside the church and among people of different faith stances without drastic changes. Doehring’s model of tri-focal lenses helps the process, and moves it beyond its earlier model. Close up, middle distance, and far distance viewing allows for a view of the whole, and in doing so, invites a different interpretation of pastoral care.

Religious care
Through the centuries, pastoral care has found expression in care of the faith life of church members and incorporation of new members into the church community. Patricia Driedger (2009) argues, however, that the Christian shepherd image is in effect an “in-house image”. It speaks of ‘the pastor shepherding the flock on its journey towards God’ (p.137). The problem for Driedger is that: ‘it is not the end goal of a spiritual path that is the primary determinant of health, but rather the process of spiritual discernment’ (p.138). This challenges the notion that the church as shepherd represents God throughout the earth; it challenges any consideration of the chaplain as the recognized expert in health and wholeness.

Discernment does not happen through being told. It comes through reflection, which may be assisted, and eventual understanding; somewhat like stepping stones over a river towards another shore. Spiritual discernment however, is not only the province of Christianity. The challenge takes concrete form in pluralism, and the claim that all have the right to live within their own faith parameters.
Articulation of pastoral care in Christian terms is expressed by many who write of pastoral care as caring for the religious feelings and understandings of Christians. Brister (1964) for example, writes of pastoral care as ‘the mutual concern of Christians for each other’ (p.12). Clebsch and Jaeckle (1964) write of ‘helping acts done by representative Christians’ (p.4). Hulme (1981), and Clinebell (1984), writing from a counseling perspective, link pastoral care and ministry; such ministry also being linked to the Christian church. Stairs, (2000) writing of pastoral care and spiritual direction, says of pastoral care: ‘In all its various forms, pastoral care seeks first and foremost to attend to the soul’ (p.7). Dayringer adds strength to these interpretations as he argues that the aims of pastoral care are closely allied to the aims of the church. These, he says are:

[...] bringing people to Christ and the Christian fellowship, aiding them to repent of sin and to accept God’s salvation, helping them to live with themselves and their community in brotherhood and love, and enabling them to act in faith and confidence (1998, p.149).

This can only have relevance if one is confining pastoral care to its historical roots within the church. Christian religious care as espoused by Dayringer, cannot be translated into a multi faith environment.

The problem with the articulation of pastoral care only in Christian religious terms lies to some extent in the belief of the provider. This finds expression in such anecdotal situations as the following dialogue which occurred between a pastoral visitor and a hospital patient. During the course of the conversation, discussion took place about God being present for the patient, and helping the patient through her sickness. At one point the patient says, “He [God] was there when I had my hypo. I was laying (sic) in the backyard all afternoon and He sent the little dog from next door. [It] kept licking my face and running back to [its] owner until he came over and found me.” The response of the pastoral visitor as she reflected on her visit was, “I was inspired and amazed by her
revelation of the dog being sent by God to save her,” and again, “God has miraculously saved her through a little dog.”

The expression of pastoral care as Christian religious care has led at times to attempts to evangelize. A duplicated paper was made available as a comment on the evangelism of children. The claim of the presenter was that it could be used as a base for exploring the way children in Australia might be evangelized. The paper was about salvation and being saved and made the point that those who are saved before they enter their teen years are more likely than those who are converted when older, to remain “absolutely committed” to Christianity.

These anecdotal references speak of miraculous experiences and evangelization, both of which, at times find a place within pastoral care expressed in a Christian framework. Leech, writing from a Christian spiritual direction perspective, claims that:

The Trinity is […] the unshakeable foundation of all religious thought, of all piety, of all spiritual life, of all experience […] If we reject the Trinity as the sole ground of all reality and of all thought, we are committed to a road that leads nowhere […] (1977, p.156).

If the Trinity, a basic belief statement in Christianity, is the unshakeable foundation […] the sole ground of all reality […], other expressions of belief are precluded. Belief that attaches to a doctrinal statement, declaring in effect that the understanding of that doctrine is its determining factor, fixes belief in

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2 Taken from a student verbatim presentation in a supervision session of the Brisbane based training programme, “Hospital Ministry and Pastoral Care Course” c.2000.

3 Source unknown. The occasion was a gathering of ministers to share a meal and discuss church matters. One of the company had recently returned from a study visit to the U.S.A. and chose to share some of his findings.

4 Spiritual Direction is not the same as Spiritual Care. It is terminology used in a mutual encounter in which one affirms/directs the religious life of another. Both director and directee will have a strong sense of the presence of the Holy Spirit as an energizing influence on religious life. Not all would endorse Leech’s standpoint.
a particular framework, from which there can be no departure. The outcome of this stance put forward by Leech, is the enshrining of Christianity as superior to all other faith standpoints. As such it is best described as pietism. Pietism is essentially individualistic in character, and finds expression in feelings of oneness with Jesus accompanied by a sense of personal well-being. Pietism is defined in the *Shorter Oxford Dictionary* as ‘Pious sentiment often implying an affectation or exaggeration of piety’ (p.1581), and similarly in the *Macquarrie Dictionary* as ‘Depth of religious feeling; godliness of life’ and ‘exaggeration or affectation of piety’ (p.1308).

The origins of pietism had a rather different emphasis than that shown above. It began as a movement towards change in the wake of the reformation and consequent upheaval in the church’s control of religious life and worship. The *Shorter Oxford Dictionary* locates it more specifically as a movement within the Lutheran church. The *Macquarrie Dictionary* more generally considers pietism as a ‘17th century movement stressing personal piety over religious formality and orthodoxy’ (p.1308) which had a considerable impact on the church. The relationship between piety and pietism, particularly in today’s climate, will be considered in the section on belief.

Pietism is questionable when found in chaplaincy practice, particularly among those who do not consider that there are boundaries in care that should not be crossed. The primary aim in any religious care offered however, should be in finding pathways that will assist patients to re-connect with important elements of their faith. Familiar rituals and symbols can lift the spirits of those whose lives are closely linked with their religious faith. Religious care, if only undertaken in the framework of “caring for the soul” may too easily become evangelism or the provision of assurance. As Driedger reminds us: ‘faith communities provide pastoral [religious] care essentially for their own members, and do not have the right to impose it on those who do not want it’ (2009, p.137).
Pastoral care, practised in a religious care framework, has its limitations none more telling than the fact that society is pluralistic, and religious care cannot legitimately be provided for all faith groups by any one faith determination. Expressing the difficulty, leads to the declaration that, in a multi-faith and predominantly secular society, hospital chaplains who from within their Christian framework, only engage in religious care, will ultimately fall short in the provision of support for the range of patients seeking healing.

Religious care itself is not the problem; rather it is in the way it is conceptualized and expressed. Pastoral care, undertaken as religious care, may be most important for the receiver. Those who treasure the symbols and rituals of their faith will find much comfort and help in their participation in these things. Rabbi Levi Meier (2008) tells stories of the impact of his small travelling Torah on the lives of patients. The portable Torah, lovingly held, became for some a transforming experience.

For Jews, the Torah is the defining symbol of religious life. It not only encapsulates the words of God as essential for their lives, it also embodies God; it is most holy. The Torah contains the truth of God and is honoured in worship as an expression of that truth with the worshipper. The integrity of the Torah is such as to become for the patients, the presence of God; a presence to be held with great care. The integrity of the Rabbi’s care of Jewish people will be breached if one from another faith attempts to offer this same religious care. Each faith stance has its own symbols and many of these will lose their meaning and potency in any transposition between faith standpoints.

Integrity in religious care will depend on the provider remaining within clear boundaries. Overstepping these boundaries because of particular religious convictions denies the relevance of diversity and results in a desire to have conformity. Any claim that one has the “true truth”, proclaims, in its telling, a judgement on all other religious standpoints as being of lesser truth. Even
within broad Christian parameters there have been many examples of, what has been termed “sheep stealing”. Integrity in faith, when devalued through proselytizing, will compromise any attempt at the provision of pastoral care. The result may well be a breakdown in communication, patients treated with disrespect, and dearly held beliefs scorned. The patient will not find healing and the pastoral encounter will have failed.

“True truth”, an expression used particularly among strongly evangelical Christians as a judgement against other faiths, expresses an opinion about “lesser truths.” Such an opinion raises barriers that interfere with any interfaith interaction. Patricia Driedger (2009) writes of her journey, from considering that ‘the role of hospital chaplain was to offer people the hope and strength of faith during a difficult time’, to an understanding ‘that a multifaith outlook is not rooted in finding the common content or common belief of different religious traditions [such as deciding whose “truth” is true] but, rather in recognition of the common process of faith’ (p.130)

Driedger writes of engaging ‘patients from within the paradigm of faith’ and illustrates this through reference to the Canadian National Anthem. Canadian society, she says, places a high value on cultural diversity and cultural distinctiveness: the national anthem portrays this (p.132). The music connects Canadians to each other, but the words from the English, French, and Traditional languages are different and contain different understandings of Canada. What binds people ‘is a common melody (paradigm of faith) rather than common lyrics (the specific tenets of faith themselves). This she says is a foundation for multifaith spiritual care (2009, p.132).

There is clearly a considerable body of writing that locates pastoral care within a Christian religious framework. Anecdotal references also highlight this Christian framework of pastoral care through the belief expressed by carers. When this belief considers Christianity as superior to other faiths, it
may be labelled as pietism. Individualistic in character it at times expresses
an exaggerated depth of feeling. Pietism, originally a movement towards
change, is now questionable in the practice of pastoral care. In a pluralistic
society, one faith expression cannot provide adequate religious care for all.
Integrity in the provision of religious care will maintain appropriate boundaries
and will not presume to have all answers for all people. Driedger’s “paradigm
of faith” is of particular importance in this regard.

Spiritual care

Bouma claims, in reflecting on spirituality:

As it is used in Australia today, the spiritual refers to an experiential
journey of encounter and relationship with otherness, with powers, forces
and beings beyond the scope of everyday life. To be spiritual is to be
open to this “more than” in life, to expect to encounter it and to expect to
relate to it (2006, p.12).

Today’s spiritual care emerged from a counseling framework in which people
were encouraged to make their own link with whatever they considered to be
holy. Spiritual care has much wider parameters than religious care and thus
takes people beyond the more immediate doctrinal limitations of a faith
community. Perhaps the most concise articulation of spiritual care is that of
Speck who makes the claim that:

Spiritual care will depend on the patient and the care giver being willing to
enter together into the experience and explore without quite knowing where
it will lead. The uncertainty which this embraces can be challenging for
both, but especially so for the pastoral care giver if he or she has not
explored ultimate or existential issues in their own life story (2004, p.21).

The key word in this claim from Speck is “uncertainty”. In this, spiritual
care differs from religious care which seeks to maintain the surety of a
patient’s belief, thus providing religious security whatever the faith of that
patient may be. Insecurity is uncomfortable and for some fearful. This
affects both carer and caree as Speck intimates. Exploring experiences
together however, allows for the possibility of self-awareness and
understanding.
Of spiritual care, Van Katwyk, a teacher of theology in a Lutheran seminary, concludes that:

Spiritual care embraces multiple spiritualities and bridges diverse theological worlds. In contrast to pastoral care, reflecting the history of religious traditions of care and one’s connection and accountability to a faith community, spiritual care is universal in scope and in its philosophical reflections on human existence and its spoken language of the social sciences (2002, p.119).

Multiple spiritualities, diverse theological worlds, universality in scope as descriptors of spiritual care, provide a stark contrast to traditional Christian religious care with its links to particular faith communities. Spiritual care certainly has far reaching possibilities in its practice but discernment needs to be exercised lest spiritual care be considered to be of greater worth than its companion religious care, linked here with pastoral care. Difference and value are not the same. My own claim is that pastoral care is the parent body in which we may find, with equal value, religious care and spiritual care. Along with “diverse theological worlds […] philosophical reflection […] and the social sciences”, pastoral care whether as religious or spiritual care, has at its core, the sharing of stories. This will be made clear as this chapter progresses.

Van Katwyck nevertheless, in his articulation of spiritual care makes clear the point that spiritual care cannot be limited to the community that believes in the Holy Spirit. Articulating the validity of spiritual care in a context wider than any one faith community, allows for trust, acceptance, compassion, respect, and honouring, as values that have the potential to unite individuals, communities, and nations. They require us to act with integrity in our lives. The following story gives expression to this integrity.

Myra, for some years lived with cancer, at times becoming very ill with the disease and the treatment she received. She writes in her story of two dreamlike experiences, and this is one of those:
I imagined myself struggling with fishing line which was tangled round my hands and feet. My niece and two children were visiting me and I asked her and the children to help me get it off. She tried to explain that there was no fishing line on me. Our minister, Jack K. came at this stage and my niece explained what was happening. Jack held me and comforted me and quietly went through the motions of untying the line from my hands and feet, talking to me all the time and explaining what he was doing. He then took the imaginary line out and threw it away. I felt at ease then and free of being tied down (Stratford, 1995, p.60).

Myra’s struggle with cancer, highlighted for her in imagination, presents a challenge for those engaged in chaplaincy. Jack K. took up the challenge and dealt with it creatively, and with integrity and compassion. Myra’s minister could have offered reassurance of God’s presence to protect her. Instead he chose to step outside his Christian religious restraints and judgements, enter Myra’s dilemma, and unravel the difficulty she was experiencing.

Helping to unravel the difficulty is part of the essence of spiritual care and is applicable in all circumstances within pastoral encounters. It involves considerable responsibility on the part of the provider of care. Unraveling is a partnership in care which needs to be recognized; mutuality in giving and receiving in the process. Both the individual carer and, as we shall see later, the organizations that appoint people to the task, need to consider the wider implications of spiritual care.

Driedger, also reminds us of the responsibilities connected with universality of care. She chooses to speak of organizations, but what she says applies also to individuals:

[…], if the organization is going to provide spiritual care for some patients it has a responsibility to provide comparable care for every patient, even those who come from very small minorities. […] it has become necessary to think about spiritual care in new ways (2009, p.137).
One way is to consider the spirit as ubiquitous in spiritual care. It may not refer to God, but will have a link to transcendence. When the chaplain places God, unbidden, in the pastoral encounter, slippage occurs and the encounter becomes inappropriate. Recognition of value in all faiths and cultures and treating all with equal respect allows for understanding, and therefore integrity in practice.

In spiritual care, we can recognize an experiential journey as carer and caree together seek meaning for life. Distinct from the sureties of religious care, spiritual care is framed in uncertainty. Speck’s claim of carer and caree being willing to enter into the experience and explore without knowing the end result, allows for self-understanding. Spiritual care is able to embrace all faith standpoints, and provide the ground for members of different faiths to explore common experiences. There is a need however, to make sure that spiritual care is not considered superior to religious care. Both, in their different ways, are valuable in the practice of care. Myra’s story, and the unravelling of difficulty is also helpful in understanding spiritual care.

**Authenticity.**

Macquarrie writes of Heidegger’s work on Being or ‘isness’:

> Like the atoms, mountains, trees, stars and any other entities we may care to mention, man is; but he differs from all these others because he not only is, but has an understanding of what it means “to be”. Within limits, indeed, he is responsible for what he is. As Heidegger often says, his Being is an issue for him. Because man has a measure of openness, of freedom, and responsibility, the question of who he is, is inescapable for him (1968, p.6-7).

If authenticity means ‘acknowledging and respecting human freedom and taking responsibility for who and what one is’ (Baggini & Fosl, 2007, p.163), then those who undertake chaplaincy need to be clear about their motivation.

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5 My use of “Spirit” in this instance is not a reference to the “Holy Spirit”. It is more akin to the Hebrew usage. ‘In the Old Testament Hebrew רוח means first of all wind and breath, but also the human spirit in the sense of life force and even personal energy. (Freeman, D.N. (ed). Eerdmans Dictionary of the Bible. 2000, p.1248). Other faiths also have references to spirit.
Macquarrie, interpreting Martin Heidegger’s work *Being and Time*, quotes him thus: ‘[…] in an authentic existence, man is open to dimensions of the world beyond the merely instrumental understanding of it’ (Heidegger in Macquarrie 1968, p.17). This then raises the question of the way in which chaplains might approach a patient. ‘An authentic solicitude for the other helps him to his freedom and to his own unique possibilities for selfhood.’ (Heidegger in Macquarrie 1968, p.18).

Mark Cobb writes of the motives, controlling forces, and mode of action [dynamics] of chaplaincy noting that in this engagement there is both change and challenge. He says in his conclusion: ‘What is critical is that chaplains are aware of this dynamic, understand its impact, and are confident to respond from a position of authenticity, theological rigor, and spiritual depth’ (2007, p.9). Authenticity captures the need for consistency. Being authentic (Shorter Oxford Dictionary, p.134) contains respect, trustworthiness, genuineness, and being true. From these, it may be said, that one who is recognized as authentic will also be recognized as one who has the capacity for self-reflection, and a commitment to realizing his/her own fallibility.

Authenticity also requires recognition of value by the body [in our case Christian church denominations] employing and appointing those engaging in chaplaincy. Such valuing makes clear that while church connections may be helpful, it is important that those practising pastoral care whether as religious care or spiritual care, develop a capacity for self-reflection. Without this, understanding may be stunted, or worse, non-existent. Self reflection includes a commitment to recognizing one’s weaknesses and mistakes as normal for one, who is a fallible human being.

Recognition of fallibility allows one to realize that a pastoral interaction does not presume that the receiver of care is less able than the provider of care.
It follows that any chaplaincy practice that engages with patients in ways that do not allow them the freedom and responsibility of being themselves, could be said to be lacking in authenticity. This in turn leads us to reflect that while the chaplain may truly reverence God, there is sometimes evidence of a lack of respect for the other.

Authentic engagement with pastoral care must engage with Cobb’s dynamic, and face change and challenges with integrity. It is not always the case that chaplains are able to do this. Authentic chaplaincy practice, however, requires that those to whom care is being offered be treated with respect and not be expected to accept whatever the chaplain offers. Religious care will only be valid and acceptable when there is a degree of congruence between chaplain and patient. The chaplain’s role, however, is not to be defined as providing religious care only. There are many times when spiritual care is more helpful. It is therefore important if re-articulation is to proceed, that in chaplaincy practice, a number of benchmarks be established. This thesis aims to establish these for consideration.

Chaplin and Mitchell give voice to these benchmarks in pointing to the importance of ‘sharing the care’ and of ‘raising the profile of spiritual care’ through education at many levels: they write of ‘self-awareness’ and support, and of ‘evaluation and research’ (2001, pp.9-10). Incorporating these into chaplaincy practice opens possibilities for chaplains to confidently engage with those to whom they offer care. Being able to more clearly define the role will also enable a clearer understanding of the circumstances in which the authenticity of both spiritual and religious care can be claimed.

Authenticity is clearly presented as an essential element in the provision of spiritual care. Spiritual care and its emphasis on facilitating the receiver’s journey towards healing requires that the one offering care has a strong understanding of his/her own spiritual journey and the meanings that have
been discerned and embraced. Such care has moved beyond the more traditional pastoral care, but nevertheless still acknowledges that traditional (that is, religious/church) care will continue to be a desire for some and therefore need to be addressed. David Lyall in his book *The Integrity of Pastoral Care*, refers to Alistair Campbell’s claim that pastoral care consists essentially in the mediation of steadfastness and wholeness (1986, pp12-13).

Lyall continues:

It involves an understanding of integrity as closely related to a concept of spirituality, encompassing a vision both of authentic humanity and genuine transcendence. The humanity is authentic because it takes seriously both the realities as possibilities of human existence. The transcendence is genuine because it points in a non-dogmatic way to the experience of the Other at the heart of life (2001, p.19).

Experiencing “the Other” may be an experience of God, or more generally an experience of whatever is considered to be holy. Being held together by the presence of the Holy requires authenticity in chaplaincy practice. This means a validation of different faith positions with a consequent setting aside of any inherent desire to change or challenge another’s faith stance.

Clearly, among those who would be chaplains, there are requirements that need to incorporate the diversity of beliefs, along with recognition that spiritual care will both challenge, and be challenged. Authenticity in spiritual care requires that the challenges be recognized, and accepted as pathways to improved understanding. Those who appoint and employ chaplains face challenges also, not least of which is a requirement for initial training and the provision of ongoing resourcing. Hill and Mullen draw our attention to a number of fundamental issues that need to be addressed by employer and employee:

For the relationships provided by pastoral care to have a salutary impact, to have heightened potential for mediating the Divine presence, they require authenticity, genuine compassion, and advanced empathy by the caregiver. “[…] the essence of spiritual care is not doctrine or dogma but the fundamental human capacity to enter the world of others and respond with feeling” (2001, p.174).
Entering another’s world requires care, along with the determination to remain in that world as long as necessary. Consistent engagement will pave the way for meaningful discourse. Anderson argues:

To meet the challenge of the pluralistic and globalized health care context, chaplains must first grasp their own spiritual/cultural constellation, which might best be described as a web of meaning, through self-assessment and definition. Second, Chaplains need to develop a capacity to assess and understand the spiritual/cultural constellation, the web of meaning of the person with whom they are professionally relating (2004, p.3).

Webs of meaning established as a result of immersion in the Christian faith contain the message that this faith stance is the only one that the world needs. It is, indeed, a major challenge for one to break some of those strands in order to consider that others’ webs of meaning establish people’s lives and contain their own legitimacy. Some of the chaplains in this study face this challenge.

The chaplain’s role contains three fundamental propositions that must be addressed if authenticity is to be incorporated in his/her practice. These are the matter of belief and its association with piety and pietism; an ability to listen to the stories of others in order to hear what the other is addressing; and the matter of presence. In order to re-articulate the chaplain’s role it is important to consider these propositions in some detail.

Authenticity captures the need for consistency, acknowledging and respecting human freedom and taking responsibility for oneself. All engaged in pastoral care therefore, need to demonstrate these attributes in their approach to those in need. Respect, trustworthiness, genuineness are also attributes of being authentic and need to be visible in pastoral interactions. Authentic practice in the role of appointers of chaplains requires that chaplains be valued and adequately resourced in order that they might develop a capacity for self-awareness. This includes awareness of one’s fallibility.
Discernment of the difference between religious and spiritual care requires benchmarks including clear understandings of one's own spiritual journey. Lyall's comment of a vision of “authentic humanity and genuine transcendence” is a doorway into the validation of different faith positions, and the webs of meaning associated with them. “Pastoral care”, claims Campbell, “consists essentially in the mediation of steadfastness and wholeness”.

Belief.
Belief is of fundamental importance in the practice of pastoral care. It establishes a framework of understanding for the chaplain, and is also a strong motivator. Much care is therefore needed when engaging with another in the provision of pastoral care. Belief within Christianity can be a complex matter. Some of this complexity becomes evident when we consider that the Christian faith has traditionally been linked to belief in the soul as that which connects the body to God and provides a pathway for the spirit of God to interact with believers. This stems from Paul and the early Church Fathers, of whom Origen (c.200-250) was one. Stevenson draws our attention to his comment on the soul in the following way:

The apostles taught that the soul, having a substance and life of its own, will be rewarded according to its deserts [sic] after its departure from this world; for it will either obtain an inheritance of eternal life and blessedness, if its deeds shall warrant this, or it must be given over to eternal fire and torments, if the guilt of its crimes shall so determine (Origen in Stevenson1960, p.213).

The article on soul in Eerdman’s Dictionary of the Bible, takes a more scholarly approach to clarify understanding:

In the OT, (Heb. nephesh) has a wide range of usage. It most frequently designates the life force of living creatures. […], when God creates Adam, God breathes the breath of life into Adam’s nostrils, and Adam becomes a “living being” (Gen. 2:7). Far from referring simply to one aspect of a person, “soul” refers to the whole person. […] In the NT “soul” (Gk. Psyche) refers to the living being of the whole person (2000, p.1245).

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6 The theology of belief in the soul in beyond the scope of this thesis.
Christian belief, in fact has its roots in the Hebrew Scriptures. The primary theme of Deuteronomy is written in the introduction to that book as ‘the reaffirmation of the covenant between God and the people of Israel.’ This ancient covenant with Israel was, early in the church’s life, considered to be superseded by a new covenant located in the life, work, death and resurrection of Jesus. The law was not discarded, but the risen Christ took precedence. Maintaining the mystery became the prerogative of priests as interpreters of the faith, and guides for the religious life of believers. Piety, with its definition of reverence for God, along with obedience and respect for others, became visible in the mutual engagement of believers with God and each other.

The Reformation brought dramatic changes in Christianity. People, controlled in their belief by the church, found a new freedom as they became able to participate more openly in the rituals that sustained the church. The translating of the bible into the vernacular made it more accessible, and people (those who could) began to read it for themselves. Those who couldn’t read could hear it in their own language. The movement was labeled as pietism and Brandt claims that it was ‘best understood as a renewal movement within the church’. He continues:

Reacting against perceived indifference in personal faith and morality, and an unnecessary doctrinal rigidity, it sought to instill living faith, and moral earnestness in people through nurture and accountability (2001, p.42).

The ramifications for the church were far reaching. The common people had found a new way of sharing their belief, and renewal of the church began. Heron says of pietism:

The desire for natural religion reflected an awareness that religious faith has to do with the inner life of human beings […] . It is significant that this same era saw the rise to prominence and widespread influence of several movements within the churches which strove to integrate warm personal commitment with the reaffirmation of the broad pattern of orthodox belief (1980, p.10-11).
One perhaps unforeseen outcome of the renewal movement in Christianity was the shift in church allegiances towards denominationalism and a sense of fragmentation in the church. People found their place within those denominations according to the particular emphases placed on the content of belief. Both piety and pietism were visible among the parts, and beliefs were, at times, held most strongly. Early in the 20th century this began to reverse with the emergence of the ecumenical movement.

The Christian church however, is today still displayed to the world in denominations. Denominations themselves contain further differences from the parent body. The Uniting Church as one denomination contains a number of differences. One of these, portrayed here as an example, calls itself the “Assembly of Confessing Congregations” and expresses the conviction that:

> Within the Uniting Church context of a very broad range of theology and practice, the Assembly of Confessing Congregations is a nation wide body of congregations and individuals whose vision is confessing the Lord Jesus Christ, proclaiming the truth, renewing the church. (ACCatalyst, 2013. July p.19).

Five goals are listed, one in particular "encouraging the confession of Christ according to their faith of the one holy, catholic and apostolic church, as that faith is described in the UCA’s Basis of Union”.

All those engaging in pastoral care within the parameters of this thesis are members of one or other denomination. Belief standpoints therefore vary and these can be recognized in the responses from the research participants. Practitioners in chaplaincy can be considerably affected in their work through the nature of their belief. Espousing the belief attitudes inherent in my earlier anecdotal descriptions, highlighted in page 12, will inhibit practitioners from moving into a more authentic approach to the needs of others. Living securely within their continuing historically Christian tradition, and feeling strongly accountable to their church, many are held captive by their own
understanding of their place in the comfortable certainties of the past; within
the framework of forgiveness and Holy Spirit presence.

I have shown earlier (p.19) that spiritual care contains the element of
uncertainty and therefore requires clarity of belief that will enable openness
and facilitate healing. Such belief, I name as piety which, in its truest form, is
the expression of a relationship with God lived out in a covenantal framework.
Waaijman provides a map of this relationship:

[Piety] goes back to the Greek word sebeia (veneration, respect) and the
Latin word pietus (purity, integrity). Both terms can refer to God, one’s
homeland, one’s parents, and the dead. Within the religious sphere, piety
encompasses cultic actions (sacrifices, processions, prayers, oracles), a
virtuous life, and feelings of esteem and respect. It is something like our
word reverence, a fundamental attitude which is fitting in worship, is the
source of all virtue, and articulates the basic feeling in which awed respect,

Maps play an important part in all aspects of life from finding one’s way in a
strange city to discovering the ramifications in the progression of illness.
Waaijman’s map is most important for those undertaking a chaplaincy role. It
articulates the detail that attaches to authentic care and establishes the
foundations for a level of belief well beyond acquiescence to religious
prescription. It is a map that has value across faiths and is therefore a firm
guide for all engaging in spiritual care.

Authenticity and piety both contain within their definitions, genuineness and
respect for others, and clearly authenticity has a most important place in the
practice of piety. There is a close relationship between them, and chaplains
need to hold this relationship securely as they seek to provide spiritual care.
Because of strong adherence to religious tradition, this is not always the case,
and for some engaging in spiritual care, the relationship is at times tenuous.
This thesis, therefore, argues that in order for the role of the hospital chaplain
to be re-articulated to provide spiritual care in a pluralist society, there must
be a stronger engagement with the relationship between piety and authenticity as values that inform the sharing of personal stories.

Waarman’s (2002) “awed respect, wonder, serious attention, and esteem” frequently emerge in life from experiences of transcendence. They also emerge when engaging with another and listening to the stories of the other. It is to this that we now turn.

The history of Christian belief has its foundation in the Hebrew Scriptures and the early traditions of the church. The vicissitudes of church growth and expansion with belief generally controlled by the church eventuated in a renewal movement named as pietism. In time, pietism moved towards individualism and personalized religious experience. Denominations emerged as an expression of ongoing renewal movements and today are accepted expressions of the life of the church. Belief therefore is a complex matter largely because each denomination has differences in its belief stance, and chaplains come from a variety of denominations. Belief, identified as piety, is an expression of a relationship with God lived out in a covenantal framework. As such it is open to possible differences. Warman’s mapping of piety provides a guide for all engaging in spiritual care.

**Story: a path to active listening.**

If respect is to be engendered then those engaging in pastoral care, whether spiritual or religious, need to engage in and develop the art of listening. The first step is to listen to the stories told by those to whom care is offered. An understanding of story as a path to active listening, in which may be discovered webs of meaning, will inform, and lead to a more valued and valuable healing experience. Recognition that even our beliefs have their genesis in story, and carry elements of our own story, will enable us to hear more clearly the stories that lie outside our Christian framework as authentic reflections of different beliefs.
Goodenough writes: ‘Humans need stories – grand, compelling stories – that help to orient us in our lives and in the cosmos’ (1998, p.174). Stories have always been part of people’s lives. Alexander Heidel (1946), Joseph Campbell (1959), Scott McPheat (1963), Charles Mountford (1965), David Leeming (1981), and many others, guide us through a variety of stories that engage our attention. Stories present challenges to many engaged in chaplaincy, particularly when they are perceived as different, and counter to all that chaplains hold dear. Stories however, need to be heard; they need to be heard not only with ears but with a deeper understanding that evokes a sense of the nature of the story-teller, and beyond to a sense of the nature of mystery. Tim Ebehardt writes of stories as part of being, citing Phyllis Trible who says:

> Stories are the stuff of life. Stories create and colour existence. Whether one is speaking of primeval beginnings or eschatological endings, youthful dreams or mature experiences, ringing proclamations or scarcely audible secrets, narrative speech prevails. Be it myth, parable, folktale, epic, romance, novella, history, confession or biography – all proclaim the power of story (Trible in Eberhardt 1996, p.23)

Eberhardt also claims: ‘Our stories are who we are. Not only do they identify us and help us make sense of our experiences, they structure our experiences and shape life expectations’ (p.25). Similarly, Maryanne Confoy writing of education for ministry quotes Walter Brueggemann, Old Testament scholar and theologian, thus:

> The deep places in our lives – places of resistance and embrace – are not ultimately reached by instruction. Those places of resistance and embrace are reached only by stories, by images, metaphors and phrases that line out the world differently, apart from our fear and hurt. (Brueggemann in Confoy 2009, p.95).

Religions have been held together, and continue to be so, through instruction. The many writings found in religious groups speak about the founder, about dogma, and about behaviour. Instruction focuses on the mind. The “places of resistance and embrace”, however, are more clearly allied to feelings, and suggest that in these places one might locate vulnerability and a glimpse of
emotion-full selves. In the telling of stories we may capture feelings, and become aware of the vulnerability of the teller, and of the importance of presence. In this awareness and in presence, we are led to recognize with Confoy that:

[...] the re-imagining process that can take place in educating communities of shared faith, hope and love will enable them to become more human and more humanizing communities (2009, p.95).

Carol Christ writing of women’s quest for meaning, argues strongly for the importance of story in daily life: ‘without stories there is no articulation of experience’ and again, ‘stories give shape to lives’ (1980, p.1). These statements draw our attention to the importance of stories in meaning-making. In connecting spirituality and meaning-making, we may note that ‘stories with a sacred dimension point to a source of meaning that gives purpose to people’s lives’ (1980, p.3). Christ continues:

Common to all stories with this “sacred” dimension is the importance given to the story by teller or hearer. It might seem that all sacred stories would have to be realistic and serious, but this is not so. The story might be of adventure if the teller thinks adventure is what life is all about, a love story if love makes life meaningful, a fantasy if fantasy is the only way to achieve transcendence. What is common to all these stories is not their genre but their function in providing orientation to life’s flow. Indeed the same story may be sacred to one person but not to another (1980, p.4).

Every religion has its sacred stories in which it is claimed, followers may find “orientation to life’s flow”. Many religions imply a host of sacred stories, and within this plurality of belief one might discover elements of exclusivity. Shared experiences can be difficult to discern. The difficulties visible in difference become pitfalls when we lay claim to absoluteness in our particular belief system. Such claims appear regularly in our media through the reporting of world events. Diversity on the other hand, has to do with variation. Acceptance of diversity is possible, but requires a reconsideration of those religious filters that may exclude others.
The function of stories in “providing orientation to life’s flow” is recognized in the writings of George Burns, who argues for the power of stories to discipline, to evoke emotions, to inspire, to change, to create mind-body feats, to heal, and illustrates these from his own store of stories (2001, pp.4-9). He writes of his own experiences as a child listening to his mother as she told stories before he settled to sleep:

Those times were special. There was something very intimate about the undisturbed temporal space of sharing a story. There was a bond that linked listener and teller like two arctic explorers somehow isolated in a world of their own, yet intimately roped together in their uniquely shared experiences (2001, p.xvii).

Recognizing the intimate moment in a story shared, requires that the pastoral carer be aware of the vulnerability of the story teller. Indeed a story thus shared, may become a time when vulnerability is also shared. Spiritual care, with its accent on meaning-making, will encourage sharing even when religious and/or personal differences are obvious.

Iain Macritchie reminds us of the importance of awareness within such a pastoral encounter:

In particular as chaplains we need to be good at learning the language of story. We are so privileged to hear people’s stories, and it becomes so much part of the work of the chaplain that we can sometimes take for granted the special nature of what is being offered, […] (2001, p.209).

Jean Stairs suggests that: ‘to be a person is to have a story to tell’ but ‘you can’t tell who you are unless someone is listening.’ (2000, p.17) and Eberhardt agrees that: ‘the power of story remains unrealized until the story is told’ (1996, p.24).

Stories are never simply the words that are said. Behind the surface of stories are a mixture of feelings and attitudes, of people who have had an effect on the teller, of physical circumstances, and many other factors.
normally stories of a life. Embedded in every life are many tales that tell of who and what we are. Anderson writes:

Since our meaning as persons is comprised of that which we value, revere or are attached to or devoted to, a strong argument can be made for a continuum of meaning that recognizes the importance of cultural, religious, and spiritual features in defining life narrative in context (2004, p.7).

Understanding the things that give meaning to our life requires us to not only reflect on them but also to verbalize them. This becomes particularly relevant in a hospital setting with patients who are vulnerable in many ways. Patients may be looking for assurance, but sometimes, simply sharing with a trusted other, relieves tension and restores some balance.

Fukuyama and Sevig, writing of cultural diversity, argue that: ‘One way to address the complexities of the whole person in a cultural context is to elicit the patient’s story […] There is something basically healing and honouring of the person when someone takes time to listen deeply’ (2004, p.36), and Maryanne Confoy, argues that:

To be authentic during times of conversation with those in need and with other pastoral carers, requires the ability to be still, to be able to take time for contemplation, to be in touch with one’s own inner thoughts, feelings, and imaginative awareness. Times of prayerful support of others call for times of inner quiet and solitude (2002, p.31).

Being still, contemplative, being in touch with inner thoughts and feelings, inner quiet and solitude, all have an impact on the value of pastoral encounters; they speak to the nature of presence. Presence is authenticated for patients in focused listening from the chaplain, when stories are heard and underlying depths revealed. From these depths, mystery may emerge, and become for some the presence of God.

There is little to add to this segment. I am in complete agreement with the sentiments expressed. It is clear in the literature that stories are part of all human life, indeed it could be said that the whole of life is a story. The
literature however, does make clear that stories when told, need to be heard. Stories lived and told, at times are seeking meaning for experiences. One task for the carer is assisting the teller to find what is sought.

**Presence.**

My earlier claim in the thesis is that belief is of fundamental importance in the practice of pastoral care, and needs therefore to find adequate expression in any pastoral encounter. For this to happen there needs to be a strong and inclusive sense of presence. John O’Donohue explains presence as both a deep desire and mysterious being: ‘Presence is something you sense, and you know, but cannot grasp’ (1998, p.55).

Concluding her study on Ministry of Presence, Janet Stokes draws a comparison between the presence of the pastoral visitor, the presence of that which is Holy, and the less than helpful visiting for a chat:

> Ministry of presence and presence of the Spirit are both viable, although somewhat separate, realities occurring during pastoral visitation. Ministry of presence is clearly defined by patients more in the sense of accompanying the patient in distress than in “passing the time of day” […] perhaps pastoral care givers might stop using the phrase “ministry of presence” to refer to shallow visitation, and instead recognize such shallowness for what it is more likely to be: a visit that does not bring or reveal the power of the Spirit, for a variety of reasons. […] Then we could reserve “ministry of presence” to refer to more graced and mutually experienced ministry (1999, p.198).

Christian providers of care, claiming the “guidance of the Holy Spirit”, run the risk of assuming that the recipient of care will automatically recognize the presence of the Holy Spirit in the provider. One possible outcome is a conversation led by the visitor, in which the church comes to the fore as an important ingredient which makes clear that God is near. Such a conversation may hinder a “graced and mutually experienced ministry”. Within the churches’ ecumenical dialogues, much has been said and written about the church as a visible representation of God’s presence. Geoffrey Wainwright,
contributing to the ongoing ecumenical dialogue, summarizes the consensus that may be found among churches:

Because God so loved the world, he sent his Son and the Holy Spirit to draw us into communion with himself. This sharing in God’s life, which resulted from the mission of the Son and the Holy Spirit found expression in a visible community of Christ’s disciples, the church (1991, p.164. Author’s italics).

A graced and mutually experienced pastoral encounter will be recognized by carer and caree as authentic presence.

Much has been written in Christian literature related to the presence of God, many of them devotional books. Two examples are Harakas (1984), a devotional book for Orthodox Christians, and Foster and Smith, who say in their introduction: ‘Genuine devotional writings [...] seek to touch the heart, to address the will, to mold the mind’ (1993, p.1). This sense of God’s presence, interpreted in a number of ways, has guided and continues to guide Christians as an expression of their belief. Chaplains, with a background of Christianity carry an understanding of God’s presence with them, and this spills over into interactions between chaplains and patients.

The question therefore, that confronts us all is the way in which those engaging in pastoral care might interpret their understanding of God’s presence, as a model for establishing and maintaining presence in a pastoral encounter. This in turn raises the further question about what presence actually means. Clearly, presence may be expressed in a variety of ways. John Macquarrie for example, in Paths in Spirituality identifies a key feature of Celtic spirituality as an intense sense of presence. (1972, p.122). Macquarrie continues: ‘The sense of God’s immanence in his creation was so strong in Celtic spirituality as to amount sometimes almost to a pantheism. Of course, Celtic Christianity was continuous with the earlier Celtic paganism’ (1972, p123). O’Donohue takes this sense a little further identifying presence as awareness of wholeness, embracing all things, all understandings, all
feelings, as a way of balance in life: ‘In order to keep our balance we need to hold the interior and exterior, visible and invisible, known and unknown, temporal and eternal, ancient and new, together. [...] This wholeness is holiness’ (1997, p.14). In all this, balance is maintained through awareness in which the spirit is also active.

In chaplaincy, the intensity in the focus of Macquarrie and O’Donohue, needs to be earthed within specific behaviours. Fraser, Purnell, Hill and Mullen, demonstrate ways in which behaviour may be earthed. Fraser describes chaplains as: ‘pastoral practitioners who seek to build a relationship of trust through compassionate presence’ (2004, p.28). Purnell says of pastoral care: ‘by care I mean being present to and engaging the other in ways that value their whole being, and their living’ (2003, p.7). Hill and Mullen make the claim that: ‘the essence of spiritual care is not doctrine or dogma but the fundamental human capacity to enter the world of another and respond with feeling’ (2001, p.174).

Blaine-Wallace adds to the sense of power in presence as he recounts an experience of listening to the testimony of a woman who endured the Rwanda genocide in 1994. His observation later that he said only 56 words over two hours is a powerful exposition of presence. (2010, pp. 6.1-4). Purnell makes a further claim that: ‘conversation that grows creatively [in the sharing of stories] requires an alert presence and disciplined observation’ (2003, p.47). O’Donohue finishes one of his works with a blessing, part of which says, ‘May you awaken to the mystery of being here and enter the quiet immensity of your own presence’ (1998, p.98). These references are a reminder that presence is intimately connected with particular behaviour in which we find quietness, preparedness to suspend time, determination to stay as long as required, being still, listening carefully, minimum talk, awareness. Presence is being there and being is me in my entirety; focused. There is nowhere else; emotionally, physically, spiritually. (My Italics).
Phyllis Cohen although commenting specifically on bereavement, provides a timely challenge about presence:

We must be willing and able just to be with the bereaved, to allow them to cry, to rage, to despair, to express all of their feelings. Rather than try to soothe them or make things better, rather than getting caught up in the mundane details of daily living, we must attempt to provide a sense of real support by our presence (2002, p.119).

Valid and valuable presence requires time, and trust, and commitment, along with a deep reverence and respect. Genuine presence allows deep feelings to stir and stories to unfold.

Presence is best understood through story and the following is a profound example. Sandy Engel tells of three visits. The occasion is a diagnosis that her infant daughter has a severe form of cancer. Her first visitor is her mother who optimistically assured her that the baby would beat the disease. The second visitor was her pastor who was lost for words, and the third visitor was a family therapist whom she knew well: ‘He came to visit one day and asked if I wanted to go for a walk outside. There was a circular walkway around a small rose garden. We started walking, not saying a word’ (2009, p.1). She tells us that as they walked she started crying and questioned out loud why all this was happening. ‘James didn’t say a thing – he just touched my arm and we continued to walk in a circle.’ She tells us that she became angry and railed against God. ‘James did not speak, but I knew he was “present” because he stayed in step with me […]’. Eventually she began to recognize the reality of what was happening:

Amazingly, James still didn’t verbally respond; but he gave me a big hug and let me cry. He neither validated my conclusion nor corrected me – leaving it to me to decide how I was going to “explain" this […] how I was going to make sense of it. He let me reach my own conclusion while being completely present and supportive (Engel. 2009, p.2).

Hadley Kifner reflects on his engagement with a caring group to facilitate growth and understanding and healing. His reflection is a compelling commentary on presence. He writes of letting others:
be who they are [...] means caring for them fully, deeply, for no other reason except caring for each other is what we are created to do. We are not to save one another, fix each other, protect each other from pain and fear and despair; we are to love and abide together (2008, p.388).

This is difficult for some whose desire is to “open doors” and “sow seeds”; an approach that hints at fixing and salvation. This appears as the outlook of the chaplain (C17) in the profile provided.

In her article, *Pastoral Counseling: The Art of Ascetic Witness*, Brita Gill-Austern makes the claim that for the pastoral counselor, what is fundamental is the question of identity. ‘Who - and whose - are you when being a pastoral counselor’ she asks, adding a reference to James Dittes’ book *Pastoral Counseling: The Basics* in which, writing of presence, Dittes identifies presence as ascetic witness. This term is also applicable to chaplains and Gill-Austern identifies something of the role which fits both counselor and chaplain, and makes visible some essential qualities of presence:

The role requires the stringent discipline of self-renunciation and a surrendering of the ego. Not problem solving but attention to feelings, unconditional regard and a gracious nonchalance are some of the marks of the counselor [chaplain] as ascetic witness. (Gill-Austern, 2003, p.81)

What is applied here to counselling is relevant to spiritual care and the relationship between provider and receiver. Religious care however, invokes God through the chaplain as “player” with specific denominational connections.

Presence is an investment of time and energy; an investment of self. Such a presence is not caught up in a need to do something but rather is content to simply be. Wolterstorff, lamenting a grievous loss writes:

If you think your task as comforter is to tell me that really, all things considered, it’s not so bad, you do not sit with me in my grief but place yourself off in the distance [...] I need to hear from you that you are with me in my desperation. To comfort me, you have to come close. Come sit beside me on my mourning bench (1987, p.34).
In such presence the recipient may be able to discern strength and understanding, and so feel cared for at a deep level. Such empathic presence expresses a sense of identification that encourages the recipient to continue the journey of life.

Karen Webb writes of her experiences as a pastor, and the difficulties she had visiting parishioners in hospital. Experiencing “depths of gratitude” she began to rethink the value of what she had been doing:

The strange thing was that, as time went on, I needed to be with people when they were hurting. I no longer stayed with them because ‘that is what pastors do,’ but because I cared about them. There was something about being fully present with my people that was closely connected to my sense of vocation, but I could not quite name it (Webb 1990, p.78).

As a pastor, Webb links her own developing understanding of presence with her understanding of God’s presence, in the following way: ‘They needed someone they could trust to listen while they worked through making difficult decisions, someone who could understand, someone who cared, someone to assure them of God’s love’ (p.79). Assurance of God’s love has a particular application in religious care. Nevertheless the assurance should be provided with caution. It is not always appropriate even among those whose religious faith is strong. Matters of trust, listening, making decisions, understanding, caring, contain the essential elements of presence, which, being modeled by the chaplain may reveal to some carees a sense of a loving God.

This is not so applicable within some other faiths but affirmation of religious attachments and valuing them, is itself an assurance that all religious connections have their own validity. Authentic pastoral care therefore, will acknowledge all religious standpoints, and seek to provide both spiritual and religious care wherever needed.

I have established pluralism as the premise from which the conclusion may be drawn that it is important to adopt both spiritual and religious care as valid. This is because in the meeting between provider and receiver of care, it is
possible that different faith standpoints may be represented, and religious care as described may be inappropriate. When both religious and spiritual care are offered, the provider of care will be aware of the needs being expressed by the receiver and act accordingly. When these needs are addressed through attention to what is being expressed by the patient, healing will be more likely. Patients will then feel well served as their stories are heard, their belief validated and the provider recognized as being truly present in the encounter.
Chapter 2. Methodology

My earlier experiences of chaplaincy included a time as police chaplain and a time as hospital chaplain, both of which were very much part time activities within my position as a parish minister. Eventually I was appointed by my church to be a full time chaplain in a church hospital in Brisbane. Apart from attending Interchurch Trade and Industry Mission (ITIM) seminars in Victoria, I received no formal training for the role. My time in chaplaincy in Brisbane, however, saw my participation as a supervisor, and for a time, teacher in a chaplaincy training programme.

Traditionally in Australia, by far the greatest number of people engaged in chaplaincy roles have been those who are adherents of the Christian church. In those roles a primary concern has been care of patients who also have a link with the church. My role in this element of social research has been stimulated through my own experiences of pastoral care, and the changes that I have observed. The setting for pastoral care, however, can no longer be that of a traditional Christian model of religious care. This older model is giving way to the provision of spiritual care. Chaplaincy today is at a crossroads with a decline in traditional Christian religious observance, and an increasing multi-faith presence.

This thesis is the result of Chaplaincy finding itself at this crossroad, and my key question is: how do those engaging in pastoral care from a Christian perspective in which God is clearly named, provide appropriately, and with integrity, for those whose lives are constructed differently? Subsidiary questions instrumental to the design of this project emerged from this key question.
These are

- Is chaplaincy the most appropriate description of pastoral care?
- Does what chaplains' believe support a limited model based on Christian religious care?
- Does pietism support spiritual care? If so, how?
- What are the links between authentic chaplaincy and story? How might story affect these links?
- Is there a problem in the administration of chaplains that can be addressed in order to facilitate a re-articulation of pastoral care?

None of these subsidiary questions can be attributed to any particular chapter because the whole is networked together across the three areas of interviews and questions. The mixing of qualitative and quantitative method is therefore considered appropriate. Indeed, Tashakkori and Teddlie make the point that 'the term mixed methods typically refers to both data collection techniques and analyses given that the type of data collected is so intertwined with the type of analysis that is used' (1998, p.43). These questions inform all of the separate analyses in ways to which I will remain alert and reflect on as I proceed. Inevitable they will inform the conclusion of the project.

The overall aim of my research then is the facilitation of a re-articulation of pastoral care through a clearer understanding of the links between belief, quality of listening, and quality of presence. This, of course, assumes that there are links; essentially they relate to feelings and meaning, and as such cannot be tested quantitatively. As Wood notes: ‘Qualitative methods of research are valuable when we wish not to count or measure phenomenon but to understand the character of experience, particularly how people perceive and make sense of their communication experience’ (2004, p.69). Meaning itself is very much an individual understanding of what makes sense in a particular life. This has very clearly a link with the perspective of the participants. Flick’s comment that ‘The subjectivity of the researcher and of
those being studied becomes part of the research process’ (2006, p.16), will be clearly visible as the research unfolds.

I do not expect the research to provide exact and unambiguous answers to my question. Indeed it is not possible to do so with such a small scale study. This, as always, is one of the shortcomings of qualitative studies. Wisker’s consideration that: ‘Qualitative research is carried out when we wish to understand meanings, or look at, describe and understand experience, ideas, beliefs and values’ (2001, p.138), is expressive of the probable outcomes of this study. I anticipate that themes and benchmarks will emerge, and provide some reference points that will enable me to offer generalized conclusions, along with recommendations for training and ongoing development of this important issue.

My study is composed in the first instance, of a questionnaire to a selection of chaplains, followed by interviews with approximately 1/3 of the questionnaire respondents. Henn et al, claim that: ‘The qualitative research style […] is to develop an appreciation of the underlying motivations that people have for doing what they do’ (2006, p.149). Appreciating underlying motivations, and understanding meanings requires of course, more than answers to questions. Answering a question on the importance of story, one respondent wrote: “very IMPORTANT”. A claim such as this requires some explanation as to why it should be this way. My choice of respondents to be interviewed was predicated on responses such as this one. The seven interviewees are representative of the responders to the questionnaire, and each invites through their answers further exploration into their understanding of chaplaincy, and how they currently create meaning around belief.

A second questionnaire was designed and addressed to those who, within their respective churches, have the responsibility for the choosing and appointing of chaplains. The design allowed each question and its answers
to be tabulated in full with a view to analyzing each segment in order to incorporate it as a necessary part of the whole. Thus, a matrix was built in which might be discovered the environment in which pastoral care currently takes its form by which it is enclosed. This has enabled me to consider and compare these responses as a necessary foil to the answers provided by chaplains.

Wood speaks of 'mining the meanings' and 'deciphering threads of meaning' (p.69). Meanings, ideas, beliefs, values, the character of experience are all linked to my claims for the need for authenticity in chaplaincy practice. Each is also an expression of piety with their connections with transcendence and respect for life. Genuine care will not be afraid of such explorations.

This generally qualitative approach is suitable because my concern lies with the challenges of authenticity and piety in the spiritual understanding of those engaging in chaplaincy in an increasingly pluralist environment, and the way in which those understandings may be transmitted to those who are the recipients of care. The matter under discussion in this thesis argues for the role of the hospital chaplain to be re-articulated with a stronger engagement with the relationship between piety, integrity, and authenticity as values that inform the sharing of personal stories. This can also be understood as mining the meanings.

The strength of this research lies in its engagement with the processes of understanding how meanings are discovered, and the resulting changes that occur in people’s world views. The groups involved represent parties that have a particular interest in chaplaincy. I recognize that in the process of data collection and analysis, I have to take care to separate the data collected from the questionnaires and interviews, from the more anecdotal data which has accrued in my own years of involvement in chaplaincy. Tashakkori and
Teddlie, however, claim that such data can be important in fleshing out the data gathered from respondents. They make the point that:

A source of data, which is usually ignored, is your [the researcher] personal knowledge about a culture, a group, or an organization. Although this knowledge is not systematically measured, it provides an auxiliary source of data that can enrich your collected data (1998, p.110).

Such auxiliary data will be recognized at times in this study.

The questions asked provide stake-holders with the opportunity to contribute to the enhancement of chaplaincy in the health sector in Queensland. The questions also reveal a variety of standpoints taken by chaplains in relation to the care they offer. One such standpoint relates to prayer. One respondent (p.193) appears to always see prayer as a positive experience; another found times when it didn’t work. This raises the problem of self reporting, of not saying if something did not work. The questions will, therefore, challenge those to whom they are addressed to reflect more deeply on the role of chaplaincy in each of the sectors.

Any survey of chaplaincy in hospitals will, nevertheless, reveal that almost all engaged in chaplaincy come from the same tradition. It is also true that within the Christian tradition there are considerable differences in belief and practice standpoints. Julia Wood writes:

Standpoint arises out of the material, social, and symbolic conditions that shape a group’s experiences. However standpoint is not a birthright that comes automatically with being born into a particular group […] standpoint is an achievement […]. To achieve a standpoint, a person must become aware of and reflect on the conditions that define and shape a group’s experiences (2004, p.212).

The group, in this case the church, has a powerful influence on standpoints of members. Numerous standpoints affect the quality of care provided by those engaged in chaplaincy. The differences become more obvious when those offering care focus on religious care as an answer to all problems. Religious care is specific to the support of people in their faith through appropriate ritual
and religious symbols, along with affirming them in their engagement with their God.

A strong religious standpoint, and there are many, does not make room for those who seek meaning in their distress, but do not find help in a religious answer. For many, an answer is not sought so much as the need to verbalize, and struggle towards understanding that is satisfying. The challenge for pastoral carers is, as Speck (2004) states, the need to explore and come to terms with ultimate or existential issues in their own life story. Strong religious standpoints affect one’s lived experiences of the world and how one creates understanding of how one lives. Understanding the motives of those seeking to engage in chaplaincy will help us to appreciate the extent and depth of religious standpoints.

There are limitations in this research, but these do not reflect on its validity. One of these is that patient needs have not been identified, except through comments from chaplains. Other limitations include (1) the subjective nature of the responses (2) there is no ‘normative’ response against which other’s responses may be measured. (3) Despite the diversity in the community of chaplains, if all are strongly Christian the responses to the questionnaire may be skewed. (4) It is recognized that the research does not involve members of other faiths. The intention of the research was to study, what in Queensland is the major thrust of chaplaincy in hospitals. Further studies of this type would be able to use this pilot study as a benchmark overall to test the significance of such issues. Consideration of the involvement of other faiths in pastoral care would be valuable.

Method
The practice of chaplaincy can only be undertaken within a framework of interpersonal engagement. In this study I use two information gathering tools; namely, questionnaires and interviews. The former are useful for identifying a
variety of candidates for the latter so both were necessary, even though the former are generally considered to apply on a larger scale in quantitative research.

A questionnaire containing 20 questions was mailed to a random selection of 40 people involved in hospital chaplaincy. A review of my questions will recognize that they are open-ended and seeking opinions, understandings, and comment. Respondents were encouraged to answer expansively. I did not expect specific answers except for four questions which asked about age, gender, and length and type of service. Gathering the responses together, my aim was firstly to interpret as objectively as possible the significance of themes, attitudes, and expectations. One drawback in questionnaires is found in single word answers. In some instances respondents simply answered “yes” to some questions.

Secondly, drawing on the answers supplied to the questionnaire, approximately one third of the respondents were invited to participate in a one to one interview. These interviews also were to be open-ended with no fixed questions. There are, however, two underlying questions that will allow the interviewees to elaborate on their understanding of their work. One of these has to do with belief and the experiences which have led the chaplain to his or her specific standpoint. The second sought an indication of the way in which that belief was currently impacting on their lives and work. The transcripts were then subjected to a textual analysis. My preferred way for interviewing was to get the participant’s permission to use a tape-recorder, and then create a transcript for analysis.

Thirdly, appointments of chaplains within the parameters of my study are almost exclusively made by churches. Five officers, representing five major church denominations were identified as being responsible for the undertaking of appointments by those churches, and a questionnaire different
from that sent to chaplains, was devised to gain a sense of the church’s perceptions of chaplaincy. The answers from respondents were placed together in relation to each question, and analyzed as a unit. This enabled comparisons to be made and offset the lack of any interviews. The value in dealing with this questionnaire was to be able to see at a glance the similarities and differences emanating from providers, indicating, as they set out their answers, the mind of their churches.

When the completed questionnaires were received, and the interviews completed and transcribed, they were subjected to textual analysis to interpret and analyze my subsidiary questions. Belief, authenticity, story, along with the practical matters of administration and appointment are of particular interest. I was seeking evidence of belief as an important element in pastoral care, and also looking for any recurring patterns of care that may indicate differing models.

Flick writes of perspectives and diversity among participants in research. ‘In order to do justice to the diversity of everyday life, methods are characterized by openness towards their objects, which is guaranteed in different ways’ (2006, p.15). The guarantees of openness in my questions and interviews are recognizable in the answers, as the participant’s perspective. I would expect to observe in the responses some clear diversity among the participants. This will become evident through the identification of the nature of pastoral care, of the articulation of belief, the power of story, and the importance of sustained engagement.

Ethical clearance (ART/19/08/HREC) has been received for this research and the project is acknowledged as low risk to its participants and as beneficial in its potential outcomes. I am aware of the importance of informed consent, and it has been made clear to participants that responding to the questionnaire constitutes consent. Agreeing to an interview was also construed as consent.
Participants have been advised that any information they provide will remain confidential and that there will be no disclosure without their consent. It has also been made clear that participants will not be identified to any other person.
Chapter 3

Questionnaire Analysis: Belief in the Identity Formation of Chaplains.

Within the parameters of health care which this thesis embraces, “chaplain” is applied to one with theological and health training who is working fulltime, and also to one with minimal training who may be active for only three hours a week. In this thesis, “chaplain” is used to embrace all, and “chaplaincy” is a descriptive title that encompasses spiritual and religious care within a particular organizational framework; in this case hospitals.

Initially, questionnaires (Appendix 1.) were mailed to a random selection of 40 chaplains. Of the 40 people approached, three responded with information that they were no longer engaged in chaplaincy and therefore not interested in completing the questionnaire. This left 37 potential respondents out of whom 19 returned answers to the questions. This represents around 50% of the total.

Status of Questionnaire Respondents

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<th>Category</th>
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<tr>
<td>Ordained</td>
<td>3</td>
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<tr>
<td>Lay/paid</td>
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</tr>
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<tr>
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<tr>
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<td>47%</td>
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There is no doubt from these results, that the major contributors to chaplaincy practice in Queensland are older female volunteers.
The responses from the respondents reveal eight themes. These themes are:

1. Reasons for becoming a Chaplain.
2. Understanding of Chaplaincy.
3. Personal Need.
5. Professionalism.
6. Story
7. Other faiths.
8. Training.

These themes can be grouped to facilitate coherent interpretation. Themes one to four relate to the chaplain’s personal belief and understanding. Themes five to eight consider professional acumen in a multicultural context, the chaplain’s response ability to patient’s stories and the role of training. This chapter considers themes one to four.

Reasons for becoming a chaplain

Religious belief of one kind or another concerns everyone; hence the complexities in believing. Why then do some seek to be a chaplain, while others have no such interest? We will become aware in the consideration of the question, “describe what moved you to take up the work of chaplaincy” that there are a considerable number of reasons for seeking a position in chaplaincy. Some have a clear desire to share their faith. I love praying with people and for people (C24): [...] a servant of and for God (C15). Some have entered chaplaincy as an emotional response to happenings in their own lives. Sitting alone for 8 hours while 15 year old son had open-heart surgery (C18). A friend my age was diagnosed with a brain

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7 This different font (NBatang 12 pt.) is introduced to more effectively highlight comments from respondents, and as a help towards clarity.

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tumour” (C22). One respondent referred to chaplaincy as an outcome of her nursing career. I could see that as time was going by there were fewer staff and less time given to patients. I could see an urgent need for someone who could sit with the patient and be a presence for them and to listen to their story (C14). Two respondents came to chaplaincy as a result of working in their parish. I started helping our priest at nursing homes and then that followed in doing Lab.1, then Ecumenical Hospital and Pastoral care, then CPE [Clinical Pastoral Education] unit (C34). Parish work and connections with the elderly (volunteer) (C35).

Three respondents were encouraged by others. I was approached to help out (C4). Encouragement from others who believed this was the ministry I should be involved in (C11). Inspired by a friend doing the training (C38). Two respondents make reference to personal need. It was in the first part to extend my own spiritual experiences, to gain knowledge and grow by reaching out to others in need. Secondly, to offer support across all levels regardless of faith (C40). Back from a long stint in Africa, I needed a ‘hands on’ ministry rather than administration (C21). Two others make reference to educational courses. After finishing an appropriate course, I was asked to find myself a suitable placement (C39). I had been encouraged to commit to the Education for Ministry course by a friend. […] I had an urge to ‘return’ care and support I had received […] decided the way to do that was to ‘pay it forward’ (C7). Such a diversity of reasons, when applied to pastoral care, raise questions about the nature and quality of care that may be undertaken.

Five of the respondents make specific reference to chaplaincy as a call [from God] but only in one instance (C6), is there reference to a need to take time to discern the nature of what might be considered a call. (C1) says: I recognized the need and answered the call to train. (C6) states: I believe I was called to work with those who are terminally ill in a ministry
capacity. This evolved over a period of many years of discernment. 

(C17) says: I believe I was called to chaplaincy. I had been working as a pastoral care visitor in a parish and became aware that I could do what I was doing in a much more helpful way if I had some specific training [...]. On conclusion of the course I was accepted to work as a volunteer. (C28) claims that: at the end of a week’s intensive in theological college I had a strong sense that hospital chaplaincy was where I was supposed to be. (C29), feeling called to ministry, says: [I] had been a registered nurse and felt there was never enough time in the work day to deal with the very important spiritual and emotional issue [...]. Wanted to move into that area more than the physical one.

Considering chaplaincy a call does not mean responding to feelings and relying on God to guide. Nor does it mean taking the call at face value and immediately seeking a place as a chaplain. As (C6) tells us it “evolved” over a period of many years of discernment. Taking time to discern allows for understanding and the consideration of a number of questions such as: who is calling? What does it mean for my life? How do I recognize this as a call? Amongst its regulations, the Uniting Church, for example, establishes that:

A call to a placement gives effect to the perceived will of God as expressed by a council or councils of the church and by the response of the Minister concerned. After careful consideration and prayer the Minister discerns therein an expression of the will of God in relation to ministry at that time (Reg. 2.7.1(c)).

This regulation is specific to a Minister, but invokes a principle that needs to be taken into account by any who consider they have a call to such as chaplaincy. The notion of call presupposes an involvement within, in our case, the Christian church, with all the denominational variations. Irrespective of denominational affiliation however, a time of discernment will be of value to both appointers and appointees in the choices to be made.
The implication in anyone being called is that the one, thus called, places her/himself in the hands of the body in which the call might be physically expressed. What therefore can be an adequate expectation of what a volunteer can achieve may need careful assessment by appointers. Belief that one has been called to the work of chaplaincy requires a balance between belief, in which emotional attachments to religious feelings may be strong, and pragmatism which can stand aside and consider the realities of what is being considered. This is not an easy task, and considering that in our sample, most are volunteers, practical difficulties need to be recognized. These include other calls on one’s time, and the risk of over commitment to a situation arising through strong religious or emotional attachments.

Limitations on availability may result in some restrictions on patient care, therefore requiring the organization to have processes in place that will offset this possibility so that continuity of care may not be compromised. Most chaplaincy departments anticipate that a certain number of patients will be visited, but limited availability of pastoral care providers may result in fewer visits than expected, or rushed calls of short duration and of minimal value. If there is also an expectation of outcomes (Dayringer 1998) other than numbers visited, limitations of time can affect the nature of those outcomes.

Karen Hanson provides us with a timely reminder of the importance of pastoral visits and the energy required, along with a very sure understanding of the commitment required. She writes of a “midwifery” model of ministry which will help to bring to birth that which waits to be born:

   The focus is not so much on doing, but on being with people in travail, on using our skills and our personalities to focus on the unique context and process of the patients and families we are privileged to attend (1996, p.250).
The responses make quite clear the variability in reasons for taking on the role of chaplaincy, but the focus does tend to be on “doing” rather than “being with”. They also make obvious that the foundation for the choice is found within their Christian faith life. Having taken on the role, how might chaplaincy be understood?

**Understanding of Chaplaincy**

Coming with a strong Christian belief and a desire to realize a variety of personal needs, reasons given for becoming a chaplain suggest a mix of understandings about chaplaincy. There is clearly a visible religious understanding, evidenced by a focus on patient comfort, erasing pain, sharing hope, expressing God’s love, as well as a sense of well being for the chaplain; making a difference, providing comfort and support. The replies that express the respondents’ understanding of chaplaincy, may be separated into four categories.

Perhaps the clearest related to being a help. Helping patients to validate their life (C1): listening and encouraging (C4): helping patient comfort (C7): seeking to make a difference (C15): erasing pain and staving off loneliness (C18): desiring to share hope (C22): giving support (C35, C39). Being a help in these instances, implies a result. Once the help has been provided the patient may be more comfortable, less lonely, and more hopeful. If, however, attention is given to the two facets of pastoral care; the provision of spiritual and religious care, the question of whether these matters were addressed is not answered. Nurses and cleaners are able, in their daily rounds, to provide comfort and stave off loneliness. Hope also, can be engendered through the visit by the doctor. The chaplain, having spent time with the patient, may find value in reflecting whether spiritual and/or religious concerns were considered in the visit.
Some of the responses are linked with presence. Listening, validating, respecting, offering hope and peace (C6): to be beside those in need […] available to listen, support and assist (C11): presence along with listening (C14): being present to the person (C21): express a call to chaplaincy in presence (C29). Marcel reminds us, however: ‘that “presence” is not identical with physically being present or attentiveness. A person may be close enough to touch, yet one may feel strongly that the person is not present’ (in Avery 1986, pp.346-347).

Two respondents offer specific religious comments in the context of their understanding of chaplaincy. Showing God’s love (C28): expressing God’s love (C38). These respondents are not clear about what they might do or say, but overtly showing or expressing God’s love fits within the parameters of religious care. One respondent (C24) has a close affinity with the Holy Spirit – I speak what I believe the Holy Spirit is telling me. This respondent also offers prayer and scripture. Another recognizes the task as a privilege (C17). Religious care cannot be considered unimportant, nor can we claim that chaplains should not need some affirmation. Pastoral engagement, however, will become difficult if these matters overshadow the need to provide care that is meaningful for the patient. In considering the way chaplaincy is understood, therefore, questions that have some relevance include; what assumptions are carried into the interaction? What results are considered the best affirmation? What is the attitude towards the patient? These questions invite consideration in more detail.

What assumptions are carried into the interaction?
Obviously, if one has been brought up within a Christian framework, the assumptions and understandings of life absorbed through that exposure will be very much part of any interaction undertaken. Robert Anderson reminds us, however, that: ‘assumptions about ethnic, religious, and age groups distort the understanding of a particular person and are often the assumptions of the dominant religious or cultural view’ (2004, p.3). Assumptions of
confession (C38), salvation (C34), the importance of prayer (C24), and sharing one’s faith (C22) all have the potential to detrimentally impact on the patient. Blaine-Wallace contends strongly that:

To presume to know about a person by means other than what is shared in conversation is a violation of the person’s humanity. Even the seemingly obvious indicators of religion, ethnicity, and gender, are apart from dialogue, hazy territories. (2011, p.2)

It is important therefore for the one undertaking such visits, to recognize the assumptions, along with the way in which they may skew or perhaps undermine attempts to provide pastoral care. Awareness of one’s own assumptions will enable insight to one’s own bias. Insight will also enable the provider of care to approach the receiver with humility, and in a hospitable manner. Reflecting on competency, Anderson notes that:

Augsburger (1986)\(^8\) described characteristics to guide the pastoral counselor [and we could interpolate chaplain] in developing cultural capability. He emphasized awareness of one’s values and basic assumptions, a capacity to welcome and value other worldviews and contexts and a willingness to be a humane and universal citizen, open to diversity that goes beyond the known and familiar to that which is divergent and unknown (2004, p.12).

In the particular task of chaplaincy undertaken by people whose lives have been strongly focused in the Christian faith, some assumptions about religion will be inevitable. Some respondents listed confession, salvation, importance of prayer, and sharing one’s faith as important components in their understanding of chaplaincy. Any assumptions however, that the elements of faith which chaplains find important, will also be important to those they visit, run the risk of rejection by the caree. It is clearly apparent that if spiritual care is to be effective, chaplains must take note of the importance of valuing other’s world views. Approaching the other with grace and kindness and openness to diversity will pave the way for meaningful discourse and preparedness to enter the unknown.

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Chaplains are not exempt from attitudes towards others. Familiarity is safe, but attitudes towards others can lead to a distorted view of the world. Suspicion of that which is unknown, however, may exacerbate attitudes. To some extent this comment links with the previous paragraph about assumptions, but also suggests different connotations. Attitudes are frequently responses to what one perceives about the nature of the other. Perception plays a considerable role in any approach made by one to another. In contrast to assumptions which have to do with belief about recipients, attitudes are directed towards the recipient. Attitudes frequently surface as a response to information received, but attitudes are also generated through information about an individual or group that has become general knowledge. Patients in hospital are no different from any other member of society except that they are, one way or another, unwell. How people look, their physical size, their attitude to their care, the degree of deformity, the nature of their illness and their treatment, all of these affect attitudes.

What results are considered most helpful, and for whom?
Entering into an interaction at this level of engagement, and expecting results can lead to awkward situations; even more so if there is a suggestion that the results benefit the chaplain. Hoping for results is evident in, for example, (C11) affirmation [of chaplain]: (C18) erasing pain and staving off loneliness: (C39) importance of sharing time: (C40) being able to assess the type of care needed. As noted in the theme of needs there is in all of us a desire for affirmation and this frequently comes through a perception of pleasing and positive results of an action. The student who gains a top Overall Position (OP) score is affirmed, and rewarded with offers to enter a coveted course of study. The business manager, who achieves beneficial financial results for the company, may be rewarded with a financial bonus and promotion. Both these examples demonstrate practical affirmations.
There are normally few tangible rewards in chaplaincy, so the question of what might constitute affirmation is very important. Affirmation for the one providing spiritual care may come in a simple comment “thank you for listening.” If genuineness is clearly present in the spiritual or religious care that is offered and received, the reward may well be a sense that the patient has benefited and is therefore more closely connected to healing.

The responses in this segment reflect the Christian connections displayed in the reasons for becoming a chaplain, linking the desire to provide help, be present, and show God’s love, to assumptions of the importance of confession, salvation, and prayer. Desiring results also reflects an understanding of chaplaincy as an activity with a positive expected outcome. This gives rise to a question about the needs and expectations of the chaplain in the pastoral encounter.

**Personal need**

Recognition of the value of the individual chaplain as distinct from the value of chaplaincy emerges as a key need in the responses to the questions. As such it reflects the general human need for affirmation. The responses refer to matters specific to a chaplain’s work rather than a broader application. Each response is the chaplain’s own and does not reflect all chaplains’ feelings and thoughts. It is possible to generalize, however, and my expectation would be that similar responses would be found in a larger sample. Whilst something of personal need surfaces in responses throughout the questionnaire, the question (Q.5) that focuses needs more specifically is: “What in chaplaincy gives you most satisfaction”?

For some, satisfaction is found in identification and affirmation of Christian connections. Statements made in this vein include: saved because Christ died on the cross (C1). I have found respect for my belief (C11). To
make clear that God is present (C15). Erase pain and stave off loneliness (C18). I can tell people my story (C22). Importance of salvation (C34). Such statements are not exclusively linked to chaplaincy; they are all commonly found within the wider Christian community. Within chaplaincy, however, one must consider whether and when the sharing of personal belief and feeling may be appropriate.

Possible difficulties may be discerned in the answers of some respondents, in reference to the chaplain's need to have some religious influence. In (C15) for example, the respondent says: I always offer prayer; and continues, in almost 10 years I have only been refused three times. There is a contradiction in this as the respondent, in answering another question (Q.14), says that unprofessional behaviour is pressing your own religious beliefs where they are clearly not warranted. A question that arises is whether the offering of prayer is always warranted. The fact that this respondent has only been refused three times, does not mean that everyone else wanted her to pray. Some patients will say yes because they perceive that the chaplain needs to have a prayer. Matthew Fox reminds us that: "Official" pray-ers – those whom society elevates as models of prayer – so often run the risk of the Pharisees' (1972, p.3). The Pharisees, as religious leaders are frequently said, in the gospel stories, to be false teachers. In Mathew's Gospel Chapter 16:6, for example, Jesus is quoted as saying 'Watch out, and beware of the yeast of the Pharisees and Sadducees'.

A number of respondents have either implied or explicitly stated the importance for them of the patient recognizing Christian links. It is clearly not wrong for a chaplain, along with everyone else, to desire outcomes that are pleasing and affirm character and skill. It becomes difficult if they begin to see these outcomes as most desirous; then they begin to affect the process of chaplaincy with less than helpful results for the patient. (C18), for example
says: I need to show Christ by being there. (C22) writes: I have eternal life and I can tell people my story. (C24), in answer to a question about what she might consider to be the most important responses, replied: Speak what I believe the Holy Spirit is telling me, offer prayer, scripture or books to read. And in answer to another question is rather dismissive of patients’ stories.

(C6) found satisfaction in providing supportive care, (C21) in being trusted with the [patients’] stories, adding that what she does is underpinned by self-knowledge. (C35) wrote of sharing the journey, and (C39) of being able to spend time with people, with a comment on the importance of Being yourself. Made explicit by (C21), we can discern in each of these four a degree of self-knowledge. The patient is the focus of attention in each of these responses, satisfaction being recognized in the pastoral encounter itself. (C40) says: To be satisfied I have done all I can to give comfort, show love and respect.

For a number of respondents need is attached to doubt. (C7) needs to know I’ve done the best I’m able, but at times she asks the question, have I done enough? Conflicting feelings are expressed by some who project a degree of uncertainty into their task. (C15) for example is pleased to state she has made a difference: by my presence I may have made a difference for a patient. At times, however, she discovers a feeling of loneliness, expressed in answer to Q.17. Sometimes it can be pretty lonely out there. (C17) considers journeying with patients a privilege but is conscious of a lack of valuing by the church. She says, again in answer to Q.17 which asks about church support, I think that the “church” still does not value chaplains to the same extent as ordained clergy in other appointments. (C18) speaks of being there to erase pain and stave off loneliness, but is disappointed at
times when facing those whom she says, don’t believe in Jesus. (C22) finds satisfaction in giving and sharing hope, but at times has a need for motivation, finding it hard sometimes just to leave the office and go out into the wards. (Answer to Q.18) These responses suggest a degree of despondency on the part of some. Clearly chaplains are no different from any other in their expressions of doubt over their belief and action.

Claiming lack of support may have some validity among chaplains. The degree to which this is true in Australia, however, needs to be tested. This is best done through a survey of health care professionals within hospitals. Flannelly et al undertook such a study on a national basis (USA) concluding that:

overall, it appears that chaplains are seen as being principally devoted to the care of individual patients, family members, and to a lesser degree staff, but they are not seen as major players in supporting some of the broader goals of the institution itself (2006, p.223).

If this is also true in Australia, it gives credence to the claims of lack of support. It would be most clearly visible among volunteers with their limitations on availability in the hospital. There may be some question, however, about the degree to which this might, or should, show in the professional setting of a pastoral encounter. Cobb more generally, makes the point that:

Chaplains cannot simply go around claiming a particular identity; the communities they relate to and deal with must validate it. Equally chaplains cannot guarantee that the identity they think they have is the one that others perceive or understand (2004, p.11).

Need for recognition (C1), satisfaction (C4), acknowledgement (C28, C29), being valued by the church (C17), and having others validate the work being done (C24, C38), are obviously important. It is also important, however, for those engaging in pastoral care to identify and recognize their own needs. Such a task could be adequately ensured through an appropriate supervisory process. Addressing personal needs is important for all people, particularly in
the consideration of relationships. There is always a relationship between chaplain and patient and in order that this may be appropriately maintained, boundaries need to be established.

Many of the responses, as expressions of a chaplain’s perception, imply that a basic patient need is religious. Patient needs, however, like chaplains, vary considerably, but perhaps the most basic need for all is to be recognized as a human being (Macquarrie 1968, p.7). It is in the sharing of personal stories that people offer a view of themselves that proclaims their humanity and invites affirmation from the pastoral visitor.

The work of chaplaincy with its diversity of understanding and complexity of needs, has an impact on the chaplain’s commitment to the task, while also being itself influenced by the strength of that commitment and its outcomes. This brings us to the matter of belief.

Belief: source of commitment

The first “belief” question (Q.10) asked, “what for you are the most important elements of your religious belief?” In answer to this question all respondents, though verbalizing their belief differently, were clear that the central all embracing presence was God, who was both powerful and loving. The answers can be gathered together into a number of categories, each one demonstrating an element of belief. The first of these includes responses that suggest some specific outcome for the believer; God who loves me unconditionally (C4): God’s presence with me (C6): Eternal life because of Jesus (C22): Saved by Jesus’ great grace (C34). The element of belief portrayed in these responses is of God having acted specifically for the believer with a resulting feeling of gratitude.
The second category contains considerations of the nature of God. All equally loved by God (C1, C11): Belief in a loving God (C7): Gift of Son (C15): Faith in God’s unconditional love (C21): loving all powerful God (C24): God’s grace (C28). God’s nature is clearly portrayed as love, restated from the New Testament description in the first letter of John:

Beloved, let us love one another, because love is from God; everyone who loves is born of God and knows God. Whoever does not love does not know God, for God is love. God’s love was revealed among us in this way: God sent his only Son into the world so that we might live through him. […] Beloved since God loved us so much, we also ought to love one another. (1 John: 7-11)

Thirdly, responding to scripture requires that the love of God experienced be shared: God in you meets the God in me (C14): We are all reflections of God and God’s love (C29): love of God, neighbour, and creation (C35). This sharing can take many forms, from strong evangelism to quiet practicality. The sharing frequently engenders community through which belief may be expressed. Some of this is through action; probably compassion and its expression in action (C38): and normally there are rituals attached to the expression of community. Baptism is important – made children of God (C39). One way or another, all of these elements of belief incorporate God in a loving, forgiving fashion. They are strong belief statements, and locate these respondents firmly within a Christian framework.

The comments from (C18), My faith is mine. I need it to survive, and (C40), My spirituality, express an outcome for these respondents that is an affirmation of their belief.

The strongest statement, which could be considered an evangelical proclamation, is found in the words of (C17):

Knowing that God, Father, Son and Holy Spirit IS. That Jesus was crucified for our Sins died and rose again, that we might have eternal life with him. That God has called me to this ministry and by his Spirit enables and sustains me. That my
God is far greater, more powerful, and more wonderful than I could even imagine. That God loves EVERYONE.

The risk in holding this stance is discovering that IS and EVERYONE do not have the same meaning for “everyone”. Discovering this could lead to feelings of failure on the one hand or a strong impulse towards conversion on the other. In the interview with this respondent, she speaks of presenting God to those whom she visits and claims that through her visits seeds are planted and doors opened. Both of these raise difficulties in chaplaincy, and I will return to these as we continue to consider the respondents’ replies.

The second “belief” question (Q.11) was, “in all that you say and do as a chaplain, what for you is the bottom line”. The responses to this question were not as emphatic as they were for the first, but we can still locate four categories. The first of these expresses belief in terms of the care offered to others. Genuine compassion (C4): supportive care (C6): I am there for the person (C11): infinite respect (C17): just be there (C18): compassionate listening stance (C21): being a presence (C29): to listen (C34): compassion (C38). Belief, as it is expressed here in caring, is concerned for the one receiving care and is therefore focused. It is not distracted by personal needs, nor by any sense of having to present God. It could be said that these are elements of spiritual care.

The second category puts God to the fore. Gods’ resources never depleted (C15): trying to be Christ like (C22): showing God’s love to all (C28). This is an aspect of chaplaincy that needs to be handled with care. An overt presentation of God in pastoral care visits is described in the literature review (p.9) as religious care. It is also noted in the literature review (p.12) that religious care is a valid response to patient requirements, but needs
discernment, not only of the need, but also of the most appropriate way to frame the response.

A third response involved human values: All humans therefore connected (C1): personal integrity (C7): be yourself (C39): to be satisfied I have done all I can (C40). These can be recognized as expressions of hope. In a fourth group, three respondents expressed uncertainty about the way in which their belief could be carried forward. One of these, (C24), said: don't know, and the other, (C35), did not provide an answer. (C14)’s response is a description of a process in which, after exhausting all possibilities, she would refer the patient to a counselor or someone from their own faith tradition. Revisiting her previous answer, could lead to a query about the nature of the God who she espouses.

These brief responses provide a portrait of the complexities associated with belief. There can be no fixed standpoint, only a broad framework in which are established a number of propositions. The source of the chaplain’s commitment is found in attachment to notions of unconditional love in God, and the centrality of Jesus in life. The nature of God is defined as love. Out of this belief stance it is considered important that the understandings be shared along with ritual and commentary on the importance of faith. This expression of belief and its possible outcomes is complex, oscillating at times between piety and pietism. These have been discussed in the Literature Review (pp.22-31) and reinforce the complexities associated with religious belief; in our case its association with those from a Christian standpoint.

A Christian standpoint, in reality makes visible one aspect of spirituality. Exploring spirituality would take us into areas that are beyond the scope of this thesis and are therefore simply acknowledged. The claim by Waaijman that:

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Piety discloses spirituality as a sturdy fundamental attitude which encompasses the whole of life: the God-relation, one’s social interactions, and the organization of one’s personal life. It can be described as deeply respectful dependency which, while it concerns the care of one’s affectivity, at the same time validates itself in conduct (2002, p.348)

alerts us to the importance of being aware of the things that guide our life, and the necessity therefore of respecting the way in which others’ lives have been guided. This is of particular importance in pastoral care encounters.

Discussion
Belief in God stands out as a primary motivator for those engaging in chaplaincy in all its complexities, and features strongly in interactions with patients. All of the respondents claim Christian faith and a strong connection with the church. The beliefs they espouse, though stated differently, contain the essential elements of church teaching; a loving powerful God, Creator, Father of Jesus Christ who is himself Saviour, and the Holy Spirit as the
ongoing expression of God in the world. Belief itself is complex, being for many, if not most, something grown into within a particular religious framework. Indeed the first step is that we are born into the religious following of our parents.

Belief may be discovered by an individual, as the result of a search for meaning. Elements of this search can be found in comments on salvation (C34) and eternal life (C22). The notion of future life is strong within humanity, and while unable to be demonstrated, can be internalized through belief in God. When God is defined as loving (C7) and gracious (C28), belief is fortified. Chaplains, growing up within the Christian faith will have come to this recognition of God and thus have their hopes for a continuation of life substantiated.

Identity formation is therefore of particular importance and in this chapter we have been able to extract some reasons for becoming a chaplain, and an understanding of chaplaincy along with expressions of personal need within the chaplaincy framework. Each of these is undergirded by belief and it is clear that belief standpoints provide a primary motivation. Identity can become clouded by the definitions of “chaplain” overwhelmingly attaching clergyman to the role. Re-articulation of pastoral care will invite greater clarity in the use of the title chaplain. It is for convenience, and bowing to general usage, that chaplain has been applied to all engaged in chaplaincy. There is clearly a need to reexamine meanings that are attached to “chaplain”; the use of the term covers a broad spectrum of situations.

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9a. A Christian clergyman attached to a chapel of an institution or ministering to a military body etc. (Collins Concise Dictionary 1995.)
b. An ecclesiastic who has a chapel […] A clergyman who is retained to provide divine service in a family. (Webster’s New Twentieth Century Dictionary of the English Language 1951)
c. An ecclesiastic attached to the chapel […] (The Macquarie Dictionary 1981)
d. The priest, clergyman, or minister of a chapel […] (The Shorter Oxford English Dictionary 1977)
The reasons put forward by the respondents for taking up chaplaincy were varied. Underlying all these reasons, however, are two in particular. The first of these is their link with their Christian heritage, aligned with the dogma of the church with which they are affiliated. The second, which could be considered the driving force, was their sense of being called by God. Five respondents made specific reference to this. As chaplains reflect on their reasons for undertaking the task of pastoral care, however, it will be important to evaluate any sense of call; to allow for a period of discernment. If this is to be adequately undertaken the companionship of a mentor is necessary. Embedded in many of the reasons put forward for becoming a chaplain can be found a desire to present God. Discernment will need therefore, to take account of the patient’s situation, of the general quality of human dignity, and awareness of the appropriateness of any overt presentation of God in a pastoral encounter. Focusing on being rather than doing is a way of enabling recognition of patients as human beings.

Understanding of chaplaincy was varied but included statements about patient comfort, easing pain and sharing hope. Some made clear the notion of chaplaincy as a work in which God might be made visible. Consideration of assumptions and attitudes in the understanding of one’s role takes on meaning when placed alongside my articulation of pastoral care as containing both religious and spiritual care. Any intention to make God visible is a presumption about the need of another. Blaine-Wallace’s contention that; ‘to presume to know about a person by means other than what is shared in conversation is a violation of the person’s humanity’ (2011, p.2) is a timely reminder of the need to be aware of the assumptions carried into a pastoral encounter.

Similar statements were made in relation to personal needs of chaplains. Some spoke of a need to express Christian connections and have some religious influence. The need for affirmation from others, along with a desire
that they might be valued more clearly by their church was visible in the comments from a number of respondents. Some had more basic needs such as a need for motivation. Words used included satisfaction, acknowledgement, and valuing. The expression of personal needs mirrors general needs found among most people. In chaplaincy practice, however, it may also reflect a degree of isolation and loneliness. The need to have some religious influence can be traced to the strength of their belief. My re-articulation of pastoral care is directly linked to the use of belief in pastoral encounters.

Strong attachment to belief in God, and the nature of God as presented in the New Testament, raises the important question of whether one who does not have this strong attachment can be a chaplain. This in turn raises a further question about the nature of chaplaincy. Answering these questions is beyond the scope of this thesis. They need to be borne in mind, however, as important and relevant. They are matters for further study, particularly in contexts such as hospitality, industry, and sport. Indeed further questions can be expected to emerge as we reflect, for example on the nature of call, strongly presented in the responses of chaplains.

Awareness is critical if the pastoral encounter is to become more than the desire that patients know God. A fundamental criterion for a pastoral encounter comes to us from Harvey et al. who claim: ‘A central interactional characteristic of the discourse is, that in seeking to elicit and foreground the patient’s voice, it is resolutely patient centred’ (2008, p.57). It is important also that in understanding pastoral care, there is recognition of the two aspects of religious care and spiritual care, along with an understanding of the difference.

The answers to the questionnaire, (elucidated in this chapter and in the following chapter four) while presenting a broad scenario with its elements of
similarity and difference, do not allow for more subtle nuances of meaning. Nor do they offer a deeper understanding of the chaplaincy task as perceived by chaplains. It was important therefore, to engage some of the respondents with an interview. These will reveal different levels of understanding, and we will become aware of strengths and weaknesses not evident in the answers to questions. All of this will be taken up in the analyses in chapter five.

Chapter Four.

Questionnaire Analysis: Belief and Structural Considerations.

Professionalism

In order to establish the respondents' understanding of professionalism two questions were asked.

- Do you consider yourself as a professional in your task? Why or why not?
- What, for you, is unprofessional behaviour in chaplaincy?
Nearly all respondents answered yes to the first question. A variety of reasons were put forward to justify the answer.

Two, (C1), (C6), considered they were professional because they were professional; a long answer to the short answer “yes!” (C15) said that professionalism was always the intention and adds: Would that I would always get it just right, the implication being that there was a degree of uncertainty. (C35), answered: Not really. Aware of my own inadequacies to relate to some people. Only one, (C18) asked what is a professional? and expressed the opinion that: the day I think I am professional, I have lost my gut feeling. but she concludes, professional conduct is a must. There appears to be some confusion in this response. The implication of being “a professional” is that such a person has been trained for a particular vocation and is being paid to undertake that role.

Six respondents link professionalism to respect. (C11) claims: I respect the aspect of confidentiality, (C38) endeavors to give respect in all situations, (C39) claims: I respect the dignity of each person, and (C17) says: for me it comes down to infinite respect again. Two allude to respect. (C14) approaches students and patients in a professional manner and (C7) believes she follows an ethical code of practice. Three respondents link professionalism to training, (C40) commenting: I have sought appropriate training. (C28) says: I am trained and continue to hone my skills, and (C29) makes a similar claim.

Others offered a variety of reasons for considering themselves to be professional. (C4) says: Training, life experiences and my own personality. (C22) was told in the academy to try and be professional and (C21) notes that: sometimes the hat slips. (C34) considered herself
professional, because God has led me in this path. Consideration of all these reasons suggests some misunderstanding of professionalism, and points to a need for a clearer grasp of professional understanding and practice.

Professional is defined, for our purposes, as “a person who engages in an activity with great competence”. Competence is defined as “the condition of being capable” (Collins Concise Dictionary). If the respondents as chaplains have been trained well, and carefully chosen for the task, they will have reached a level of professionalism. There is however, an additional factor which I consider as important. Attitude towards the task and intention to continually improve abilities are the factors through which one might truly claim to be professional.

In general, chaplains recognize their work in chaplaincy as a response to a call from God, reinforced through participation in the church. The messages of care, love and commitment evoke for some a desire to express these values in some concrete form, and this frequently happens within the church or amongst friends and neighbours; this may include visiting the local hospital to talk to fellow members. Within Health Care Systems today, however, with all the ramifications attached to clinical care in hospitals, there is no longer an appropriate framework for chaplaincy that only considers religious assurance as its task. Chaplaincy is a more directed practice of pastoral care, into which some, responding to a call, find their way. Health care now requires that chaplains undertaking pastoral care be professionally attuned within clinical settings.

A booklet prepared by Queensland Health, and the Multifaith Health Care Council in 2008/2009, sets out a Framework for Integration of Pastoral Carers and Chaplains in Queensland Health Facilities. The Director General of Queensland Health establishes the purpose of the book in the following way;
The purpose of the document is to clarify the roles, responsibilities, and competencies expected of chaplains/pastoral carers, visiting clergy, and pastoral visitors when they are given permission by Queensland Health to enter public hospitals to offer pastoral care services on behalf of their Church or Faith. The document also seeks to integrate pastoral care services into the continuum of care offered by public hospitals (p.2).

The book contains a number of directives for the proper practice of chaplaincy; too many to relate here. There is, however, one point within the role description for Pastoral carer/chaplain that is pertinent to this particular discussion. Point 6 reads as follows:

Undertake ongoing education and development activities. As demonstrated by:
- Attending and completing mandatory training.
- Attending professional development courses and workshops as available and appropriate.
- Engaging in regular professional supervision. (2009, p.5)

This departmental directive for those undertaking a chaplaincy role in a hospital is a clear requirement that chaplains maintain an acceptable level of professional competency. A further requirement is that chaplains will develop ‘Knowledge and understanding of the skills that other members of the multidisciplinary team possess in relation to spiritual care’ (2009, p.6).

Any confusion about being a professionally attuned chaplain may be dissipated in one’s attention to these requirements. Such attention needs also to be applied by those in the churches who appoint candidates to the role. As a result of his study on managing chaplaincy service delivery, Chris Johnson, with his particular interest in the National Health Service (NHS) in the United Kingdom, posits a number of assessable qualities that are of value when determining whether chaplaincy departments are delivering an economical, efficient and effective service. He relates these to the NHS, but they are also relevant for us. These qualities include matters of professionalism and training along with regular reviews of the chaplain’s work. Standards and expected outcomes should be in place and periodically revised. ‘Good
practice (and reflective practice) should be demanded from Chaplains’ (2003, p.36).

Bay and Ivy in a report on chaplaincy research, also consider that in the practice of chaplaincy, proof of professional competency should be visible:

[...] research requires clearly articulated professional pastoral research focused on ministerial effectiveness. The research challenge also grows from chaplains’ shifting identity away from religious identity and toward spiritual care identity. As chaplains represent themselves as specialized spiritual practitioners in a medical setting, other professionals have every right and responsibility to ask, “And what do you contribute here?” When competency is a major professional statement, then proof of that competence is required (2006, p.343).

Being professional therefore does not entail “losing one’s gut feeling” (C18), rather it means stretching one’s ability in order to practice competent care as an outcome of one’s calling.

The responses, however, to the second question: “what is unprofessional behaviour?” provide an understanding of professionalism as a way of working. Respondents, made a considerable number of comments referring to that which was considered unprofessional within the chaplain’s activity. These include proselytizing (C1); breaching confidentiality (C4, C7, C11, C14, C18); “goofing off” (C6); pushing one’s own ideas (C24, C29, C34); flirting, meeting patients and relatives outside the work place without good reason (C6); not adhering to hospital protocol (C7); overt desire for conversion, “sickness a result of sin” (C11); causing patients, staff, or relatives discomfort, inappropriate comments (C17); and gossiping (C22).

These comments suggest that those engaged in chaplaincy, have a sense of how to do their work in a professional manner, even though they may not use the term. All chaplains surveyed have had some training, and all can be said to have had some sense of call, and recognition of value in continuing education. Working professionally, if notice is taken of such as Johnson, and
Bay & Ivy, will require not only a sense of what is right and proper, but a commitment to engage with the directives from Queensland Health. Development of professional acumen will enable discernment in the provision of appropriate care.

Being called by God is for many a valid reason for entering on a chaplaincy task. Some would claim that because they have been called, God will provide all that is necessary for adequate pastoral care. (C24) finds satisfaction: “knowing that I am taking the Holy Spirit into a situation where a patient is in need of healing physically, spiritually, mentally or emotionally.” One difficulty, however, is that even those who attend church regularly, and would consider themselves faithful Christians do not necessarily appreciate such visits. If pastoral care was only a matter of caring for souls; of providing care in the form of prayer, acknowledgement of confession, and assurance of God’s presence, it may be deemed sufficient. The reality is that this is not the case. While a call might be a basic first step, the matter of discernment must also be brought to bear. Discernment takes time and the risk is that what was considered a call may in fact turn out to not be what had been assumed.

In summary, professionalism is a requirement from which chaplains can no longer escape. Not only is it a requirement of government departments, it is also recognized as essential in a hospital setting with its numerous professional clinical staff. Chaplains, as clinicians in their own field are expected to do their work in a professional manner. There is, however, a degree of confusion in understanding professionalism which needs to be addressed, although chaplains are generally aware of the need for professional behavior. Research makes clear the need for a clearly articulated demonstration of professional competency in the practice of chaplaincy. VandeCreek, in a 1999 USA study on the recognition of chaplaincy, concluded that: ‘If professional chaplaincy is to thrive in the future,
it must redefine and espouse its professional expertise for health care decision makers and insist on involvement’ (1999, p.432).

Value of Stories.
Ebehardt’s (1996) words, ‘Stories are the stuff of life’ are a claim that the whole of life finds meaning in the multitudinous stories that are woven into every day of our lives. Stories describe fragments of our life, but also provide a tableau of all our life. In what way, we might ask, do the responses speak to story as the “stuff of life”? Stories give shape and meaning; each has a rich store available for exploration. Recognition of their worth is the key towards understanding and acceptance. What indicators among the chaplain’s responses can we discern? To assist discernment the following question was asked. How important are patient’s stories in the care that you offer? All respondents, ‘though differing, placed considerable value on story. In considering the answers I have established four categories.

1) Some respondents used one line or one word answers without considering the matter any further. Respondents in this category used words like, top priority (C22): vital (C28): very IMPORTANT (C34) (capitalized by the respondent). These are obviously emphatic answers which clearly represent the respondents’ opinions that stories were significant in a pastoral interaction. To claim something to be very IMPORTANT requires some explanation as to why it should be this way.

2) Some considered stories useful for the provision of information. Respondents in this category appear to find patients’ stories particularly important in advancing the chaplain’s ability to provide appropriate care. Stories not only reveal facts but clues and insights for the listener into the patient’s character (C7). This suggests something of a clinical approach; a means for assessment. Another response reads rather like a
defence of the chaplain’s role. We listen to all patients as we work with all faiths and cultures (C14). Apart from the word listen, there is no reference to story nor to its value in engendering understanding and presence.

A third chaplain likes to hear the patient’s story, as: it gives me more of a handle on what to say and pray for (C24). It may be that after hearing a patient’s story there will be matters that invite prayer. Considering the story as a handle however, suggests that the respondent views prayer as a necessary part of the interaction and welcomes the opportunity provided. It appears also that the carer is not giving sufficient time for engagement with the patient. The claim that most patients don’t’ feel the need to, or don’t want to tell their story could be a cover for a lack of professionalism and capability. The respondent in answering another question talks of visits of 2 minute duration. The fourth respondent (C38) acknowledges that: the patient’s story is just the beginning, but while she may find some understanding of life as it is for them she does not then say how she might respond to that current expression of life. What she does is comment on how she might become more theologically attuned; not for the patient’s benefit but for her own. The last respondent in this group (C40) recognizes the importance of stories but then talks about them as tools for assessment. Without the information it would be difficult to assess the type of care, prayer or conversation to engage with the patient.

3) In a third category one chaplain (C1) identified empathic listening as a key to understanding. Empathy speaks of entering into another’s emotional space so as to comprehend. Empathic comprehension may well enable the other to open windows and allow light and colour to flood in. Another, (C4) spoke of “holy ground” and one can claim that if there is authentic presence, the other’s story does constitute holy ground. It portrays depths of attachment
to life that may not otherwise be visible or heard. (C21) makes the important point that: stories are not necessarily told all at once but may occur over two or three visits. This points to the importance of continuity in care in which the chaplain needs to be prepared to wait, listening carefully, and recognizing the barriers that people erect which may be broken down in the sharing of stories. Continuity of care will also allow time for people to become less hesitant in unburdening what might be most important aspects of their lives. We do well, also, to hear Margaret Guenther who writes, ‘Separated from our stories, we lose our identity’ (1993, p.149).

4) The fourth category considers a number of responses in which the chaplain appears to have a good understanding of story as an unfolding of events. (C6) claims stories as very important. She says: listening to them and respecting these stories affirms a person’s worth, purpose and meaning. Especially at end of life they assist in bringing clarity as they transition into the end journey which is very unknown. This response reveals one who does stay close to the patient, and indeed helps the patient to unfold the story and integrate life and death. In my interview with this respondent she told a story about a Korean Buddhist in the hospital who also welcomed her as a Christian. Others thought him “weird” in wanting to hold both his Buddhist cultural roots and his interest in Christianity. The respondent says: I don’t find anything weird about it at all. He has embraced his background, his culture but he is also embracing the culture that he has been immersed in for about 20 years. That could sound very conflicting but it wasn’t for me. (C11) says that stories are important in that they indicate often the degree of trust that can exist between chaplain and patient. Trust becomes a story enabler. (C15) reminds us that the story being heard may never have been told previously. It may be the only time that these stories have been verbalized. The result for the teller may be a sense of peace. (C17) speaks of: spiritual healing, restoration, reconciliation.
and release from past hurts. (C29) moves beyond trust to “sacred trust” in which she claims a special [holy] nature for stories. They are a means of reviewing and healing hurts and experiences, and in the process finding meaning. Stories she says: are a connecting point.

The responses point up some clear differences among those who practice chaplaincy. The importance of story varies considerably in the respondents’ understanding. Listening for a particular clue, for something on which to hang a response may well lead to a grasping of a point and a failure to hear a story through. This may have something to do with the way many listen to, or watch television; interspersed with adverts. (C35) for example, implies in her response, “it varies quite significantly”, that some stories are of more value than others. Clarity in understanding requires authentic presence and focused listening, along with continuity of care. Much of this develops through experience, but experience itself needs clarification for it to be useful. Continuing supervised practice will open the necessary windows for the practitioner to see more clearly

Listening, respecting, affirming, all lead to clarity and trust. This, in turn, may reflect peace, restoration, reconciliation and release in which spiritual healing may be revealed. As patients become more deeply involved in their stories, involving the chaplain through their telling, the stories become a connecting medium. Not all stories, however, are verbalized.

Chamberlain, for example, tells of visiting a patient nick-named by staff ‘The Bear’ because of his size and condition. The story of this man was acted out as the chaplain began to understand what was happening. The patient had been a long-term patient in a mental institution where for years he had ‘been on a constant diet of lithium and a couple of other anti-psychotic medications.’ Suddenly having them stopped, he was now restrained in hospital ‘pulling against the restraints […] with such ferocity that the heavy hospital bed shook
and rattled.’ Gradually, however, he began to improve. The chaplain, returning on the Monday of the new week was stunned by the transformation. ‘He [the patient] greeted me by name as I approached the nurses’ desk, where he had been standing and chatting amicably with those on duty’ (2007, p.133-134). This patient had clearly re-connected with his life. Stories, whether told with words or through actions, have the potential to enable patients to re-gather fractured elements of life and re-establish a sense of wholeness. Together, chaplain and patient may find links with belief in which the Spirit gathers the hurts and establishes meaning.

Doehring reminds us that ‘[…] pastoral care draws upon narrative sources and norms of authority, in that both the care seeker’s and the caregiver’s stories are valued as creative ways in which persons, families, and cultures construct meaning’ (2006, p.8). If, as Eberhardt (1996) says, ‘Our stories are who we are’, this is something respondent (C24), who claimed that most patients didn’t want to tell their story fails to recognize. The same respondent, visiting for a maximum (in most cases) of ten minutes and claiming that many visits were of two minutes duration, is expressing little interest in story. Again from Eberhardt: ‘Listening indicates awareness, awareness of ourselves as being affected by another, and awareness of our being in touch both with ourselves and the other at the same time’ (1996.29). A visit of two minutes precludes such awareness.

Stories don’t just happen at the drop of a hat; they evolve. Mary Marrocco \(^{10}\) tells us of Frank, and in our hearing of this brief story we may discern a journey that, while hidden, provides us with a glimpse of spirit presence:

Frank is a thin, ragged man, always wearing a baseball cap and dirty jacket, who commonly eats with us. But not till I sat down with him at table, asked his name, and inquired what he had been doing with his day, did I learn that he spends most of his days visiting his mother in a

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\(^{10}\) Ms. Marrocco at the time of writing, worked in a Mission parish located in east-end Toronto, Canada. The mission is a drop-in centre for many of the underprivileged people of Toronto.
chronic-care hospital just up the street, and so I learned to see in this tattered street man a loving and beloved son (1999, p.411).

Stories are told for a purpose. For the teller they articulate a sense of self. If stories are not heard, or considered to be of little account, the sense of ‘who I am’ may be diminished.

One respondent spoke of listening to and respecting the story as belonging to the teller. It was in the telling that the person found affirmation, self worth and meaning. Again we listen to Doehring:

When caregivers immerse themselves in the details of the narratives that unfold in pastoral care, they are less likely to miss narrative complexities and ambiguities that are lost when caregivers move too quickly to using diagnostic categories. […] caregivers who listen to careseekers’ stories as if they were artistic renderings of life will apprehend the mystical and aesthetic experience of these stories, […] (2006, p.166).

The impression gained from the response of (C40), for example, is of one moving too quickly to using diagnostic categories: Patients’ stories are an indicator as to where they are at the moment […]. Without the information it would be difficult to assess the types of care. And, to quote from Eberhardt one more time:

Story telling, particularly in context of a pastoral care relationship, becomes a sacrament […]. Stories are part of virtually all possible relationships in life. Storytelling especially in the context of pastoral care has tremendous power to evoke emotion, and provide a sense of spiritual conviction (1996, p.31).

(C29) says: The stories are a sacred trust given to us. They are a means of reviewing and healing hurts in their lives and finding meaning.

Reiterating some words from the Literature Review: “The first step is to listen to the stories told by those to whom care is offered. An understanding of story as a path to active listening, in which may be discovered webs of meaning, will inform, and perhaps restructure, the social and religious beliefs that will lead to a more valued and valuable healing experience. Recognition that even
our beliefs have their genesis in story will enable us to hear more clearly the stories that lie outside our Christian framework as authentic reflections of different beliefs”.

**Other Faiths – engaging difference**

Although responses to the questions about other faiths indicate rather minimal contact, there is nevertheless a wider issue of engagement with difference. Daily news bulletins regularly show the difficulties in relationships between faith groups. Muslims, Christians and Jews all find within their religious systems a degree of antipathy towards each other. This is exacerbated, in part, by perceptions that others are out to convert.

The Christian church itself has a history of difference, this being found in our day, in the multiplicity of denominations. Facing the differences has in the past led to considerable dislocation within such groups. The increasing visibility of other faith groups, along with a steady growth in their membership, has confronted chaplains from time to time with a need to examine the way in which they may engage with difference. Difference is not only to be associated with faith standpoints outside Christianity, it also occurs within the broad parameters of Christianity. Chaplains, therefore, have to grapple with these differences along with the increasing number of people who claim no faith.

We also need to acknowledge that religious difference has always been part of religious life, with at times considerable impact on political and social life. For many years denominations have been, at times, considered different faiths; in their practice denying the legitimacy of each other. This history, along with the growth and increased visibility of new faith groups has resulted in some confusion among more established faith perspectives.
What does not appear to be understood is that difference is inevitable. Religious differences, however, when considered along with cultural differences, have the potential to awaken fear of the unknown. When chaplains consider their primary task as the provision of religious care, difference is magnified and difficulties become obdurate. Churches as appointing bodies are also implicated. I will have more to say on this later in the thesis. Re-articulating pastoral care (Thesis p.12) to be aware that the other side of religious care is spiritual care, will reduce the magnitude of the fear and allow difficulties to be viewed more calmly. Difference offers opportunity for understanding, and through understanding, to meaningful encounters.

Meaningful encounters allow for the ambiguity experienced by chaplains, even with their own strong faith convictions, to provide a way to acknowledge the right of others to express their faith standpoint, and so discover mutual respect. Herbert Anderson writes of ambiguity as a vital factor in living with, and dealing with pluralism:

> Because of the complexity of an increasingly pluralistic society, we need women and men with high tolerance for ambiguity, who are capable of living with uncertainty, mystery and doubt. Learning to respect diversity, to enter into conversations with those who are different expecting to learn from them, and even celebrate diversity as a sign of God’s extravagance all require the capacity to embrace ambiguity (2009, p.164)

Seeking understanding of the chaplain’s place in this web, two questions were asked. The first was: “Have you had experience in working with people of other faiths? Describe your approach.” The second asked: “What in other faiths challenges your faith stance? Are these challenges hindrances to your ability to provide care?” The answers to the first question fall into two broad groups. The first of these is recognized in those who say yes (or a variation of yes) followed by a description of their approach. In all the responses, confusing as some may be, there is a clear understanding of the importance of respect. (C6) answered yes, saying: I work from a spiritual base and support people appropriately no matter what faith position they hold.
This respondent’s approach is clearly evident in the interview in which she participated. (C7) claims limited experience. She writes: I try to encourage expression of feelings, maintaining their dignity, and respecting their rights to privacy. She is willing to learn, focusing on similarities rather than differences. These are all general statements, however; they do not necessarily involve other faiths. She continues: I have found those claiming atheism or agnosticism may be aggressive and in my opinion less secure than those who claim a God/s. There appears to be a degree of confusion in what she considers to be another faith. Her desire, expressed in her answer to question five, to “leave a patient more relaxed and even smiling, than when I arrived”, suggests a modicum of anxiety about the outcome. There is, however, a clear problem, if this is the desired outcome of the chaplain. If the chaplain is to engage with patient differences, and listen attentively to the story, whatever the outcome might be needs to be respected.

(C11) answers: A little – working beside people of Islamic faiths within the hospital context. (C15) says: Yes I have. I simply let them set the agenda. Experience however limited, is nevertheless experience, and needs explanation and evaluation. (C24)’s comment: Mostly if patients are spiritual and from another faith, they are usually happy to talk to a chaplain raises the question yet again of the meaning of spiritual. There are those from some Christian denominations who would be prepared to argue the merits of their faith over against the faith of others. Those from other faiths might be more respectful. The comment about “spiritual patients” points to the question: Is it possible to have someone from a faith group who is not spiritual?
(C29) obviously recognizes differences. She claims daily contact and proceeds cautiously: I always approach with respect any person regardless of faith […] I don’t presume I know what they need (C34) recognizes difference, rather than faiths, as defining her approach. I introduce myself. When they say they are Muslim or JW or other, I say that’s great. I respect their faith. The meaning this respondent places on difference is unclear. “Muslims and Jehovah’s Witnesses” clearly differ in their faith standpoints, but Jehovah’s Witnesses also differ considerably from traditional mainline Christian standpoints. Her categorization of these suggests some confusion. Religious care, focusing on belief and feelings will be confronted by differences in belief to the extent that the focus of the visit can be lost in comparisons of religious understanding; favourable or unfavourable. One possible result may be settling on faith differences or faith similarities, with pastoral care being submerged in the ensuing discussion.

The experiences of the respondents are clearly varied, but all the variations can be recognized as being within rather narrow parameters. Essentially difference is considered as “other”, as standing outside a “normal” faith stance. If, however, we consider difference within wider parameters then we need to acknowledge that Christians have always been located in denominations precisely because of differing aspects in their belief. Denominations, and therefore difference, have proliferated throughout the world and adherence to any one of these, colours the response one might make to another. Some are able to give some accommodation to those in other denominations but difficulties remain. Recognition of difference, both within denominations and within interfaith activity, points clearly to a need, in any pastoral care encounter, to choose carefully which of religious or spiritual care is most appropriate. It is a reminder of the ambiguity in the provision of pastoral care in these circumstances.
(C6) who supports people appropriately no matter what their faith position is able to work with difference in creative and useful ways. As we follow the responses in her interview this will become clear. There is, claims Viti: ‘a growing need to minister to others regardless of their religious affiliation, lack of religious affiliation, the nature of their faith, and their type of spirituality’ (2009, p.11). Difference, in Viti’s opinion is clearly much wider than the differences of other faiths.

Pastoral carers will find a multitude of difference in their encounters with others in need. These differences do emerge to some degree in the responses, even though the question placed the focus on other faiths. Difference will continue in all of life and for chaplains in particular there is an obvious need to develop understanding of how differences might affect what they believe. Difference may give rise to uncertainty, particularly in those pastoral encounters from which one may emerge with personal doubts about one’s ability.

Encountering uncertainty can be exacerbated by institutional regulation. The privacy legislation established as a protection against intrusion has left chaplains in some hospitals unaware of the differences they may encounter as they seek to engage pastorally. Lack of available information about patients, also leads to uncertainty. (C1) and (C14) both comment on the uncertainties that they face because of the legislation. I am unaware of a person’s faith affiliation (C1): we minister from bed to bed (C14). (C18)’s response is, Denominations – yes. Faiths – no. (C21) says: I enjoy the camaraderie of working in an ecumenical team but does not answer the question. (C22) reflects on JW’s attitude to some aspect of medical care which has the potential to challenge her faith stance. (C35) claims experience with other denominations only.
(C38), however, makes a practice of asking what in their faith lives gives them strength. This is one pointer to spiritual care and suggests that this respondent is endeavouring to overcome the differences, and show respect for the other’s faith. (C28) claims that the only change in her approach to one of another faith is a change of wording in her introduction. The problem with this is that there is no indication as to what the approach might be, nor any suggestion of engaging with difference. (C40), who works with people from both Christian and other faiths, says: “I have no problem discussing mutual situations, (patients and hospital) with them” suggests that difference is given minimal attention. She continues: As we are ecumenical in our hospital we often share visits to the same patient. Sharing visits to patients with other chaplains does little to admit of difference and difficulty. There is also a degree of disrespect in assuming that there is no requirement for constancy.

Two matters come to the fore in this group of responses. The first, and the one which affects all in the public hospital system, is a structural problem which has a particular impact on chaplaincy. The political correctness in the system in effect denies the chaplain’s pastoral function and minimizes the pastoral care that may be offered. It contains the assumption that chaplains are not included in the clinical team and therefore must struggle along to the best of their ability without a sense of being valued within the framework of care. Some chaplains have commented on their sense of not being valued. Others appear to have overcome this and it may suggest that in some hospitals there is more flexibility and more valuing than in others. The second is that when value is recognized and chaplains seen to be an important part of the whole team, there is a greater probability that chaplains will value themselves and consider it important to be clear and professional in their work.

The responses to the second question asking about challenges can be divided into three groups. For some respondents, other faiths were not
recognized as challenging. This stems from a sense of their own faith position. As one respondent tells it: My faith is fully grounded. I aim to serve in a non-judgemental attitude (C15). One difficulty that arises is the degree of difference each has experienced. Clearly if one has not had personal experience of the differences, there will not be any challenge. It may also be that, because “faith is fully grounded”, there is no opening for any other expression of faith to find a footing. One respondent (C1) claims that she respects all faith as valid for the other person but this still leaves fully grounded faith untouched. Respecting a faith position as valid for the other person may not mean that that faith is considered to have general validity as a faith. In this lies the challenge. There is, nevertheless possibility for “spiritual care” as (C1) says, and certainly for this to occur, respect must be evident.

There were some who had virtually no experience with interfaith differences. (C4) says: Non Christian because of my lack of knowledge. No. It is of course not appropriate to consider therefore that there is, or will be no difficulty in the future. One respondent (C24) claims: no challenge with ‘other faiths’. Patients from my own church are more of a challenge but claimed support from the Holy Spirit in meeting these challenges. A number found the differences challenging but these differences were not all located in “other faith” situations. (C6) for example, found: fundamentalist Christian groups and individuals more challenging than other faiths. Commenting on control as a challenge (C7) observes that: The control that some sects have over family or finances is a little confrontational, and (C29), who has issues with those faiths that oppress women, suggests evidence of a challenge in the structures rather than the faith itself.

In responding to the question, (C38)’s comment is something of an admission. She says: Probably my ingrained attitude to people who think
they have all the truth, which challenges me to look at how I think the same. (C40) says: probably the only challenge from other faiths is when they are assumed to be the only faith. She continues: In my work environment this is not an issue to me personally. The claims “to be the only faith” and “to have all the truth” in fact reflect similar claims that emanate from within Christianity. The respondents’ answers could just as well refer to denominations within the wider parameters of the Christian faith. (C40) actually makes the statement: I work with people from other Christian faiths as well as people from other faiths. Another respondent, however, (C22) writes: Have met a few at my hospital, Moslem (sic), Hindu, Jehovah’s Witnesses, most protestant faiths. Here, some confusion is apparent, but the question is not answered.

In general, the responses to the question about experience in working with people of other faiths appear to refer to denominational differences within the Christian framework. This reflects the comments one will find among Christians when speaking generally about faith. Most will talk about the Baptist faith or the Catholic faith, and so on. Fundamentalism was a challenge for some respondents; not necessarily involving other faiths. One respondent identified denominations as familiar but not faiths (C18). This was essentially because she lives in a small rural community. Another commented: I enjoy the camaraderie of working in an ecumenical team […] provide good debriefing opportunities as well as social contacts (C21). The word ecumenical, from the Greek “Oikumene”, has been traditionally attached to the church as a description of the church as a universal body of believers. The context for (C21), it would appear, has to do with a mix of denominations. Whether the intention is to include other faiths is therefore somewhat unclear.

Three respondents treat “challenge” rather differently. One, (C17), provides a viewpoint that appears to place the onus on patients. She says: As a
chaplain, I believe I am seen as a Christian representing God. The challenge is with the person of another faith and whether they are willing to accept that I am there for them. Such a viewpoint runs the risk of involvement in confrontation. Two others found yet a different challenge, as they took time to reflect, in their consideration of other faiths. Their commitment to actually practising what they believe is often greater than mine and challenges me to take my practice of my faith more seriously. This is an asset rather than a hindrance (C28). I have issues personally with those faiths that oppress women. They do not hinder me in my work, however, as I respect that they are entitled to believe and follow what tradition or faith they wish. […] I have a right to believe what I wish but so does everybody. (C29).

Acceptance of diversity in religion is a most difficult exercise for many Christians, some of whom cannot countenance pluralism as acceptable. Suchocki reminds us, however, that:

we cannot assume that our religious norms are universally applicable to other religions any more than we assume that the norms of other religions apply to our own […] there are a variety of religions, each of which in its own way generates a community of inclusive well being, enriches the overall welfare of the world, and speaks to its people about that which is sacred. (2003, p.16)

Hick also, in a discussion on religious pluralism, considers that it is best described as the worldview that one’s religion is not the sole and exclusive source of truth, and thus recognizes that some level of truth and value exists in at least some other religions (1980, p.4). This view can be discerned, for example, in the responses from (C6), supporting people appropriately, (C7), maintaining their dignity, and (C29), approaching with respect, and also in more detail as we shall see in the interview responses of (C6) and (C7). Hick’s consideration is of particular relevance when chaplains of a specific faith engage with patients with a different faith standpoint, but with an
underlying belief that the chaplain’s standpoint is the true one. One such chaplain wrote in the following vein, declining an invitation to join a chaplaincy organization.\(^\text{11}\) “Thank you for the invitation but I must decline the offer. While I follow Jesus’ example of caring for people of all faiths, I believe for me to become part of an organization that embraced all faiths would be to approve pluralism.” We need to note, however, these words from Hick who writes: ‘I submit that, when you know that there is true sanctity within the other great religious traditions, as well as within your own, then you have to enlarge your theology to fit the facts’ (1980, p.5).

The ‘web of meaning’ for Christians is constituted by church dogma in which God is located as Father, Son, and Holy Spirit, and Jesus recognized as the Way, Truth, and Life. The web has become very strong and the attitude of many Christians is either to deny the validity of all other affiliations or consider them less than perfect. The difficulty with this consideration, however, is that all religious webs are culturally linked. This means that for many, what lies beyond cultural boundaries is considered to be of little consequence, and indeed is frequently outside their experience.

Chaplains, however, are constantly challenged to weigh and evaluate what is out of the range of previous life experience (Anderson, 2004, p.3). The comment from respondent (C14), who says: I have received my faith nourishment in the Catholic tradition for the last 48 years, expresses something of the challenge facing chaplains in the 21st century, as more and more clearly, society becomes increasingly pluralistic, and the sense of the absoluteness of Christianity becomes less plausible. Banchoff extols the value of religious pluralism as authentic belief:

> Because it involves beliefs and practices suffused with ultimate meaning, religion is a deep seated marker of collective identity […]. A multiplicity of

\(^{\text{11}}\) From a letter addressed to myself in the context of the development of an organization named Spiritual Care Australia. This is a successor to an earlier Chaplain’s Association, and has a broader base than the original.
faith traditions presents not just challenges for social cohesion and governance but also opportunities for a more vibrant civil society and political culture (2007, p.4).

Certainly in those countries where sectarianism is rife, “the civil society and political culture” are recognizably on the verge of collapse.

Any religion that takes the high moral and spiritual ground has little respect for others’ beliefs. Writing about the non-absoluteness of Christianity, Hick recognizes major problems in claims to absolutism which are present in many religious forms. Besides Christianity, which is his particular field of reference, he notes that:

the claims of other religions to absolute validity and to a consequent superiority have likewise, given the same human nature, sanctified violent aggression, exploitation and intolerance. A world wide and history-long study of the harmful effects of religious absolutism would draw material from almost every tradition (1987, p.17).

Brad Mellon, states: ‘It is not only important that the chaplain who serves patients of different faiths possesses a theological foundation, but he or she must also be able to balance personal convictions with the orientation and faith of those receiving care’ (2003, p.60). The comments from the respondents to the questionnaire reveal limited experience with the differences expressed in other faith groups; their attitude favours respect. (C6), for example, is comfortable with faith differences, and this emerges strongly in the subsequent interview. (C29) claims frequent contact, and declares that she always respects others. (C28) expresses awareness of the faith commitment of others as being “often greater than mine.” What is important for all is that they hold on to their own faith. The general desire is to be respectful.

We need to acknowledge, however, that many chaplains have little opportunity to address other faiths within their working environment. This was noticeable in some of the responses received. This is not surprising, given the
numbers of those associated with other faiths within the total community. The percentages in that wider community are mostly reflected in the percentages among patients on any one day in hospital. The Australian Bureau of Statistics notes with regard to religious affiliation in 2001, that Buddhism attracted 1.9%, Hinduism 0.5%, Islam 1.5%, Judaism 0.4%, and other religions 0.5% of the population, whereas Christianity, in one form or another attracted 68%. 12 Later figures, published in 2011 establish a significant reduction in Christian affiliation (down to 63.8%) and a considerable increase in “nil” religion. Other religions have increased marginally (from 4.9% to 5.6%) Even though Christianity has declined by 4% the effect this may have in pastoral encounters in a public hospital is minimal. Any effect would not be the result of encountering those of another religion so much as encountering those who claim no religion. Their numbers have increased by 3%.

It is nevertheless important that in any pastoral engagement with those of another faith, or no faith, [ie. with difference], it is necessary to consider what models of pastoral care might be most helpful and most appropriate for all. The chaplain, who considers him or herself a health care professional, will not take issue, overtly or implicitly with the faith standpoint of the one being offered care.

Training

The matter of training is of considerable importance for the professional practice of pastoral care. The ramifications that flow from an initial desire to be a chaplain have been made clear in the preceding pages. Under this heading therefore, respondents were asked two questions, (Q. 15, 16) the first being: Do you consider that you were adequately trained? In their replies, all respondents answered ‘yes’ with a variety of additional comments. There is a clear claim among the respondents that training is important.

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12 Australian Year Book 2006. Table 12.27.
Three categories, however, can be recognized in our consideration of the responses. Firstly there were those for whom training appears as a one off event. (C1, C4, C22, C24, C28, C34, C35, C38, C39) all simply answered yes, four of them nominating their programme of study without further comment.

In the second category are those who comment on what can be described as “in house” training. (C14) says, yes I do. I have been mentoring and coordinating the course for many years and learn many new aspects of care every year. The team in our hospital is offered five education and nurturing days each year and this keeps our accreditation updated. We have a library in our rooms which we can access as we wish. (C15) also answers: Yes I do. My facilitator was considered tough but this was to my benefit. He peeled me back like an onion and when things got tough, deliberately blocked my exit and made me accountable. I will be forever grateful to him. (C17) claims: in a word, “yes”. I believe that the EHCC [Ecumenical Hospital Training Course] as it was, provided them with the skills and practical experience they would need. This was basic training and graduates were encouraged to develop as they gained confidence in their practice. Most hospitals provide in-service training to this end.

(C29) said yes, and continued: But it is necessary to continually keep training, reading, learning, growing. This contrasts with (C39) who commented: yes I do consider my training was adequate. I feel that you learn a lot from hands on experience. This is not to say that (C39) considers she has done enough. The information presented is not enough to

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13 This respondent has been a local coordinator within a regional hospital in which numbers have taken part in the course to which she refers.
make a judgement. (C40) says: Yes I do. Doing 12 months theory combined with practical supervised training. A further 12 months on the wards supervised work. Then working in extended, but associated tasks that add to an ongoing chaplaincy role.

Thirdly, three respondents laid claim to some considerable extra training and education. (C6) states: I have BTh, M.Couns, [Bachelor of Theology, Master of Counselling] and many other certificates. I have taken seriously the idea of professional development. Important not to stay comfortable but continue to challenge myself. (C7) claims: the initial Hospital Ministry Pastoral Care Course through Uniting Church (ecumenical) Brisbane College of Theology worked for me but was enhanced by extra theological study. Cultural/ethnicity training was minimal and too late in the course I took. […] I felt the need to refresh and refocus 4–5 years later and this was why I took the 20 week CPE (basic) course at the hospital. (C11) responds: Yes having done hospital chaplaincy training during formation, completing Clergy Effectivness Training which includes active listening and narrative therapy training.

All but one of the respondents were unequivocal about the value and adequacy of training. The equivocation of (C18) who, in her response, says: First reaction – never! But I feel I have sufficient basics to know when something is not right and I am brilliantly supported by my hospital’s pastoral carers. It’s an ongoing thing, appears to relate more to a sense of there never being enough training, rather than training itself being unhelpful.

In summary, for some it was a one off event, for some an initial event with recognition that further training would be helpful, for others a clear
understanding of the value of ongoing training along with specific action to upgrade skills.

Clearly responsibility lies with chaplains who need to update qualifications, and also with those who appoint and employ chaplains, who need to ensure that training and abilities are adequate. The matter of adequacy is a most important dilemma. Learning skills is clearly important and needs to be one facet in the training process. But how can one be trained for presence? How can one be trained to provide spiritual care? These are not qualities that can be provided in a lecture, or in a seminar. One can learn about them but not internalize them without some added help.

My earlier comments in the discussion of story make the point that continuing supervision of those engaged in pastoral care is an important adjunct for practice and understanding, opening the necessary windows for the practitioners to see more clearly. Such supervision will assist those engaging in pastoral care to understand presence more clearly and also learn to discriminate the differences between spiritual and religious care.

Question 16 alluded to the notion of additional help when it asked: “What other things in your training would you have found helpful for your work as a chaplain?” Because of the variations in the answers it is difficult to categorize them adequately. It is, nevertheless, possible to recognize two broad groupings. The first of these returns to the simpler yes answer to the previous question, and three respondents, (C14, C24), and (C34) who answered yes, had nothing more to add. Two others, (C1) and (C38) would have been helped with some additional study of other churches and other faiths. One training course currently on offer does include these matters. There is, however, a general difficulty of different content in the training programmes available.
The desire to have input about other churches and faiths in training programmes makes clear the difficulties faced by some in dealing with difference. I have already made clear that differences observed through the presence of faith expressions other than Christianity are also present within denominations in the Christian church. There is, therefore, a clear need for all training courses for chaplaincy to contain a significant element on difference, embracing all aspects of religious expression.

In the second grouping there is a significant mix of learning experiences considered to be helpful. The range of these suggestions is considerable; one respondent (C6) believes additional tertiary studies (Psych. Degree) would be helpful, another, (C22), says “buddying”. My assumption is that she would have appreciated a mentor. Among these suggestions for add on training, (C4) speaks of dealing with the pain of death for families. (C7) observes: I think my initial training was adequate for a novice. Hindsight is not helpful. But ongoing training as one becomes aware of gaps or of the need to focus on particular areas or lack of skills, serves to enhance experience and improve the quality of service one offers (maturity). I would not have known what I needed earlier on. (C11) says: narratives from chaplains – both retired and practising along with ‘Supervision practice’, and (C15) seeks: more involvement from my own church leadership. (C17) claims: I have continued to take advantage of opportunities to attend workshops, conferences, seminars, study modules, retreats and a CPE unit, all of which she adds to her practical experience in order to: upgrade and become a more professional and effective chaplain/pastoral carer. Basic training is fine, she claims, but: individuals should seek the various avenues available for self improvement. The ongoing training is necessary also in order: to comply with the requirements of the health service in which they are
working. (C18) observes: I see and hear things in black and white so find this ‘grey’ hard to understand. I don’t ‘read’ people easily. If you tell me something I usually believe it unless my God’s prompting is strong.

The “greys” in life, however, are legion, and in the practice of pastoral care will always be evident in any interaction. There is a degree of naivety in believing all that is said; the matter of “reading” others needing constant and vigilant attention. In an earlier answer to a different question, this respondent expressed a need to “show Christ”. This expression reflects an evangelical understanding, and listening for God’s prompting would most likely be influenced by her need.

Some commented on the importance of more specific input relating to such matters as palliative care and mental health, along with ways to deal with traumatic death. Bedside ritual and prayer were also considered as important. Some expressed gratitude to teachers and mentors

The responses, varied as they are, make clear that each person has discovered a different need for the enhancement of chaplaincy. Nevertheless all the needs being expressed would be beneficial to all. Including all the options suggested, however, would add considerably to cost, time, and commitment of the trainee. Rather than seeking to change an initial training course, it would be more appropriate to indicate, not only additional courses, but that continuing supervision be an essential aspect of training and needs to be recognized as an integral part of any chaplaincy work. (C11) and (C39) make specific reference to supervision, but this is in the context of the course they were undertaking, and is related to an experience that is more akin to tutoring. Such tutoring occurred in small groups and was linked to practical work they were required to undertake. It needs also to be noted that there is a considerable disparity in educational background evidenced by the requests
being put forward. (C40) claims, in her workplace: no supervisory or counseling support. Apart from these few, no mention is made of supervision. This, however, should not be construed that all eschewed supervision. Comments were not specifically requested.

Pohly provides us with a definition of supervision as mutually negotiated and accepted covenants (2001, p.50), and in the Pastoral Supervision Guidelines from the Uniting Church, we are reminded that;

The desired outcome of truly pastoral supervision is a continuing enhancement of the ministry we offer. Along with this can go increased self respect, released potential, the capacity to see, feel and hear what we have tended not to see, feel and hear, and the bonus of increased health and well being, as well as increased effectiveness in ministry. Research shows a high correlation between good supervision and vocational satisfaction (p.3).

The difficulty with supervision, experienced by some, is in effect a lack of understanding of its role. A more urgent difficulty is that there are simply not enough qualified people. The outcomes expressed in this previous quote, if accepted by those engaging in pastoral care, would lead to understanding and thus be embraced by all. I have already noted the study of Carey and Davoren and their conclusion that: 'it can be argued that there is an immediate and obvious need for an increase in training and resourcing of Christian health care chaplains to cope with current changing demands.' (2008, p.31)

John Meteyard writes of many challenges facing pastoral care and counseling in Australia. Of particular importance are the challenges associated with the provision of meaningful spiritual assistance to others while remaining true to one’s own faith tradition, the ensuring of opportunities for support for pastoral care workers, who frequently feel lonely and isolated, and a need for theological reflection grounded in an Australian perspective. (2009, pp. 9-20). He continues:

All this in a vocation often carried out by volunteers, part-time practitioners or as one aspect of a person’s role amongst many others with little or no
training or continuing support! It seems almost self-explanatory therefore, that those involved in these valuable and yet demanding roles require specialized and continuing training and support to help them manage the challenges inherent in their vocational calling (2009, p.15).

Part of the problem lies with the churches, and becomes visible in two ways. Firstly is the matter of priority. These priorities themselves are complex. The Christian church as a whole, visible as denominational groups, considers, and this of course has been the historical reason for its existence, that the primary task is proclaiming the gospel. This is attached to scriptural warrant which calls on Jesus' followers to seek converts to the faith. This has been recognized as a primary role for clergy and training has been established accordingly. The care of parishioners has been framed by this role; hence the care of souls. Because resources have been focused to this end, and because those resources rely heavily on congregations, churches have found their focus in congregational life. Standards of living, mobility, work choices, and a multitude of other variables have left many denominations floundering, uncertain about future directions. As a result, provision of resources has become more difficult. Churches, if they respond to Meteyard with a degree of agreement, must then find the resources to make things happen.
Discussion
In this chapter, “Belief and Structural Considerations”, professionalism, the elements of story, other faiths, and training can be said to be a way of putting belief into action. The challenge for chaplains is to recognize that one's understanding of chaplaincy, or one's own desire to share belief, are not in themselves sufficient for adequate pastoral care, and in particular, spiritual care.

A number of respondents spoke of “being called”. This, however, needs to be considered carefully, particularly in the light of expectations of professionalism within health care facilities. (VandeCreek 1999; Johnson 2003; Bay & Ivy 2006). Appropriate articulation of professionalism is the task of chaplains, the hospital in which they are employed, and of those who appoint. In answers provided by appointers, however, as we will observe, not all were passionate
about professionalism in pastoral care. While there was a degree of uncertainty about being a professional, respondents do have an idea of the nature of professional behaviour. Professionalism is one matter that needs to be clearly addressed in training, given that health care facilities require that chaplains undertaking pastoral care be professionally attuned within clinical settings. This is particularly applicable to spiritual care and is further evidence of the need for re-articulation of pastoral care.

There is a professional body for chaplains. Spiritual Care Australia\(^1\) has a number of requirements for membership. These include participation in ongoing development and regular supervision. A requirement that all exercising pastoral care become members of S.C.A. will enhance the life and work of chaplaincy. If chaplaincy is to be authentic in its practice, if chaplains are to be authentic practitioners, all the matters listed above need to be addressed. Whether offering religious care, or spiritual care, each must be provided with integrity. The most appropriate way of working within pastoral care is spiritual care, in which, along with Speck (2004), provider and receiver explore together the difficulties being experienced in order to let meaning and understanding emerge. Meaning may also include coming to terms with faith and its connotations of spirit presence and the value of symbols that express that presence.

Paying attention to patients’ stories may be considered as fundamental within spiritual care, and generally there was a valuing of story as important for understanding. Around half of the respondents were able to recognize stories as an unfolding of events. (Ebehardt 1986; Goodenough 1998; Anderson 2004; Confoy 2009). In the answers provided, however, understanding of story was somewhat mixed, some considering stories as a source of information. One respondent, (C24) saw little value in stories claiming that

\(^1\) www.spiritualcareaustralia.org.au
many patients didn’t want to tell their story. It appears that for many, there is misunderstanding of story and little recognition of its deep value for all. If chaplaincy practice is to be adequate, however, training needs to take into account the emotive force of stories and the need therefore for deep and concentrated listening. Doehring claims that: ‘When caregivers, immerse themselves in the details of the narratives that unfold in pastoral care, they are less likely to miss narrative complexities and ambiguities […]’ (2006, p.166). She warns, however, of the necessity of recognizing that there are cultural contexts for all narratives (p.166).

Because life takes place in a pluralist society, questions were asked about other faiths. The answers demonstrated a lack of experience but also confusion over what constituted another faith. For some a different denomination equated to a different faith. The nature of Christianity is such as to pose difficulties in acknowledging validity in other faiths and this was hinted at in some of the responses.

One who believes [in God] risks confrontation when faced with one who does not believe, or someone who lives within a different faith system. Authentic spiritual care requires that the chaplain close the door on his/her belief in order to allow the other some freedom to tell his/her story. The faith standpoints of others need to be acknowledged as valid without mental reservation that they would nevertheless be better off as Christians. Such acknowledgement could be construed as practising hospitality, and Blaine-Wallace offers a whimsical, but ultimately creative way for crossing the bridge of acknowledgement. ‘A ministry of curiosity, through the relational ethic of alterity\(^\text{15}\) and the practice of relocated hospitality, while potentially disconcerting, is likely to become a generative journey’ (2011, p.7)

\(^{15}\) Alterity means otherness, “a quality or state of being radically alien to the conscious self” (Blaines-Wallace p.5). See also, Shorter Oxford English Dictionary, 1977, p.53.
Kenneth Pargament’s writing, referred to in the Literature review, is specifically about psychotherapy, but the words he uses are also pertinent to the business of chaplaincy. ‘The spiritually integrated psycho-therapist [we can substitute chaplain] will need to be spiritually multilingual in years to come’ (2007: p.20). Being spiritually multilingual requires recognition that difference is inevitable, and respect important. Becoming spiritually multilingual will lead naturally to a re-articulation of pastoral care, and to a reduction in the fear factor associated with difference.

All respondents to the questions in this chapter claimed that their training was helpful; for some, more helpful than others. A number recognized that training was ongoing and not limited to a first course. Training, as I have indicated above, is essential, but needs also to be recognized and supported not only by those who appoint, but also by the body in which chaplains may be employed. It is in the best interests of hospitals to help chaplains who earnestly seek further training and to encourage those less enthusiastic. An obvious ongoing device for assisting chaplains in education and upgrading is supervision. This needs to be built in to every chaplaincy appointment as a requirement, and then needs to be monitored in order to make sure it occurs. There is clear evidence in the literature that studies have established the necessity for chaplaincy to be adequately resourced and adequately monitored.

I began this discussion with the claim that the themes in this chapter could be recognized as belief in action. Certainly in pastoral care, it is essential in both religious care and spiritual care strands, that those providing care be adequately equipped. Spiritual care, in particular, needs a degree of professionalism if the passion of belief is to be translated into helpful action. The belief that is essential in the formation of the chaplain’s identity and the actions necessary to channel that sense of identity into effective action belong together. The structural and institutional requirements for training and
professionalism, the recognition by chaplains of the importance of these requirements, and the realization of value in faiths other than their own, combine to provide both opportunity and will for re-articulating pastoral care. The interviews, appearing in the next chapter, provide an important component in the chaplains' understanding of belief in their lives and the nature of their task; also important in the task of re-articulation.

Chapter 5. Profiles.

My study is specific to health care in hospitals in south-east Queensland and the engagement of chaplaincy in this care. To speak of chaplaincy, is to speak of chaplains, and it is important therefore to consider the backgrounds out of which chaplains emerge. It is true to say, certainly within the parameters I have drawn, that chaplains almost without exception belong to a Christian church. Denominations within the church vary considerably in their exposition of the faith, and those differences can be, and frequently are, carried forward by chaplains. These differences, arising from belief, produce variations in the way meaning is created. These variations are not always a conscious choice but are implicit in the exposition of belief in action. This is noted here in order that we might
better understand the impact on interactions with patients, and with hospital staff. In this chapter I analyze the chaplain/patient interaction.

The questionnaire answers supplied by the chaplains were supplemented by interviews with seven of the respondents. My focus in the interviews was seeking deeper responses to two underlying questions in order to understand how chaplains currently create meaning around belief. One had to do with experiences which had led the chaplain to the belief now espoused; the other sought an indication of the way in which that belief was currently impacting on their life and work.

In the Literature review (p.23) I have claimed that “Piety is, in its truest form, the expression of a relationship with God lived out in a covenantal framework.” Here this is restated as an expression of my understanding. Considering this, will provide opportunity to better understand the variations in understanding presented by the interviewees. This is important because piety speaks to belief and obedience, and authenticity speaks to genuineness and truth. Together they are the basis for pastoral care, in which I am arguing, religious care and spiritual care are contained in ways better suited to the multi-cultural context.

Both spiritual care and religious care need to be undergirded and held fast through presence and on the whole allow for stories to emerge, and events become meaningful. In the interviews, respondents speak of presence in two ways. In the first instance they speak of their presence with a patient. Secondly they speak of the presence of God. In order to distinguish between these expressions, in this chapter I have capitalized Presence when attached to God and left the word in lower case when attached to the chaplain’s being with another.
With permission, I used a tape-recorder where possible. The coding of the respondents in these interviews is matched with the coding of respondents to the questionnaire.

(C6) Summary
Interviewee 1 is a married woman in her middle 50’s who grew up with a strong connection to, and involvement in her Church: I was born into it. I was baptized. I was confirmed. Her mother was also a strong influence in her life: My mother always went to church and took me to church. The respondent says of her mother: she always had a simple obedient faith. The respondent has a clear understanding of what she believes, and speaks of many things that influenced her as she was growing up. These include the influence of another girl who lived nearby, and with whom she attended church. She speaks of immersing herself in church life, of reading the Bible,
and learning to pray, and comments that all of this enabled her to deal with difficult times: When life got tough, I had a faith to call on.

This respondent’s story is one of continuous connection to the church and to God. She writes of a variety of people who accompanied her and of her exploration of scripture. I met a Christian girl in my street: a neighbour who took great interest in me. When I read about the life of Jesus and read some of the stories: […] they inform me how I need to live my life as a Christian.

Her initial chaplaincy training occurred around 15 years ago. This was a developing response to what she understood as a call from God to care for others. She has consistently upgraded her training, eventually being ordained for ministry in her Church. For 10 years or so she has been employed fulltime in the provision of pastoral care to people in the hospital’s palliative care ward. In that time, she continued to upgrade her skills, engaging with a number of short term certificate courses and completing a Master of Counselling degree.

She responded immediately to my request for a follow-up interview. When we met she was relaxed and eager to talk about her work. At no time did she appear uncomfortable or confused. Her responses were always clear and articulate. The interview lasted for about an hour.

**Analysis**

Key words – presence; obedience; respect; genuineness; journey.

Presence emerges as fundamental to this respondent’s life and work.

1. God’s Presence is very real and personal. The words, “I will never leave you or forsake you” (Heb.13:5b) are like a mantra for her.
2. This Presence has sustained her on her faith journey in which both good and bad things have happened, and will happen: God has
helped me get through dark places in my life into the next part of my journey.

3. The journey is partly expressed as obedience to a call, and recognition that God has not abandoned her, resulting in a determination that she will not abandon others.

Two meanings for presence emerge in this response. One is the Presence of God and the other expresses the nature of her presence with others. Here the Presence of God is clearly associated with belief, supported by childhood practices, and modeling by parents and significant others. This has all had a considerable effect on this respondent. She speaks of her experiences in the church, in reading the scriptures, and in the influence of others, through which she learned about God, and from what she says, her knowledge and understanding continued to grow. But she also considers that from all of her experiences she found God to be present most of all in a way that helped her through hard times. She says: There have been many big dark holes in my life and God has helped me get through those dark holes into the next part of my journey, and there is trust about God’s Presence. For this respondent, God’s Presence is so strongly evident that we may well consider Presence as a synonym for God.

This sense of Presence enables this respondent to speak also of constancy, claiming it as a two sided affair. She claims in the first instance the constancy of God and links this with her own feelings of abandonment as a little girl. It is essential to her that such abandonment cannot be applied to God, of whom she says, He had not abandoned me. This has confirmed for her the importance of not abandoning others. Not abandoning means being present at a deep level of consistency. Presence has particular relevance in spiritual care in which we engage with others, as Speck (2004) indicates, on a mutual search for meaning without prejudging the outcome. For this respondent, both
presence and constancy are considered to be important in the provision of pastoral care.

**Belief finds expression in the words:** I know I will never be alone and that God is faithful to God’s word ‘I will be with you always’. That shapes my life. **Belief stands out in this interview as a primary component in the subject’s construction of the meaning of pastoral care which emerges from her own consciousness of Presence.** The respondent says of belief: I believe in God. I believe that Jesus is the Son of God. **She speaks of her attention to the scriptures and expresses a belief that from the scriptures comes direction for living her life as a Christian in God’s Presence.** This she recognizes as being called to a journey of faith.

She notes, however, that while she believes, she cannot explain, and indeed doesn’t need to. It is mystery but I believe it. **The idea of God, or more widely, divine mysteries, is centuries old and can be recognized as embedded in the psyche of humanity.** Her belief was established and nurtured through the influence of her mother, the church, and numerous others associated with the church. The result was that in facing difficult times she: had a faith to call on. An important outcome for this respondent, in reflecting on her journey, is **obedience.** If I am obedient […] then God will be Present with me on that journey.

**Belief in general, however, can be unclear, in that understanding of what constitutes belief varies considerably.** We have noted evidence of this in some of the answers to the questionnaire, (chaps. 3&4). This variability in belief can have significant consequences in the exercise of both religious and spiritual care, particularly in pastoral encounters with those of another faith persuasion. We will discover examples of this as the thesis progresses.
Difference is also a mark of pastoral care, which, in its full articulation should recognize the two aspects of religious and spiritual care. Our respondent says both are important. This respondent’s concern is that pastoral care be offered in a real and genuine way. To illustrate this point she relates her reaction to two speakers at a conference; one a Rabbi and one a Muslim Imam. Of the Rabbi she says: If the Rabbi that spoke came as a chaplain, to see me, I wouldn’t be comfortable with him, not because he is a Jew but because he is arrogant, and from the dictionary, we find that arrogance is defined as overbearing or presumptuous (Shorter Oxford Dictionary p.108). For this respondent there is no place in pastoral care for overbearance. Of the Imam, she says, I would be very comfortable with the Muslim chaplain because he presents realness, and genuineness, the grace of God, and I would feel he was bringing with him something of the Presence of God. The Shorter Oxford Dictionary defines authentic as, among other things, someone or something judged reliable, trustworthy, and genuine (p.135). This respondent finds authenticity, in what she discerns are values assignable to pastoral care.

We have in these comments from our respondent, who has placed herself in the position of a recipient of pastoral care, a demonstration of the feelings and discernings of one receiving care, which she links to genuineness as a basic quality. It may be true that both the Rabbi and the Imam were clear and passionate about their respective topics, but for this respondent, considering them as potential providers of pastoral care, there were clear differences in the way she perceived them and created meaning around their engagements. The Muslim chaplain’s potential for caring was recognized by the respondent as a pathway to understanding. She discerns in the Imam elements of genuine compassion, along with the potential for mediating the Divine Presence.
The experiences of this respondent in encounters with difference, along with her response to those experiences, portray an understanding of belief that embraces difference as natural and valuable. Her argument in relation to the Rabbi, is not about culture or religion; it is about attitude, and its potential impact on the receiver of care. Attitude is an aspect in the practice of care that is considered in training programmes. One might assume therefore that practitioners in pastoral care would all be aware of its pitfalls.

Intolerance, however, is not restricted only to attitudes towards ways of being and engaging other than our own. It can be found in many instances where there is difference, including among those who make up the numbers that fill churches. The opposite, however, can also be recognized. This interviewee, rejecting intolerance, tells a story from younger days of a demonstration of tolerance which at the time affected her deeply. The action took place as a regular occurrence in the church she attended: There was a man whose wife had died. He turned into a transvestite (I didn’t know this at the time). He used to dress up in his wife's clothes: dresses, beads, lipstick, and hat. He would walk up and take communion and nobody laughed at him, nobody judged him. He was just one of the people and I can still see that happening. That made a big impact on my life.

This was very important in shaping her life. It helped me not to judge people by who they are […] but to understand that God loves them. In the terminology that Flohr (2009) uses, she was 'learning to live with ambiguity' (p.152). There is therefore, no need to convert others as some might want to do when associating with members of other faiths.

Our respondent expresses a conviction that difference is acceptable and indeed fits naturally into the being of God. She is clear about being called by God, but not in order that she might consider herself a special person, but in
order that she might become more self-aware. I have been called into my true nature to use the gifts that I have naturally. Her understanding of God’s Presence leads her to consider the “natural gifts”, one of which is that she is: broad in her faith and believes that people don’t have to be Christian to be with God or understand God. This is in direct contrast to those seen in the questionnaire who thrive on spiritual feeding (C17) or seek spiritual growth (C40). This respondent’s sense of valuing others is reinforced in her comments about people of other faiths. Along with Flohr, this respondent would find agreement with the words:

The multicultural pastoral care provider is asked to embrace a “both/and” perspective and, for instance, to be able to say with integrity, “I can be a Christian and value someone else’s experience and faith.” [...] The diversity of communities, [...] and visions of God [...] is an opportunity for our energetic engagement and dialogue with one another (2009, p.151).

The respondent recognizes her task in pastoral care as helping others on their own faith journey, not to question what they believe but helping them in their own search for meaning. This is reinforced in her answers in the questionnaire. Reflecting on stories, she says that they are very important with a further comment that: listening to them and respecting these stories affirms a person’s worth, purpose and meaning. She continues in her commentary on other faiths: I believe there are many pathways to God and that God reveals Godself to people in different ways. If others want to dip into the Christian faith, she is happy to engage but will not try to change them. She tells the following story: I had one very interesting experience with a man who was Buddhist but he also wanted to say the Jesus prayer with me. He believed in Jesus. He wanted me to come in when he died but he also wanted the Buddhist priest to come in when he died. That was his background; his culture. He came from Korea and he had a cultural background that was very important for him but he also believed in Jesus, That wasn’t conflicting for me. Other people said,
isn’t that weird, he is having a foot in both camps and I said, I don’t find anything weird about it at all. He is embracing both cultures.

Purnell (2003) confirms this position when he says of pastoral care; ‘By “care” I mean being present to and engaging the other in ways that value their whole being, and their living’ (p.7). Our respondent says that: God is Present in many different ways and reveals himself to people in various ways. It is not up to me to judge. That is not my journey.

Training and belief have, for this interviewee, supported and enhanced each other. The partnership between faith and training has enabled her deep understanding of the chaplaincy task. Apart from her initial chaplaincy training, she has engaged intentionally in courses to enhance her work as a pastoral carer. This includes theological training and becoming a priest, and engaging in a counseling degree and many other courses. There have clearly been difficulties in her life but nevertheless, there are clear understandings of God in her life. Her sense of Presence is clear. God has not abandoned me, I will not abandon others. This understanding emerges in her comments associated with presence and the valuing of others. Her stories of those who are perceived as different in their personal lives, and also of those who espouse a different faith demonstrate her understanding and commitment.
Interviewee 2 is a widow in her late 60's, who at age 22 emigrated from England to Australia. Some time prior to this, the family had lived in South Africa where she experienced something of the clash of cultures through Apartheid. Emigration was a "major decision." She found the long air trip and her experiences on arrival in Australia rather "daunting".

Her belief in God as Father, Son and Holy Spirit, with Jesus providing an example for life, was inculcated at an early age through the influence of parents, (reared from my mother’s knee), church, hearing Bible stories, and an Aunt who was an Anglican Nun and her God-mother. She comments:
I’ve grown up in the Christian faith right through. She has worked as a volunteer chaplain for about eight years. She was encouraged by a friend to enroll in a four year Education for Ministry course with the Anglican Church. During that course she felt a need to enroll in a further course on Pastoral Care. Her primary work place is in a large regional hospital and at the time of the interview she was the department coordinator. She also works an after hours shift in another hospital’s emergency section, for which she is paid. She has continued to upgrade her skills, completing a Clinical Pastoral Education (CPE) course as she felt the need to refresh.

She responded to my request for a follow-up interview with a little hesitation, but no objection. We met at her home and she was relaxed and friendly and talked freely with very little prompting. This interview lasted an hour.

Analysis Key Words. respect; firm faith; reassurance; understanding.

This respondent’s faith life has, in its development, been considerably influenced by family and church: I’ve grown up in the Christian faith right through. She says of belief: basically, as a Christian I believe there is God the Father, God the Son, and God the Holy Spirit, and I do believe particularly that God speaks to us in different ways, and that Jesus has given us an example of the way we should lead our lives. The strength of her early enculturation into Christian beliefs and practice is such that she claims that for a long time she believed without question. Eventually, however, through her reading and thinking she began to ask: why do I believe what I believe? I ask myself, do I really believe that? Reflecting on this question through a series of Bible studies, she found her faith to be secure.

One of the questions exercising her mind had to do with the nature of prayer. The normative church practice has been to offer the prayer to God, through
Jesus Christ. I sometimes personally have a problem pushing all prayer through Jesus. She says that she is a person who: “likes to go to the top.” This betrays some inconsistency in her faith standpoint. A “firm faith foundation” implies strong links to all aspects of Christian faith. Questions about prayer and the place of Jesus led to some insights, however: firstly, that sometimes our thoughts are prayers, and second, that Jesus worked with both marginalized and mainstream people. Through all of this she was, nevertheless, able to say: I found my faith was sound.

A grounded and secure faith appears as a central issue for this respondent. She mentions the term a number of times, and speaks of steady growth in faith: Mine has just been steady growth from a strong foundation. This is a continuing process. Her study and her reading reinforce her faith growth. From her study she says: I find the Jewish faith […] very interesting but, she continues, not enough for me to give up what I already do. The result of her reading and study around faith is, that: all it is doing is reinforcing me and bedding me down. This is reflected in what appears to be a normal process of decision making for this respondent. Talking about her decision to come to Australia, she spoke of: weighing things up and putting them out there. In making the decision, she: took some time to think about it; to let it all shake down.

To what extent “bedding down” may be a credible position through which to practice pastoral care is called into question by Hill and Mullen who make the claim that:

the pastoral person who seeks to communicate and represent the nearness of God’s presence in the face of human tragedy, to bring genuine hope in the midst of suffering, must develop a deep awareness and acceptance of one’s own process of becoming (2001, p.174).

A “process of becoming” and “bedding down” are quite different expressions. The first is open ended. It is something of a journey in which the end is not
realized, and, indeed, perhaps not as important as the journey itself. Through such awareness, the chaplain is able to share his/her vulnerability with vulnerable patients. This is the position of (C6), who, in her declaration that she will not abandon others, is accepting the possibility of vulnerability in her pastoral encounters. Bedding down, on the other hand, while ensuring that one’s faith foundation is solid, runs counter to Speck’s (2004) claim about spiritual care as exploring without quite knowing where it will lead. Our respondent is very particular about the solidity of her own faith foundation, and defends it even as she interacts with those who have a different faith standpoint. She speaks of times when you may introduce some of your own thoughts in order that you might be recognized as validating your own religion.

A strong faith foundation can be likened to a fortress in which one finds safety and refreshment. If one ventures from the fort from time to time it is always with the awareness of safety nearby. Minimizing the risk may be important in day to day living but if applied within a pastoral encounter may stultify the interaction and limit the outcome. Engaging in spiritual care with its many unknowns and the possibility of becoming vulnerable may become too hard. We are reminded of the earlier reference in page 8 of the Literature review and Kristen Johnson’s timely warning of the difficulties which may be associated with making sure that our faith is secure. (2007, p.103)

This respondent, however, despite her concern to validate her faith, is able to recognize difference as complementary, and worthy of respect. The respondent says, with regard to other faith groups: I think we all have to address our own spirituality. The respondent has obviously given this some thought and even though their way is not the way I do it she is prepared to accept for herself that this might be one of the mysterious ways in which God works. She comments further: It is up to me to respect that
person for who and what they are and for who and what they believe. This appears as contradictory to a “bedded down” position of faith, but we need then to note the respondent’s earlier comment: I do believe particularly that God speaks to us in different ways. It appears therefore that the respondent’s “firm faith foundation” gives her the freedom to not allow this to restrict her human understanding of the needs of others. Thus, difference is acknowledged and acceptable; foundational for the provision of spiritual care.

She says she has had limited experience of people with different faiths but does try to understand, saying: I think we can actually learn from others. The respondent relates a story from her hospital experience that portrays some understanding and respect. Six years ago we had one Muslim doctor who liked to pray and one of the other pastoral carers used to unlock the counselling room so he could go in and say his prayers in private. A couple of years later I was put in as coordinator for a while, and I said you know this is a worship centre – maybe we need to find out whether they [Muslims] would rather be in the worship centre. Do we need to say to them we don’t want anyone to see you, let’s put you in a separate room? We had a discussion about the matter and talked with one of the doctors. He was very helpful. Now we have a corner of our worship centre which faces Mecca, we have a Koran, prayer mats, and people come and go. A nurse comes; she has a veil which she keeps in a little cupboard.

The respondent has already commented on her interest in the “Jewish faith”, although not to the extent of giving up her own faith position. She is also able to consider that there is some validity in Islam because she says, it has a link,
a common beginning, as do Christians and Jews, back to Abraham: It sits on the shoulder of Abraham as do Christians and Jews. This provides some credibility to her belief that God speaks in various ways. She is not so sure about Hindus but makes the comment that: all humans are spiritual beings. What is important for her is respect for each other without denying one’s own faith perspective: We all have spiritual feelings and they have developed in different ways depending on culture. This may also reflect her own experience of cultural difference in Africa.

Crowley presents the notion of a ‘tolerance continuum’, one end of which could be termed intolerance, and the other pluralism. ‘At the pluralistic end of the spectrum, interactions are marked by the effort to create peaceful coexistence based on acknowledgement and respect for religious, cultural and ideological differences’ (2011, p.191). Respect and tolerance are portrayed in this respondent’s comment about other faiths: I think that people of those other faiths want what we want: food, clothing, shelter, and a good life for their children and grandchildren. It is because her belief is established as a firm foundation, that she feels able to respect members of other faiths and also respect the differences in faith standpoints. One might suggest that having the fortress of firm faith she is able to acknowledge other religious standpoints without compromising the certitude of her security. One may venture a little further into the unknown. In any conversation with someone from another faith, any comment she might make about her own religious standpoint would not be aimed at seeking to convert; it would be a way of validating the “security of her own grounding.”

A pastoral conversation has the potential to explore both religious care and spiritual care. If such a conversation merges into a validation of one’s own

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16 Genesis 16 contains the story of Hagar and Ishmael her son, in whom it is claimed, Islam has its roots.

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faith, the interaction runs the risk of stalling. There is a little hesitation also about what might happen in an extended pastoral visit. She says: If it is a protracted number of visits and if there is more opportunity then what you do is introduce some of your own thoughts. When asked why, she responded: Just to show balance. Showing balance is more of an outcome of a religious discussion in which there may be some agreement about standpoints while ensuring that one is not stronger than the other.

Spiritual care, on the other hand is an exploration. It is not primarily concerned with beliefs and even less about balancing those beliefs. In spiritual care the task of the chaplain is to be available to help others in their search for meaning in adversity. “Showing balance” as an outcome of one’s own faith suggests a degree of anxiety at the direction of the interaction. It also suggests some contradiction with the claim of Hill and Mullen (2001) and the implication of vulnerability in their comment on pastoral care.

She does not, however, feel any need to convert and seeks to listen to people’s stories and see that they are comfortable: Individual stories need respecting, as do people who choose not to see a chaplain. If, as Ebehardt (1996) claims: ‘Stories are the stuff of life.’ and if, as Carol Christ (1980) claims: ‘Without stories there is no articulation of experience,’ one with a strong foundation runs the risk of not adequately hearing the stories. Fukuyama and Sevig claim, as a result of their research: ‘There is something basically healing and honouring of the person when someone takes time to listen deeply.’ (2004, p.36). Her faith stance is such that she is able to provide reassurance and be: Jesus’ hands and feet in the care that she offers.

The interviewee’s responses are, at times, indicative of religious care which offers assurance in the face of hurts and anxieties. The interviewee appears to be most at home in the provision of religious care, through which she can
reassure the patient: I have seen people who are dying having need for reassurance. Making confident and positive assertions at such times, however, is unlikely to be beneficial to one facing ultimate realities. The respondent nevertheless, states: there are times like that when God/Jesus is very near, and comments that she has a sense, at times: of being on holy ground when with patients. Religious care appears as this respondent’s most used aspect of pastoral care. Respect, a word she uses a number of times in the interview, may not be enough when stepping on to “Holy ground”.

If we were to consider that respect is related to value, (Shorter Oxford Dictionary p.1809) and so replace respect with value, the dynamics of pastoral care will change. Respect can occur at a distance and does not require a close encounter. Valuing another, however, opens a door to vulnerability in one’s person and in one’s faith. Our respondent has a sure foundation, and a relevant question asks is it possible to come from a sure foundation to vulnerability. To do so is to shake the foundation. This leads me to consider that there may be a contradiction between the respondent’s strong foundation, and her respect for others. Nor is this tension between a firm foundation and respect, the only grounds for contradiction.

When comparing two hospital systems, she makes the claim that in the emergency ward where she works: people are less likely to have a Christian faith. She doesn’t say why she thinks this. But the question is why does it matter? The opportunity to offer pastoral care in an emergency ward may be severely limited by the nature of the case but always there are others about who are affected by the emergency. An emergency ward is one in which there will frequently be questions about meaning from those caught up in the extreme anxiety of traumatic happenings. In the face of trauma, one’s faith is at times placed under considerable stress. To sit with another in extreme circumstances, is to become vulnerable to the hurts and
questionings that are so raw. This will have an impact, even on sound foundations.

Her other place of work is a large general hospital where she says: I am more likely to find people with a Christian faith. One question that follows suggests a preference for people who indicate a Christian faith. From her comments it also appears that she appreciates the greater opportunity to engage with people of similar faith in a setting in which she can provide the sacrament of communion. She says she has the authority of the church for this, but not in emergency wards.

Contradictory elements can be discerned in the comparison of those who are or are not Christian and the chaplain’s response to the two situations. Along with this is the availability of the sacrament, in one hospital, through her as pastoral carer, but not in the other, a contradiction attributable to the church. Thirdly there is the extreme trauma in the emergency ward, and the comparatively less trauma in the general hospital along with the level of pastoral care the respondent feels able to offer. Her preference appears to be to engage with Christians.

The respondent’s belief about Jesus providing an example for life does not lead her into deeper levels of engagement with others. We can acknowledge some engagement with the differences of other faiths; it appears, however, to be more of a practical nature. There is no evidence of engagement at the level of spiritual care. She has little to say about listening and therefore about her own presence to the patient. In being deeply present to others, one becomes vulnerable and this is avoided when one continually affirms a strongly grounded faith. A position of strength militates against effective pastoral care in which the discerning provider may recognize the complementary value of both religious and spiritual care.
Our respondent does, however, respect others, and shows tolerance to other faiths, and she is helpful to members of other faiths. She is prepared to acknowledge that their faith journey is, like hers, a spiritual journey, commenting: We all have to address our spirituality. I would never say it wasn’t a true religion. All this, she claims, she is able to do because she holds fast to her own faith. Pastoral care, however, with a focus on the patient’s needs, will risk the firmness of faith; venturing from the fort to enable the recipient to explore his/her own meaning path. In the exploration, the recipient may discover a different way. One committed to holding a strong faith foundation may feel the need to correct the differences. There is a hint of this in her comments about “showing balance” and about “reassurance”.

The respondent’s desire to maintain her strong faith foundation, along with her comments about giving assurance and being Jesus’ hands and feet; that is making Jesus visible, contrasts strongly with her decision to listen to stories, and her recognition of common spiritualities. The two aspects of spiritual and religious care are somewhat jumbled, making clear that re-articulation of pastoral care will offer some clarity, and allow those who provide pastoral care to recognize the value of both, and choose wisely between them.

There is much to affirm in what she says. Her strength however, could also be said to be her weakness. It is clear that her chaplaincy activity is founded on her firm faith foundation. The contradictions in her responses indicate a preference for those who are Christian. She acknowledges and respects difference but even these are subservient to her own sense of faith. We all have to address our own spirituality. What appears as uppermost in her mind, however, is her desire to secure and maintain a firm faith. This is so despite having completed courses over a number of years, including education for

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ministry and pastoral care. Current training, however, is not in order to change belief; rather it is to establish skills and understanding of a more complex and open approach to pastoral care.

If a pastoral carer cannot step back from his or her own belief in order to support others in their belief, it reduces the likelihood of a re-articulation of pastoral care being facilitated. Being “Jesus’ hands and feet” and providing “reassurance” establishes the chaplain as one who stands away from the patient; who gives something to the patient. Having and maintaining a “firm faith foundation” restricts one’s ability to draw near in a variety of ways as required. It keeps clear of vulnerability, providing care from a distance; giving assurance, giving communion. This is in contrast to our previous respondent (C6) who, whilst also having a solid faith, is able to acknowledge her vulnerability and is prepared to be vulnerable in her offering of care. In this she reflects her sense of God not having abandoned her in her difficult times. Our next respondent takes us into a different expression of belief as we explore its impact on the pastoral care that he offers.

(C 11) Summary. 
Interviewee 3 is a male, married, around 60 years old, and an Anglican priest. He has worked as a chaplain for about 3 years. His parents had been brought up in the church, but in life, struggled at times to maintain the family. He was encouraged to attend Sunday school. At age 12 he was confirmed by the Bishop with an expectation, brought about through the confirmation instruction that he undertook, that he would receive the Holy Ghost.\(^\text{17}\) When nothing happened (as a twelve year old) he was let down. His early working life was as a teacher where he found difficulty in fielding questions from the students about God. He eventually trained at a theological college which, he says, opened my mind and challenged beliefs. In his answers in the questionnaire, he wrote of participating in pastoral care training and

\(^\text{17}\) Earlier traditional terminology for Holy Spirit.
completing a Clergy Effectiveness Training workshop, which included active listening and narrative therapy training. Another priest he says: was a strong influence in his life. [Possibly as a mentor]. He responded readily to my request for an interview and despite the difficulty of having to sit in a rather crowded, noisy area of a large hospital, was relaxed and talked freely. The interview lasted around 30 minutes.

**Analysis.** Key words. understanding of God; listening; acceptance, perfect love, presence. The respondent began the interview with the words, my understanding is of God as perfect mind and finished the interview with the words, what is essential is belief in a supreme being. What lies between is the substance of this analysis. When asked about belief, the respondent replied: The God of Christians – our understanding of God is too small. The respondent continued: My understanding is of God as perfect mind. The result is: God can therefore accept all the input of humanity and the imperfections of creation.

Among the many definitions that are attached to “perfect” (Collins Concise Dictionary p.993) is, “having all the essential elements”. Other words used include: “faultless, of supreme moral excellence, entire” (Shorter Oxford Dictionary p.1553). The respondent’s belief of God as perfect mind, as having all the essential elements, suggests an inexhaustible capacity to contain all things; all the input of humanity, and the imperfections of creation. An inexhaustible capacity to contain all things reflects a sense of grandeur in God. The comment our understanding of God is too small could therefore be construed as a lack in people’s perception of grandeur as it may be attached to God. When faced with the grandeur of the world through the beauty of natural scenery, for example, many stand in awe. Expanding one’s understanding of God may lead to one standing in awe.
The respondent’s further statement, Our understanding of God is too small, reflects a sense of God being bound to the Christian way. It is as if God has been remade by the church. In some ways this could be recognized as true, and the proliferation of denominations with differing and even conflicting belief, could be cited as evidence. Clearly, there is truth in the words, our understanding of God is too small. Limited understanding is reflected in his own experience as a young boy being “let down” at confirmation, and then as a teacher of a class of young students “fielding questions about God”. Both of these experiences highlight his lack of understanding of God at that time. He says: I couldn’t answer at that stage. It could also be said he experienced some remoteness. The fact that he was “let down” is itself evidence of the church’s understanding, as too small.

(C11), having been through times of incomprehension as a small boy and as a teacher, found his entry into priestly formation life changing. He faced many challenges in his theological training, including church teachings on this life and the next. In these challenges, he says that he began to understand the possibilities of relationship with God; even the possibility that this might be what heaven is. Through this training he developed his sense of a “supreme being” in whom one finds purpose for life. His claim is that the church’s viewpoint has resulted in a lack of depth in understanding, but one would assume that the church projects a normative belief. Within the church, however, with its host of denominations, the beliefs expounded are almost legion.

In this thesis belief has been identified as being primarily an individual’s understanding of relationship between God and self, and this has been clearly portrayed in the responses of all participants, including those who only answered the questionnaire. It is also clear that each of these individuals has associations with a church body through which the object of belief has been
narrated and taught. Since its beginning the church has interpreted God in the light of Jesus Christ. This has, through the centuries, become normative for the church, and also for individual members.

In an effort to clarify what the respondent was putting forward, I sought a second interview which was granted. In this second interview, the respondent, enlarging on his belief in God as perfect mind, spoke of God in terms of perfect love, sufficiency in God’s self, perfection in understanding. He also went on to say that: God, despite all this perfection, wanted to draw nearer to what had been created. All this was contrasted with the inability of people to recognize God’s attempts to draw near. Some who had a partial understanding can be found among the Old Testament prophets. The respondent’s final comment that God always desired relationship is realized in God taking on the nature of people in Jesus Christ.

In theological terminology, the one with an inexhaustible capacity to contain all things drew near in the person of Jesus Christ. All of the above needs to be recognized as a statement of belief. “Drawing near” suggests Presence and this could be said to have been foreshadowed in (C11)’s words: accepting all the input of humanity and the imperfections of creation. The “drawing near” of God has always been recognized as mystery. Mystery and difference are inseparable in all attempts at understanding meanings in life circumstance. Our respondent, however, having spoken of a “supreme being”, and established clear differences between God and people, endeavours in his pastoral activity to see God in everybody. His perspective of grandeur in God leads him to a sense of Presence among people.

The respondent, when describing his belief in God, spoke of perfect love, sufficiency in God’s self, perfection in understanding. These are theological
words, but they allow us to refer back to the earlier paragraph in which “perfect” was defined as having all the essential elements and linked to inexhaustible capacity. It can be argued therefore, that (C11)’s “Supreme Being” encapsulating his belief of “perfect mind”, has also an inexhaustible capacity for love and understanding. Considering God in these terms, and adding the additional belief statement that all this became personified in Jesus, is a profound mystery.

It is in this context that (C11)’s words, our understanding of God is too small take on significance in the search for meaning. It suggests that ultimately, any search for meaning remains a search, in which it may be said, mini-meanings emerge. The respondent outlines his belief on a large canvas, while at the same time acknowledging that he also belongs in the church, in which, our belief is too small. The important question that follows asks how this affects an individual’s desire for meaning in life, and more pertinently, the nature of pastoral care.

Religious care occurs within the boundaries of the body to which one belongs. I have noted throughout the thesis, the proliferation of groups within the general parameter of Christianity, let alone all other religious expressions in the world. The provision of religious care is able to meet particular needs, with the proviso that it is best done by one who is within the same standpoint as the receiver. Difficulties arise when a chaplain only offers religious care. It has the effect of reinforcing religious beliefs and obstructing deeper exploration of meaning in the difficulties being experienced. It also provides reinforcement to the respondent’s claim that our understanding of God is too small. Religious care does not appear to be the model followed by this respondent.

The human search for meaning is an important and difficult one. Exploration and understanding are the foundation for spiritual care, but neither
necessarily link to “God’s understanding” which is indeed a mystery. Both do consider that people are able to undertake the search. Tacey, writing of what he names as the spirituality revolution, proclaims: ‘Our spiritual lives are no longer ruled by bishops and clergy, but by our own inward conscience, by insights gleaned from self-reflection, reading, meditation, and talks with friends and spiritual counselors’ (2003, p.38). Appropriate spiritual care will lead into the deeper issues in which life and death need to be explored in a context of ultimate meanings for life. Along with listening and meaning making, mystery may also find a place in spiritual care. I am reminded once again of Speck (2004) and his claim that spiritual care is a mutual search for understanding.

A further claim from the respondent opens the possibility of contradiction in his chaplaincy activity: After ordination, however, I had some answers and it appeared to me that if there is no Supreme Being, life has no purpose. The respondent also makes the claim that: all have a place in God’s society; a claim that might not be acceptable to many other faith groups where there is little agreement as to what might constitute God’s society. This is also true of a number of Christian denominations. God’s society, according to the Christian scriptures is discovered in righteousness, truth, peace, wisdom, love, patience, and others.

What then does the respondent do? He claims that his belief helps him: to allow relationships with people to develop no matter what their background. He says also that he tries to see God in everybody and tries to show perfect love. These responses reveal something of one who is endeavouring to portray the inexhaustible capacity of God, indirectly through the life of Jesus, and through his own participation in pastoral care. His comment: Jesus had feelings and understood feelings, with its implication that God has a sense of ordinary human feelings is a reminder of
his earlier claim of a supreme being with an inexhaustible capacity for love and understanding.

Having such a strong sense of God, the respondent runs the risk of seeking to have others believe the same. In fact, he considers that all people have a place in God’s society and this allows him to: sit with someone for as long as necessary and listen with all senses. Being and listening are strong indicators of presence and for this respondent also of Presence. While there is no overt discussion about the patient’s search for understanding, what he claims to do can be designated spiritual care.

The respondent’s experience with other faith standpoints is limited, but he says in any such encounter it is a case of listening trying to understand. This requires, contrary to his “perfect mind” belief, a modicum of vulnerability; a definite advantage in moving towards any acceptance of other faiths. There is a contradiction in his claims of listening to understand; his further comment in the subsequent interview is that: those who fail to recognize God as revealed in Jesus cannot be in a relationship with God.

This raises the question of what it means to be in a relationship with God. If God has an inexhaustible capacity to contain all things, it follows that God will seek to be in relationship with people; the claim being that God activated this in the person of Jesus. One could argue from this that there is no prior commitment required from people. This argument is important in the context of spiritual care, and even more important in discovering the meaning the respondent attaches to his own words. Spiritual care does not contain suppositions of the patient’s relationship with God. It is care that steps outside religious standpoints to journey with one who is finding his/her own way in the discovery of meaning.
The respondent says he found answers through his training and in his ordination. The risk in having answers is that they may be deemed applicable in all situations. If, however, 'perfect mind" does encapsulate an inexhaustible capacity to contain all things, standing in awe must include vulnerability. If the chaplain can understand this, listening with all senses will allow this vulnerability to become visible.

What if God also, was vulnerable? The Christian viewpoint suggests this is a possibility, when expressing the belief that God became human in the person of Jesus. Carole Gould, a Jewish chaplain, also offers a perspective that is helpful for the search for meaning. She writes from a different faith stance, and while acknowledging mystery, describes a different way for recognizing the Presence of God, a way that includes vulnerability:

Maybe God is limited in what God can do by the laws of nature and by human freedom. Or maybe God is the spark of life that enables us to endure our pain and our suffering […] Martin Buber teaches that divinity lies in connections among people and between people and God’s world. I strongly experience God in these connections. When we offer our presence, we act in imitatio dei; we bring comfort as God comforted Job (2011, p.8:1-2).

Such a viewpoint, with its suggestion that chaplains might act in imitatio dei, is also expressing the validity of vulnerability. It is in fact necessary in spiritual care, if meaning is to be adequately explored. Imitation of God requires one to enter into a search for understanding, in which mystery will become an important element. The interviewee’s claim that the church was not the best teacher of mysteries is a reflection of the importance for the church in holding on to mystery, as it did for centuries. Despite the church’s lack, mystery remains. It does not follow, however, that mystery cannot be probed and considered. Mystery is found in any search for meaning. Mystery is always present and this can be illustrated from stories told by those who search for meaning in their troubles. Myra’s story, narrated elsewhere in this
thesis, is a case in point. Discovering some meaning in her dreaming, she was able to find some comfort and peace.

The respondent, despite contradictions in his belief standpoint, does from what he says, stay with those in need, and listen to their stories with attention and compassion. He is present to his patients and, as a result of his own insights and understanding of God, we may assume that in his encounters God also is Present.

(C 17) Summary.
Interviewee 4 is a married woman, about 60 years old, dedicated church member as a result of a “Holy Spirit experience”. She has worked in chaplaincy for over 10 years. Her parents were not church goers but sent me to Sunday School. Grandparents encouraged this. As a young person she was considerably influenced by Sunday School teachers who had a very real relationship with God and were “very spiritual”. One of whom she speaks was on fire for the Lord. Her early life was in the church, but then for a time she left the church until her religious experience in her early thirties. She had a variety of voluntary positions in the local church, including being church secretary. She had undertaken some study but then decided to study seriously for a Diploma in Theology with Catholic Education. This gave her: a broader appreciation of Christianity, […] being introduced to the saints […] broadened my outlook. It gave me an appreciation of the Catholic faith […] I think in chaplaincy it must be so hard for people who are
just tunnel visioned with one particular faith. **She has continued to upgrade** her qualifications through a 2 year course with Catholic Pastoral Care, and a few years later a similar course over 1 year through the Uniting Church.

She was a little hesitant at first when asked to participate in an interview, but happy to agree. We met at her home and she was mostly relaxed and certainly had a lot to say. The session lasted for an hour.

**Analysis.** Key words. spiritual; religious experience; seeds; opening doors, personal growth, represent God.

The faith life of this respondent is intimately connected to what she calls a Holy Spirit experience. This was life changing for her and led her on a journey to seek out that which was spiritually vital. She says of her experience, that she was prayed back into the church and that in the experience her heart burned within her. 18 **A “Holy Spirit experience”, nominated by this respondent as life changing, is generally linked in church circles to what is described as a charismatic experience. Charisma is generally defined as a divine gift in which followers are inspired with devotion and enthusiasm (Shorter Oxford Dictionary p.316). A traditional church which she joined, after returning to the city from the country, did not satisfy her: I felt a great loss coming from B where I was being fed spiritually all the time to a traditional church. I am not criticizing the traditional church. It has its own purpose […] I don’t believe that everybody has that spiritual awakening necessarily […] that spiritual element is not always present in a traditional church.

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18 Compare, for example, Luke 24: 28-34.

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Strong and present religious experiences and the feelings that go with them raise a number of issues that impact on pastoral care. Her reference to “that spiritual awakening” appears to be a reference to her own experience. It is true, of course, that others have not had her particular experience. Her comment, however, also raises the question of what is meant by “spiritual awakening”.

Her personal desire for “spiritual feeding” along with disappointment with the “traditional church” are questionable attitudes to take into a pastoral encounter. The chaplain engaging in pastoral care will encounter a variety of belief positions among those being visited. A number of those would be closely associated with the “traditional” church. While each one of these standpoints needs to be respected as true for the believer, the respondent’s faith position could emerge as a temptation to engage in what could become an argument about faith. While the respondent claims she is not criticizing the traditional church there is in her comment almost a wistful desire that the traditional church might share her understanding of spiritual experience; being on fire for the Lord. Her comments suggest that she has established a measure of difference between herself and the “traditional church”, her own experience being superior, or at least, more complete.

She is pleased to: welcome the advent of a ‘spiritual’ minister, leading to a renewal of her spiritual feeding. In talking of her spiritual experience, and the lack in the “traditional” church, she makes a comment that is somewhat confusing. Before her experience she: would have followed tradition. By this she presumably means being comfortable within the church. But after that [conversion] I experienced it [her relationship with God] as real: to be able to pray anytime, anywhere, without needing fixed times. He was there all the time.
These spiritual experiences undergird the respondent’s work as a chaplain. She claims that she could not be a chaplain without the spiritual feeding. In this lies the potential for conflict between her own desires for ongoing “spiritual experiences” and the importance of putting the patient first in a pastoral encounter. Brita Gill-Austern makes clear that: ‘In order to be a presence and not a player one has to develop a certain detachment and a capacity to renounce the satisfaction of any personal needs while relating to the counselee [patient] with unconditional regard’ (2003, p.89).

The respondent finds, in the spiritual reinforcement of her chaplaincy, apart from her church involvement, that retreats, and conferences, are very helpful. Because of all the spiritual help she receives she has a sense of God/Jesus going with her. This sense of God helps her to believe, when she visits as a chaplain, that a door has been opened; a seed sown. She says further: I’m only able to give that person infinite respect because of what I know Christ expects of me. Such a faith position as this, however, may ultimately be a hindrance to spiritual care because respect is not limited to religious expectation. Hill and Mullen claim that: ‘the essence of spiritual care is not doctrine or dogma but the fundamental human capacity to enter the world of another and respond with feeling’ (2001, p.174). Respect has to do with esteem, valuing, admiration, and reverence, all of which are related to feelings.

The respondent alludes to presence as she talks about “being there” and claims that: one of the things that is important in chaplaincy is people knowing that you represent God. No matter why people are in hospital or what their belief background might be: when they are in hospital in a vulnerable position, just the fact that you go there representing God, to me sends them a message that God cares about them. […] Just by being there
we can plant seeds, we can open a door for them to be thinking about God.

There are a number of questionable matters in this statement, but first it needs to be stated that it is not a fact that the chaplain represents God; it is a belief. This respondent says of the patients, that they are in hospital in a vulnerable position, but enters the encounter with the intention of presenting God.

Bringing a message that God cares about them, however, is not presence. In the Literature review (p.37-38) I quoted O'Donohue (1997, p.14) who identifies presence as awareness of wholeness, embracing all days, all understandings, all feelings, as a way of balance in life. Our respondent has placed herself in a position of strength reinforced by her “Spiritual experiences.” “Planting seeds and opening doors” portrays one who with a position of strength in belief stands aside from the vulnerability of the patients. The claim that she brings a message ‘that God cares about them”, speaks more to her own place with God than it does to the needs of the patient. The strong religious care that she is offering has her in an invulnerable position as one with the answers to the patient’s needs.

It would appear that “being there” with its allusion to presence has missed the mark with this respondent. She has visited patients and undertaken a form of Christian care which in essence has been an assurance of God’s caring. She has “opened some doors” and “planted some seeds”. Presence, however, is not according to Avery (1986) ‘a temporary loan of resources’ (p.346-347), as it appears in this respondent’s description of pastoral visits. One should not enter into a pastoral encounter as a mediator of God’s love; rather one should, as Purnell (2003) suggests, ‘engage the other in ways that value their whole being’ (p.35). Pastoral encounters, whether in the form of religious care
or spiritual care, are not a matter of making people aware of God. Pastoral care can happen most effectively in an encounter between people, both of whom recognize their vulnerability. Maryanne Confoy argues that:

To be authentic during times of conversation with those in need [...] requires the ability to be still, to be able to take time for contemplation, to be in touch with one’s own inner thoughts, feelings, and imaginative awareness. Times of prayerful support of others call for times of inner quiet and solitude (2002, p.31).

Opening doors for them to be thinking about God is what the chaplain wants, but vulnerability suggests the need for a rather different approach. If the patient senses that the chaplain considers her/himself to have the right viewpoint and the right solution, the two cannot meet. They may talk but they cannot meet. Marcel’s view that ‘presence is not identical with physically being present or attentiveness,’ expresses this exactly.

Doug Purnell writes of intentional pastoral conversations in a group setting. He says: ‘In these groups people could have large slabs of time to address the questions and then equally large slabs of time to “tell their story”. When they shared their stories with others in the group, they were creating a quality community’ (2003, p.43). In spiritual care, presence means offering patients large slabs of time to “tell their story.” Versalle comments: ‘The story is the way we create our lives. It’s how we tell ourselves who we have been, who we are, and who we might become’ (2009, p.21.1-2); presence enables the hearer to receive the gift of the patient’s life musings.

The respondent’s answers to questions about relationship with other faiths give rise to contradiction and possible conflict. She says that: as a chaplain I have no right to question another’s faith, but if I was a missionary, I would see it as my right and duty to be proclaiming Christian faith. There are those in the church, she says: who would applaud a missionary approach in hospitals. She says that she: would be happy to talk about
her faith if asked, but would never initiate. But then she qualifies this with the further comment: shouldn’t say never. “Opening doors” and “planting seeds”, however, are clearly missionary tasks that she prefers not to label as such.

We noted earlier that she discovered new ways to consider prayer. In the first place she was: prayed back into the church and exulted in being able to: pray anytime anywhere. Prayer would be an integral part of “spiritual feeding”, so to engage in prayer with those in hospital would bring her pleasure and satisfaction. A risk associated with such feelings is that sensitivity to other’s needs may be overshadowed by personal need.

Two encounters, however, do portray a degree of sensitivity. The respondent speaks of two “beautiful experiences”, one of which was a Jewish man with whom she prayed and who was so “appreciative”, and another in an emergency ward, praying with “a young Muslim lass” after a request from her father. She says: The appreciation shown there also made me realize that whether they believed in God as I do didn’t really matter because God knew what he was going to do. Christians, Jews, and Muslims have common faith origins, so what God might be going to do, in this respondent’s view, is somewhat clouded. She has on more than one occasion spoken of planting seeds and opening doors.

In a dialogue with a Buddhist, however, and contrary to the “beautiful experiences” recognized in the invitations to pray, the respondent becomes almost insistent in her desire to offer prayer: I’m just thinking of a Buddhist whom I came across and I visited with him and he said I’m a Buddhist and I don’t want anything to do with the Christian faith. I said that’s fine, I’m not necessarily here to talk to you about faith. I’m here to talk
about how you are feeling and where you are at the moment in your situation in the hospital. How are you going? And we chatted on quite well for some considerable time and he was having surgery. When I left I said, is it all right if I pray for you – for your surgery tomorrow. He said as long as you don’t come here to me. I said no I’ll just pray for your surgery if that’s all right with you and he said I suppose so. That is my attitude.

Claiming her right to pray demonstrates a lack of respect and a lack of understanding. The Buddhist was clear with his request, but in the end this was ignored. Her comment: “that is my attitude” is perhaps a truer word than she intended. In this encounter, we have an example of religious care, applied here inappropriately; engaging in spiritual care may have been more helpful and certainly more caring in paying attention to the patient’s request.

Prayer, as Christians understand it, does not have a place in many Buddhist practices. The most important religious practice, says Chin Kung is the: ‘regular and consistent recitation of the name of Buddha’ (1999, p.579). ‘Diligent practice of the Ten-Recitation Method, together with unswerving belief and vows, can ensure fulfillment of our wish to reach the Western Pure Land of Infinite Life and Infinite Light’ (p.580). The three learnings in Buddhism are self-discipline, deep concentration and wisdom (p.xxx).

Self discipline in a pastoral encounter requires the provider of care to ensure that personal beliefs and feelings do not overshadow the needs expressed by the one seeking care. Deep concentration requires the provider of care to listen carefully and respond appropriately. When prayer is requested even the wording of the prayer needs to be considered. “Pushing all prayer through Jesus” as (C7, p.112) says she was taught, is inappropriate and demonstrates a lack of awareness of different faith perspectives. In any
prayer with one of another faith, as this respondent describes in her encounters with the Jewish man, and the “Muslim lass”, (C7, p.112)’s “going to the top” avoids the stumbling block of Jesus. Determining to pray, however, despite the wishes of another, demonstrates a lack of respect. Wisdom is knowing that one’s own stance on matters of faith can never be a final answer.

The driving force in this respondent’s life is her “Holy Spirit experience” and this emerges forcefully in her chaplaincy activity. Despite her claim that being a chaplain is not being a missionary, the desires and hopes that she takes with her suggest a missionary at heart. The nature of the experience the respondent describes and the lyrical description of what it means to be spiritually fed virtually precludes any possibility of authentic interaction with one from a different faith. Opening doors and planting seeds overrides any consideration of the needs that others might have to discover their own meaning in adversity. Encounters with this backdrop will inhibit any search for meaning. Macquarrie, in his commentary on Martin Heidegger writes: ‘An authentic solicitude for the other helps him to his freedom and to his own unique possibilities for selfhood’ (1968, p.18).

In this interviewee’s response to a question about training in the questionnaire, she mentions church related studies: Studying with Catholic Education gave me such a broader appreciation of Christianity. She also describes an initial training course that she undertook as “adequate”. She continues: I have continued to take advantage […] workshops, conferences, seminars, study modules, retreats, and a Clinical Pastoral Education unit […] to become […] a more professional and effective chaplain/pastoral carer.
Health care now requires that chaplains undertaking spiritual care be professionally attuned within clinical settings. This is a considerable challenge which will need addressing in training programmes into the future. Key issues include: supervision, acceptance of vulnerability, validation of faiths other than one’s own, understanding presence, and awareness of stories as some examples in the development of professionalism in chaplaincy. These matters will emerge as the thesis develops.

(C 28) Summary

Interviewee 5 is a single woman in her 50’s, working fulltime as a chaplain in a large public hospital. She is an ordained minister, paid by her church. She grew up in a family that experienced many difficulties. As a teenager this respondent attended a “Youth for Christ rally” and eventually responded to “an altar call”. For a time she was moved by this experience but it did not last.

She eventually moved to the city for work, living in a hostel for a time. She became involved in a church youth group and as a result of that involvement, the church became the centre of my life for quite a long time. She eventually got caught up in the Charismatic movement. After a while she was accepted into a theological college to study for ministry, and then life was
incredibly busy. Her intense religious experiences were shattered and she says, I actually became an atheist for a while in my first year in college.

After graduation she was appointed to her first parish trusting that the church was making a right decision and believing that God spoke through the church. She found the town a place where she could exercise her love of community. She endured some difficulties in her third parish and during recovery undertook what is called a 12 step program to self understanding in southern Queensland.

Recovering, she found solace in the care provided by friends, along with what became for her, a retreat experience in a theological college overseas. More healing occurred through some workshops that she undertook. With the help of friends, of whom she says one was very instrumental in my recovery she gradually returned to health, finding “affirmation and acceptance”, and developed a strong sense of God’s Presence surrounding me. Before taking up her work as a chaplain she completed a Clinical Pastoral Education (CPE) unit and has undertaken a variety of training and educational courses. She has a particular interest in mental health. She responded warmly to my request to interview although rather surprised that she should be asked. We met in her home and she talked a great deal. The interview lasted over an hour.

**Analysis** Key words. Ambivalence, Community, ministry, breakdown, healing, prayer, God’s Presence.

The respondent explains her belief in this way. I believe that Jesus was the Son of God. I believe in the resurrection. I believe we have salvation through following Christ. I believe we are meant to live lives of love and peace the way Jesus lived. **Having said this she confesses a degree of ambivalence with each of these statements.** I’m undecided there and I’m
open to other possibilities. While other respondents express their belief from a background of support and encouragement, the life picture presented by this respondent suggests a loner who had, to some extent, to find her own way.

Disillusionment with the actions of the church, and her own excesses in her working schedule I was a workaholic, left the respondent with little choice but to re-evaluate her life. Seeking help from a spiritual director, she says of her experiences: it was as if I was a jigsaw puzzle that had been tossed in the air. The church had not treated her well, and while rejecting to some degree, the church which had caused her so much trouble, she also rejected the notion of the church as the arbiter of God’s activity. She does however, acknowledge her own part in the difficulties that assailed her in her parishes: We have to take some responsibility for our own decisions.

The respondent did take responsibility for her own healing, and in her recovery spent some time overseas, living and working in a theological college. Of this experience she says: I went to the College and L. said you don’t have to go to chapel but it would probably be good if you came the first time so that people will know you. I didn’t want to have anything to do with the church at that time. So I went to chapel and the singing was magnificent. In the whole six weeks I was there I don’t think I missed chapel once. The students were very accepting and affirming – great for building confidence.

It is clear that in this experience she found acceptance and warmth and affirmation. She discovered new confidence in herself and a strong sense of God’s Presence. God was really there. Another important lesson arising from
her experiences with the church was the insight that she: no longer believes that God necessarily speaks or works through the church.

The respondent claims that her appointment to a hospital as a chaplain was not without controversy. She says: some thought that I was too good a parish minister to be wasted on hospital chaplaincy. The implication of such a comment is that for a number in the church, and many of those would have been clergy, the important work of the church is mission. This is usually interpreted as winning people for Christ. There is also the implication that hospital chaplaincy is not valued as important. This leads to the issue of whether the respondent considered that she also was not valued because she had chosen this path, rather than the more acceptable path of parish ministry. Chaplaincy, therefore, began rather ambiguously, with criticism from other clergy who in different circumstances, such as parish ministry, may have been more supportive.

As we saw with (C7) and (C17) within the general framework of pastoral care one matter that can pose difficulties is the use of prayer, and the respondent admits to being challenged in her use of prayer. Prayer, she believed, along with having sufficient faith, would have a healing effect on patients. This understanding changed dramatically for this respondent when: one man who was a lovely man had an abscess in the centre of his brain which had grown […] ultimately he was going to die. Every time I prayed for him he got worse. This was a considerable challenge and: for quite a while I found ways to avoid praying for people […].

Eventually she began to pray again, not for healing, but recognizing that: the prayer of faith is about praying and believing that God loves the person sufficiently to look after them regardless of the outcome. Prayer therefore, she
decided, is letting people feel extra love surrounding them. It is about sending out energy to people.

The ambiguity, evident in this respondent’s commentary on her life and work, surfaces again in her rather confusing response to a question about spirituality. It should actually be part of every bit of religious care, for starters, […] but it doesn’t have to have anything to do with religious care either. Traditionally, spirituality has been contained by, and within the church, in the adherence of Christians to religious teaching. Spirituality has been located in one’s belief in, and sense of Holy Spirit Presence, and one’s ability to live within this framework. David Tacey (2003), however, offers a rather different description:

To fall into spirituality is to fall into a larger pattern of reality over which we have no control, and before which we stand astonished, mystified and often disorientated. […] We are overpowered by a force that is greater than we are. This can be miraculous but it can also be dreadful and humiliating to the ego. […] spirituality is a kind of alien abduction; we are seized, taken over and coordinated by an outside force (p.143).

Our respondent claims that spirituality is about finding meaning and purpose and value in life and in yourself. It is about forgiveness, reconciliation where possible, with yourself, with others and with the power of the universe. Forgiveness can have the effect of leaving one astonished and mystified, and reconciliation can, in the process, lead to a degree of disorientation. It could be said of her comment that she has been, in Tacey’s words, ‘overtaken by a greater force’. Commenting on the nature of a spiritual person, the respondent says that: it usually means that they are in touch with something greater than themselves […] are usually perceived to be, or perceive themselves to be people of great depth not superficial people. […] people who meditate or pray or spend time sensing the divine in nature.
She lays claim to being a spiritual person and says that for her it means communing with God; spending time in prayer and meditation. Asked about other faiths, her response reflects her earlier discovery that God does not necessarily speak through the church: I’ve come to the conclusion that it is not just Christians who get into heaven, whatever that might mean, or who have salvation, or who God loves. She is now able to speak, in her work with people of other faiths, of: oneness with the wider creation and we all have the same call to live lives of love, and peace, and forgiveness, and reconciliation. Oneness with the universe reflects a sense of wholeness in which it is also acknowledged that one has a particular place, along with all other individuals. The respondent is able to claim all as “having the same call” and recognize the value of each one within the whole. She finds, in her involvement with other faiths, common relationships which include for many: a sense of the greatness of God.

Common relationships across faith are more akin to spiritual care than they are to religious care. “Oneness with the universe” runs into difficulties with religious care, in which boundaries are visible in the particular beliefs that sustain denominational divisions. The differences can be exacerbated if the encounter becomes a discussion about belief, and runs the risk of falling into argument. Spiritual care can, on the other hand, acknowledge “the value of each one within the whole” and therefore be an enabler in any search for meaning within adversity.

Having some recognition of Presence in the “oneness with the universe” will facilitate this search. The respondent has experienced presence; those who cared for her after her breakdown were present for her. Her friends on the Gold Coast did much to succour her in her need, and the people at the theological college were caring and helpful. She also speaks of an awareness
of: God’s Presence surrounding me. Again she is able to say God was really there.

The experiences that have engaged this respondent’s life suggest one who is still looking for her own place of belonging. She has an ambiguous relationship with the church that nurtured her faith and trained her for ministry. Her church, however, along with her own “workaholism” has been disruptive and unhealthy for her life. The insensitivities of individuals in her church, ostensibly available to be helpful, have further added to her sense of estrangement. Despite all this she has continued to engage with her belief, with her sense of call to ministry, and with God. She has reflected carefully on aspects of pastoral care, including prayer, spirituality, and the value of other faiths. The respondent has also continued with her learning, completing an initial unit of Clinical Pastoral Education (CPE) and continuing with: a variety of training and educational courses. She has established a particular interest in mental health.

Through her life and church experiences the respondent has come to understand the meaning of vulnerability, resulting in an ability to be aware of the damaging effects of vulnerability in others. She has a strong sense of God’s Presence, God was really there, and her attitude to people from other faiths suggests that she is able to be truly present to them in her offering of spiritual care. The respondent has not identified the nature of her “training and educational courses”. Clinical Pastoral Education is specific to pastoral care, and her theological training would have contained some pastoral care input. To some considerable degree her chaplaincy has been built on her experiences and the insights she has gained with respect to prayer, God’s Presence, and self understanding.
(C34) Summary

Interviewee 6 is a married woman in her 60’s who works as a chaplain volunteer. Her Christian background is in the Orthodox Church in which her parents were involved in Melbourne. Her grandparents, however, migrated from Turkey and their background was Muslim. Her parents called themselves simple Christians. Because the Orthodox Church was some distance from home, she attended other churches and Sunday Schools that were closer. She began in pastoral care in her local Anglican church about 12 years ago, helping the priest by visiting nursing homes. From this she progressed, after some training, to visiting in hospitals. She says she was: led [by God] to do chaplaincy work. This was partly through bouts of cancer
which both she and her husband experienced, at the same time finding “God’s strength”. Referring to her belief, she said, I am a great believer that God guides and helps in my journey and in my belief.

The respondent considers ongoing training as very important, and engages in a variety of courses, and had completed 2 units of Clinical Pastoral Education. At the time of the interview she said: I am actually doing my 3rd CPE unit at the moment, which she says “refreshes” her. She welcomed the opportunity to be interviewed and when we met at her home, was relaxed and open. She articulated her work and beliefs clearly. The interview lasted for about an hour.

**Analysis.** Key words. Holy Spirit/God, guidance, church.

**Asked about belief the respondent answered:** I’m a Christian. I believe in God and the main one is the crucifixion. The crucifixion is a foundational religious claim of the church. It is this that gives body to belief in sacrifice and salvation on which the church stands. Her orthodoxy shows through in her devotion in the morning and she attends church regularly along with her husband: We love to go because we believe in the Holy Communion.

**Despite these practices, she says:** If someone says “I’m not religious”, I often say I’m not religious either, because I don’t believe in a lot of the man made tradition even though I do attend the Anglican church and there is some tradition there.

A focusing tenet of religious faith within the church is claimed in words that speak of God as Father, Son and Holy Spirit. Our respondent states this as her belief: God is Father, Son and Holy Spirit. She continues, I am a great believer that God guides and helps. Arising from this belief she claims that she: tends to be more the spiritual. What does it mean to be spiritual? The
respondent answers: the spiritual is really our spirit that ’journeys’; the Holy Spirit.

There are three elements of spirit in this answer. Firstly, “spiritual” can be discerned as a particular pathway that is connected with that which is sacred. As such, it is universal; it has no specific religious home. Tacey writes of: ‘spiritual hunger’ (2003, p.56) which for many lies outside established religion. It can be compared with Driedger’s “melody” in which she links diversity in spiritual care, with reference to the Canadian National Anthem. This she says, demonstrates the universality of “spiritual”. Different language groups use different words, but it is the music that ‘connects Canadians to one another and to their country’ (2009, p.132). The respondent’s use, however, suggests strongly, as it does for (C17), an attachment to her Christian faith.

Secondly, to say “our spirit” is to speak of a personal acknowledgement that an element of the sacred is part of the human psyche. It is far more complex, however, than the descriptions that attach to psychology, to emotion, to thought, and the like. The notion of journey, expressed by this respondent, suggests an intimate link. Many in the church would refer to this as their soul, and consider it an indispensible part of who they are. Many would still claim the essentiality of the soul as opposed to the body as a temporary dwelling.

Thirdly, Holy Spirit is one of the descriptors of God and as such is religious terminology within the Christian faith. If we place the respondent’s beliefs, (God is Father, Son, and Holy Spirit) and her actions in the church (we love to go to church) together, we receive a strong impression of one who clearly is religious and just as clearly committed to the Christian faith. All three comments about the spiritual hold sway in her experience. She says: My faith is my strength. It has held me throughout my life.
The respondent has previously indicated that she is a regular attendee in her church, where along with her husband she "receives Holy Communion". Her attendance there is not an extra dimension in her life, with the Holy Spirit as another. The two belong together. Listening to the Holy Spirit is simply another part of her Christian life. Her story is somewhat like the anecdotal illustration on p.12 of my literature review in which the pastoral worker, hearing of an event, placed God in the event as its prime mover. In some ways this respondent makes her own links with the Holy Spirit in the consideration of events that have already happened. The events become attached to the chaplain’s belief. Discernment of the work of the Holy Spirit ultimately depends on the nature of the perceiver’s belief. The belief of this respondent is very strong: I usually say, Lord, guide me to who you want me to see.

The claim of being spiritual, that is, closely allied with the Holy Spirit, particularly when framed within religious parameters, will more likely lead to the offering of religious care than spiritual care. Spiritual care, as has been said in this thesis more than once, is a mutual search for meaning in which may be found some elements of transcendence. This is clearly, from our respondent’s descriptions, not within the parameters of her caring. One possible outcome of spiritual care is, in Tacey’s words: a ‘fall into a larger pattern of reality over which we have no control’ (2003, p.143). Having no control suggests uncertainty, and we are reminded of Speck’s (2004) claim of spiritual care embracing uncertainty. Our respondent’s belief in the guidance of the Holy Spirit finds little place for this uncertainty.

Claiming the guidance of the Holy Spirit and relating this to events that others might consider fortuitous is a mark of a person with strong religious links, and this emerges in the stories she relates. In one story, she recounts that she and a colleague were not able to get into a particular ward because the swipe
card would not activate the lock. Deciding to go elsewhere they encountered in the corridor, a lady in distress and as a result spent some time with her. After some time she looked down the corridor and noticed doctors entering the ward which she was not able to enter. She saw this as the work of the Holy Spirit guiding them to the distraught lady: Many a time I feel the Holy Spirit guides me. She recounts another instance in which, instead of proceeding to her original destination, she found herself in another ward where she was greeted by a nurse with the words, “we were just going to call you, for a dying patient”. Our responder says: That’s what I call the Spirit guiding me to these people. That’s very important for me to listen to the Spirit.

Despite however, the centrality of Holy Spirit guidance in her work, the respondent admits to finding her work with children the most difficult; it is one of the hardest parts of my chaplaincy. The particular difficulty is seeing children suffering, especially when they are too young to tell us where it is hurting. It appears to assail her faith: I know that God never forgets any of us but when I see a child suffering […] The sentence was unfinished. The respondent’s expectation of secure guidance from the Holy Spirit appears to be affronted by suffering among children, buffeting her resolve. She is nevertheless prepared to respond saying a prayer for a child at its grandmother’s request; upholding it in God’s love. She finds it a little easier when there is no suffering. She recounts a time when she sat with a little boy and “shared time”. I was in the children’s ward and there was a little Sudanese boy of 2–3 years. The parents weren’t there yet and the nurse said they will come but the boy can’t speak English very well. So we sat on the floor and we played clapping and everything so to me although we weren’t conversing and his language wasn’t right, we just shared time.
Recognition of the Holy Spirit’s guidance is an individual experience and springs from close religious ties to the church’s articulation of the faith. Holy Spirit guidance in the church may be prayed for, but recognized in events that concluded favourably; this is the respondent’s experience, and is articulated as such in the examples she provides. The care this respondent offers is religious care, anchored in her attachment to the Holy Spirit, and through prayer, comfort, and reassurance helping people to be more attuned to God.

The respondent’s pastoral care of members of other faiths, however, is more difficult to ascertain from her brief comments. Nevertheless, we can discern four elements in what she says which together speak of acceptance, tolerance and respect. Firstly, she speaks of herself as an ecumenical chaplain. The context suggests that she means that her task as a chaplain is not limited to one denomination or one faith; it is essentially a matter of being there. Here we have an expression of presence. Secondly, upholding one from a different faith with prayer may result in misunderstandings of meaning, but is possible when done with sensitivity to other faith standpoints. Thirdly, the respondent finds a degree of commonality with people of other faiths in communing with nature, and finding there a sense of God’s Presence. The respondent speaks of it as a spiritual journey in which she can join. Fourthly, even though Jesus Christ is my Lord and Master she is able to respect the spiritual journeying in other faiths.

There is always contradiction, however, in matters of belief, even within Christian boundaries. A declaration of Jesus Christ as Lord can carry a number of variations of meaning within Christianity. Failing to understand the foundations of other faiths, however, considerably diminishes the possibility of relationship. Mackenzie et al make a telling comment on interfaith relationship:
We have learned that true interfaith dialogue cannot focus solely on sharing the sweetness of each tradition. We must also become more honest with each other as we share those aspects of our traditions with which we are less than comfortable. We become more vulnerable as we share our discomfort, and our vulnerability enables our relationships to grow deeper (2011, p.2)

Here we have the word vulnerable again, and I want to ask the question, when one has a sure hold on the guidance of the Holy Spirit is it possible to feel vulnerable in a pastoral encounter? In considering the interviewee’s responses, there is a strong suggestion that the answer is no. Even in the encounters with those of other faiths there is a sense that she remains in control. The stories that she relates express a surety that she attributes to the Holy Spirit’s guidance. The only hesitation she has is with children who are suffering, but even in those situations she is able to rely on the Holy Spirit, and offer a prayer, upholding the child “in God’s love”.

In the questionnaire, this respondent was clear that her training was helpful. She nominates three separate training procedures, but each of these is essentially basic training. She would have re-visited a number of basic chaplaincy principles in all of them. The difficulty in her interview is an apparent lack of connection between training and her strong religious links. The analysis demonstrates, however, that, even though the respondent is steeped in her Christian faith, she does offer respect to others. She respects their journey she says of members of other faiths. She recognizes that there can be some common ground despite differences in faith standpoints although she does not articulate this clearly. This chaplain clearly cares despite a lack of clarity about religious and spiritual care. This issue of care emerges again for our next interviewee.
Interviewee 7 is a married woman about 50 years old. She grew up in England where she was involved with the church until she was around 20 and then lapsed. She and her husband eventually emigrated to Australia but did not link up with a church until 1987. They became more and more closely linked with the church that they had joined. In Australia she worked full time but as they became more involved in the local church she resigned from her position and took up a part-time position in the church office. She felt after a time that she needed to do more, and after reading a flyer about a pastoral care course, she enrolled. She reads a lot and attends workshops and meetings to keep up to date and maintain her skills. I interviewed her in her
home. She talked freely, although she was very intense about her belief throughout the interview which lasted for about an hour.

**Analysis.** Key words. Holy Spirit, spiritual additions, belief, knowledge of Bible.

Asked about belief, the respondent answered: I certainly believe in God and Jesus and I believe in miracles, having personally been involved with one particular one. I also believe that if we pray, God answers our prayers. As a way of confirming this she kept a prayer book for several months and every time I prayed for something, I put the date and what it was. Prayer in particular is: the great calmer; it quietens the soul. It can be, she says, uplifting or help people to be comfortable with what I am praying for or talking to them about. Praying for something assumes that words are necessary; it also assumes that the prayer is to be directed towards God and therefore away from the receiver of care. Prayer that "quietens the soul" is obviously couched in terms that are pleasing to the one receiving care. Prayer for this respondent appears to be always a positive experience.

The respondent places considerable emphasis on what she considers the efficacy of prayer, but her words, comfortable with what I am praying for or talking to them about raise questions about efficacy. One implication in "what I am praying for" is that she is determining what the subject of the prayer is; what is good for the patient. Prayer that helps people to be "comfortable" is for this respondent the "great calmer". Prayer, however, can also be a cry of despair, a cry for help, a lament for things lost. Wolterstorff, in his lament for the loss of a son says: 'I need to hear from you that you are with me in my desperation' (1987, p.34). The prayer from Jesus on the cross, as reported in Matthew's gospel is far from comfort: 'My God; my God, why have you forsaken me?' (Mt. 27:46). Prayer may be more robust, and
intimately linked to deep feeling, than that portrayed by the respondent. We remember also that a previous respondent (C28), discovered for a time, that prayer frequently did not work.

The strong religious feeling evident in the comments on prayer by the respondent is potentially a barrier to effective spiritual care. There are no doubt some who will engage with her in conversation about prayer and the Bible; witness the following conversation: I was with a person of another faith\textsuperscript{19} […] He said to me, I don’t need you, I’ve got my Bible. illustrates this point. She did, however, respond to the patient, and the visit became a question, answer exercise and: we did that for 45 minutes. The result was that he agreed she knew the Bible. This was apparently an enjoyable religious discussion, and as such, has a place when appropriate.

The respondent’s understanding of pastoral care, indeed, becomes suspect with her judgmental comments about others engaged in pastoral care and a sense of wanting to be present to evaluate a pastoral interaction. Sometimes I think that I would like to do a pastoral visit with them just to see how they work their way through a visit. I don’t think a person you are visiting will respond to our pastoral visit if you are too worldly or too down to earth because pastoral care is all about caring for the person.

The immediate question that arises asks what her understanding of “caring for the person” might be. She has, by her claim, established a dichotomy in which her care is contrasted with the offering of a “worldly” person.

Pastoral care in this respondent’s view must contain prayer, linkage to God, use of the Bible, and talking to people, apparently about religious matters.

\textsuperscript{19} Faith most likely means denomination in this instance. The person appears to be a Christian.
This viewpoint rather clearly recognizes pastoral care as religious care. The inclusions, however, can be seen as meeting the chaplain’s need to establish religious connections, rather than caring for the patient. A difficulty with this respondent’s comments lies in the understanding of “too worldly” and the consequent belief that such a one is not able to care for patients. One could also ask whether it might be possible to be “too other worldly”, and whether one holding this stance may be considered not able to care for patients.

“Caring for the patient” by providing prayer, Bible readings and the like depicts a lack of presence. If, as appears, the chaplain is meeting her own needs, she cannot offer her whole self (Avery 1986, pp.346-347)). As we have noted in the section on presence in the literature review, Fraser (2004) writes of ‘compassionate presence’ (p.28) and Purnell says: ‘engaging the other in ways that value their whole being’ (2003, p.7). Presence is not an easy matter. It requires a conscious effort to be one with the other, even more so when facing differences of belief. Honouring these differences requires that an ethic of care, which focuses clearly on patient needs, be established and followed. As Bueckert (2009), says:

> When their ministry is informed by an ethic of care, chaplains serve patients and families as they would hope to be cared for themselves, while keeping in mind not to make assumptions based on their own preferences. They are attentive to the question: what does good news look like for this person. [...] An ethic of care recognizes that human beings exist not in isolation but in relationships. We seek to support care receivers’ experience of right relationship (p.30).

Good news for a patient may not be recognizable in one like this respondent with her strong convictions about her own growth and development: The Holy Spirit is very much part of my life – I feel the Holy Spirit working within me – It is sometimes very strong – I do feel very spiritual. In the laying on of hands for healing she says: I feel this huge outpouring of strength; a beautiful feeling. But the respondent also speaks about pastoral care as: caring for the person – being there for them – we don’t
do things but are there for the person – give them infinite respect. There is an obvious contradiction between the respondent’s claims for herself, her determination that pastoral care needs her stance to be valid, and her comment about respecting patients; a respect that does not appear to extend to a consideration of patient needs.

If, however, pastoral care is about caring for the person, then one must first of all seek to understand the person. Pastoral care is not advanced if the one presuming to offer care, presumes also, that he/she holds the key to its direction. The re-articulation of pastoral care however, requires not only an understanding of both religious and spiritual care, but also the ability of carer and caree to meet in a mutual search for understanding. Our respondent, with her ongoing search for spiritual nourishment will be more likely, it seems, to align her views with those of Dayringer (1998) and his argument for religious care and its close link to the church.

This respondent’s major concern appears to be in seeking spiritual additions for herself: I know all the stories – I know everything about the Bible but I can’t say to you, you should read specific texts. At least I do know the content of the Bible. This sense continues in her words, I find it lovely to be recognized as I walk into a ward and a patient might say you are a God person. If one is seeking “spiritual additions” for oneself then clearly the focus must be on oneself. For this respondent, being spiritual is an important qualification for true pastoral care, and she speaks of being “there for the person” and of “infinite respect” at the same time, speaking judgmentally about other chaplains. In this, there are some serious contradictions. For her, being “too down to earth or too worldly” precludes one’s ability to care for another. This is not true, in fact, but it also implies some spiritual superiority on her part as well as lack of respect.
The interviewee’s intense desire to be more spiritual does not bode well for her ability to provide effective pastoral care in the terms of this Thesis. The words “the more involved I become, the more spiritual I become” speak of a rarified atmosphere that precludes the chaplain from relating to someone who “is more down to earth”. Allan and Macritchie, discussing proactive and reactive chaplaincy, observe in their conclusion that:

One of the most important skills that should be looked for in chaplaincy is the ability to relate to people generally, but also the gift of being able to engage at deeper levels with those who need more time and pastoral attentiveness at that particular occasion (2007, p.13).

There is some contradiction and considerable confusion in this respondent’s description of religious and spiritual care: The religious part of it [pastoral care] is whatever the person themselves is going to give to me. They are disclosing where they are at. The spiritual side is when they need you to explain to people, we are ecumenical when we are doing this.

One of the interviewee’s answers in the questionnaire expands this somewhat confusing statement. The answer is in relation to a question about story. It serves as a reminder that it is the patient’s agenda. Without this information it would be difficult to assess the types of care, prayer, or conversation to engage with the patient.

While this further statement does not throw a great deal of light on the earlier statement, what follows is significant. There is a suggestion that whatever the patient might offer in the way of “agenda”, the respondent’s claim is: Notwithstanding I prefer, if I can, to talk to people about God and prayer and what is actually happening to them. If you can get to that level where they can confide in you how they are feeling then you can get to a position where they are comfortable.
Talking about a variety of matters with its overtones of explaining those matters, and with a view to getting “them to a position where they are comfortable” suggests a lack of engagement and a lack of presence. It is somewhat like a one-way street. Purnell claims, however:

conversation that grows creatively requires an alert presence and disciplined observation. Attending means giving yourself fully to the person, the object, the experience before you. It means turning off the interpreting gears and opening your senses to experience the other as fully as possible. It means allowing yourself to experience being with this person (2003, p.47)

Activity, which also involves talking, can become tiresome for all. Blaine-Wallace says of the matter of listening and the necessity of silence for that to properly proceed, that:

Silence is not the beginning of a linear process of pastoral talk, the hush before the rush of dialogue. Rather, silence is the spring from which those who are beheld find the fresh water of words to communicate their experience. Hence, silence is a listening that watches and waits and receives what and when others are able and willing to share. (2010, p.6.2)

The tenor of the respondent’s response to a question about other faiths is to portray one who is seeking to maintain control over the interaction. Establishing the religion and the topic, “what would you like to talk about” she says: I’m quite open to discuss what your faith is and how you believe. As long as that person doesn’t think you are trying to preach to them or convert them they are quite happy to have a semi-social visit which includes the pastoral element.

The words, I prefer, if I can, to talk to people about God and prayer suggest that this might be what she calls the “pastoral element”. She tries, she says, to make them feel comfortable talking about it.

Maintaining control, seeking information, and seeking to talk about God and prayer, further contradicts her earlier claims about pastoral care as caring for
the person, being there for them, and giving them infinite respect. She seeks to make others comfortable but does not herself, appear to be comfortable with silence, nor to listen in the way that Blaine-Wallace claims, is most appropriate. The respondent appears to be insensitive to what others are able and willing to share. It is clear from what she says that pastoral care is shaped for her by her belief, but even more so, by her desire for her own spiritual growth. I needed to expand […] I needed more depth than I was experiencing […] I felt […] I’m being guided. Then a flyer came out in church looking for people to register to do a pastoral care course. All this was considered to be guidance by the Holy Spirit, but as a reason for undertaking a pastoral care course, it has difficulties. It raises an awkward question about training. In what way is it possible for training to offset some of the excesses of belief? I will return to this matter in the discussion that follows.

There are many contradictions in the interviewee’s responses. She says: I attend workshops and meetings to try to keep up to date with all the facets, but also claims there are: a lot of occasions when I feel very spiritual. The “facets” that are important in pastoral care include listening, and presence, and acceptance, and perhaps most important of all, vulnerability. None of these are clearly visible in these responses. Of her initial training the interviewee, responding in the questionnaire, speaks of: doing twelve month’s theory combined with practical supervised training, [followed by] a further 12 months on the ward supervised work. [This in turn was followed by] working in extended but associated tasks that add to an ongoing chaplaincy role. There does not appear to be, however, any visible link between training and action for this respondent. Pastoral care, that is subservient to a belief that makes strident claims about God’s Presence, will not recognize the importance of Janet...
Mayer’s claim quoted by Hill and Mullin, that: ‘the essence of spiritual care is not doctrine or dogma but the fundamental human capacity to enter the world of another and respond with feeling’ (2001, p.174).

Discussion
In chapters three and four, and again in these interviews, it is clear that belief emerges out of a series of pathways, which are not sequential, nor separate, but interweave constantly in the life of the believer. Belief may begin as one reads, and studies, and engages in discussion with others. All of the interviewees speak of reading the Bible, and of engaging in a variety of studies. Belief may emerge through experiences which include: parental influence, attending church, attitudes and activities of others, and engaging in prayer. All of our respondents make mention of all or some of these influences in their lives. Belief emerges in specific personal experiences which are regarded by the believer as the Presence of God at a particular time, with a specific outcome. A number of respondents (C17, C28, and C40)
recall such instances as having a profound influence on faith life, and life generally.

I have claimed on a number of occasions, demonstrated by evidence from the literature, and from some of the answers to the questionnaire, that belief is foundational in the provision of pastoral care. Belief, however, in the lives of people is something of a smorgasbord, and therefore complex in its application. While it can be shown that within the church there are a number of core beliefs, such as Jesus as the Son of God, his crucifixion, and the resurrection, it can also be shown that across the wide spectrum of Christianity, variations are rife. One example can be found in the way the Bible is used. The Bible is for some, the literal inspired word of God. Others interpret the Bible through their own writings, one example being the Book of Mormon. It is within this variety that the key words in my analysis; religious care, spiritual care, authenticity, belief, story, and presence are given shape and focus by the chaplains.

Earlier in the thesis, belief was recognized as taking two primary forms (p.31). One of these was piety which was loosely defined as reverence for God and dutiful respect and regard for others. Piety is strongly attached to the social, cultural and liturgical life of belief. Pietism is, according to Carl Trueman (Ballard & Holmes 2005 p.92), ‘notoriously difficult to define but is perhaps best captured in the idea of prioritization of personal experience [...] and a certain prioritization of the religious sphere’ (p.93). Both of these will be clearly visible. In the profiles, piety can be attached to (C6) and (C11), while pietism fits more readily into the experience of (C17) and (C40).

In my opening paragraphs of the discussion following my analysis of the answers to the questionnaire, I wrote, “Belief stands out as the primary motivator for those engaging in chaplaincy in all its complexities, and features strongly in interactions with patients.” All of the respondents claim Christian
faith and a strong connection with the church. The beliefs they espouse, though stated differently, contain the essential elements of church teaching; a loving powerful God, Creator, Father of Jesus Christ who is himself Saviour, and the Holy Spirit as the ongoing expression of God in the world. Belief, however, is mostly something that we grow into within a particular religious framework. We saw that this was so with, for example, (C6, C7,) and (C11).

What was said earlier stands as an entry into this discussion of the interviewee’s responses in the interviews. The following quotation is helpful for our understanding. It is from Driedger, who says:

The specific faith of the caregiver may motivate the caregiver and may give meaning and purpose to his or her work, but the terms of the caregiver’s faith are not the focus of a spiritual care visit. This is because the spiritual caregiver plays the melody, but the care receiver provides the words (2009, p.141).

There are four elements in this quotation each of which, considered separately, allows us to discern some of the complexities associated with pastoral care. As a reminder to the reader, my rearticulation of pastoral care considers it a generic term, in which is contained religious and spiritual care as two separate but related entities, each of which requires different skill sets and attributes. My plan is to take each segment of the quotation in turn and consider it in relation to the evidence we have from the interviewees.

Firstly ‘The specific faith of the caregiver may motivate the caregiver and give meaning and focus to his or her work.’ Articulating their experience in different ways, each respondent held strongly to the fundamentals of the Christian faith. From the research we can, therefore, capture some phrases and sentences in each response that encapsulate their application of belief to pastoral care.

(C6), has Bachelor of Theology, and Master of Counselling degrees, and has also completed the Hospital Ministry and Pastoral Care Course, and a unit of
Clinical Pastoral Education. She has completed theological training and been ordained for ministry. Along with all of these she has undertaken many short certificate courses, all of which are associated with chaplaincy activity. She speaks of obedience arising out of her sense of God’s Presence in her life. In the trials and tribulations of her life, she recognized that God did not abandon her. As a result she will not abandon others, and in doing so is prepared for vulnerability.

(C7), a lay member of the Anglican Church has completed an Education for Ministry course, the Hospital Ministry and Pastoral Care Course, and a unit of Clinical Pastoral Education. In contrast to (C6), she expresses concern that the strong foundation of her faith developed in earlier years, be maintained in the pastoral interactions in which she engages. She is, however, respectful and caring of others.

(C11) is an ordained minister. Apart from his theological training, he has participated in a pastoral care course, Clergy Effectiveness Training, including Narrative Therapy Training. He speaks of the grandeur of God, and portrays this with descriptions of God as “Perfect Mind”, and as “Supreme Being.” He claims that the inability of people to grasp this nature of God leads to a recognition of a considerable difference between God and people. Consideration of this gap, however, does not lessen his desire and ability to express care and concern in his response to patients.

(C17) completed a Diploma of Theology course with the Catholic Church, a two year Pastoral Care Course with the Catholic Church, and the Hospital Ministry and Pastoral Care Course over one year. She is driven by a prior “Holy Spirit experience” which impacts strongly on pastoral care. She declares that representing God in pastoral encounters is most important, and expresses the hope that “doors will be opened and seeds sown”.

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(C28) completed Theological training and is an Ordained Minister of her church. She has also undertaken, and completed a unit of Clinical Pastoral Education, along with a number of short certificate courses. As a result of experiences that have engaged her life, she is still looking for her own place of belonging. She continues to engage with her belief and her sense of call to ministry. The respondent has come to understand, as a result of her experiences, the meaning of vulnerability resulting in an ability to be aware of the effects of vulnerability in others.

(C34) has completed three units of Clinical Pastoral Education. She has a strong attachment to the guidance of the Holy Spirit. She has a strong hold on this belief and places her encounters in this context. The result is a conviction that, in whatever she does, guidance will be visible. It is difficult to consider that she might feel vulnerable in a pastoral encounter. Mackenzie et al, however, consider that becoming vulnerable is an important component in true pastoral care: ‘Our vulnerability enables our relationship to grow deeper’ (2011, p.2).

(C40) has completed the Hospital Ministry and Pastoral Care Course. Her pastoral encounters, however, are shaped by her desire for spiritual growth. She says, there are a “lot of occasions when I feel very spiritual”. This desire is such, that it may be said she does not appear to recognize the importance of the claim by Hill and Mullin (2001) that the ‘essence of spiritual care […] is the fundamental human capacity to enter the world of another and respond with feeling.’

All of the interviewees have completed pastoral care training courses. All would have received similar input from their pastoral care courses. Some have gone beyond this specific training and some have completed theological training and been ordained. The range of skills development is considerable. If a continuum were established, based on the evidence available, (C6) would
without doubt be at the end labeled most skilled and most able. I would then consider (C40) as the one most likely to be at the other end. She has completed an authorized course, but does not appear to have followed it with any other courses. Two things seem to motivate her, one of which is “spiritual additions” for herself, and the other a need to always offer prayer. This is in stark contrast to (C6)’s obedience and commitment to constancy. Arising from the interviews I would also be prepared to claim that of the interviewees, those most likely to consistently provide religious care are (C17, C34, C40)

The motivations of the care providers are clearly related to belief but expressed very differently even across this limited sample. Rather than consider yet again, all the respondents, I will focus on two that appear to me as complete opposites. (C6) has a commitment to obedience in her heeding of God’s call. This obedience, however, has nothing to do with evangelization or proclamation. It has to do with the way she perceives God’s Presence. “God has not abandoned her” and her awareness of this means a conviction that she will not abandon others. This is a preparedness to be vulnerable. It is a commitment to presence with the recipient of care, and a determination to help others on “their faith journey” not to question what they believe, but helping them in their own search for meaning.” The key is her belief that there are many pathways to God and that God reveals God’s self in different ways.

(C17) conveys a strong desire for spiritual additions for herself, and makes much of “spiritual feeding” as undergirding her work as a chaplain. She does speak of the vulnerability of patients but then presents herself in the strong position of representing God. Her motivation for chaplaincy lies in her sense of spirit Presence. Her spiritual experiences have been enjoyable experiences. That she says is one of the reasons: I enjoy retreats, seminars […] all of that. There is: a sense of God/Jesus going with me […] have to believe a door has been opened. An inward quest is difficult to authenticate. It relies heavily on personal feelings and beliefs. These are subjective activities,
“spiritual feeding”, which benefit only the one so engaged. Her experience could be said to be euphoric. It could also be said to be alarming in pastoral care. Lartey reinforces the idea of alarm, with referral to Leech, who he says ‘is rightly alarmed at the confinement of spirituality to the realm of the private life of individuals. On such a view, instead of spirituality being seen as a way of living in every sphere, it becomes a sphere in its own right – “the spiritual dimension”’ (2003, p.145).

Secondly. ‘The terms of the caregiver’s faith are not the focus of a spiritual care visit.’

My contention is that within the general framework of pastoral care (in our case solely administered by Christians) the issue of difference must be acknowledged and accepted. This we have recognized in interviewee responses is difficult for some. (C7, C17, C40)

The terms of the caregiver’s faith can be recognized as twofold. My focus is the Christian faith, and in this framework we can find faith encompassing core beliefs that are common to all, and faith filtered through denominational differences. These are the matters that must not intrude into a spiritual care visit. The focus for such visits can be recognized as a mutual exploration of circumstances in life in a search for meaning. The search belongs to the recipient of care and the pathway therefore needs to be kept clear as the story is allowed to develop. I will look at story shortly.

Appropriate and ongoing training is a fundamental requirement in enabling care providers to understand correctly the focus for spiritual care, and its difference from religious care within the work of pastoral care. Training programmes for pastoral care, while differing in some aspects, all contain basic tenets that must be understood. These include such as listening, respect, appropriate response, reflection, evaluation, and self-understanding. All of these will enable some focus in pastoral care that will recognize the
receiver as the most important person in the interaction. Training, however, can never be a one off event in the context of human encounter. Many factors beside skills can impede or progress an encounter. The focus, however, can be continuously re-established, as it needs to be, through quality supervision. In this process the focus can be developed and sustained.

Thirdly. *This is because the spiritual caregiver plays the melody’.* What is this melody? Patricia Driedger explains it this way;

> The shared melody of all spiritual traditions is heard in the questions of meaning and purpose that are the same for everyone. The music of the spirit is expressed in the universal quest for love, inner peace, belonging, and hope. This quest is the same whether one is Christian or Muslim, Jewish or Buddhist or agnostic. All people have a need to ask questions about the meaning, purpose and value of life; and each person needs to find answers that enable him or her to respond to the unique experiences of his or her own life (2009, p.138).

Consideration of interviewee’s responses suggests that many chaplains find great difficulty in understanding the melody. The desire of some (C17, C40), for their own spiritual growth, contains an implication that those whom they encounter might also develop the same desire. The need to hold fast to one’s own faith suggests an anxiety that this might be subverted. Holding fast to guidance from the Holy Spirit carries an implication that this is the best way to proceed.

Others do have a sense of meaning in their pastoral activity. (C7) for example comments that all humans are spiritual beings and again, I think that people of those other faiths want what we want: food, clothing, shelter, and a good life for their children and grandchildren. (C6) discerns elements of genuine compassion; she embraces difference as natural and valuable; she helps others in their search for meaning; she understands vulnerability and will not abandon others. Chaplains, holding to the melody and recognizing its extreme importance will facilitate reconciliation, peace, and hope.
The melody, however, may be interrupted and frequently is within the world, by war, and famine, by hatred, by destructive actions. In spiritual care the interruption can be discerned in the words of C24’s, questionnaire responses, who spoke of stories as giving her a handle on what to say and pray for and claimed further that most patients don’t feel the need to, or don’t want to tell their story. The same respondent also commented that many of her visits were of 2 minutes duration. Mackenzie et al claim that:

Religions go astray when they contribute more to human suffering than they do to human healing. We go astray as individuals when we forget the essential nature of our being and identify only with the things we have and the things we do. We become human *doings* and human *havings* rather than human *beings*, and the consequences are greater separateness, conflict and hopelessness (2011, p.159).

Some respondents appear not to have heard or understood the melody. The claims of some to close and personal ties with the Holy Spirit (C34) suggest separateness in their links with “ordinary people”. One interviewee (C17) claimed that it was only through her religious experiences that she was able to work as a chaplain. For her it was important that others knew that she was representing God. Another respondent (C40) lauded the power of prayer and considered that some pastoral providers were “too worldly” to adequately fulfill the task.

Forthly. *The care receiver provides the words.* These become most evident in the stories that the receiver shares. The stories that people have to tell are legion, but will not be told if there is a perception of busy-ness or discomfort or disinterest. I have established, in my literature review the importance of story in people’s lives. In that review we found Ebehardt writing: ‘Stories are the stuff of life [they] create and colour existence […] our stories are who we are […] they structure our experiences and shape life expectations’ (1996, p. 23). In Confoy, (2009) we find words from Brueggmann; Deep places in our lives, places of resistance and embrace […] are reached only by stories […].
Confoy writes further of re-imagining, and Carol Christ claims that: ‘without stories there is no articulation of experience.’ (1980, p.1) The words from patients will be heard by the pastoral care provider who through his/her attentive presence provides the ethos that allows the stories to be told. “I will not abandon others”.

Authentic spiritual care allows the receiver of care to explore his/her own way in life. The search for meaning is an individual search and cannot be assumed to belong in a particular faith perspective. Finding meaning is not about finding God and therefore being satisfied, it is an ongoing search which will find from time to time temporary solutions which satisfy, but do not satisfy permanently. This is because human beings, despite gaps in understanding of life (C11), nevertheless have the ability to continue searching.

Authenticity, in which genuineness and respect are visible, will be recognized in chaplaincy, in consistency and in validation of faiths. The one providing spiritual care will be seen to be assisting the search for meaning of the other, even if that search takes the searcher in a direction somewhat different from that which the chaplain might consider most appropriate. Among the interviewees, (C6) stands out as authentic in the spiritual care that she offers. Certainly, a chaplain who speaks a lot in the encounter will not provide the necessary space for the patient to, perhaps hesitantly, share a story about life.

In the interviews little is said about story. There is some mention of bible stories, but only in one instance does the interviewee refer to stories in her pastoral encounters. “I try to listen to stories” (C7). We can discern, however, in two other responses references to sitting with patients; being and listening. (C6) speaks of “not abandoning others”, implying continuing presence in which stories may be shared. (C11) speaks of “listening with all senses.” (C34), in answer to a question about stories, responded I pray that I am able
to listen and watch and have the perception. This is much less emphatic than the other respondents but does leave open the possibility that stories told, may be heard. The interviews themselves are stories, and as we have discovered through reflection and analysis, reveal considerable detail about the interviewees. They demonstrate the power of story.

The gap between the techniques of pastoral care gained through training, and belief is considerable. Training courses need to be regularly restructured to provide holistic understanding of religious and spiritual care; understanding the difference but also understanding the value of both. Belief that is excessive, however, is very difficult to change in a training course. A more likely scenario with possibilities for change is found in good supervision. This is a continuation of training that allows for ongoing reflection on belief, and other matters, and their affect in a pastoral encounter. It requires that the pastoral provider develop insight into the consequences of providing God and prayer instead of listening carefully to what the receiver desires to achieve. A most important achievement for pastoral providers, not generally taught in training programmes, is an ability to, remain silent. Shuji Moriichi, chaplain and Director of Spiritual Care at “Cerenity Care Center” Minnesota, writes of the rediscovery of silence in pastoral care:

Right now, the people who ‘do not speak’ at the nursing home help me to continually embrace silence as an essential part of who I am and what I do, and hence help me to serve more authentically. They teach that silence is such a precious gift of God (2009, p.6).

To sit in silence is indeed a rare gift; one which, from the interviews, is possessed by very few. Those who “represent God”, who want to “tell of their own salvation”, who seek to have “others know Jesus”, can be caught up in the telling process as a legitimate opening of a door, but in holding open that door, fail to recognize that there are other doors nearby. Opening a door is not always recognized as an invitation to proceed. An open door makes visible another dimension that is outside one’s own space and this can
produce considerable anxiety. To be silent, to listen, to be aware, along with such as vulnerability, attention to story, and respect are pathways to discerning the need of the other. That need might be to remain silent, to remain in a familiar place. As healing begins the patient may take courage and open his/her own door; and this may not be the door that is the desire of the chaplain.

All engaged in chaplaincy are responsible to others in the carrying out of their task. Their primary responsibility is to those who appoint them, and we have recognized that in South East Queensland this is almost exclusively the province of the churches. The thesis has claimed throughout, the importance in chaplaincy of the provision of both spiritual and religious care, and the necessity that chaplains recognize this and become aware of the difference. Awareness should then lead to appropriate practice that embraces both religious and spiritual care. The next chapter seeks to understand the institutional requirements within which chaplains work and with which they sometimes struggle.

**Chapter 6. Appointers.**

This chapter will help our understanding of some of the institutional constraints within which chaplains and providers work. There are three layers of expectation discernable in consideration of the chaplaincy task. There are, in the first instance, the expectations of those choosing and appointing one to the task. In South East Queensland, appointments to chaplaincy work in hospitals are almost exclusively made by churches, so a primary expectation is that the chaplain will have an established Christian belief. Training is not only an expectation but a pre-requisite. Secondly there are the expectations of those undertaking pastoral care. These, presented in the answers to the questionnaire, and in the interviews, have been extensively analyzed.
Thirdly is the expectation of the institutions, and there are two institutions to be considered. Firstly is the church, with its primary commitment to mission. Although there are basic Christian standpoints which all accept, differences in the articulation of chaplaincy tasks and denominational expectations will be recognized. Secondly are the hospitals which have their own variations (e.g. Acute care, Palliative care, Mental Health care). All require professionalism from their clinical staff, with regular reporting and responsible provision of care. Both provider and chaplain need to be aware of these conflicting expectations, and understand the nature of the constraints.

Therefore, in conjunction with the questions asked of chaplains, a set of questions was posed to those who, in their various denominations, are responsible for the appointment of chaplains. Five people were approached and four responded. These are delineated as A, B, C, and D. Their answers provide a record of their attitude to chaplaincy and the way in which they approach their task. The analysis of their answers should not be construed as criticism, nor should it be assumed that these respondents were not interested in their task. Clearly the opposite is the case. Three of the respondents work under severe financial restraint, attempting to fund the work of chaplaincy largely through donations. This makes full time chaplaincy virtually impossible, and the result is considerable reliance on volunteers with some training. The other respondent does have access to sufficient finance to fund a number of full time appointments, but this funding is currently, in that church, facing difficulties. Having money to pay, however, does not mean that those who apply, and are appointed, are necessarily the appropriate people for chaplaincy.

The paramount theme which this thesis addresses is the re-articulation of pastoral care. I have claimed throughout that pastoral care needs to be recognized as containing two modes, namely religious care and spiritual care. Both of these have been recognized as important, with a proviso that religious
care is more suited to specific instances of need that may be present for those with a close affiliation to the religious expressions of their faith. Consideration of Bouma’s claim that: ‘as currently used in Australia the term religion refers to more socially organized and structured ways of being spiritual’ (2006, p.15), leads us to recognize that, in his thesis those whose task it is to seek out and appoint personnel to pastoral care, work within Christian structures. It is from this experience and understanding that appointments are made. It is likely therefore, that their preferred model for care is religious care.

Bouma, commenting on “the spiritual”, claims that:

As it is used in Australia today, the spiritual refers to an experiential journey of encounter and relationship with otherness, with powers, forces and beings beyond the scope of everyday life. To be spiritual is to be open to this “more than” in life, to expect to encounter it and to expect to relate to it (2006, p.12).

Spiritual care, if this is taken into account, will require a wider commitment of energy and time, and will require appointers and chaplains to step out of their religious comfort zone to consider issues of meaning that will not be solved with religious terminology. The issue of meaning is important for those who appoint chaplains; they reflect the meanings attached to chaplaincy by the church. My choice of recording and analysis for this group of responders therefore, was to incorporate all of the responses to each question with a view to comparing each set of responses as important for our understanding of the reasoning of the church in its attachment to chaplaincy.

In all, the providers of chaplaincy were asked thirteen questions. These are grouped in five categories: Matters of practice (1,2,3); Difficulties (4,5); Professionalism and Training, including Theological training and Supervision (6,7,8,9,10); Multi-faith concerns (11,12); and a question (13) about the future.
Practice Matters.

1. *Chaplains speak of themselves as pastoral carers: what do you understand this term to mean?*

   **A.** The two terms have various meanings in various sectors. Some reserve the word chaplain for ordained ministers; they tend to equate chaplaincy to sacramental ministry and pastoral care to supportive engaging of meaning-making. The lack of one consistent use of these terms across the four different streams of hospitals [...] leads me to be pragmatic and use the terms interchangeably, adding as well, spiritual care.

   **B.** I understand pastoral care to be grounded in our Christian faith which recognizes that the individual is valued. The Christian faith represents all persons as being loved by God, and recognizes the whole of the person, physical, spiritual, social and emotional. Therefore, pastoral care is that care which seeks to reflect God’s love for the person in offering care to the whole person as able and appropriate. Its context is the relationship between pastoral carer and those for whom care is offered. This relationship may be very brief in some circumstances, however, the relationship built of mutual engagement by pastoral carer and ‘caree’ is the place where care is offered according to the ‘agenda’ of the care recipient.

   **C.** To be empathic listeners enabling patients to self direct their journey to wholeness in body, mind and spirit.

   **D.** Simply that the chaplain walks with the ‘client’ in the time they have together in the client’s journey.

**Analysis and Comment.**

Respondent (A) declares “a lack of one consistent use” of chaplain and pastoral carer across the four different streams of hospital care visible in Queensland. This inconsistency in the nomenclature of chaplain has the potential to create some problems in the facilities in which chaplains work. In one Pastoral Care Department of which I am aware, there has been an insistence on all being designated chaplain and wearing a chaplain badge.
This has, at times led to some confusion of expectations among both patients and staff.

T.S. McGregor in the *Dictionary of Pastoral Care*, defines the task of hospital chaplaincy as providing ‘a supportive, pastoral or sacramental ministry to patients’ (1990, p117). Describing pastoral ministry, he continues:

Pastoral ministry demands sensitive listening, perceptive observation, careful response, emotional warmth and a capacity to confront ultimate questions of meaning in such a way that patients may be comforted and may come to use their experience of illness positively (1990, p.117).

Expectation of sensitivity and perception, along with a willingness and ability to deal with the hard questions about meaning, points to an expectation that the provider of care will have sufficient awareness to discern in the patient’s expression of need whether to provide religious or spiritual care. As stated earlier, both of these are important, and the provision of sacramental aspects will be part of this. This, however, poses difficulty for volunteers who, if they are non-ordained will, in most cases need specific church permission for the provision of sacraments. Church sacraments are specific to religious care and their provision is an expression of the faith stance of the receiver.

A number of denominations strive to maintain the title chaplain for those who are ordained clergy and therefore have authority to administer the sacramental aspects of pastoral care. Non-ordained persons in those churches have been titled pastoral care assistants, or something similar. (A) writes of some equating “chaplaincy with sacramental ministry, and pastoral care with supportive engaging of meaning making.” Chaplaincy is a way of describing the work of a chaplain. But this work is not only a “sacramental ministry”. Sacraments have to do with church involvement and the provision of these caters for the religious needs of church people. Chaplaincy, however, must also include the wider aspect of pastoral care. “Supportive engaging in meaning making” is spiritual care, and that is the work of the chaplain within
the parameters of chaplaincy. The understanding of some, referred to by (A), is inconclusive in naming the business of chaplaincy.

This exacerbates the difficulty in naming who will be a chaplain, and becomes a problem at times for the institution [in our case, hospital] in which chaplains work. The practice of some denominations in only naming clergy as chaplains conflicts with those who are comfortable in naming all as chaplains. Part of the difficulty is theological, and is dependent on the theological standpoint of particular denominations.

Respondent (A) notes the inconsistency in naming and describing those who undertake pastoral care, and states that because of the differences of terminology he has become pragmatic in its use. He represents a denomination that favours the title of chaplain for clergy so his pragmatism appears as an acknowledgement of a situation he cannot control. There is some acknowledgement by (B) that visits vary in time and that they may be brief, but a primary aspect of any visit is seen to be the reflecting of God’s love. How one might “reflect God’s love” (B) becomes an important question in pastoral care. It is a question strongly related to belief, and as we have already noted, belief varies considerably within a Christianity that is split by a large number of denominational differences. Reflecting God’s love in a pastoral encounter presents us with a dilemma as we consider the variety of ways this may be interpreted. Reflecting is not telling, nor is it sharing Christian teachings. Some, however, will want to explain their own experience of “God’s love” in the hope that others will have a similar experience (C17 and C40). This is rather different from “not abandoning another” (C6) as a reflection of God’s love. Macritchie claims: ‘we need to be good at learning the language of story’ (2001, p.209). Hill and Mullen, as previously intimated, write of: ‘the fundamental human capacity to enter the world of others, and respond with feeling’ (2001, p.174). Perhaps in these, we find a “reflection of God’s love”.

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Respondent (B) “understands pastoral care to be grounded in our Christian faith”. I have indicated earlier that pastoral care is a church concept and can be traced through the church’s history. Recognition of its origins, however, invites us to consider how pastoral care might be re-articulated in order that it may be considered relevant in a context that recognizes all faiths have a place. A clear understanding of expectations, therefore, between appointers and appointees is critical in the practice of pastoral care. If, in the minds of appointers, religious care is considered to be the most important, those who appoint and those who are appointed need to establish boundaries so that care may be appropriate to patient needs. Ethicists, Baggini and Fosl, with whom I agree, claim that appropriateness in care is found in: ‘acknowledging and respecting human freedom and taking responsibility for who and what one is’; this in turn may be claimed as authentic behaviour (2007, p.163).

Spiritual care, an exploration of circumstances with a view to discovering meaning, requires close attention by the care provider to his/her presence in the encounter. Not only is it important that the care provider be deeply engaged, it is also important that any development of Spirit Presence in the encounter be grounded in the recipient’s searching and not in the agenda of the provider. “Pastoral care grounded in our Christian faith” needs to be re-articulated in such a way that recognition of Spirit Presence becomes an emerging awareness from the receiver. John Macquarrie (1968) writes in Martin Heidegger, ‘An authentic solicitude for the other helps him to his freedom and to his known unique possibilities for selfhood’ (p.18). Presence and presence may be discerned in this line from Macquarrie, and the type of encounter described, claimed as authentic.

Although articulated differently by (B), (C) and (D), there is in each response, recognition of the significance of presence as an expression of pastoral care. “Supportive engaging of meaning making – reflect God’s love in the context of
relationship and mutual engagement – empathic listener (C), chaplain walk with the client.”(D). The question that needs to be asked, however, is whether the person engaging in pastoral care has the same understanding. The responses from the chaplains (e.g. C17 and C40) reveal some misunderstandings of presence. Journeys to wholeness (C), and engagement with meaning-making (B), require an investment of time and energy. Whatever wording is used, understanding the role and carrying it out is what ultimately becomes most important.

Swinton and Mowatt, in researching what chaplains do, found within the general framework of change in religious life and practice in Scotland, that:

with the general cultural movement away from religion narrowly defined, to a more generic understanding of ‘spirituality’, understood as a diverse human universal, there has emerged a redefinition of the spiritual positioning of chaplaincy (2006, p.164).

A similar cultural movement can be recognized in Australia, but among those whom we see here endeavouring to establish an acceptable meaning for chaplaincy, there are still strong links with the traditional positioning of chaplaincy as being concerned with religious care. Nevertheless, in religious care, there is also the necessity for presence and focused listening in order to follow the needs voiced by the patient. The difference is that, despite similar methods of engaging with the patient, religious needs will be established and addressed. Religious requirements will frequently shape the encounter.

Spiritual care, defined elsewhere in this thesis, (pp.13-16) requires a presence that can be sustained, along with a clear recognition that religion, as understood by the church, needs at times, to be placed to one side. Spiritual care requires a more open, broader ranging approach, so that any engagement with spiritual care from those who appoint and from those appointed, will require continuing reconsideration of the nature of care. All will also need to come to terms with the fact that a most important difficulty is the limited time that volunteers can offer; sometimes as little as three hours a
week. Long term presence however, is most difficult within limited time frames. Sharing visits, as claimed by C40 is not helpful in the provision of ongoing focused care. Spiritual care cannot happen in such a scenario. The difficulties associated with short term, part time volunteers need attention and monitoring.

2. What are your church’s criteria for the practice of chaplaincy?

A. Balanced person. At least certificate standard of training in pastoral care. Either

   • Ecumenical Hospital Ministry and Pastoral Care Course. [HMPCC]
   • Academy for Chaplaincy and Community Ministries
   • Two Clinical Pastoral Education course units.

B. If criteria means ‘minimum requirements’ for being employed (including volunteers) as a chaplain then the criteria for the UCA, at the time of writing would be the HMPCC or equivalent. However, the UCA is in the process of re-developing its approach to Chaplaincy Education together with the development of competencies for chaplaincy in line with the [church’s] regulations around the Ministry of Pastor. Therefore, the criteria that currently exist will be replaced within the next six months. If something else is meant by criteria then I would need to understand what else the question might seek.

C. Appropriate qualifications as firstly required by Queensland Health and then spiritually, theologically and appropriate training for its practice.

D. The church criteria (in relation to being involved in a form of chaplaincy) In denominational chaplaincy

   1. Freedom to be able to do ministry where the chaplain sees fit (acknowledging that the chaplain is aware of his role as part of a team of professionals and so working in with the team).

   2. The chaplain has a role description.

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20 Ministry of Pastor is the designation in the Uniting Church, for those who have not been fully trained, but fill the role of minister with some limitations on the role.

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3. The chaplain has a supervisor where the chaplaincy is to take place.
4. The church would like some form of memorandum of understanding between the chaplaincy and the place where the chaplaincy is to take place.

**Analysis and Comment.**

One primary criterion, even if unstated, is that the appointee be connected to the church; words such as “Ministry of pastor – theological – ministry” are all church words. This is, of course, eminently understandable given that churches are appointing people on their behalf. Church appointments are normally made to further the aims of the church. In the Uniting Church, for example, the “Basis of Union” makes clear what that church’s aims are. One brief statement reads: ‘to hear anew the commission of the risen Lord to make disciples of all nations, and daily seek to obey his will’ (1980, p.6). Such statements will be found in all major denominations.

In the matter of pastoral care, however, and particularly in relation to spiritual care, appointers need to take account of the ramifications of such care, particularly in hospitals which expect that pastoral care is for all; a hospital is not the place to further the aims of the church. The needs of patients in hospitals are more akin to a search for meaning than they are to receiving comforting words and a blessing. The model of care being researched in this thesis acknowledges value in comforting words and blessings but considers spiritual care a more helpful process within the holistic framework of patient care. It follows therefore, as stated elsewhere, that the church needs to step back from historic claims and re-articulate its expectations more broadly.

The second criterion is qualification and maturity. Specific reference is made by three appointers to a variety of training courses. Reference is also made to the Queensland Health handbook which establishes a framework for pastoral care within Queensland Health facilities. This framework, along with well
established matters of pastoral care team involvement and care provided to patients, families, and staff, provides for liaison with clinical staff, contribution to quality improvement, and maintenance of a safe environment. The aim is for the chaplain to be incorporated in a holistic environment of care. The matter of maturity will be discussed at length in response to question 3. (D) writes of “denominational chaplaincy” and lists some criteria for its practice. There is no specific mention of training so perhaps that needs to be assumed. If, however, there is an assumption that “chaplains” are visiting only those within their own denomination, there may be an implication that any training provided will be church based. “Freedom to be able to do ministry where the chaplain sees fit” is vague and appears to say that the choice may include a number of hospitals, or perhaps locations within a hospital. It may not extend to “doing ministry” among those who are of a different denomination or faith. A “role description” may clarify this. If the “chaplain” is to move across hospitals, the matter of supervision, as stated, also needs clarification, as would any “memorandum of understanding”. There are limits to denominational chaplaincy, given a close faith relationship between members of the same denomination, and probably expectations of religious care.

Unclear expectations of, and by chaplains of the task, along with the assumption that chaplaincy is a work of the church, has the potential to raise difficulties within the workplace. It is reasonable to accept that appointing churches would expect those whom they appoint to take a specific interest in members of that church. The result could be ambivalence in the provision of care to other faiths and to those who claim no faith. The preferred structure for chaplaincy established by Queensland Health makes clear its expectation of chaplains through a number of role descriptions. A portion of one role description reads: ‘In recognition of the need for holistic health care, Pastoral Carers/Chaplains provide pastoral care/chaplaincy and spiritual and emotional support to patients, families, friends and staff’ (Framework for
Pastoral Carers, 2008/2009, p.4). This supports my own description of pastoral care, and is in marked contrast to the aims of the church and the desire to “make disciples.” It is interesting to note that in the appointers’ responses the criteria do not include anything of the task.

This framework for the work of chaplaincy is a most important change to the way chaplains need to work within the healthcare system. It involves both chaplains and appointers acknowledging that, as Swinton et al discovered in their own health care context, there was: ‘a movement from being a specifically religious carer to being a deliverer of spiritual care’ (2006, p.162), so in the religious culture from which chaplains are appointed in this country, some changes need to be acknowledged and acted on. Care of patients in hospitals is considered by both state and church to be important. Consultation therefore, between these bodies needs to occur in order to reach some agreement about the value of chaplaincy as it is currently formulated. Understanding and developing its potential, in the provision of holistic care will only occur when it is adequately articulated.

A chaplaincy culture in which chaplains are appointed by, and in some instances paid for, by churches, limits any chance of change. A two tier system in which we find many volunteers, and some paid clergy, exacerbates the limitation. Change will only occur as providers work closely with chaplains and hospital management, in studying the situation, in continuously upgrading training, and in seeking more specific state support.

Hospital requirements for holistic care, include professionalism from all those involved with patients, and commitment to spiritual care. When chaplaincy is seen by the churches to be a ‘work of the church,’ one important implication for spiritual care is that it be framed within church parameters. If however, we agree, as I do, with Speck’s (2004, p.21) articulation of spiritual care as depending ‘on the patient and the care giver being willing to enter together
into the experience and explore without quite knowing where it will lead’, then we also must acknowledge its challenge for pastoral care givers and appointers, who may not have explored ultimate or existential issues in their own lives.

3. What qualities, qualifications, and experience do you look for in choosing one to engage in chaplaincy?

A. See Above.

B. Qualities: Compassionate, self aware, empathetic, generous, organized, self-starter, and others.

Qualifications. HMPCC or equivalent. Equivalence to date has been CPE units. Chaplaincy training through another denomination, pastoral care or pastoral counseling courses through other RTO’s, Aged Care Chaplaincy Course run by Blue Care. As identified above, we are looking to re-develop our approach to chaplaincy education and will appropriately review this expectation in line with the new approach.

Experience: we have people engage with chaplaincy from a very wide variety of backgrounds and experiences. There are no set experiences that we look for. However, we do believe a variety of life experiences are valuable.

C. See pages 4-11 in ‘A Framework for Integration of Pastoral Carers and Chaplains in Queensland Health Facilities.’

D. 1. Faithful worship life
   2. Involvement in the daily life of the church
   3. Long term study of the bible
   4. A past experience of caring for people.
   5. Maturity of faith.
   6. A willingness to do some professional study

Analysis and Comment
(B) outlines courses that have been the mainstay of chaplains’ preparation but also refers to changes ‘as we are looking to re-develop our approach to chaplaincy.” (D) also makes reference to “some professional study.”

With regard to qualities, respondent (D) lists, among the qualities needed by those who would engage in chaplaincy, the importance of faith maturity. Faith is defined in Webster’s new 20th century Dictionary, (p.630) as assent; as agreeing to a particular formulation of ideas from an individual or a group. One such group, the one pertinent to this response, is the church. In this context, the Shorter Oxford Dictionary, (p.720) says of faith, ‘Belief in the truths of religion as contained in Holy Scripture or in the teaching of the church’. Acknowledging this as a description of faith, however, raises further questions about the nature of truth and the teaching of the church. In the definition, faith is also associated with conviction, and I would therefore describe faith in terms of an inner conviction of the validity of that to which assent has been given. An additional difficulty within churches and among chaplains is the considerable variety of convictions. This is evidenced in the responses of the interviewees, and also in the plethora of church denominations.

The reference referred to in (C) outlines the role of the chaplain in a number of categories. These categories include Duties, Knowledge, Accountability, Skills and Abilities, along with a number of core values. The list includes compassion, empathy, flexibility, tact, discretion, integrity, and respect. (A) and (B) write of the importance of being “a balanced person, of self-awareness, being empathic, organized, and a self-starter.” All of these answers from our respondents point to a need for general maturity. Two meanings of maturity are of relevance in the consideration of who may take on a chaplaincy task. In the first instance, it refers to adulthood, and it should go without saying that this is of primary concern. (B)’s reference to life experiences reinforces adult maturity.
The second rendering, however, is more closely allied with faith maturity. This rendering enfolds wisdom in which we may discern experience, reliability and responsibility. Wisdom, however, is much more than this. It carries in its meaning, ‘soundness of judgement: sound sense: wise thing to do: dignity: respect: wise discourse: (Shorter Oxford Dictionary, p.2557). If this kind of maturity is expected of those desiring to take on a chaplaincy appointment, it may become too hard. If, however, there is discerned among those responding to a call to chaplaincy at least some of these qualities, it may, at least in the beginning, be deemed sufficient.

That which establishes an appropriate framework for faith is found in maturity, expressed in wisdom, and in self-awareness, and it is in these that we may contextualize an appropriate attitude to, and expression of pastoral care. (D) links faith maturity closely to the church. “Involvement in the daily life of the church, long term study of the bible, faithful worship life”, are all recognized as integral to faith maturity. It may be said, however, that while faith can be acknowledged as having clear links, (in this context), to the Christian religion and more particularly to specific church doctrines and rituals, attachment of maturity to that faith may be questionable. Maturity of faith could also be that which marks out the believer as being secure in his/her belief while at the same time being open to dialogue with others, not for conversion but for understanding. In the chaplain profiles, (C7) desires her faith to remain sound, and acknowledges limited experience with people of other faiths but seeks to understand others; “I think we can actually learn from others”. (C6) expresses a conviction that “difference is acceptable and indeed fits naturally into the being of God.”

Maturity of faith therefore would suggest that the one providing care is able to interact with those outside a Christian standpoint in such a way as to support appropriately the need being expressed; presence being critical in the
encounter. Recognizing Van Katwyk’s (2002, p. 119) claim that: ‘Spiritual care embraces multiple spiritualities and bridges diverse theological worlds’, and that ‘Spiritual care is universal in scope’, requires that faith be exercised maturely and with discernment. The matter of training is most important in this regard. It is incumbent on providers therefore, to ensure not only adequate initial training, but ongoing resourcing that will allow chaplains to distinguish between religious and spiritual care, and to apply this with discernment.

**Encountering difficulties**

4. **Describe some of the difficulties that you are aware of in the practice of chaplaincy?**

A. Lack of funding

B. Internally: From a big picture viewpoint, adequately resourcing chaplaincy contexts with adequately trained and gifted people to offer quality pastoral care is a huge difficulty. This then extends to the provision of appropriate in-service training and opportunities to continue to develop skills. Financial issues, and the need to appropriately resource the ministry is also a burden. This has flow-on effects in all areas of Chaplaincy, but most particularly in the exploration of new and emerging Chaplaincy contexts.

Externally: Some of the contexts in which Chaplains work are less than encouraging of the role of Chaplains and this provides particular difficulties. The image/understanding of Chaplaincy, and therefore the expectations of the role, can provide difficulties. Legal frameworks such as Privacy Legislation can provide difficulties depending on interpretation. The multi-faith context in which Chaplains operate can cause difficulty, particularly for those without experience in multi-faith contexts.


D. 1. Perception of relevance.
    2. Perception of professionalism of chaplaincy by others.
    3. People’s own religious beliefs and feelings. Not just
clients but staff as well.

4. Where does the chaplain fit into the health team and who has authority of them.

5. Trust of chaplains and the problems they can cause clients in stability and peace.

Analysis and Comment

While funding is the consistent and prioritized problem, this is quickly overshadowed by difficulties associated with choosing, training, and equipping people for the task of chaplaincy. Lack of funding, on the surface, appears for (A) to be the most pressing difficulty which may never be solved adequately. One wonders however, whether this is the only difficulty for (A). Clearly it is not, for his responses to question 1 raise difficulties about inconsistency in naming and describing those who undertake pastoral care. The question posed here, however, seeks commentary on matters which may pose greater problems than lack of funding.

The care models canvassed in the Literature Review in which I consider pastoral care as a generic term, reveal difficulties in the practice of chaplaincy. Not least of these is the choice that needs to be made between religious and spiritual care. This is related to awareness and may be discerned in attitudes to story and understanding of presence, and also the Presence of God, as markers of authenticity.

Respondent (B) considers the difficulties from two perspectives which he labels internal and external. In the first instance, he focuses on appropriate choosing; “resourcing chaplaincy contexts with adequately trained and gifted people to offer quality pastoral care is a huge difficulty.” Right choice is of primary importance; it establishes the standard upon which all else depends. As stated early in this chapter, appointers work within the church structure, of which, they are a part. Because the people they choose need, at least in the eyes of the church, to reflect the beliefs and values of their church, there is a
risk that those appointed will be more likely to engage in religious care than spiritual care. Much therefore depends on the appointers’ willingness to stand aside a little from what might be deemed ill considered restraints based on an overly zealous attachment to the “mission” of the church.

In the re-articulation of pastoral care this is a major obstacle, particularly if seen in the church as counter to the church’s expectation of those in chaplaincy on its behalf. My model, seeking as it does, to implement within the pastoral care umbrella, a process of discernment among those engaging in pastoral care, requires an understanding of when religious and spiritual care are appropriate. Always it is important for providers to remember that hospitals have requirements that must be met if chaplains are to be recognized as team members in the provision of holistic care. If this happens, my model will be more clearly facilitated. My goal in re-articulating “pastoral care” is that spiritual care will be claimed by appointers and chaplains alike, to be the way in which patients and hospitals will be most served in their search for meaning in trying circumstances.

As (B) tells it, funding has “flow on effects” that impact on a variety of situations in which chaplains may find themselves. It raises difficulties for the provision of resources but “some of the contexts in which chaplains work are less than helpful.” This emerges in some responses from chaplains who wrote of not being valued. (B), through his comments on “contexts” raises questions of understanding, of expectations, and of the difficulties relating to privacy legislation. Along with these he makes clear that difficulties emerge as chaplains without much experience seek to work in multi-faith contexts. There will always be difficulties; the important thing is to minimize these through a thorough training programme that continues throughout the appointment, in the ongoing provision of resources for personal development. Respondent (D) mirrors many of the concerns of (B) in his comments on relevance, professionalism and the mix of religious beliefs of all associated with
chaplaincy along with his questions of the chaplain’s place in the health team. (C)’s “recruitment of suitable persons” is also about right choice. The key, an important component in my model, is discernment by all parties that the primary common factor must be the person in need, irrespective of particular religious beliefs.

Clearly, making a right choice for the task of chaplaincy is difficult. Right choice requires criteria that are realistic, but also reflect the importance of the task. The appointers’ criteria for choice are revealed in their answers to the previous two questions. My discussion (pp. 62-65), following the chaplain’s answers in Chapter three, highlights matters of belief, reasons proffered by some desiring to be chaplains, and variability in chaplains’ understanding of chaplaincy, with in some cases the possible intrusion of personal beliefs. It was also recognized that as well as needing to express their faith, some declared a need for affirmation of their value to offset any isolation and loneliness. All of these contribute strongly to the importance of wise choosing. Respondent (B) presents a significant number of problems associated with chaplaincy. The responses suggest some despondency, but also make visible the complexities in chaplaincy appointing.

(D) in his comment “trust of chaplain”, and further of “the problems they can cause clients” focuses some of the comments made above. If trust is to be established and maintained, the expectation of the appointer needs to match the expectation of the appointee. This is more likely to occur if role descriptions are clear and acceptable to all. Clear guidelines are also needed in the choosing process. The problems chaplains may cause are not specified. They could be an outcome of belief, and seeking to provide religious care rather than a more open venture into spiritual care. Problems may arise if the chaplain appears as an evangelist, or attempts to solve problems with prayer and scripture. Some may seek to minimize the difficulty, assuring the patient that God is in charge. (D)’s comments add to the
complexity of chaplaincy, and point up the necessity of adequate training which includes understanding the nature of people.

My model of pastoral care contends that the complexities may be more adequately addressed if appointments became a collegial matter rather than following the current practice of individual attachment to particular churches. All of the complexities may be exacerbated by the primary assumption, already addressed, that chaplains represent the church, and are to reflect God’s love. Re-articulating pastoral care, so as to engage more with spiritual care will help to clarify some of the matters raised above. This model allows for religious care, indeed recognizes its value, but is not driven by it. Collegial appointing will need to re-articulate the expectations to be placed on chaplains, and conclude that engaging in spiritual care will be more beneficial to all who are the receivers of care. I would expect that appointers also will recognize benefits in sharing pastoral care.

Some other matters in the responses, other than funding, are also important. One of these concerns the image that others have of chaplaincy. In this regard we may note that one USA study for example, by Flannelly et al, concluded:

> Overall, it appears that chaplains are seen as being principally devoted to the care of individual patients, family members and to a lesser degree staff, but they are not seen as major players in supporting some of the broader goals of the institution itself' (2006, p.223).

If the pastoral visitor only offers religious care then this matter of relevance becomes important. Relevance and image go together. Consideration, in the institution, of the chaplain’s task as irrelevant, because chaplains are perceived to do little more than provide prayer and consolation, and attaching this to short visits and lack of engagement as appears to be the case in C24’s answer (p.79) diminishes chaplaincy. Institutions dealing in public health have an expectation that all those so engaged will exhibit a degree of
professionalism. This will be taken up again in the responses to further questions.

If course fees are considered too high and time commitment too great, (C) chaplaincy will decline and revert to people of goodwill visiting church people. Clearly there needs to be a re-articulation of chaplaincy if such matters of concern as cost and time commitment are to be considered adequately. Some of this can be alleviated through cost sharing. Cost is less of a factor when some passion for the task is in evidence; similarly with time commitment. If the task is considered important enough, time must be taken in the equipping of one for the task. The further commitment to the carrying out of the task is a matter of mutual negotiation and agreement. Effective training, however, is essential.

In summary, the difficulties that the respondents have raised, apart from funding, reflect the importance of relevance (D), visible at times in the perceptions of hospital staff, making the right choice in deciding who may be an appropriate appointee, and the challenges that need to be faced in multi-faith situations. This challenge, however, is not only for chaplains; it is also a challenge for appointers. Other difficulties include the challenge of church attitudes and the attitudes of chaplains themselves.

5. How is chaplaincy funded?
A. By the church, mainly though seeking donations and fees for speaking at conferences
B. Currently a mix between wider church funding (approximately $1.1m) and local organization funding. The wider church funds Tertiary Chaplaincy, Public Health Chaplaincy, Tourism Chaplaincy, and some Prison Chaplaincy. Local funding is provided by the organizations in which Chaplains exercise their ministry, for example; Blue Care, Uniting Care Health, Queensland Police Service, Mission Australia etc.
C. Diocesan funding for full time chaplains only. Very occasionally a part-time chaplain may be funded a few hours.

D. Through church appeals and donations from groups within the church and through the church’s community ministry.

Analysis and Comment

Funding emerges as a major difficulty for at least three of the churches, in the resourcing of chaplaincy. Church appeals and donations are clearly inadequate in seeking to sustain any regular payments to those engaging on behalf of their church, in pastoral care. Hence the considerable use of volunteers. The inability of churches to incorporate chaplaincy as a regular budget item may also be a comment on the worth attached to chaplains’ activities. The comment from (C28) (Thesis p.136) in her interview “It was said I was too good as a parish minister to be wasted in hospital chaplaincy”, and the comment from (C17) (Thesis p. 130-131) about the viewpoint of some ministers towards chaplaincy as mission, could be seen as a reinforcement of this attitude in the church towards chaplaincy.

Organizationally, most churches have financial worries. A perceived need to grow, or be recognized as failing, requires a commitment of funding to a variety of developments. One of the difficulties that beset churches is their propensity to extol projects as evidence of growth and commitment. Projects, however beneficial, are by definition limited in time and scope. Projects are finite and measurable by results. In church life, experience shows that people will give to specific, finite projects, but are less likely to commit to something which is not finite but ongoing, not specific but indefinite, and at times vague.

Difficulty in finding adequate funding therefore may require an answer to a prior question about the value of chaplaincy and its usefulness to the church. One respondent is able to claim a considerable budget, but maintaining this is only possible through levies on the hospitals that this particular church owns.
Failure to fund adequately means a greater use of unpaid workers, and this presents us with serious difficulties such as limits on time, adequate training, supervision; all of which appear in answers to other questions.

Professionalism and Training
6. *Are chaplains expected to be professional in their approach to chaplaincy? How might this be assessed?*

A. Yes.
Providing chaplains with a position description; meeting with the team a few times a year; encouraging ongoing development through attending workshops and conferences.

B. Yes professionalism is expected.
As we develop competencies for Chaplaincy we will begin to develop review tools based on those competencies to ensure that chaplains are operating at an appropriate level across a number of different areas of skill, knowledge and behaviours.

C. Yes.
Hence the training and qualifications. Assessment difficult. Ongoing training essential – in-service programmes.

D. Yes.
Probationary periods; annual reviews; reports to supervisor.

Analysis and Comment.
The matter of professionalism is a vexed question, as evidenced in the responses of chaplains to a similar question. Chaplains had a mixed response to the question of whether they considered themselves professional, but were willing to say what they considered to be unprofessional behaviour (pp.68-69). To the question as it is posed here, all the respondents agree with a resounding yes, that chaplaincy should be done in a professional manner by people who have been trained. One, however,
indicates in answering a further question, that chaplaincy has “become too professional.”

The process of assessment of the professional competency expected of chaplains, however, varies considerably. The provision of a “position description” (A) may set out requirements, but monitoring those can be quite difficult. Meeting with the team may be helpful, but how rigorous might this process be without upsetting faithful chaplains. Assessment of competency needs more than encouragement and more than occasional meetings. Developing competencies and review tools based on those competencies (B) suggest collaboration between appointer and appointees. Competencies in chaplaincy will emerge more adequately from an action/reflection process through which competence may be monitored and subsequently improved.

Adequate supervision and mentoring are important for the proper development of these tools. This is in marked difference to (D) who writes of probationary periods and annual reviews and reports to a supervisor. The implication of such requirements is that they have been established by those in authority with an expectation that they will be undertaken. While they are important in the professionalism of chaplaincy, they could appear as an imposition rather than an acceptable and valued response to a chosen vocation.

Differences in the processes offered as methods of monitoring and assessing, are not conducive to sound practice. Perhaps assessment needs to be written into articles of appointment. In signing a covenant there could be recognition: a) that the one providing care will do it well, and be prepared to engage in ongoing checks, and b) that those doing the appointing will do all they can to resource their ‘chaplains’ in all possible and relevant ways. A difficulty in all the responses offered is that they are non-specific. They do not attend to any detail. (A, C, D) all offer generalities, but do not manage to engage with, or
offer examples of better practice. (B) proffers some specific action, but continues with more generalities. This suggests that he is still engaged in endeavouring to establish the nature of the action to be undertaken.

Assessment of professionalism requires a concentrated effort to delineate the processes by which adequate assessment can be made. Professionalism is a way of acting within a chosen task. It requires a code of behaviour that can be both clearly seen, and adequately measured. Best practice needs to be established and then sustained. This is a matter that providers could best establish by acting in concert. Best practice is required by hospitals but can only be established in the arena of pastoral care through the collaboration of churches. It is indeed essential if those engaging in pastoral care are to become providers of spiritual care.

Monitoring and assessment are necessary if chaplaincy is to be recognized as important and valid within the hospital in which chaplains are placed. All others who work in hospitals face regular assessment; why not chaplains? There is a clear need for both appointers and appointed to agree to some monitoring process. Until recent times there was no professional body specifically for chaplains. Such a body has now been established. One way therefore of developing professionalism in chaplaincy could be a requirement by providers that all chaplains take up membership within their own professional association.

Ongoing training, however, needs to be carefully structured to be of value for the work being undertaken. A considerable difficulty in establishing any training programme, is ensuring that chaplains attend. Volunteers, in particular, cannot be coerced into attending. Probationary periods could be helpful, but annual reviews would need to be rigorous, as would reviews of the probationers. Encouraging ongoing development needs to be matched with appropriate financial help. Failure of chaplains to attend could be due to
a number of factors such as cost, appropriateness of venue, distance. It could also be construed as a lack of professionalism. It is not an easy matter to solve.

Establishing a covenental relationship between appointer and appointee, more likely with (B) than with (D), will recognize the need for ongoing assessment, and make clear what that entails, and how that will be accomplished. In a covenant there is possibility for both appointer and appointee to express their desires and expectations, and reach towards some mutual agreement on their understanding of the chaplaincy task.

What is not said in these responses is the desire of chaplains themselves. The pastoral carer who truly understands the importance of adequacy, and indeed, authenticity in the practice of pastoral care will work towards competence in all aspects of his/her work. Elsewhere in this thesis (p.69), Bay and Ivy are cited, claiming the importance of professional competency in chaplaincy practice: ‘[…] research requires clearly articulated professional research focused on ministerial effectiveness. […] When competency is a major professional statement, then proof of that competence is required’ (2006, p.343). Professionalism requires continuing upgrading of skills in order to develop competence, but even more than this, it requires a passion for a task that is both difficult and rewarding.

7. Are there specific requirements for training? Can you enumerate these?
A. Nil Answer
B. See above re. Criteria. The movement we are engaged in currently is toward a Cert. IV in Pastoral care which will provide a well rounded approach to Chaplaincy education. The Cert. IV will provide core units in developing skills for pastoral care as well as self-reflective tools, and then elective units will allow the person to focus on their particular context and develop specific skills and knowledge in those areas.
C. See page 8 (Qld. Health Handbook) under other requirements. 1-4.

D. Yes.

A diploma to a theological degree, and above to Doctorate through the church’s education system. Clinical pastoral Education units, at least one; Wesley hospital chaplaincy training; mentoring.

Analysis and Comment
Schipani and Bueckert (2009) summing up the essays in their book on interfaith spiritual care, write of ‘professional wisdom’ (p.315). Growing in pastoral wisdom they claim requires spiritual care givers to participate in ‘circles of learning’ the essential elements of which are knowing, being, and learning (pp.315-319). In what way might it be considered, therefore, that the responses to the question embrace knowing, being and learning?

Training could be recognized as participation in ‘circles of learning’. It has already been noted in this thesis that training is an ongoing process through supervision, seminars, conferences and the like. Each of these could be called a ‘circle of learning’, and in each could be found elements of ‘knowing, being, and learning’

(C) refers to the Queensland Health handbook (p.8) which states,

a. Must be nominated by […] own denomination.

b. Must possess a suitability card […].

c. Must have completed training appropriate for this position.

[Examples of programmes, all of which have been referred to a number of times in this thesis, are presented.]

d. Must have completed appropriate Queensland Health induction.

Of all these, only (C) refers to training but provides no details. Training courses listed include Clinical Pastoral Education (CPE) and the Ecumenical
Hospital Ministry and Pastoral Care Course, along with relevant (unspecified) experience (p.8). No doubt each has its own curriculum; (C) offers no preference.

(A) has chosen not to respond to this question although he comments elsewhere on processes that would assist the development of ‘circles of learning.’ The focus for training in (B)’s response is “Cert 4 in pastoral care” in which, he claims there will be skills training and “self-reflective skills” along with a variety of elective units. (D) adds to these courses with a desire for theological training. The range of this training is very broad and it appears that acceptable qualifications range from a diploma to a doctorate.

In each of the responses we may recognize outcomes of knowing and learning. Being, however is less visible. (B) writes of “self-reflective skills” and the development of these will open some understanding of being. Macquarrie, commenting on Heidegger’s work on being claims that people not only recognize themselves as such, but have an ‘understanding of what it means “to be”’ (p.6-7). “Self-reflection” therefore becomes an important element in training.

8. What are the requirements in chaplaincy for ongoing training and development? What programmes do you have to assist chaplains to meet those requirements?
   (This question is an extension of question 7. The aim of this question was to seek more detailed responses and seek out the ongoing support being provided.)
   
   A. See Above
   
   B. There is a standard expectation that all people in ministry positions in the church engage in CEM. [Continuing Education for Ministry]. This requirement exists for all chaplains. Until now, we have not monitored effectively people’s
engagement in ongoing education and training. Nor have we provided options for Chaplains to hone their skills or explore new learning. The Cert IV mentioned above will offer units that people can engage on a one-off basis in particular areas of interest or skill. We are hooked into the Network for Christian formation of which Pilgrim Learning Community is a part. As they continue to make courses available across the church, we will be highlighting opportunities for chaplains to engage.

C. Ongoing training essential. Each hospital chaplaincy department has its own programme of regular speakers, some monthly, some quarterly etc. D. Regular meetings of chaplains; encouragement to attend seminars etc.

Five scholarships a year they can apply for through the church

Analysis and Comment

There are a number of options for ongoing training on offer, according to these responses. One needs to ask however, what their value is and, more importantly, how they can be assessed. “Highlighting opportunities” (B) is insufficient for the meeting of requirements, and indeed, calls into question the strength of those requirements. Programmes such as in-service training using speakers, in hospital chaplaincy departments (C), may not serve all of those engaged in pastoral care in those hospitals. As we have discovered many volunteers have limited time available, and these times vary across the volunteer population. There will no doubt be some who cannot be present at a given time. There are also those who will not be present whatever the time. I can recall a male chaplain a few years ago saying “I’ve done the course, I don’t need any more.”

In-service training was considered by the respondents to be very important. None of the respondents, however, was able to be clear and direct in the responses. (A) simply says “see above”. In response to question 5 he wrote of meetings a few times a year and “encouraging ongoing development
through attending workshops and conferences”. (B) refers to expectations of ongoing involvement in his church’s Continuing Education for Ministry programme. He admits to some lack but claims opportunities are being explored and activated. (C) claims that ongoing training is essential, but seems content to find local hospital programmes adequate. (D) points to regular meetings with chaplains, encouragement to attend seminars and the like and makes some scholarships available. Only in (B)’s response do we find a specific church wide programme in which chaplains, whether paid or not are expected to participate. The difficulty with all responses lies in their individualistic and ad hoc approach. Varieties of requirements for ongoing development, particularly if they are denominationally based are not conducive to the integration of chaplains within their work situations. It needs to be recognized, however, that some churches place limitations on their chaplains, requiring that they visit within their own denomination. A number of denominations place strong emphasis on sacramental help. For those denominations, sacraments such as communion (Eucharist) are considered to be pathways to spiritual healing. They are not magical elements, but the attachment of the recipient to his/her faith is assisted, in the reception of the sacrament. This is clearly religious care, and just as clearly is most important for many recipients. Such care, however, can be restrictive, and if only undertaken in this way may leave some less cared for.

The reality is, however, that pastoral carers, whether volunteers or fully paid workers, are frequently required to work across church boundaries in a hospital setting. The Queensland Health handbook (2008/09) is clear that requirements for all engaging in pastoral care encompass a wider compass than religious care for one’s own denomination (pp.4-8). What is needed therefore, in order that all may function as satisfactorily as possible, is an integrated training programme for all. Such a programme needs trained teachers and an agreed syllabus which would include information about other
churches and information about other faiths. Such a programme has the potential to enhance professionalism in spiritual care. The model I am presenting would welcome such a move. This will provide equal opportunity, and also provide a standard benchmark by which all can be supervised. Supervision will be enhanced even further if supervisors are chosen on the basis of qualification and skill.

If chaplaincy is to be carried out professionally, training standards and requirements need to be clear. Both appointers and appointees should subscribe to a commitment to professionalism, and strive to ensure that the best possible care is provided. A basic standard training course such as Clinical Pastoral Education (CPE) can be enhanced by meetings, seminars, and department workshops. Clearly there will also be a need for consideration of the cost of quality in-service training. Quality resourcing will be recognized as important for those engaged in pastoral care. Continuing education raises the question, if one is an unpaid volunteer, who pays for the on-going learning?

9. Do you place a high value on theological training? How does such training make a difference in the work of chaplaincy?

A. Yes.
By providing a framework for imagining how God may be active in people’s lives in and through sickness/accident. Having clearly articulated understandings of theodicy, revelation, humanity, sin and grace.

B. Yes.
Theology of Pastoral Care is and will continue to be an important facet of the training that is offered. Our theology of pastoral care, of the human person, of sin and grace etc informs our practice of pastoral care. It shapes our worldview, and the way we engage in the worldview of others. It is vital that we engage in this dialectic through the training phase for all Chaplains

C. Yes.
A sound awareness of theology is essential. Theology brings an ‘understanding’ of God and what the two great commandments mean in practice – not just theoretical theology.

**D.** We would like it for all chaplains but realize that this is not possible.

1. Wider range of understanding
2. More willing to listen than to discuss one’s own theories.
3. More time for chaplains to analyze their own views against others and church.
4. Professionalism in all areas

Willingness to continue and learn.

**Analysis and Comment.**

The matter of theological education is important. It can open a pathway to understanding what one believes and how it may influence a pastoral encounter. The answers, however, expose even more questions around the process of pastoral care. Respondents (A,B,C), each in their own way, lay claim to theological training as a framework for understanding religious questions about the interaction between God and people. A) and (B) write of the importance of clearly articulated understandings of a variety of elements of doctrine, and both make reference to sin and grace which “shapes our world view and the way we engage in the world view of others.” (C) claims theological training as essential.

(C)’s claim that theology enables the receiver to understand that the practical application of “the two great commandments” implies that without such training understanding of these commandments is, at the very least, limited. Theology is normally defined in terms of “systematic study” which could be applied to (C)’s “theoretical theology”. In reality, the practical application of the “two great commandments” requires that firstly one should know what they

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21 Mark 12:29-31. Jesus answered, ‘The first is “hear, O Israel: the Lord our God, the Lord is One; you shall love the Lord your God with all your heart, and with all your soul, and with all your mind, and with all your strength.” The second is this, “You shall love your neighbour as yourself.” There is no other commandment greater than these.’

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are, and secondly subject them to reflection rather than systematic study. Respondent (D), below, has a more open approach which allows for reflection, and a “wider range of understanding”. The key to understanding lies in the word, love; the practice of love is fundamental to spiritual care. A world view shaped by sin and grace can have awkward outcomes if carried into a pastoral encounter. The theology of sin and grace posits a world in which all are naturally sinners, in opposition to God, but may attain forgiveness, salvation, and a renewed life simply by accepting these as gracious gifts from God. (A) and (B) are both reflecting doctrinal statements common to all churches. Engaging this with “the world view of others” runs the risk of engaging in argument rather than pastoral care. Doctrine strongly held is not conducive to spiritual care.

What might be taught in “theological training” will vary from denomination to denomination with implications for those engaged in pastoral care. It is recognized that there is a core Christian theology, and this core sustains the church. Within this broader theological framework there are differences, and it is these differences that make and sustain denominations. Theological training is largely an academic exercise, and in the main applies to those who have responded to a call to ministry and been accepted by the church for training. One who is to be considered as having an adequate theological understanding may be required to complete three years of study. Even after this time there is an implicit understanding that, having embarked on the process, theological education is an ongoing and continuous activity.

If theological training is to be, as (C) suggests, “essential”, what follows is that only those who have received this training can be chaplains, and this in turn implies that only those recognized by the church as ministers/priests, can fulfill the task. In chaplaincy, some would have undertaken formal theological study, some would have engaged in a course of religious studies, and some, as regular church attendees may have engaged with Bible study groups.
Whatever the level of study undertaken, it is most important that those engaging in chaplaincy should understand their own faith stance, as well as having an understanding of other denominations, and faiths. Understanding includes knowledge, and knowledge removes us from the emotion of a faith stance in which feeling predominates.

Respondent (D) offers a differing viewpoint. He agrees that theological training is important but is also realistic in acknowledging that it is not possible for all chaplains. From (D)'s response we may discern that while doctrine is important for a religious life, it is also important that understanding of one's faith convictions needs to be tempered with an understanding of a wider world. This world will become visible as we listen to others rather than discuss our own beliefs, and discover common aspects of humanity; acquiring wisdom.

(D) adds a dimension to theological training that allows for variations in theological understanding which do not need a strong adherence to doctrinal matters. He writes of chaplains being able to “analyze their own views against others and the church.” Theological training is specific in the first instance to the denomination providing the training. The tendency therefore is toward a narrowing of understanding. (D), however, claims rightly that chaplains need rather ‘a wider range of understanding.’ It is most important, however, that those engaging in chaplaincy should understand their own faith stance, as well as having an understanding of other denominations, and faiths. As (D) says, there needs to be a “willingness to continue and learn.”

Our focus throughout the thesis has been on chaplaincy staffed by Christians. The belief stance of those Christians, however, is for each within a particular theological framework; it should not be considered to be encompassing all. Belief is nurtured and developed through study and experience within a denominational framework. The uncertain nature of belief, first noticed in the
chaplains’ responses and now emerging here, is apparent in the recognition of denominational differences, and religious differences within denominations. There is no definitive foundation that includes all, nor is there common agreement on the validity of faiths outside Christianity.

It becomes an urgent problem when theological understanding, at times exacerbating divisions within the church, can not, or will not allow for understanding and acceptance of other faiths. A strong personal faith stance may intensify an exclusivist attitude towards others. The choosing of one to be a chaplain can become fraught with difficulty. (D), (pp. 182-183) raises this matter, and it is considered more widely in analysis (pp.183-184). Much needs to be considered in the placing of a chaplain within a health care facility, including matters of privacy, of respect, of professionalism, and of the primary ethic of causing no harm.

David Coulter, writes in his foreword to Critical Reflections on Stanley Hauerwas’ Theology of Disability, edited by John Swinton, of his own experiences in working with children who were different. He writes of looking three times at the individual. The ‘first was a recognition of the other person as an individual human being’. The second was to see the other person as ‘an individual person like myself.’ The words he uses can be applied to the differences we recognize in chaplaincy tasks. He writes: ‘I came to realize that what we were sharing was our spirituality and that this did not depend on age, race, sex, wealth or ability. Indeed the “third look” is to see in each other the ground of all being and existence, the transcendence of divinity that informs our spirituality’ (2004, p.xv).

Theological training, as it is presented in the answers to this question has its home in the church and more particularly in a denomination. It is not generally oriented to any comprehensive engagement with religious difference.
Theological training which takes a third look will enable us to consider the value, and validity of others in their faith.

In all the responses, only (D) may be considered as taking a third look. “Sin and Grace”, theology as essential, imagining how God may be active in people’s lives, all establish a focus on acknowledging systems of belief that are handed down. As they stand they present a direction for belief. (D), however, moves beyond this, anticipating a wider range of understanding for chaplains and a determination that listening in a pastoral encounter takes precedence over discussion of one’s own theories and beliefs. These need to be considered but not in any way that may be considered a simple acceptance.

10. What steps have you set in place for the supervision of chaplains?

A. Chaplains are able to claim up to $500 per annum for expenses (including supervision) associated with the provision of pastoral care.

B. If by supervision you mean professional supervision, there is an expectation that all Chaplains will engage with a professional supervisor, and exploring that practice is part of any review process. If lines of accountability are meant by supervision, Chaplains work within multiple accountabilities. They are accountable to the Commission for their professional Chaplaincy conduct, they are responsible to their Presbytery for their ministry and mission and discipline (if ministry agents) and they are responsible to their organization for internal standards, policies and reporting.

C. Regular meetings with me as coordinator and regular interactions within each hospital with that hospital’s chaplaincy team coordinator.

D. Regular meetings; reports from chaplains; visitation by chaplaincy coordinator.

Analysis and Comment.
There is general agreement that supervision is important. There is, however, considerable difference in the way this is approached. This ranges from an expectation that chaplains will engage with a professional supervisor to meetings with the coordinator, group supervision within the chaplaincy team, reports, and visits by the coordinator. Being aware, however, that some money can be made available may not greatly encourage chaplains to participate in supervision sessions.

If chaplains are resistant to anyone “looking over their shoulder” supervision becomes difficult. One way of overcoming this difficulty is through a role description in which expectations and responsibilities are established with each appointee being required to sign.  

The Queensland Health booklet states, under a general heading of the duties of a chaplain, that those engaging in the work of pastoral carer or chaplain, must participate ‘in all in-service and supervision sessions arranged for the pastoral care/chaplaincy team/department’ (p.4). There clearly needs to be an understanding between providers and those who are appointed, that this will be undertaken by all on a regular basis. ‘Where circumstances prevent hiring paid staff, volunteers will respond effectively if the mission is compelling, standards are kept high, and accountability is assured through the guidance of a well trained supervisor’ (HCCVI Guidelines 2009, p.15).

Estadt et al, (1987) write of supervision in counseling. What they have to say however, is also pertinent for all, whether chaplains or appointers, engaging in pastoral care. They speak of supervision as a primary catalyst in the acquisition of knowledge and counseling [pastoral care] skills; the ability to facilitate personal growth and developing one’s personal understanding of counseling [pastoral care] (p.7).

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22 Note the report on Guidelines for Pastoral Care Volunteers (HCCVI, 2009. p.21-27) www.hccvi.org.au

23 This could be understood as the task, or assignment.
Requiring practitioners to have regular supervision can fall down on two counts. The first is quite simply, avoidance from the chaplain. Forgetting, not arriving for an appointment, can minimize the number of already limited contacts. The second happens when the appointer, desiring to maintain a chaplaincy presence, be it full or part-time, does not follow through any stated requirements for supervision. If, however, supervision can be recognized for its value as a resourcing and training medium, such valuing will encourage all to make the most of this resource. Any failure of practitioners and providers, however, calls into question the professionalism of all. Professionalism is required of clinical staff within hospitals. The chaplain who aspires to recognition and acceptance in the hospital culture will need to accept the discipline of supervision.

Another of the difficulties for supervision is that many who engage in chaplaincy consider their faith to be more than adequate for the task. As one chaplain respondent stated, “I take the Holy Spirit with me”, with the implication that nothing more was necessary. This, however, is clearly an inadequate way of undertaking a pastoral encounter, but without proper supervision the inadequacy will not be addressed. Despite difficulties, supervision is necessary, and as it is considered to be important, it would be helpful if all appointers could together agree on a common strategy. Good supervision, undertaken by all, will ensure understanding of the differences between religious and spiritual care, and the need to honour both as important.

Multi-faith Encounters

11. Do you have a strategy for assisting chaplains under your jurisdiction to minister in multi-faith situations?

A. No strategy per se. However, the academy students address this in their studies. As well I have spoken at workshops across several metropolitan
hospitals re. ministering in multi-faith situations. Papers are available on the Centacare website on the issue.

B. One of the significant aspects of the new Cert IV in Pastoral care has been ensuring that there is opportunity to engage with the multi-faith context, and explore what is means to work as a chaplain within it.

C. This is a de facto part/requisite before appointment and forms part of their training programme.

D. Yes.

Analysis and Comment.
None of the providers of pastoral care workers could clearly articulate a strategy for assisting their workers. There was certainly some awareness about possible ramifications in addressing multi-faith concerns, and some attempt to address the issue, either through incorporating some aspects in training or in workshop discussions. Given that in large public hospitals there is a considerable possibility that a care giver will encounter someone from another faith, it seems important that the church provide clear guidelines. As long as the church, however, appoints from within denominational structures, guidance in multi-faith matters will be mixed. Denominations exist in the church because of theological differences; expressing differences in belief, and in attitudes towards others.

“Exploring what it means to work as a chaplain” in a multi-faith context may be partly accomplished in a particular course or by listening to one speaking about other faiths. Understanding, and entering appropriately into a pastoral encounter, must still deal with the biases of one’s own belief. (D) answers yes to the question but leaves what the strategies might be to one’s imagination. From the answers to question 7 we may infer that regular meetings, reports, and visits by the coordinator might go part of the way in establishing strategies. Learning about multi-faith matters (C), may not be sufficient for an adequate pastoral encounter with one from a different faith perspective. The
reality is that learning about another faith is not sufficient for a genuine encounter.

Retracing our steps to the literature review (p.4) we can be reminded again by Fukuyama (2004) that entering into a multifaith interaction requires a degree of unlearning. ‘[…] truly valuing differences and taking risks to build alliances, are formidable and painful tasks’ (p.31). It is most important therefore that chaplains be adequately resourced for the task.

Validating difference, as it is found in the beliefs of those whose faith stance is at odds with Christian tradition, is a major difficulty for the church and therefore for those who appoint chaplains from within an established church structure. It becomes a major problem finally for chaplains themselves, who having come as a church appointee carrying their own faith in which they have been nurtured. This is to be expected and should not be decried. The problem, however, needs to be addressed. Within the Christian church itself there is dissension about the nature of belief; how much more difficult is it therefore to have to come to terms with a completely foreign faith stance?

There is an added difficulty, not clear in the answers; that of the standpoint of appointers to interfaith matters. Committees of Appointment are made up of denominational members who will naturally reflect the denomination’s faith standpoint. All of this will become problematic if there is no sense of the importance of validation of another’s faith.

12. How might you assist chaplains to adequately deal with multi-faith difficulties?

A. Chaplains do, at times pick up the phone and call me to talk through issues (whether multi-faith or other) that they confront in their work.

B. I am closely connected with the Synod Inter-faith relations committee, and seek their support and wisdom as well as seeking to make resources
available as they come to hand. The UCA National Assembly has also developed a resource entitled “Neighbourhoods of Difference”, which explores the issue and which will be made available to all Chaplains soon.

C. Visiting multi-faith speakers. Chaplains are instructed to contact the particular patient’s faith group if so required. That is, if they cannot minister to that patient.

D. Education on how we can share pastoral care; help chaplains understand that pastoral care is not teaching but caring; meeting with and working with other faiths.

Analysis and Comment.
This is an extension of the previous question and continues with the reality that multi-faith matters are always difficult for Christians. Many Christians would prefer that those of other faiths would take the option of becoming Christians, and this has been alluded to in chaplain responses elsewhere in the thesis. From (C17 page 130), we listen to the following. The respondent says: “as a chaplain I have no right to question another’s faith, but if I was a missionary I would see it as my right and duty to proclaim the Christian message.” She says further that she would be happy to talk about her faith if asked but would never initiate. This is then qualified with the words, “should never say never”. The church has presented an exclusivist standpoint over centuries, and that standpoint remains visible. The words attributed to Jesus, ‘I am the way, the truth, the life, no one comes to the Father except through me’ have rallied Christians into evangelical ventures that have converted some, and created hostility in others.

The providers of chaplains, and the chaplains themselves, have grown up within the church’s faith standpoint and so it is extraordinarily difficult for many to step out of the established boundaries. For some, to do this, is to be guilty of apostasy. Hence there is considerable difficulty in coming to terms with the need to recognize and validate difference in religions. All four respondents make the point that advice is available. This takes a variety of forms from
phone calls (A), to “visiting multi-faith speakers” (C). One respondent (B) mentioned preparation of resources; another (D) spoke of education. All of these are viable options, but the question about the impact of belief still remains largely unanswered.

Bueckert says to us from her experience: ‘I must be willing to behold the world of those I care for and allow them to teach me, from the wisdom of their own experience’ (2009, p.34). “Allowing others to teach me”, particularly in matters of belief, can generate anxiety; for some the undermining of faith. Uncertainty and anxiety are historically, triggers in the world for violence and fear. Bueckert speaks to us of her Mennonite belief: ‘Part of a Mennonite understanding of interfaith spiritual care includes the belief that building relationships with people from other traditions diminishes fear and violence’ (2009, p.34). Beholding the world of those I care for is a key element of my model of pastoral care. Re-articulating pastoral care in order to reveal clearly the value of both spiritual and religious care will reclaim the integrity of care in which the faith stance of all care receivers is honoured and validated. Addressing the issues that emerge from Bueckert’s words, would be an important addition to the resources provided by appointers.

Respondent (D)’s comment that “pastoral care is not teaching but caring” is an important reminder within our multi-faith environment. All people carry with them both hopes and fears. These may be intensely personal or may affect communities and even nations. Care can be exercised at all levels by individuals, communities and nations. The problem is that frequently care is tied to conditions, some of which are explicitly stated and others implied. Mackenzie et al (2009) offer a wise word that chaplains and appointers might take to heart.

[…] we think it is crucial to point out that interfaith dialogue and interfaith celebration are not about conversion. […] Each of the three of us continues to experience a deepening of our roots in our own faith tradition as these
roots are nurtured by wisdom teachings of other traditions. We feel more complete in our spiritual identities because of our sharing (p.3).

**And in the future**

13. *In your view, how might chaplaincy be done differently?*

**A. Nil Answer**

**B.** I think the answer to this question depends too much on the context and 'industry' in which the chaplains offer their services to be able to give one response. There are a number of ways that ecumenical developments, partnerships with community organizations, policy and practice development, better training, resourcing and equipping could significantly improve and re-shape the face of Chaplaincy.

**C.** Qualifications and cost prevent many compassionate people from visiting sick people.

It has become too professional- a sort of illuminati grouping! Revert to denominational visiting would negate much of the Hoo-Ha.

**D.** Well, and to the glory of God and the care of the client/patient.

**Analysis and Comment.**

Problems already canvassed associated with the desire by some, both respondents and chaplains, include: maintaining chaplaincy as a religious function; finance; confusion about the way chaplains might work more effectively in a multi faith society; the problems associated with training and with supervision. This question, raising the possibility of doing chaplaincy differently appears to be a major issue for appointers. The answers to this particular question reveal considerable gaps in the approach of appointers to the task. (A) did not answer the question, raising the possibility that changes were not considered necessary. It is not appropriate to impute reasons for not answering, but lack of response leaves the matter of the future of chaplaincy unresolved.
(B), in effect, shifts the emphasis away from the church as appointer, onto the varieties of contexts in which chaplains are placed, at the same time acknowledging that a number of matters, if considered carefully “could significantly reshape the face of chaplaincy.” Clearly context plays a part, there being, for example, significant differences between a sports chaplain and a hospital chaplain. (B) therefore, appears as the one who has most clearly grasped the ramifications of chaplaincy practice.

The differences themselves raise many questions about the meaning of chaplaincy. The word “chaplain” springs originally from the church and in particular the story of St Martin of Tours. 24 In our context, however, the question seeks some sense of how chaplains might work differently within their hospital setting. “Training, resourcing, and equipping” will have an outcome but more fundamental differences stem from belief and the desire to share that belief. These differences have been illustrated for us in a comparison of interview responses from (C6) (pp.101-107) and (C40) (pp.146-152). These need to be addressed by the churches if pastoral care is to be recognized as distinct and professional in the overall provision of care.

(C) expressed a desire that chaplaincy revert to denominationalism. This would certainly simplify matters in that church’s approach to chaplaincy, but would not solve the larger difficulties of adequate care for all. A reversion to particular belief standpoints, while finding acceptance within a particular faith group, will in effect widen gaps and find little acceptance within the holistic

24 The story is a long one. Briefly, as a soldier Martin met a freezing beggar and cut his cloak in half giving half to the beggar. That night he dreamed, and in the dream heard Jesus speak about him as “the one who clad me.” The cloak was miraculously restored, and eventually preserved as a relic. The Latin word, Capella (short cloak) was extended to the people charged with preserving the cloak. They were the Cappellani, or Chaplains.

www.religionfacts.com/christianity/people/martin_tours.htm – St Martin of Tours (316-397). Also “Catholic Online”
care frameworks that hospitals, and the re-articulation of chaplaincy for which I argue, now endeavour to promote.

(C)’s comment that: “Qualifications and cost prevent many compassionate people from visiting sick people”; contains an implication that being compassionate is all that is required in a pastoral encounter. In his answer to Q.6, however, (C) agreed with the proposition that chaplains be professional; “ongoing training being essential.” Qualification in this thesis however, means adequate training that will permit compassion to be more clearly applied. (C)’s “Reverting to denominational visiting” implies minimizing training heading to his further remarks about the many aspects of professionalism as “Hoo-Ha”. This is defined in Collins Concise Dictionary as a noisy commotion or fuss (p.621). The Macquarrie Dictionary also lists “Hoo-ha” as fuss; turmoil; argument (p.852). The implication is that references to qualification and professionalism are a fuss that obscures the work of “real” chaplaincy. One must ask, is this the intention of the respondent? (D)’s response locates chaplaincy firmly within an evangelical tradition; “well, and to the glory of God and the care of the client/patient.” I do not consider, however that it is necessarily sequential in its application. The word “well” carries, in the context of this question, an implication that chaplaincy is not currently being done well. “Well” in itself, however, does not convey any clarity about current practice and what the difference might be. The respondent then adds what can be construed as an evangelical imperative “and [also] to the glory of God”. God could be seen to be glorified in the way in which a chaplain approached the task; exemplified through faith and skills. The third point in this response is “and [also] the care of the patient.” The patient is not necessarily third in line. Doing pastoral care well, to have any meaning at all, must involve the patient.
Discussion.
There was general agreement among the respondents that those engaged in chaplaincy should have links to the church, and specific qualities and qualifications should be required. Engagement with the church is a reasonable requirement, given that the respondents each represent particular churches and naturally recruit workers from within their own denomination. If the task of pastoral care is framed within church boundaries, however, difficulties may occur if the intent is to have chaplains only work within those boundaries. Denominational visiting and evangelistic approaches cannot be sustained if there is a clear understanding of the provision of spiritual care.

Churches have always struggled to find sufficient funding to pay for the many activities they wish to pursue. Congregationally based, it is from these congregations that a considerable income is garnered. There is much the church feels it ought to do, there is much it would like to do, there is much that
it wants to do; priorities have to be set. In some parts of Australia, government assistance is available for hospital chaplaincy. In Queensland hospitals, chaplaincy is almost entirely paid for by the churches.

The institutions in which chaplains work, focused in this thesis in hospitals, have an expectation about chaplaincy that includes training and competence and an ability to provide pastoral care across a wide range of recipients. The skills asked for by Queensland Health require a close relationship between chaplain and clinical staff. If undue emphasis is placed on ordination and sacraments there is a risk that the pastoral care provided will be somewhat less than expectation. Hospitals, however, do not appear to have grasped the importance of having integrated health care that includes chaplains.

The questions about multi-faith issues drew answers that demonstrated that not a great deal of thought had been given to this matter. This may be because churches, naturally enough, are generally focused on their own lives, but also may be because chaplains have had limited opportunity to engage at this level. Some chaplains’ responses indicated this. Dealing with other faiths, however, is part of a wider involvement with difference, and this can be recognized as also embracing denominationalism within the church, along with those who demonstrate a fundamentalist standpoint, or a “no faith at all” standpoint. The provision of advice or of speakers has the advantage of providing information, but is not ultimately helpful in a specific interaction. Difference impacts on belief, and this needs therefore to be dealt with if it is to allow the pastoral encounter to be helpful. Ongoing supervision, and the reflective practice linked to it, is most important in this regard.

Supervision, while considered by all respondents as important, lacked definition in its implementation. Supervision needs to be considered as an integral part of continuing education, and something that can be agreed on by all concerned. A difficulty for the respondents appears to lie in having

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sufficient personnel for continuing supervision. Occasional or yearly assessments are only partially successful and do not allow for the development of confidence and trust that is so important within a supervision agreement.

The final question sought the respondents’ opinions on ways in which chaplaincy might be carried out differently. It was an invitation to consider new possibilities. The responses received, however, demonstrate that little thought has been given to this final question. This may be because time is being consumed in maintaining what is happening in the present. Interestingly there is some evidence in the responses of a preference to return to earlier days when members of a congregation visited other members in hospital. There is nothing inherently wrong about this, and in fact this kind of visiting continues and is generally helpful. It cannot stand alone as a preferred option, however, in a multi-faith context, and it cannot be considered to be a professional task.

Professional appointment within healthcare facilities requires chaplains to “step into the borderlands” (Bueckert 2009, p.6) and validate the integrity of other faiths. Those who appoint chaplains to health care institutions, in all their diversity, need to recognize the practices of those institutions. Such appointments cannot be denominationally based. Clarity of expectation from appointers will establish achievable roles for chaplains.

Appointers and chaplains alike need to ‘acknowledge and respect human freedom, taking responsibility for who and what one is’ (Baggini and Fosl 2007, p.163). In this, they claim, lies authenticity. It becomes visible when skilled and competent practitioners are able to provide, as outlined in page 22-27 of the literature review, authentic pastoral care. This is not an adjunct to whatever else happens in hospitals; it needs to be recognized as integral to the overall health care of all patients.
Chapter 7. Reflection

The literature review embedded in this thesis was a way of mapping key areas in pastoral care, namely pluralism, differences between religious and spiritual care, authenticity, belief, story, and presence. These concepts and processes belong together and interact with each other to fill out, not only existing practice but to emphasize the importance of re-articulation for the future. The mapping is further detailed in the responses from the research participants, in which it becomes clear that pastoral care, particularly as it is expressed in chaplaincy, needs to be re-drawn. This chapter therefore, examines the responses gathered summarizing comments and presenting an analysis.

Gathered in chapter 3, the data has particular relevance to the relationship between chaplains’ beliefs and their understanding and reasons for chaplaincy involvement. Throughout the chapter belief can be seen to
undergird and infiltrate all the responses. This is to be expected given that all are members within the Christian church.

Coming with a strong Christian belief and a desire to realize a variety of personal needs, the reasons given for becoming a chaplain suggest a mix of understandings about chaplaincy. There is a visible religious understanding, evidenced by a focus on patient comfort, erasing pain, sharing hope, expressing God’s love, all of which are primary Christian values. These are allied with a sense of well being for the chaplain; making a difference, providing comfort and support. Five of the respondents wrote of being called [by God] but only one wrote of the importance of discernment of such a call.

Personal need was expressed in a number of ways. Some found satisfaction in the affirmation of their religious connections, and respect for their belief. Satisfaction was also claimed in their being able to make clear that God is present, erasing pain and staving off loneliness, telling people their [chaplain] story, and the importance of salvation. Some found satisfaction in the provision of supportive care, being trusted with the patient’s stories, being able to spend time with people. There were also some expressions of doubt, of occasional loneliness, and a sense of lack of valuing by their church.

In the expression of reasons, understanding, and needs however, what is said does not sit well with spiritual care.

Spiritual care as a mutual search for meaning must take account of human being. Spiritual care does not locate the caree within specific religious frameworks. Rather it locates the caree within a human framework, as a fundamentally spiritual being. Spiritual care lays claim to the wholeness of persons, a wholeness that includes all that is seen and unseen. The search for meaning may find a place for this or that individual within a particular faith stance, but that is not the primary aim. If in the process, a specific faith stance which is valued by the caree emerges, it should be applauded as a goal.
discovered. Discovery is perhaps always the goal in a search for meaning, even if only a goal on the way.

It is argued that if the respondents were only providing care within specifically Christian situations it could be said that making clear that God is present, with associations of salvation, prayer, and comforting support was appropriate, even adequate in some circumstances. Many of the responses however, can be recognized as matching Dayringer's (1998) criteria for allying the aims of pastoral care with the aims of the church; inadequate for deeper understanding and healing.

The analysis of responses clearly indicates that the question of spiritual care remains unanswered if the primary focus is on seeing that patients live comfortably within their religious framework. This becomes particularly difficult if carers are seeking to cross barriers and reach out to those who are different. This will be discussed in the following section.

The variety in the reasons offered poses questions about professionalism (also considered in the next chapter) in chaplaincy. Two things are clear. One is the chaplains’ strong involvement with their church denomination, and the other a firm belief in God. Belief in God however, is not consistent across the Christian spectrum. Belief itself is a continuum in which may be discerned ranges of belief that are very dissimilar from each other.

Although respondents placed different emphases on the reasons offered, in all cases there is an underlying assumption that the basic task is caring.

Professionalism, training and engagement.
Chapter 4. presented the data from the chaplains’ responses to the questionnaire with particular reference to the structural considerations of chaplaincy. These include professionalism and training along with chaplains’ engagement with story and difference.
Professionalism was not understood or stated very well, although when asked what they considered to be unprofessional behavior, respondents were able to answer clearly with comments such as: breaching confidentiality, “goofing off”, pushing one’s ideas, flirting, and the like. It is clear however, from our review of the literature, that professionalism in chaplaincy has become necessary for the overall care of patients in a professionally functioning holistic health care team.

Appointees were required by their appointing denomination to participate in training modules prior to receiving any appointment. What is gained from the experience however, even though being awarded a pass, is dependent on at the least, the participant’s overall commitment. The analysis suggests that training needs to be continually upgraded to provide quality and encouragement for continuing professional development. The data from the respondent profiles adds detail to this and will be considered in the next section.

We recognized in the literature review that “story” was a most important component of pastoral care, and needed careful attention by the one offering the care. Most of the respondents considered stories to be important although some considered their relevance more useful for information and assessment.

Engaging with difference was difficult for many, in part because many had had little experience in working with people of other faiths. To some extent this could have been the result of limiting research to the South East Queensland parameters. Immigrant groups in this geographical area as in other cities, tend to live close to each other, and if with a strong faith, close to their worship centre. In Brisbane, this also places some of those groups in close proximity to particular hospitals which they then attend when necessary. Chaplains in these hospitals are more likely than others to occasionally cross paths with faith differences. The evidence suggests that it is important that difference be recognized as wider than faith standpoints.
From the respondent data the evidence indicates that opportunity is limited for contact and engagement with difference. It is obvious also that some respondents, when speaking about “other faiths” are in fact talking about denominations in the Christian church. This has been a typical way of referring to denominations over the years. We can recognize in some of the responses however, that when a chaplain is faced with such difference he/she is at least respectful of difference.

Another ongoing dilemma facing some who visit as pastoral carers, is the failure of the hospital to provide appropriate information for the chaplains. This has occurred as a result of privacy legislation some years ago, but has been interpreted differently in diverse hospitals. There is clearly a need for all hospitals to consider chaplains as part of the health care team; and of course the corollary is that chaplains seek always to be professional and undertake professional development. This is underscored by the responses of one chaplain who can be recognized as clearly acting professionally, able to listen to, and understand stories, and be comfortable working with difference. That chaplain undertakes regular professional development.

In summary, despite differences in expression in the responses, those given the responsibility for a chaplain’s task, undertook the task with compassion and care. The kind of care they appeared most comfortable with was religious care, reinforced by their own strong Christian belief.

Context of belief position and its impacts.
In this research seven participants were invited to participate in an interview to explore more closely the matters raised in their original answers. The focus for the interviews was on seeking deeper understanding of two underlying questions. One had to do with the experience that had led the
chaplain to his/her belief position, and the other sought an indication of the way that belief was currently impacting on their life and work. Each profile thus contains, as it were, a signature which indicates a basic value in each person’s understanding of the task; recapping of profiles and analysis follows.

The signature, in C6’s profile is constancy. The respondent recognizes her own vulnerability and acknowledges the vulnerability of others. This respondent tells of difficult times in her growing up. She speaks of many “big holes” but this did not prevent her from developing a sense that God was always with her. She says, “God had not abandoned me”. As a result she determined that she would not abandon others, and this became a guiding principal in her chaplaincy activity. Her belief in God’s constant Presence led her to be constant in her care. Religious and spiritual care are elements of pastoral care and this respondent says that both are important. Her encounters with difference portray an understanding of belief that embraces difference as natural and valuable. The respondent appears comfortable with ambiguity. She has embraced personal development and confirms her task as helping others in their own search for meaning.

The central issue for respondent C7 appears as the maintaining of a “grounded and secure faith”. Difference is acceptable, although it appears at times to embrace only Jews and Muslims, both understood as having a common heritage with Christians, because each considers Abraham (Genesis) as a faith father figure. She says she “tries to understand” and speaks of respect for those with a different faith standpoint. Her pastoral activity appears to be mostly concerned with religious care, and this is evidenced at times by a desire to provide assurance and “be Jesus’ hands and feet”.

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Respondent C11 brings to his understanding of chaplaincy a strong statement of belief. For him God is perfect mind. He also spoke of God as perfect love, of sufficiency in God’s self, and of perfection in understanding. A difficulty perceived by this respondent is that people in the church have not clearly understood the nature of God as he expresses it. We may recognize in these comments one who, being theologically trained, has some gaps to fill in integrating this belief with pastoral care. The respondent also makes the point that for him, the perfection of God was put aside in order for God to enter into the nature of people. This was a task of Jesus. He nevertheless tries to understand the faith position of those outside Christianity, and considers that God has an inexhaustible capacity to contain all things. As a chaplain he appears to stay with those in need, and listen to their stories. He does not appear to want to impose his beliefs on others.

Chaplaincy for respondent C17 has its roots in a “Holy Spirit experience” claimed as life changing and a catalyst for entry into pastoral care. This experience is visible in a number of places and finds some focus in her desire to present God in her pastoral encounters, and the hope that seeds will be sown and doors opened. The respondent claims that without “spiritual feeding” she could not be a chaplain. There is a strong inference in her comments of an expectation of response from the patient to her chaplaincy presence. She speaks of the patient’s vulnerability when in hospital but also seeks to have people aware of God. At times her responses portray a degree of sensitivity but at other times, patient’s wishes do not appear to be heeded.

One respondent verbalizes belief in traditional Christian language but then confesses a degree of ambivalence (C28). She undertook theological training but says that at one stage during that training she became an atheist. The ambivalence follows her as she explains that the church had disappointed her. She found warmth and acceptance from some during troubling times but experienced some criticism when appointed as a chaplain. She talks of her
difficulties with prayer particularly when, in praying for patients she found nothing changing. She speaks of spirituality as a search for meaning and claims that she is a spiritual person. Her experiences have left her with a sense of vulnerability and she recognizes the vulnerability in others.

Part of respondent C34’s religious background is Orthodoxy and this emerges strongly in her statements about her belief. The strength of her belief allows her to say she “is more the spiritual”. Then she says “the spiritual is really our spirit that journeys; the Holy Spirit.” She does not want to be called a religious person but she has a close involvement in her church. Her ultimate claim is that her faith is her strength. Her pastoral care activity is based on the guidance of the Holy Spirit. As such, it could be said to be religious care, for it revolves around the guidance she perceives. It is as if she and the Holy Spirit are together able to maintain some sense of control in difficult circumstances. She does however, recognize some commonality between faiths, even though unclear about how that might be so. Overall it can be said that this chaplain cares despite a lack of clarity about religious and spiritual care.

Respondent C40 has an intense belief, seeing prayer as most important and labelling it with such comments as helping people to be comfortable and considering it the “great calmer”. She is somewhat judgemental of other carers who do not believe in the same intense fashion as she does. The respondent considers that pastoral care must contain prayer, have a link to God, use of the Bible, and discussion of religious matters. She claims respect for others but at times her words imply that pastoral care is best applied through her actions. She speaks of seeking spiritual additions for herself but does not appear to be able to offer spiritual care for others. Her claims also suggest a lack of engagement and a lack of presence in her pastoral encounters. Listening, presence, acceptance, and vulnerability are not clearly visible in her responses.
Providers—chaplaincy and ministry of the church.

Providers, in the context of this thesis are the people who have been charged by their denomination to appoint and oversee on behalf of their church, those who will take up a chaplaincy task. I have arranged a summary of their responses to a questionnaire into five categories. The responses from each of the providers present a sense of hospital chaplaincy as something of a continuation of the ministry of the church to its members. This understanding of chaplaincy reinforces the sense that what is important in hospitals is religious care.

The providers were questioned about matters in the practice of pastoral care. The providers’ understanding of pastoral care includes sacramental ministry, supportive engaging in meaning making, reflecting God’s love, care offered according to the “agenda” of the care receiver, empathic listeners, and walking with the “client”. The criteria for the practise of pastoral care, includes effective training which provides a recognized qualification, supervision, having a role description, and a memorandum of understanding. Qualities looked for include compassion and self-awareness. Additional qualities included church involvement, Bible study, and maturity of faith.

The providers agree on the importance of training for all seeking to engage in pastoral care. There was also general agreement that training should result in qualification. One referred to the Queensland Health criteria which seeks qualifications such as Clinical Pastoral Education (CPE). The nature of the care eventually carried out was not nominated, but “reflecting God’s love, church involvement and Bible study” suggest a desire that pastoral care might stay within Christian boundaries, in which case it would most likely be recognized as religious care. It could be argued however, that maturity of faith and meaning making carry the possibility of spiritual care.
Respondents listed difficulties such as funding, adequate resourcing of chaplaincy, costs associated with training, difficulties of recruitment, and perceptions of relevance.

Inability to provide resources, particularly financial resources, suggests that chaplaincy, and therefore pastoral care, has a low priority on the churches’ calendars of events. Part of the difficulty is that from its beginning the church has recognized its purpose as proclaiming “the risen Christ as Lord”. As demonstrated in the literature review, pastoral care was originally identified as care of the soul, with its primary function of watching over members’ association with the church, and more importantly with God. Pastoral care has undergone changes but appears to be still considered by some to have close associations with the church. The “mission” of the church still appears to have priority. In the profiles, for example, one chaplain commented on some controversy over her appointment as a chaplain, saying: “some thought I was too good a parish minister to be wasted on hospital chaplaincy”. If this should become a general opinion considerable problems could arise with pastoral care relegated to the background.

All respondents agreed when asked about professionalism and adequate training that there was an expectation of professionalism. Agreement on how it might be assessed, however, was varied. The respondents wrote of monitoring, ongoing training, the importance of competency and authenticity but were short on detail. In answer to a further question they all agreed that training programmes needed to contain specific requirements. Ongoing training was recognized as important but there was an admission that it was not being done very well.

Theological training was considered to be important, one respondent capitalizing it as ESSENTIAL. A looming difficulty in theological training is that when studied within a traditional Christian framework boundaries may be fixed allowing participants little room for lateral thinking in confrontation with
difference. In the responses one respondent had some hesitation about theological training as not being a practical pathway for all undertaking pastoral care. It was said that there needed to be a wider understanding than would be available through studying theology, and also that trainees needed to develop an ability to listen and to self-reflect. Supervision was also considered important but its implementation was severely lacking.

Questions 11-12 referred to difference – in particular interfaith difference. The response to a question about strategies for interfaith pastoral care was that there were no specific strategies apart from workshops and elements within training programmes. When asked what assistance was available, for chaplains, it was stated that assistance was offered through telephone calls, visiting speakers, education to help chaplains understand that pastoral care is not teaching but caring. The matter, however, is more complex than can be explored in occasional workshops and lectures. Crossing faith boundaries in offering spiritual care touches the core of one’s own belief. It requires from the carer an acceptance, not only of a person with another faith stance but an acknowledgement of the validity of that faith stance and its right to exist alongside one’s own faith without let or hindrance. In the literature review, the words of Fukuyama were recorded as “entering a multifaith intervention requires a degree of unlearning.”

The question asked about the future drew answers that demonstrated little or no close thinking had been brought to bear on the future of chaplaincy. The responses ranged from generalizations about developing ecumenical partnerships, to a suggestion that too many qualifications and too much professionalism were detrimental to care, to a suggestion that in the caring, God should be glorified. None of these can be said to be wrong; it could be argued they are simply not adequate for the future practice of pastoral care in a society of difference.
There is a clear indication in these answers that chaplaincy can be just as well served by compassionate Christian people caring for others. If this is the case we have a complete misunderstanding of chaplaincy and a cogent argument for the re-articulation of pastoral care. Chaplaincy does not discount the care of compassionate people. Such care is ongoing particularly within denominations, and many people are helped in many ways by visitors from their church.

Pastoral care however, as shown in this thesis, must move beyond religious care to spiritual care if it is to embrace parameters wider than those of the church. In this country around 40% of the population has no Christian church links. Many have no religious viewpoint, and many live within a totally different faith standpoint. Compassionate people alone cannot meet their needs.

In summary:
1. The first thing to be recognized is that those who responded are people who care.
2. Understanding of chaplaincy is in the main circumscribed by the nature of one’s belief with many of our respondents presenting a strongly Christian standpoint.
3. Understanding of difference was unclear particularly with reference to other faith standpoints. There was a suggestion in some of the responses of a preference that all would be amenable to the Christian way.
4. Within the parameters of our study however, it is recognized that some respondents had a very limited experience of contact with difference; some claiming none at all. Why this is so was not clear and was not explored.

The differences among respondents was considerable and the question of some kind of synthesis of belief and understanding needs to be considered.
This is a training problem but is also a difficulty for professionalism. Accepting spiritual care and carefully analyzing what this means will help the difficulty and allow for better practice. Associated with this is the need for ongoing supervision and professional development without which little will change.

I have demonstrated that pastoral care does need to be re-articulated by both those who appoint chaplains and by chaplains themselves. In doing so the claim that “authentic pastoral care within our pluralist society is dependent on appropriate articulation of belief, intentional listening, and sustained engagement” will be validated, and pastoral care become a professionally recognized application of religious and spiritual care.

Chapter 8. Conclusion
This study of pastoral care has highlighted some significant findings about the nature of the meaning and practice of that care; belief and concerns held by the chaplains themselves as well as the providers; the structures, processes and implementation of chaplaincy in hospital settings; and provided suggestions for fruitful discussion and further research.

The research reveals that despite differences in understanding and ability, it is clear that those participating in pastoral care can all be recognized as caring people. This is acknowledged as fundamental in the practice of spiritual and religious care. The research is also clear that, while chaplaincy is generally carried out faithfully by sincere and dedicated people, there are nevertheless some difficulties that need to be addressed.
The belief standpoint of most engaged in pastoral care makes for difficulty in engaging with those with a different faith standpoint, some chaplains preferring that people of other faiths, or no faith, were Christian. The research has also highlighted the problem of Christian v. Christian when facing faith standpoints. It is important therefore, that the potential difficulties of difference be explored as people enter into any chaplain training programme.

In modern hospitals and other institutions, professionalism is required of all involved in the care of persons. If therefore, professionalism is to be taken seriously in pastoral care, the term chaplain [current usage] should only be applied to those who are trained, who work full time, who undertake ongoing professional development, and who are eligible for certification by a professional body.

Training needs to be undertaken more intentionally for pastoral care to become a truly professional activity, and all appointees should be required to have regular supervision and attend professional development activities. Membership of a professional organization would be helpful in ongoing professional development.

The research highlights the point that many engaged in pastoral care do not understand the significance of presence and of story. More attention needs to be given to these in training programmes in order that practitioners will come to recognize the fundamental importance of presence and story in all aspects of pastoral care.

Any understanding of chaplaincy with its overtones of Christian allegiance needs to become an open and inclusive expression of health care, embracing a holistic understanding of the human person. The challenge for church and chaplain is to recognize that such care is not solely the province of Christians.
A more intentional application of the validity of other faiths will be important in the training of people for spiritual care. **Spiritual care** embraces an understanding of the importance of all facets of life, and steps aside from current religious standpoints, to take time to listen to and ponder with, those whose need is to find healing and wholeness.

**Authentic chaplaincy** approaches another with a determination to listen closely and creatively. In order for this to occur, there must be a clear recognition of the need to be present to the moment.

The research demonstrates that within the boundaries established in this thesis we can say that those engaged in hospital chaplaincy are more likely to offer religious care than spiritual care. Religious care is not wrong; indeed at times it is most helpful. It is therefore important that those seeking to engage in pastoral care discern the difference between religious and spiritual care and engage appropriately.

Within the parameters of this study, **appointments** in chaplaincy are made by representatives of Christian denominations. It appears that religious bodies will consistently require a presence in hospitals as long as the current system of appointment prevails. Any attitude that all churches must have access needs to be reassessed, and trust developed. Also, **opportunity needs to be provided for church, state, and hospital authorities, to confer on expectations of what may now be required of appointees.**

This conclusion highlights the matters needing consideration as it draws together he findings of the thesis regarding belief, story, presence and the importance of a professional approach to chaplaincy. Authentic pastoral care will be recognized in the strength of engagement with difference, and in the application of spiritual care.
Appendix 1

Questions to Chaplains.

1. What is your chaplaincy status? Circle one of the following –
   [Ordained full time]       [Ordained – part time]
   [Volunteer]
2. Age Range; tick one.   [Under 30]    [30 – 50]
   [Over 50]
3. Gender; tick one     [Male]    [Female]
  1. How long in chaplaincy [0-5 years]   [5-10 years]   [More than 10 years]
  2. What, in chaplaincy, gives you most satisfaction?
  3. Describe what moved you to take up the work of chaplaincy.
  4. Describe the work of chaplaincy as it is applied in your hospital?
  5. How important are patient’s stories in the care that you offer?
  6. Describe what are the most important responses that you would consider
     making, when listening to patients describing their difficulties.
7. What for you are the most important elements of your religious beliefs?
8. In all that you say and do as a chaplain, what for you is the bottom line?
9. Which of spiritual care and religious care best describes your approach? Are you aware of any differences between the two?
10. Do you consider yourself as a professional in your task? Why or why not.
11. What, for you, is unprofessional behaviour in chaplaincy?
12. Do you consider that you were adequately trained for the work that you do?
13. What other things in your training would you have found helpful for your work as a chaplain?
14. What are some of the ways in which you would prefer your church to support you?
15. In your daily program, what do you find most difficult as a chaplain?
16. Have you had experience in working with people of other faiths? Describe your approach?
17. What in other faiths challenges your faith stance? Are these challenges, hindrances to your ability to provide care?

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