M.E. - What's it all about?

Much confusion reigns over the concept of M.E.! The term M.E. was introduced in the 1950's – "M" for myalgia (muscle pain which occurs) and "E" for encephalomyelitis (inflammation of the brain and spinal cord for which there is no scientific evidence).

The wider medical profession accepts the term Chronic Fatigue Syndrome (CFS), a term which both those with special interest and sufferers dislike intensely. After all, the term "fatigue" suggests something from which one can readily recover. We know that the illness involves persistent fatigue plus post-exertional malaise (after both physical and mental activity).

Sufferers may experience the following symptoms:

- Pain including the myalgia, but also joint pain.
- Headaches and nerve pain and/or pins and needles.
- Desperate sleep disturbance, which can involve both insomnia and sleeping for very long periods (called hypersomnia).
- Significant cognitive disturbance, involving concentration, short-term memory problems with planning and organising thoughts, spatial disorientation and word-finding difficulties.

Also frequently encountered are:

- Feelings of poor temperature control.
- Dizziness on standing and even on sitting up and eating when very severely affected.
- Increased sensitivity to light and noise.
- Recurrent sore throats and tender lymph glands.
- Marked digestive disturbances including nausea and appetite-loss with frequent change of bowel habit, abdominal bloating and cramping.

It is not surprising, therefore, that the term "CFS" is so inadequate. The above symptom list suggests problems with the immune system but, amongst other possibilities, involvement of the brain and in particular, the brain stem and its knock-on effect on the hormonal systems. I, therefore, much prefer the term M.E.

M.E. appears to have a UK incidence of 3 to 4 per 1,000 head of population and it affects men, women and children of all ages and backgrounds, but is more common in females. Further research into possible causes and appropriate management strategies is needed. It appears, for example, that approximately 60 per cent of cases have a definite infection as their apparent final triggering cause. These cases are therefore often labelled as Post Viral (or Bacterial) Fatigue Syndrome and, if symptoms persist for more than 6 months, the CFS label is then applied.

In cases without an obvious infection trigger increased over-activity, or various stresses and physical injury may play a part. Trauma as a result of a road traffic accident appears more likely to trigger Fibromyalgia, which is a condition with approximately a 75% overlap of M.E. symptoms but in which severe whole-body pain is a very dominant feature.

Stressful life events such as bereavement or divorce are common around the onset of symptoms, or triggering event, such as an infection. It is becoming increasingly apparent just how much stressors can affect the physiological processes of our bodies. In cases where there has been a clear history of earlier physical and/or emotional abuse, symptoms of M.E. often begin after life has apparently improved for the individual and escape has been made from the source of abuse. It is recognised that conditions such as Post-Traumatic Stress Disorder and Post-Head Injury Syndrome share several features of M.E. but have distinguishable symptoms to clarify diagnosis.

M.E. is often diagnosed late and still, all too commonly, is considered as a diagnosis by exclusion. Often careful history taking might reveal an obvious cycle of events suggesting the onset of M.E. This can help in early diagnosis and seeking specialist help. A recent study of 200 local patients sought to understand why some people develop severe M.E. whilst others have a less severe illness. Initial findings suggest that those people ill for more than 5 years before diagnosis are more likely to be severely ill. More of the people with severe M.E. had had a severe infection in the month before they fell ill with M.E.

Frequently, the first resort of the medical practitioner has been to prescribe an anti-depressant. However, experience shows that some modern anti-depressants are often unhelpful due to the side effects and poor tolerance of drugs when given in the standard recognised dosage. However, use of very small doses of older anti-depressants help sleep promotion and these, used together with anti-epileptic drugs, help as pain pathway blockers.

As there is no obvious curative treatment at present, emphasis is placed on symptom relief and helping patients by recognising their illness and assuring them that they have a real condition. Supportive counselling may also provide a valuable resource for the patient to be able to cope with the changes occurring in their life. The patient needs to recognise the 'illness-maintaining' factors i.e. sleep disturbance, and that excessive pushing of activity followed by inactivity can cause a worsening of symptoms. These setbacks and relapse of symptoms form a peak and trough pattern, are common and can prolong the illness. An Occupational Therapist may help patients to pace themselves at a level of sustainable activity thus avoiding the peaks and troughs. This, coupled with a programme of self management, hopefully encourages healing in time.

Dr Martin Lee

Life Issue Workshops

A series of open workshops on issues of common concern will take place at The Pilgrim Centre in June 2005.

Each Wednesday evening during June, a representative from a local organisation will cover a topic from the programme to the right:

The evenings are free, although donations are invited to cover costs.

Who is it for?

Anyone interested in finding out more for themselves, their families, friends or clients, Pastoral Care teams, counsellors etc.

Please put the enclosed flyer on your Church notice board.

1st June	**Bereavement** Cruise Bereavement Centre
8th June	**Depression** MIND
15th June	**Cancer** Macmillan Nurses
22nd June	**Broken Relationships** Swift Family Therapy
29th June	**Stress** Willows Counselling Service

Training

Introduction to Pastoral Counselling Course

Level 1 Training: Cost £160
ACC Level 1 Course in Christian Counselling (CTi/NOCN Introduction to Counselling Units)
This is a 12 week evening course and will commence in September 2005.

One Year Certificate Course in Integrative Christian Counselling

Level 2 Training: Cost £835
ACC Level 2 (CTi/NOCN Advanced Certificate in Counselling Skills)

This is a daytime course to be held on Wednesdays 14th September 2005 - 5th July 2006 9.30 am - 2.30 pm and Saturday 26th November 9.30 am - 4.30 pm, plus three Topic Workshops
Entrance criteria - Successful completion of a Level 1 Training Course

Two Year Level 3 Advanced Diploma in Therapeutic Counselling

A Diploma Course is being rewritten to comply with the criteria laid down by the Counselling & Psychotherapy Central Awarding Body (CPCAB). This will be an ACC accredited course and is planned to commence in September 2006.

Saturday Topic Workshop Programme

Jointly organised with The Harnhill Centre of Christian Healing

Venue: The Harnhill Centre, Cirencester, Gloucester
01285 850 283

Cost: £18 per Workshop (£50 for 3 Workshops booked together)

14th May:	"Issues for Partners and Families of Abuse Survivors" - Mike Fisher
11th June:	"Depression" - Dr Stephen Brooke
9th July:	"Emotional Dependency and Co-Dependency" - Dean Fudge
15th October:	"Stories and the Journey of Life" - Chris Sunderland

Myers-Briggs Topic Workshop

Saturday 26th November 9.30 am - 4.30 pm

For further details of the above courses, please contact Avril Fray, Training Manager at Willows 01793 706646
E-mail: training@willowscounselling.org.uk

How to contact us:

The Willows Christian Counselling Service, 496 Cricklade Road, Swindon, SN2 7BG.
Tel: 01793 706 646 **Fax:** 01793 728 345
Email: willows@willowscounselling.org.uk **Web site:** www.willowscounselling.org.uk
Reg. Charity No: 1037677

pastoral care news

EDITION No.7 Your Resource for Better Living! MAY 2005

What is Dissociation?

Dissociation is a term that is becoming more familiar and widely used. So what does it really mean?

Dissociation describes a process of mental, physical or emotional disconnectedness within ourselves. It happens when the brain focuses upon some things and excludes awareness of other things from consciousness. It happens when we are absorbed in a book or a hobby and have lost awareness of time or of what is going on around us, or if we are daydreaming i.e. when we have not heard what someone has said to us.

Another good example is if we are driving a car, engrossed in conversation or in our own thoughts and fail to realise how far we have driven or even been conscious of what else is on the road! We have been driving in an autonomous state of mind. Dissociation plays many roles and functions in our life and we utilise it without realising it.

Cont'd on page 2

Is Sandplay Therapy just for Children?

Sandplay is a gentle, but deeply powerful, form of creative therapy using miniatures/objects and sand to create stories, scenes, images, patterns, shapes etc. within a box (tray), which acts as a safe container.

Sandplay was first used with children in 1928 and subsequently evolved in many ways. It is now also extensively used with adults. Sand Therapists are trained in the most widely recognised form, largely based on Jungian psychology, Sandplay is practiced by a global network of therapists. Its main aim is to facilitate personal wholeness, enabling individuals to be more at peace with themselves and to relate better to the outside world.

Cont'd on page 4

Healing Wounded History – Listening to the Stories of the Land

Listen! Your brother's blood cries out to me from the ground. (Genesis 4:10)

Every so often an issue surfaces in the counselling world which strikes a chord and beckons you to follow its trail into making new discoveries. For me, the book 'Care of Persons, Care of Worlds' (Abingdon Press, 1992) by Larry Kent Graham was one of those moments. Graham used the word 'psychosystemics' to describe the process of not only counselling and caring for individuals, but also attending to the corporate or group stories which have influenced their lives. It was from this revelation that my adventure in exploring wounded history began leading, eventually, to a book with that title in which I identified some of the group stories of family, church, community, tribe and nation. The journey into wholeness requires us to respect and work with the stories which have shaped and made us.

I remember attending a Christian celebration walk in down-town Toronto with bands playing and huge numbers of people singing and enjoying the event. I noticed one man who stood out from the crowd because he looked so hostile and angry. I approached him and asked why he was reacting like this to the Christian witness. He said that he thought they were proud and arrogant and, when I pressed him, went on to say, 'These are the people who stole my land!'. He was a Native Canadian and the route of the march was through the area from which his people had been forcibly removed to a reservation. All he could see were Christians walking his land, singing songs of triumph about Jesus conquering their enemies.

Cont'd on page 2

Inside:

Healing Wounded History

(Cont'd from page 1)

What he heard was white people saying they had won. His unhealed history was acting as a filter for his present response. He might have been more attracted to Jesus if the march of witness had included a confession and apology for the evil done to his people.

In order to help people find healing we may have to discover the group stories which have shaped them – but how?

We need to listen to God. God told Cain in Genesis 4 that He could hear the land crying out with the blood of Abel. Cain did not want to acknowledge murdering his brother and so the ground was to be cursed until the story was owned. Then the land would be healed. What people do affects the place in which they do it and, as such, goes on influencing people for generations. God can reveal these things to us.

We need to listen to the stories connected with our land. When Jesus prayed for Jerusalem in Matthew 23 He was probably looking across the valley at the familiar outline of the city and thinking of its history - the stories that had moulded it. He saw the most important factor about the life of the city as being shaped by the stoning of prophets and the rejection of the Good News. He knew how Jerusalem operated and saw the consequences it would suffer. His prayer was an appeal that the city would wake up to God and change how it shaped itself. Our clients are also shaped by their environment and part of our counsel and care is to take this seriously.

We need to own the stories of our community. There are five examples in the Bible where people owned and confessed the sins of various groups even though they themselves were in no way involved or responsible. Moses confessed the idolatry of his nation whilst he was away on the mountain with God. Nehemiah confessed the sins of a city he had never lived in. Ezra, who was celibate, confessed the sins of a nation losing their national identity by intermarrying. Daniel confessed as his own the sins of a rebellious nation from before he was even born. Supremely, Jesus, the innocent and holy Lamb of God, confessed and paid for the sins of all people. These prayers redeemed tribes and nations, restored cities, and made possible forgiveness of sins for the whole world.

One of the new adventures in healing is to discover how group stories affect us today. We must locate these stories, listen to and reflect on them, own and confess them, and then offer them to God for release and healing. Let us learn how to heal our history and make room for more wholeness in our own lives, and in our communities and nation.

Revd Russ Parker
Director, Acorn Christian Foundation

What is Dissociation

(Cont'd from page 1)

Dissociation also has a pathological role in 'trauma', when our brains and bodies dissociate from the impact of trauma to stop us being completely overwhelmed by it. Anyone who has experienced any sort of childhood abuse or trauma will also experience degrees of dissociation, as will any adult suffering from any form of past traumatic symptoms.

Severe dissociation can give rise to some of the following symptoms:

- Loss of feelings
- Loss of awareness of oneself
- Loss of sense of ones own body
- Sense of numbness
- Memory amnesia
- Not feeling in touch with ones own body or having out of body experiences.

Dissociation can also give rise to experiencing feelings or reactions, developed at the time of the trauma that intrude into ones consciousness. These can include bodily pain, overwhelming emotions, hearing voices in ones head (not to be confused with schizophrenia or other forms of psychosis).

Dissociated disorders are a natural body and brain response that many people may experience to differing degrees. It is not a psychosis or a personality disorder and can be treated.

More understanding of Dissociative Disorders will increase the chances of recovery for many people.

Mike Fisher

For further information:

t.a.g website: www.tag-uk.net

Mind booklet: Understanding Dissociative Disorders

U.K.S.S.D. (United Kingdom Society Study of Dissociation) Website: www.ukssd.org

Sidran Trust: www.sidran.org

Pottergate Centre: www.dissociation.co.uk

Pastoral Support for Parish Clergy

Stuart Taylor gives a personal reflection of Pastoral Support for Parish Clergy in a Changing World. How can Clergy lead, care for and help congregations to grow without adequate personal support?

I have little doubt that the work and role of clergy is a most difficult task. Like all of us, they work in a culture which gives the appearance of changing day by day.

Like many of us, they feel under-resourced to meet changing needs in a professional way. The context in which they work, the assumptions about them as people, the roles projected on to them, are difficult enough, but today these are compounded by reduced personnel, smaller congregations and higher expectations of presentation and commitment. My own work as Pastoral Adviser for Clergy and Families in Bristol Diocese brings me into contact with many in the Anglican Church for whom these are important issues.

The Role

Clergy are expected to fulfill many roles. The combinations can be pretty formidable. A brief look at adverts for parish jobs will confirm that many are looking for some ideal projection of the Christian life all contained in overflowing measure in one person. What is required is a prophet, a preacher, a teacher, a pastor, an administrator, a person of prayer and a person of utmost integrity, preferably married with a young family and the energy of a 40 year old! It is interesting that many, churchgoers and non-churchgoers alike, cannot see clergy as normal ordinary people with human limitations. It intrigues me that many clergy I work with have no job specification, which leaves them open to the private and undeclared expectations of every member of the congregation.

The Task

The job itself involves working with people at vulnerable times of their lives, sometimes working pastorally with highly dependent people, with all the emotional energy that this demands. Added to this is the disadvantage, for many, of working from home which encourages messy boundaries of working hours and lack of privacy for the family. Living in a tied house can also present untold complications when retirement looms or when marriages are showing signs of strain.

It is true, of course, that there are many rewarding moments in parish ministry. Sharing the high points and the desperate moments of people's lives is an enormous privilege. Being with those who are dying, providing appropriate pastoral support in many contexts and turning potentially destructive situations into creative possibilities is immensely rewarding. Preaching and teaching is stimulating. Accompanying people on their spiritual journey is fascinating, but all this can be very seductive. If all of this is put into a work context that was more appropriate to life 50 years ago than it is today, it is no wonder that many Clergy feel a sense of inadequacy and failure. This is compounded by the fact that we live in a culture that insists on quantifying everything. Much of what a parish priest does is hard to quantify; in fact the most important moments of life defy such a strait-jacket.

Caring for the Carers

My particular role with Clergy and Families in Bristol Diocese involves working as a counsellor in the formal sense, seeing people for a number of sessions. I might then refer people on to therapists with particular skills. I also work as a pastoral counsellor with the more fluid boundaries involved in visiting people at home. I sometimes work as a spiritual director on the understanding that there are often powerful interactions between the spiritual, personal and emotional aspects of people's lives. As a counsellor I am, of course, required to have regular supervision, I find this immensely valuable, not least because it makes some of the more difficult tasks manageable. I cannot believe that clergy should not have similar support, and I am increasingly encouraging people to have such supervision from those who are skilled either as work consultants or therapists.

A mutual support group has also been established. The aim of this group is to provide a confidential forum for people from the same profession to explore their difficulties. Two skilled facilitators support the group when they meet. The model used was devised by the Tavistock Institute as a support for GP's and relates well to clergy.

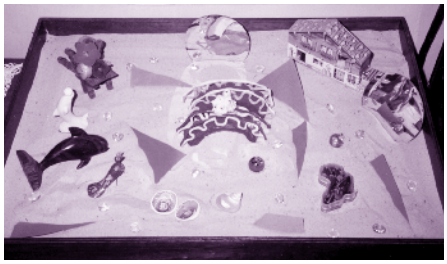
The basis of Mission

One of the priorities of the Christian Church is Mission. I firmly believe that pastoral support of the clergy is a pre-requisite of mission. How can they lead, care for and help congregations to grow without adequate personal support? My hope is that, increasingly, such encouragement comes not only from those who 'employ' clergy but that it is firmly seen as a task of the congregation as well.

Stuart Taylor
Bristol Diocesan Pastoral Care Adviser for Clergy and Families

Sand Tray Therapy

(Cont'd from page 1)



The following principles are important in understanding how this form of sandplay is seen to operate:

- People have a spiritual dimension.
- People have a conscious (known) and unconscious (unknown) aspect. The conscious works in words and concepts, the unconscious in images and symbols. Images are instinctual, and include "God" (however regarded), father, mother, hero figure and many more. Symbols hold meaning , but are not fully understood. Similar images and symbols exist in all cultures, (hardly surprising if we are all created in the image of God).
- Through trauma, loss, rejection or lack of spiritual/emotional resources, people bury supposedly "unacceptable" parts of themselves into a hidden, "shadow" personality, unacknowledged but constantly at work, often in conflict with the conscious.

Integrating and reconciling the conscious and unconscious brings healthy self-awareness, potential self-acceptance and the possibility for further growth. Sandplay facilitates this process by working at all levels of our being, revealing and freeing our "true self".

Sandplay can be used as a "one-off", but works best as a process. It can be used as a "stand alone" therapy or alongside other therapies. It is supremely flexible and is a creative therapy that requires no artistic skill.

Who is Sandplay Suitable For?

- People with identity or self-acceptance issues, relational difficulties; those deeply traumatised, those with early life issues.
- People who have problems communicating, or learning difficulties, especially if also traumatised.
- People who feel "stuck" using other therapy.
- People with mental problems.
- People who may not feel in obvious need of therapy, but who wish to develop their self-awareness.

The Sandplay Process

The following is typical, though there are widespread variations and new ideas evolving. The requirements for sandplay are two rectangular sandtrays, (the inside of at least one, usually the "wet" sandtray, is painted blue to represent water or sky) and a wide range of objects/models - usually including people, animals, plants, buildings, stones, glass beads, mythological and fairytale figures and religious symbols and anything else appropriate. (The client's history is obtained before sandplay commences.)

In each session, the client chooses to work with dry or wet sand by what "feels right" and is encouraged to work spontaneously, without pre-planning the tray. If the wet sand is chosen more water may be added. The "play" lasts for a maximum of 50 minutes.
The therapist acts as a silent witness to the process, noting how the tray is created, which can be important. The client may talk, but most do not. When finished, the client tells "the story of the tray", what it means to them, if they or others are represented in the tray, and any feelings or thoughts that have surfaced. The therapist notes the comments and photographs the completed tray. There is no analysis at this stage.

When a series of sandplays (not a set number) comes to its natural conclusion, the individual sessions (photographs and notes) are reviewed in sequence. The client describes what it means to them now. The therapist may contribute some insights of their own – interpretation of sandplay is not an exact science, but there are common themes and symbolic meanings, which may help the client's understanding. The whole process is reflected on by placing the photographs in sequence before the client and the therapeutic effects are considered.
The client receives a complete set of photographs as they may like to re-review the process at a later stage. Therapy, possibly including sandplay, may continue if the client chooses to.

Conclusion

Sandplay, particularly when used as part of a process, can be immensely therapeutic. Not only can the effects of trauma be worked though at the client's own pace, but it enables the client's "true self" to develop and emerge freer, to relate more healthily to God and others, and in Christian terms, be able to have more of the " abundant life" Jesus promised.

Chris & Sue Monckton-Rickett

Recommended Books for a good understanding of Sandplay Therapy:

SANDPLAY – PAST, PRESENT & FUTURE – Rie Rogers Mitchell and Harriet S. Friedman

SANDPLAY – SILENT WORKSHOP OF THE PSYCHE – Kay Bradway and Barbara McCoard.

For a Christian application of Jungian psychology. DANCING WTH YOUR SHADOW - Steve Shaw.

Debt Advice Service Progress

On the 10th January 2005 William Cullen left his family home saying he was taking a day trip to France. He failed to come home. In fact, he had driven to his workshop and took his own life out of despair over the amount of debt he had accumulated. He owed £130,000.

Against this tragic background, I'm delighted to say we are making great progress in setting up the "Willows Debt Advice Service" (WDAS). We had an amazing response to the request for people to sign up to become advisors and the 3 days of training is complete. We are planning to run the course again in the Autumn so if you're interested in becoming an advisor please let us know and we'll put your name on a shortlist.

The WDAS intends to work closely with Consumer Credit Counselling Service to achieve the greatest throughput of cases possible for the local area whilst still maintaining a professional, but personal, service to clients. The details of how the service will operate, the processes and procedures have been defined and it is planned to finalise the launch arrangements and publicly make the service live to the community after Easter.

For more details, see enclosed WDAS Newsletter. For more information please contact the Willows office.

Stephen Natt
Chair of Debt Advice Service Steering Group