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CHAPLAINS AND PERSONAL GROWTH, NATIONAL EXPERIENCES.

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After the interesting contribution of reverend Kirsti Alto from Finland, it is an honor to present to you my contribution to the topic of “Chaplains and personal growth” from my experiences on a national level. I will try to hand you some anchor points out of my experience as a catholic spiritual caregiver. For the past fifteen years I have been a spiritual caregiver in a mental health facility called Mediant in Enschede. This institution has some units for admittance, an outpatient facility and some other forms of care for people older than eighteen years.
As a spiritual caregiver I do liturgy, rituals and I work with groups and families in an interdisciplinary context. In this short contribution I will limit myself to the main part of my work – which I cherish most – namely the individual dialogue with patients.
In the short time that is given to me, I would like to offer a view on some of the anchor points in the personal dialogue with patients that I developed. My personal growth as a spiritual care giver has taken place through insights, feelings and competences regarding those anchor points.
I would like to start with my vision on the patient, followed by the one on the spiritual caregiver and to conclude on the dialogue between both of them. I have to say that dividing those three is artificial in order to learn, as one cannot speak about the one without involving the other two. The influence between the three named aspects is typical for an evolving dialogue from the perspective of a hermeneutical narrative approach – which I support.

The patient

I prefer the word patient to the much used client when I talk about the people in my work I have conversations with. The word patient indicates that someone who needs care can feel sick, in need of and not okay. This in contradiction with the word client which emphasizes autonomy which is not something a lot of people in our facility can live up to sufficiently. I learned that it is better to name the negative, the suffering and in that sense the ‘passion’ of people. An optimistic use of language disguises negative experiences.
In my office I receive patients on a voluntary base. They can choose to come and talk with me or not. There is no obligation to do so, nor are people forced to. Patients enter with a story. This story can refer to themselves, or an experience in daily life, or an experience in the past or an experience referring to their future. In the patient’s story, all these dimensions can resonate separately or together.
Patients often experience loss in the present. They can lose their health, their autonomy, their self-worth, physical, social and psychological competencies, their identity, relations, societal value, freedom, contacts and intimacy within a contact, their happiness, faith, hope and love. To name a few. And in most cases we are not only talking of loss but also of an increase in fear, guilt, shame, internal and external pain, illness, unhappiness and loneliness.
By telling a story the patient can name these experiences and thus learn to relate to them. He can try to give them a place (*een plekje geven*) as people say. By telling a

story a patient can learn to understand himself better and face his life history and eventually accept it. He or she can even – in a psychological sense – regenerate out of patterns of feeling, thinking and acting which are imprinted in a distant or near past. By telling a story a patient can start thinking and feeling differently about the future and give a turn to the experience of events. He or she can acquire a different feeling connected to experiences. Summarizing: by telling a story a patient can start to feel better.
He or she needs a space to do that, a listening ear, understanding and encouragement, so that words can be born for the many experiences, also words for experiences of emptiness. The patient needs to feel safe in that space given by the spiritual caregiver, understood and acknowledged, in who he is, was and wants to be.
Mostly patients come with superficial stories under which a deeper meaning is buried. An insight I developed is that everything said has a meaning. Nothing happens for nothing.
In a mental health setting patients usually come to find me with underlying life-questions, with experiences on a deeper level, with stories about the meaning or lack of meaning of life, with the slow questions (questions that do not know a quick answer) of life. They enter with stories about life and death and everything in between that is meaningful or meaningless. They talk about life and death in every day. The patient often seems to acquire experiences under a magnifying glass. Feelings show themselves more intense and hefty than outside the mental health facility: overpowering feelings of fear, guilt, emptiness, and sometimes of extra ordinary happiness which can also be uncomfortable because you can lose yourself in it. In a mental health context existential experiences seem to be more dense. Life and death, happiness and unhappiness are being magnified and are focused on. Quality of life is often a topic of discussion. And of course the patient also always has a story about soccer or food or the weather. But a good listener can hear more.
Sometimes God is brought up or new words are given to who God is for me. Sometimes religion is brought up as a source of destination, confirmation, expansion, as a source of happiness. But probably more often religion is discussed as a source of fear, lack of freedom and a form of imprisonment. Religion can be good news, liberation, gospel – and that is the intention – but many experience in and through religion limitation, a belittling morality and a fear for living and dying. I deliberately expressed the above in terms of religion. Often one can observe the negative function (for themselves) of Faith in faithful people in a mental health facility. But this does not only goes for a religious life view. In our individualistic and pluralist modern society people construct their own life view. People can be burdened by their life view. It is the task of a spiritual caregiver to make this burden lighter or to transform it into support. And thus we come to the spiritual caregiver, as a partner in dialogue with the patient.

De geestelijke verzorger – the spiritual caregiver

(Translator's note: the term '*geestelijk verzorger*' does not easily translate in English, but we will use the term 'spiritual caregiver')
The name 'spiritual caregiver is a big failure according to me. This is certainly the case for a mental health setting but I suspect also for other health care institutions. As if a spiritual caregiver only 'takes care' of the 'spirit' whatever that is. A lot of extra explanation needs to be given to the use of the term 'spirit', before I am able to use it

in the context of a mental health facility, which in my country is called '*geestelijke gezondheidzorg*' (care for the spirit). Also the thought of care giving is nonsense if you want to work in a culture of dialogue, a context of mutuality. There is no good name at this time, probably also because the content of the profession is changing, in any case in the eyes of outsiders who often don't understand a lot of what we do. This is also caused by spiritual caregivers themselves who participate to little of in societal debates and therefore fail to communicate the knowledge about the content of their work. But this as a side remark.

Back to my topic: where did I grow as a spiritual caregiver? What did I grow to value?

First I want to talk about space, creating a space to talk, yes even creating an as neutral as can be space. The spiritual caregiver needs to try to create an empty space in his or her office which invites the patient to tell his story in his ways and fill the space according to his or her thinking and feeling. The patient benefits by storytelling and by telling it in his or her own way. An encouraging, waiting and interested attitude of the spiritual caregiver is a must. This seems like a given, an open door, but in practice it is not an easy thing to acquire.

Books on individual conversations learn us that the spiritual caregiver does not need to steer the conversation by asking straight informative questions. Nor can the spiritual caregiver use advising, moralizing, generalizing remarks or expressions. An integrated attitude of empathy is usually advised. In theory one often refers to Roger's methods of empathic feedback. Those are certainly good directions for a conversation.

What is of value to me is that I try to create space for a dialogue and try to be myself as much as I can in that space. Congruence, we call it, a merger of your role with yourself, to put it simply. I am convinced that the patient can tell his story best to a human being of flesh and blood, who is also standing in life, searching, having emotions, thoughts, attitudes, with a certain print of the past and a vision on the future. The created space cannot, however, be taken in by the spiritual caregiver. The space is there for the patient. The patient decides which direction it goes, what is discussed, he or she brings in 'something'. The spiritual caregiver tries to be a functional instrument, which every capacity he has as a person. He or she engages out of personality in a dialogue which is functional for the patient.

In creating space for the patient, confidentiality is an important element. It is a condition for creating a real free space for the patient. If there is confidentiality, there is free space. The image of confidentiality of the spiritual caregiver is rooted in his or her ministry. The patient counts on it.

The contact between the patient and the spiritual caregiver is of the highest importance. Only within a meaningful contact, a patient can tell a story and listen to himself talking. The spiritual caregiver therefore needs to offer himself as person in the contact. If the spiritual caregiver is stuck in a to functional perspective on his job, the contact will be less meaningful and thus superficial and therefore less of a support to the patient. A spiritual caregiver needs to express as much trust as possible by trusting the patient and himself. Both are not easy and must be gained in the dialogue. They are not a given.

To gain insight in to a patient, I often use the image of breathing. I often pose myself the question: how does the breathing of this patient looks in his social environment? Can he breath in sufficiently? Is he getting enough? Does he breath out sufficiently and does he give enough? Does the movement of breathing comes easy as an

unconscious method or not? O do not discuss it with the patient in this manner but at a certain point I use this knowledge in the contact.
The contact between patient and spiritual caregiver has a base of equality. Both partners are worth the same. The contact is not mutual because the spiritual caregiver steps into the contact out of his function and the patient does not. The contact needs to be or become functional for the patient, not for the spiritual caregiver. That is a major difference. The spiritual caregiver needs to be a guarantee for that. It is balancing on a rope between distance and closeness, between a functional role and an intense personal intimacy. If the spiritual caregiver forgets himself at home, the patient can forget a functional contact.
Another image I often use is the one of seduction. It seems strange to use it in this context but I do mean it. The spiritual caregiver needs to try to seduce the patient in a relationship of trust to other thoughts, other behavior, another world of feelings. The patients often wants something to change. It usually does not help, as you know, to tell him to make the changes. An advice like that is often forgotten and taken lightly. It does not work well. The only way is within a relationship where the patient values the opinion of the spiritual caregiver. In that context he will need to be invited to – step by step – see and feel something different. The art of seduction is an important art for the spiritual caregiver. Based on where the patient stands, he or she must try to bring the patient to seeing and feeling differently. It must be attractive for the patient to change, because changing and learning always hurt. You cannot learn the important things in life without hurting. A spiritual caregiver must own the art of seduction.

To conclude I would like to say something about the love of the spiritual caregiver for the patient. A big word with a lot of possible misconceptions. I won't go into that. What i want to express is the following: I have experienced as a spiritual caregiver that if you love a patient in an appropriate way, you can apply the art of seduction better and this will be functional for the patient. The thought appeals to me and I experienced it that way. It is always love that needs to do it. The love of the spiritual caregiver for the patient is healing, makes him whole through his own activity, because eventually the patient needs to do it himself. That brings me to the last part: the dialogue.

The dialogue

The dialogue between the spiritual caregiver and the patient is a unique event. Always different and always evolving. This is how I came to think about it. I have learned to start the dialogue with an opening sentence. Mostly I ask the patient: How are you? And most of the times the patient starts telling. I think this a broad opening sentence. I am convinced over the years that whatever is weighing on the patient will come up. Even more: he or she can't help it and is driven towards a strategy of solutions, whether it will help or not, but wants to discuss it anyway. If something is bothering you it comes up sooner or later. Also covering it up will show. Where the human spirit searches towards a solution, it will come up autonomous. It is up front. Even if the dialogue tackles football, the problem resonates to, because it bothers or burdens the person.

As a spiritual caregiver I don't take notes of a dialogue anymore. I did when I started out but found it more of a burden than an advantage. This because of my growing conviction that whatever needs to be told will be told if I listen in a good way and try to bring it to the surface in communication. It makes the dialogue also more to a dialogue where everything needs to happen. It's not about what I remember well or

not. My memory is selective and it can be beneficial if I forget some things and the patient needs to retell. This story telling will be different the second time.
In a dialogue the mirroring of each other by the spiritual caregiver and the patient will among others determine what is talked about. The story of the patient will become differently because of it and he or she might come to changes in experiencing. In the presence of the other one becomes more him- or herself. In the dialogue with the other one becomes more himself. These are expressions that are helpful to me. The more the spiritual caregiver is able to be present in a congruent way, the more the patient will discover or find himself in his own story, in his life story. Congruence in one partner in the dialogue calls for authenticity and congruence in the other. And that is healing.
There is much to be said still about dialogue. It is always about hermeneutics: understanding, seeing and feeling the story of the patient. It is also always about the hermeneutics of the dialogue in its whole. That what is happening in a dialogue from a meta perspective. The whole of the dialogue can also be understood as standing in the presence of God or the divine.
I think it is a beautiful thought to see and experience God as the third one in the relationship (*Der Dritte in Bunde*). He is also looking. Under God's hands we are active in this dialogue. He is in and determines the content of the dialogue! My relationship with God, the relationship of the patient with God or the divine resonates to, at least in our experience. The dialogues are not always explicit referring to Him, but He is present and I see myself in his image (face), I look at the dialogue in His image. I experience the patient as someone to whom God is also a Father. The patient can either experience it that way or not. The criterion for that is the function for the patient. That is an anchor point for me: the dialogue gets its form in the presence of "*Der Dritte in Bunde*". And this turns the dialogue into a pastoral dialogue.
I want to round it up here. I tried to take you on the road of my personal growth as a spiritual caregiver in a mental health setting through some concepts, experiences and insights. All that I mentioned is of a high importance to myself. It became the base for the dialogues I have with patients. I hope that my learning experiences will be fruitful for all of you.

Thank you for your attention.

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