Practical Theology

ISSN: 1756-073X (Print) 1756-0748 (Online) Journal homepage: https://www.tandfonline.com/loi/yprt20

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To cite this article: Steve Nolan (2011) Chaplain as "Hopeful Presence": Working with Dying People, Practical Theology, 4:2, 165-179, DOI: 10.1558/prth.v4i2.165

To link to this article: https://doi.org/10.1558/prth.v4i2.165

Published online: 21 Apr 2015.

[PRTH 4.2 (2011) 165-179] *Practical Theology* (print) ISSN 1756-073X
doi: 10.1558/prth.v4i2.165 *Practical Theology* (online) ISSN 1756-0748

Chaplain as "Hopeful Presence": Working with Dying People*

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Abstract

This study examines the clinical experience of 20 palliative care chaplains. Using Grounded Theory with unstructured individual interviews and group work, the study aims to understand how palliative care chaplains work with dying people at the point when it has been decided to cease active treatment, the point where they risk losing hope and falling into despair. Analysing the data, four "moments" in the chaplain's being-*with* dying people are identified as modes of presence: "evocative presence"; "accompanying presence"; "comforting presence"; "hopeful presence." These four moments focus attention on how the quality of a chaplain's presence may help a dying person develop "a hopeful manner" in which hope may be reconfigured into an attribute of being. It is concluded that spiritual care demands a degree of presence such that it may be appropriate to regard presence as *the* mode of spiritual care for people who are dying.

Keywords: chaplain; dying; Grounded Theory; hope; palliative care; presence.

* Note: The research was approved by the Research Ethics Committees of the Department of Psychology and Counselling, The University of Greenwich (5 November 2008) and Princess Alice Hospice (19 November 2008).

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Introduction

As a chaplain working in palliative care, a critical incident in early 2008 posed a question that challenged my working practice (Nolan 2008a). I had been asked to visit "Daniel," a man in his late-twenties admitted for terminal care. Something about the way Daniel was awakening to the fact that there was only one way through his situation touched me with the presence of the dying he was living. Coincidentally, I had been invited to write a short article on hope (Nolan 2009) and discovered a model of hope developed by Rumbold (1986), who argues that failure to support dying people face and explore the possibilities for dying can mean that they fall away into despair; alternatively, with appropriate support they may be helped to find a form of hope beyond recovery.

Reading Rumbold, I realized that I had encountered Daniel at precisely the point at which he risked falling into despair; but I was left questioning whether I had given him the support he needed at the point he needed it, and wondered how my work with him compared with the way other palliative care chaplains worked with dying people.

Exploring this question through intensive interviews with palliative care chaplains in southeast England,[2] I came to an understanding of the way in which, by offering their *presence* to a dying person (their being-*with*), chaplains might enable that person to become hopeful—not in the sense of helping them to reorient towards the future realization of an unfulfilled desire, but in the sense of living "in a hopeful manner" (*Compact Oxford* 2003). For some, the presence of a religious person is positive and reconnects them to good memories of church and childhood and to what one chaplain calls their "residual faith." For others, more apathetic to such presence, a chaplain who persists in "being me," being an ordinary, accessible human being, may be able to deconstruct a whole set of negative associations. In either case, the effect of the chaplain's committed presence is the possibility that hope may be reconfigured. This study identifies four "moments" in the chaplain's being-*with* dying people, which I describe as four modes of presence: "evocative presence"; "accompanying presence"; "comforting presence"; "hopeful presence."

Methodology

Because I wanted to re-theorize my own counselling practice, I decided to use Grounded Theory methodology since it provides a model of research and theory building aimed at allowing theory to develop

2. I interviewed 20 palliative care chaplains between 18 December 2008 and 27 August 2009; in total, they had in excess of 100 years' experience in chaplaincy.

through systematic analysis of the data while ensuring that findings remain grounded in that data.

Reflexivity

It is important here to make clear that I chose to follow Charmaz's (2006) version of Grounded Theory because, unlike many Grounded Theorists, Charmaz is explicit about the constructivist nature of the theory that emerges from the Grounded Theory process. As such, as the investigator, I acknowledge that I am thoroughly implicated in the research process: that my concerns shaped the participant selection, the interview style and the direction of travel along which the process moved. This is an accepted part of Grounded Theory practice; however, because my research was formalized as part of an MSc programme in Therapeutic Counselling, it means that the process has been informed by psychotherapeutic theory, simultaneously limiting what I might "find" in the data and opening particular possibilities for the types of discoveries I might make. For example, psychotherapeutic theory directed my thinking towards how a chaplain works in the *relationship* with a dying person. Specifically, I came to see this in terms of "transference" (although, arguably, I might equally have seen it in terms of Rogers' "core conditions"). It seems to me that this is a particularly useful and insufficiently considered way of thinking about the chaplain's working relationship, although I accept that approaching the data within another theoretical frame would have made possible (and prevented) other "findings." This touches on questions of ontology and epistemology that are beyond the scope of this paper, suffice it to say that I acknowledge the subjective nature of these findings and note that Grounded Theory methodology safeguards against excessive subjectivity by using the "constant comparative method" (Glaser and Strauss 1967: 105–13) and by insisting that the credibility of the study be evaluated by those who participated in it.

Initial Sampling

I conducted five initial sampling interviews (all with Christian chaplains), using an intensive style of unstructured interview. In each case, having explained my working definition of counselling—as "something that takes place when a person asks another person to listen, and help them to explore a problem in living, under conditions of confidentiality" (McLeod 2003: 190)—and having outlined Rumbold's model of hope development, I enquired how the chaplain worked with dying people, inviting them to relate stories of their experiences with particular individuals. Essentially, I was interested in three simple questions:

- What was their experience?
- How did they experience their experience?
- How do they understand their experience?

Using the "constant comparative method" (Glaser and Strauss 1967), I compared data with data for similarities and differences, comparisons and contrasts, and I used code-based theory building CAQDAS software (NUD•IST 5) to complete line by line and incident by incident initial coding for each transcribed interview. The processes of initial and focused coding prompted an unexpected observation that problematized my intuitive assumption that palliative care chaplains were concerned to help dying people find hope. However, I also began to identify an emergent theme about the chaplains' *presence* and the positive and/or negative responses it evokes in those with whom they work.

Chaplains' Workshop

In association with the South East Region of the Association of Hospice and Palliative Care Chaplains I conducted a workshop to test my initial findings. Seventeen full-time, part-time and volunteer chaplains (plus a hospice Psychosocial and Spiritual Care manager) took part: sixteen interviewees were Christian; one was a female Muslim volunteer; three were among my five initial sampling interviewees. I presented a summary of my initial findings and invited participants to consider two questions:

- Should we as chaplains see ourselves as "purveyors of hope" (a term borrowed from an initial sampling interviewee)?
- In what ways (if at all) have a dying person's positive or negative reactions to you affected how you have offered them spiritual care?

Theoretical Sampling

To gather more data about the chaplains' presence and to understand more fully a theme that emerged in the workshop on chaplains as providers of comfort, I conducted three theoretical sampling interviews. These interviews gave me data that I considered saturated my theoretical categories.

Credibility and Limitations of the Study

To evaluate the credibility of my research, I sent a summary to each one-to-one interviewee requesting they respond to questions representing what Glaser and Strauss regard as the four "highly interrelated properties" that should characterize Grounded Theory (1967: 237):

- How closely does the theory fit your experience?
- Is the theory readily understandable?
- Can the theory be generally applied to your daily work?
- Would the theory help you read and respond flexibly to situations you encounter with patients?

Six (out of seven) interviewees responded, all very positively with comments such as:

> "The theory does fit my experience fairly well."
> "I think the theory can be applied to much of my daily work."

Regrettably, the study tells only half the story, since the voices of those for whom chaplains care are silent. In large part this is because, as an MSc project, my study was limited by the deadlines of an academic calendar and the realities of gaining ethical approval, therefore, I restricted my project to palliative care chaplains in order to avoid anticipated delays. Further research with dying people would provide very rich data and would balance and deepen the study.

Findings

What I found immediately striking in the data from the initial sampling interviews was the observation that *hope does not feature in any direct sense in how chaplains describe their experience of working with dying people*. This is in contrast with the importance nurse researchers assume for hope (Reynolds 2008; Garrard and Wrigley 2009) and suggests chaplains see hope in a different way to their healthcare colleagues, who often regard the spiritual distress associated with loss of hope pathologically (Saunders 1988; McSherry 2006; White 2006). However, while they may not conceptualize their work as helping dying people find hope, chaplains nonetheless regard it as an important aspect of well-*being*. Several chaplains want to define hope in terms of what it might be in the *present*. Given that many writers assume hope is future oriented (theologians: Moltmann 1967; Rumbold 1986; Herbert 2006; healthcare professionals: Herth 1990; Nekolaichuk and Bruera 1998; MacLeod and Carter 1999; Chi 2007; Garrard and Wrigley 2009), talk of hope "in the present" fundamentally redefines the concept.

In what follows, I describe what emerges from the interviews as "moments" in the chaplain's being-*with* a dying person; moments through which a chaplain may become a *hopeful presence* to those with whom they are able to work.

The First Moment: Evocative Presence

The chaplain's presence is obviously premised on their physical presence. However, Christopher[3] records how his presence as a "rather formal looking, religious gentleman" can evoke a certain religious nostalgia. For Joan, an elderly patient:

> when I turned up at her bedside she was very emotional, she wanted to cry. And I was, obviously, very gently, tried to go down the road of trying to find out what that was about, and why I evoked those tears in her…for some people it's sometimes guilt… I don't think with her it was quite that. It was more wistful; it was more nostalgic; it was more a sense of loss.

For Christopher, the response he evokes in a dying person is at least as much to do with his presence as anything he might say: it is his physical presence, as a visibly religious person, as much as her reception of the sacrament he brought, that reconnected this woman "to something that was clearly very important to her as a girl"—what he calls her "residual faith."

As a psychotherapy student, I understood this chaplain's observation in terms of "transference" and, without using the language of psychotherapy, other chaplains describe their experience in ways that resonate with being the object of another's transferential projection of religious phantasies. Analysing their comments, I identified several ways in which positive and negative transferences operate to affect different outcomes. I want here to highlight those projections that appear to lead to a positive outcome—I define "positive" outcomes here as outcomes that facilitate some form of working relationship and "negative" outcomes as those that undermine any form of working relationship.

Christopher's description of an elderly terminally-ill woman as "delighted to see me" characterizes the reactions chaplains may experience when they evoke *positive transferential projections*. Typically, the feelings associated with a positive transference are favourable and often key in to positive memories of church and possibly childhood (Jacobs 1999: 16). Significantly, the positive transference seems to result in chaplains "connecting" with a dying person in ways Christopher identifies as helping:

> And as she remembered this stuff…she was just lightening…it was all becoming not quite so bad, somehow. And so, it was as if I took her to another place in that conversation, that in her recollection of her girlhood—which I think was basically happy—she was taken then into quite a good space (Christopher).

3. All names are pseudonyms.

In contrast to these positive transferences, the chaplains I interviewed recorded that *negative transferential projections* may manifest in extreme responses; although David, an experienced, unpretentious and very frank chaplain, highlights that responses such as "Bugger off, I don't want to talk to you!" are generally more apathy than antipathy. Either way, chaplains find negative transferences "hard work" (Susan) or at best "a little barrier" to be overcome in order for the relationship to be therapeutic (Christopher). David, for example, finds being the object of negative projection "very uncomfortable" and speaks about the reluctance he experiences around meeting a new person:

> I've been doing this for ten years, but I always hate—to a certain extent fear—that first encounter with a new person.

It seems, however, that working with negative projections can be an important part of achieving a positive outcome. The resistance a number of chaplains have to being the object of any transferential projection, regarding them all as inherently unhelpful, seems to be a way in which some work with such negative projections. For example, lacking the language or training of psychotherapy, David intuits a way of working with transference that he describes as "stay[ing] with" the negative:

> you don't run away from it…if you can stay with that…you're, kind of, working in the opposite direction to it, and it might result in confusion—"This is not how vicars are supposed to be!"—that it creates an opportunity for movement I think.

For this reason, the idea of "being me" appears to be central to the way some chaplains work with negative transferences. They understand "being me" as a position from which to deconstruct what they consider to be wrong-headed and unhelpful preconceptions about God, specifically any emphasis on a judgemental God:

> by meeting a religious figure, a perceived religious figure who is different and acts in a way that is different from how they would expect a religious figure to act and behave in terms of attitude and so on—and particularly in terms of acceptance—that may help people to move on in a particular direction (David).

This chaplain puts particular emphasis on deconstructing the logic of the judgemental religious phantasy:

> the chaplain represents God,
> God is judgemental,
> therefore, the chaplain will be judgemental.

The clear implication is that "being me" deconstructs the unhelpful preconception that God is judgemental:

the chaplain represents God,
the chaplain is not judgemental,
therefore, God may not (after all) be judgemental.

But also, the dying person's experience of being unconditionally accepted by the figure they perceive to be religious may actually "help people to move on in a particular direction." While not "[prescribing] what that direction should be" (David), this is likely to include the sense that the person is accepted as, and for whom they are:

the chaplain represents God,
the chaplain accepts me as I am,
therefore, God may (after all) accept me as I am.

The implication is that it is the contrast, perhaps even contradiction, between the way dying people expect chaplains to be and the way chaplains in themselves are, that the chaplain's way of being-*with* dying people starts to become therapeutic. For David, this deconstruction is the thing that "can be creative about the role of chaplain" and the moment of the "I'm-not-religious response" is "where most of the creativity happens," because "that's the point at which you can work through to a meaningful relationship in which the person's spiritual issues can emerge."

The Second Moment: Accompanying Presence

Unlike other healthcare professionals, chaplains seem not to conceptualize their clinical work in terms of therapeutic aims. In other words, they don't see themselves as having to *do* anything particular *for* a person who is dying, but speak in terms of being-*with* them.

The idea of being-*with* fits well with Heidegger's description of "dwelling" (*Aufenthalt*): "a holding-oneself-back from any manipulation or utilization" with the result that "the *perception* of the present-at-hand is consummated" (1962: 89). Expounding Heidegger, Ladkin comments that "dwelling" demands particular attention is paid to the *being* of the other, such that the one attending should "suspend their sense of self" (2006: 93). According to Ladkin, "Heidegger refers to this as 'presencing', and he suggests that through such presencing, the 'Being of Beings' comes into manifestation" (2006: 93).

Dwelling with an other has a quality that resonates with Buber's *I–Thou* relationship, in which "the *Thou* becomes present" (1958: 26) and with what in Buddhist therapy is compassion (*karuna*), which "sees through the eyes of the other…without any private agenda" (Brazier 1995: 195). Chaplains appear intuitively to understand and incorporate this spiritual quality into their clinical practice, for example, in the way they make use of self in their being-*with*. Susan, a full-time

lay chaplain who has lived through her own experience of life-threatening illness, explains how for her "just being" is sometimes purely instinctual:

> I sometimes feel I don't know what I'm doing and I don't know what I can do. All I can do is go…and be there.

For Levinas, it is when we address the other "face to face" (2006: 9) that we understand the other. Entering the physical space in order to "be there," chaplains encounter the face of the dying other and, because "the primary experience of being is situated at the level of emotion" (2006: 41), they enter the emotional space of a person who is without hope. Facing the face "in its mortality" with its "summons," "demands" and "claims" (2006: 125) has an emotional cost that, as Susan observes, can "grind staff down," leaving them unsure of what they have to offer. But as she comments:

> that's maybe where we come in, at least we're still saying, "Well I'm still gonna come and listen to you." But I often think in those situations, "I don't know what I should be doing here." And I think, if nothing else, it is just the physical presence and the holding the hand and the listening to what's being said.

This chaplain expresses intuitively what Levinas expresses philosophically:

> *the Human* consists precisely in opening oneself to the death of the other, in being preoccupied with his or her death…it is no longer just a question of going toward the other when he is dying, but of answering *with one's presence* to the mortality of the living (Levinas 1999; cited in Cohen 2006: 26, emphasis added).

In other words, the extent to which they respond to the call to be open to the "impossibility of possibility" (Levinas 1969; cited in Cohen 2006: 30) is the extent to which chaplains in particular, but in practice any palliative care staff, already understand what they have to offer.

The chaplain is in a place to experience something of the experience of the dying person in a way congruent with Carl Rogers' observation that the process of psychotherapy enables clients to gain "awareness of [their own] experience." This Rogers terms "the experiencing of experience" (Rogers 2004: 76) or being physically present and emotionally available. In experiencing a degree of that experience, the chaplain is available to permit the dying person to experience their own experience (Nolan 2008b). Susan describes this well:

> there are times when I look at patients who are feeling hopeless and I suppose I feel hopeless with them and for them, but at least I'm allowing them to feel hopeless, whereas other people maybe aren't. And I think when you just leave somebody feeling, "If you won't let me talk about it,

> then what I'm feeling must be so awful that I can't share it with anybody else and I'm left here with it on my own." Whereas, if we let people talk about it, then it loses some of its awfulness, I think.

With mental health training, Elizabeth describes her work in terms of entering a dying person's darkness in order to "hold" something of their experience:

> I think to enter it is to be able to hold whatever it is, and for them to see that you're not disturbed by it; that nothing that they can be or say would affect the relationship that you're building, I think that's very key for chaplains, the way that we are present to the other.

The Third Moment: Comforting Presence

Initially, I ignored the idea that chaplains bring comfort to those who are dying; probably, like others, I was prejudiced against the stereotypes associated with this term. However, despite my prejudice, several chaplains are less troubled by the term. As Elizabeth puts it:

> starting from the baseline that I cannot give people hope, but I can be with people without any kind of hope in a way that is helpful and comforting and, perhaps, strengthening for them.

Her understanding gets close to the Latin etymology: *confortare*, "to strengthen."

Physical comfort is important to the rationale of palliative care, but the more pervasive idea among chaplains is that of bringing "spiritual comfort." Describing the content of being comfortable as, to "Feel at ease with; to be peaceful about; to be accepting of," Paul and Margaret speculate that some dying people find comfort in the presence of the chaplain:

> I think sometimes just presence does give reassurance and comfort (Paul).

> I think being present [allows] them to express their despair and all of that, which I think does sometimes release the pressure, which then allows them to relax a bit, and that can make them more comfortable (Margaret).

Chaplains appear to make their comforting presence available actively, in friendship building, and passively, in silent presence. I will focus here on their passive presence, the way chaplains might simply stay with the pain of the dying person's present experience. Paul, a lay chaplain with training in contemplative traditions, voices what for many chaplains is a common experience that silence can speak eloquently and with effect:

> I've been into rooms and, you know, I might have been a little bit uncomfortable about where we are in that moment with somebody's last bits of their life… But staying in that uncomfy place with them is what we're called to do, and I think staying with them gives them presence and does give them comfort.

Whether, as Paul goes on to suggest, chaplains are mystically "a bit of God" with the person who is dying, for him being a comforting presence communicates a sense that the dying person is loved. This perspective resonates with the mysticism of Buber's *I–Thou* relationship, where the *I*, retaining awareness of the particulars of the *It*, connects with the universal in the *Thou* to undo something of "The melancholy of our fate" (Buber 1958: 39). Such quality of comforting presence implies what Rogers describes as an "atmosphere which simply demonstrates 'I care'; not 'I care for you *if* you behave thus and so' " (Rogers 2004: 283), which is love in all but name.

Several chaplains speak in terms of being-*with* dying people explicitly in terms of loving them:

> My job is to enable people to feel loved and valued and accepted just as they are, by me—and hopefully by other staff; by God, if they're open to hearing that (Susan).

> They need to know that they are unconditionally loved, and that nothing that they've done…or not done can affect their relationship with God (Elizabeth).

Almost by way of counterpoint, David wants to qualify the quality of the love that he offers, describing it as a "professional being with," a being-*with* that is "professionally circumscribed." He references Campbell's (1984) idea of "moderated love":

> [loving the dying person] is something that I am doing in this situation… I'm not gonna take it out with me…this is not gonna be burdening me once I leave that room.

He has a point, and Campbell himself agrees: "the professional does not and cannot love (or hate) a person as a relative or friend does. There is a necessary detachment in professional care" (1984: 85). Nonetheless, Campbell insists that the "moderated love" offered by professionals "*is* love": "It is a reaching out to another in the desire to enhance the value which is seen, and such reaching-out requires the non-rational connection which feeling alone can create" (1984: 85).

Writing personally about professional love, Sheila Cassidy observes that healthcare professionals, "trained to *suppress* our love," keep a safe distance from patients with the result that they meet as "professional and client, not of the frail human beings that we all are" (1988: 22). In her experience, "those facing death have a particularly urgent need of human warmth and honest straightforward communication" (1988: 26). She goes on to describe, graphically, simply holding (physically) her patient, stripped of all her intervention skills, medical and counselling, left simply as a being-*with* (1988: 61–64).

The Fourth Moment: Hopeful Presence

I have noted that, although chaplains seem not to think specifically in terms of helping dying people find hope, they nevertheless feature hope as an important aspect of their clinical work. In part, they reconceptualize hope as *hope in the present*, a move that seems counter to common sense and to the concept analyses that regard hope as future oriented (Benzein and Saveman 1998: 323; Chi 2007: 415; Johnson 2007: 454).

However, redefining hope in terms of the present is congruent with the traditional use of "hopefully," in the sense of to be "in a hopeful manner" (*Compact Oxford* 2003). As such, hope in the present tense relocates hope as an attribute of being; as Smith-Stoner and Frost put it, "the energy to move forward" (199: 48). In the face of a terminal diagnosis, it seems possible for hope to be reconfigured: not only a dying person's specific or particularized *hopes* (Nekolaichuk and Bruera 1998: 38), but *hope* itself.

Philosophers Garrard and Wrigley argue that, for dying people facing despair, what Marcel (2010) terms "absolute" hope can and does change. Absolute hope becomes possible when an individual is threatened with despair. In this situation, absolute hope becomes "an overall stance towards life," which recognizes the inevitable yet remains open to the possibility of experience and "involves hope in others" (Garrard and Wrigley 2009: 41). Garrard and Wrigley accept the objection that absolute hope is not "what we mean when we commonly use the term 'hope' " (2009: 42). Nonetheless, they highlight the subjective quality of hope that, for others is "grounded in the uniqueness of experience" (Nekolaichuk *et al.* 1999: 592).

Ronnie Levine, a psychoanalytic group psychotherapist, articulates the complex and subjective structuring of hope operating at the level of the unconscious with regard to internal object relations. He describes the individual with good internal objects as able to experience "mature hope" and "able to perceive and respond to new possibilities" (2007: 299). The parallel with the individual threatened by despair is obvious (Garrard and Wrigley 2009) and the prospect of such a person achieving absolute hope is remote unless, as Levine suggests, they experience "surviving empathic failures" through interaction with a good enough object (2007: 302).

There ought to be little surprise that the findings of hope research indicate the importance of human relationship for dying people. Rumbold identifies strong supportive relationships with other persons as "common to all cases where there is a hopeful acceptance of death" (1986: 70) and "interpersonal connectedness" comes at the top of Herth's seven categories of hope-fostering strategies (1990: 1254). Her

participants describe this as "'the feeling that the person is truly present with me', 'the touch or hug that communicates "I'm with you"'" (1990: 1254). (It should be noted that Herth's findings were replicated by Buckley and Herth [2004], and more recently Chi found the importance of "affirming relationships," "positive relationships with professional caregivers" and "supportive family or friends" rated highly in five out of seven research projects she identified as addressing "the strategies patients used to maintain hope" [Chi 2007: 421].)

Several chaplains express the idea that being with dying people who are without hope effectively says to them, "You're not alone; there is someone with you." Elizabeth describes herself as being "used to sitting in the pits with people and not trying to change it for them." She speaks of "the kind of black despair in which the only way to help someone is to enter it with them and to stay with it." For her, being with people in the hard and difficult place is far from hope-less:

> I don't see it as hopeless work at all…staying with people in the darkness is, is not a hope-less situation, because I think, in the process of grief, working with people in that pre-death, pre-bereavement work, I see it as (more for the person who's dying), a support and a love, and to be loved when you are without hope is something that is actually beautiful.

As Paul puts it:

> hope can be hoping for a comfortable death and being loved while you're dying.

Christopher explicitly identifies his presence as actively evoking a sense of hope, which he associates with giving the dying person a feeling of security:

> by the time that I actually came to see her, she was not really able to speak; but I think that there was hope, there was certainly an element of hope in the encounter, evoked by my presence, which made her feel secure.

Significantly, he feels that what was important to this dying woman, whom he imagines felt "cut adrift" by her illness, was that she had made "connections to stuff that [she felt] safe with…knowing that [she was] anchored in some sense, that [she'd] got some kind of solid foundation." For him, this sense of security "is a source of hope."

Conclusion

This study was prompted by my question about whether I had given Daniel appropriate support at the point he needed it, the point at which he was at risk of falling into despair. What has emerged from the study is the idea that the most significant "tool" a chaplain brings to his or her

work with a dying person is not religious knowledge or liturgical skill, but himself or herself; that offering their *presence*, their being-*with*, may in itself help a dying person be hopeful.

It is significant that chaplains appear to have understood and to practice this way of being-*with* intuitively, in other words, without consciously processing it. But then so much of what goes on between the chaplain and the dying person is unconscious, which is why the language and the categories of psychotherapy have a particular relevance to thinking about this relationship. However, chaplains are unlikely to have had the kind of training that would equip them to be even more effective in their work and this research hints at the potential value in training chaplains (and probably all religious ministers) to work relationally.

The study reaffirms the distinction between religious and spiritual care, both of which are the work of chaplains. However, while it is possible for a chaplain to deliver religious care without ever actually being present (in the sense of being a presence) *with* a dying person, spiritual care depends on a high degree of presence, such that it may be that presence is *the* mode of spiritual care, certainly for people who are dying.

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