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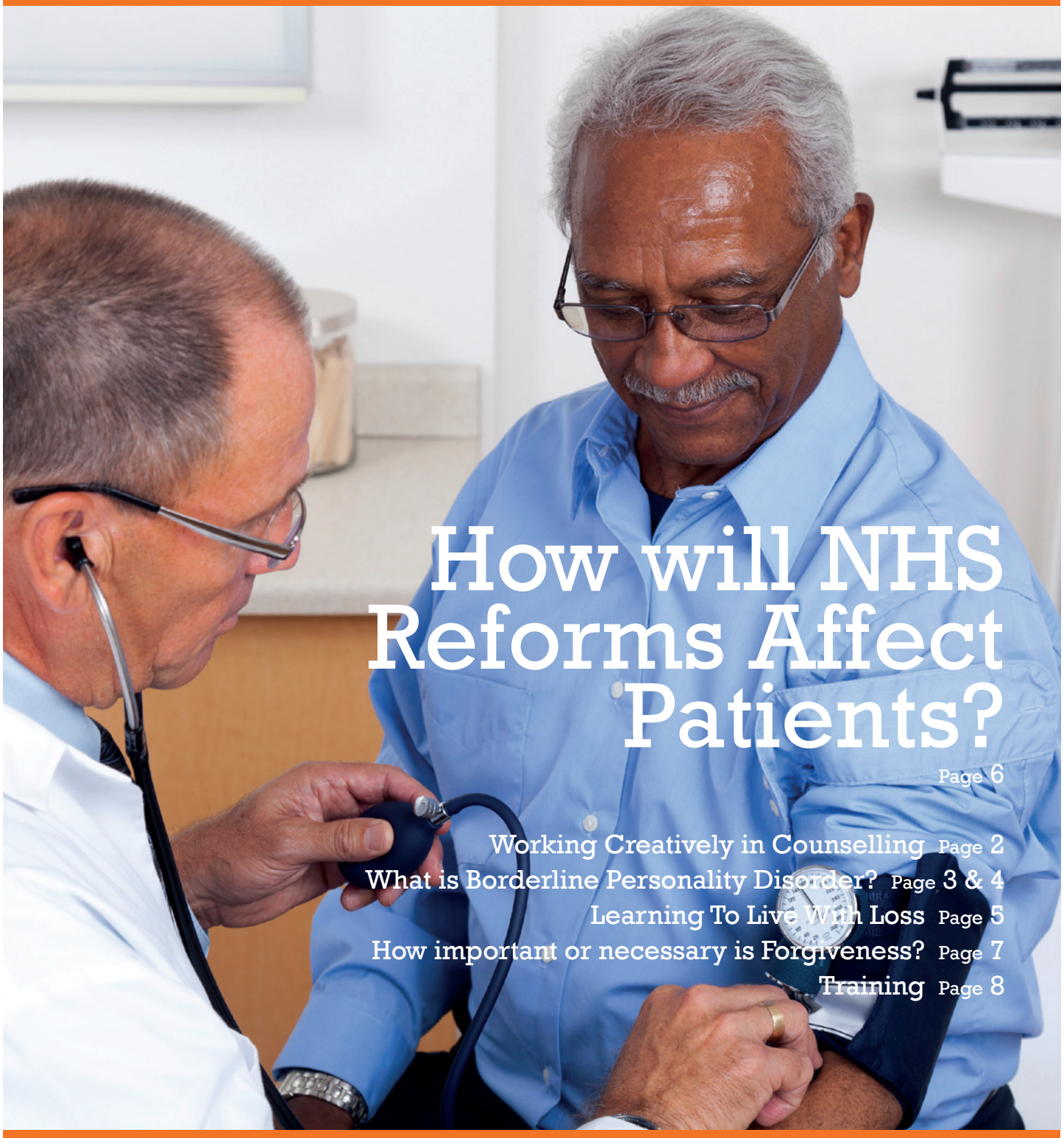
Pastoral Care News



How will NHS Reforms Affect Patients?

A Willows Counselling Service Publication

Working Creatively in Counselling

by Liz Day

Willows counsellor Liz describes how working creatively helped a client with long-term unresolved grief.

Florence, *(a pseudonym)* who is in her 60's, came to Willows to try and identify issues that might be contributing to her chronic depression. During the first session she was able to tell me a great deal of background information about her life. From this it became clear that she was still struggling to come to terms with the stillbirth of her daughter in 1982.

Pauline was born six weeks prematurely three days after Florence had been told that her baby had microcephaly and would probably only live a few hours. Microcephaly is a medical condition in which the circumference of the head is smaller than normal because the brain has not developed properly. Florence spent much of her prolonged labour alone as her parents were caring for her older children and she did not want her violent husband present. When Pauline was born (having died during the labour) she was immediately removed from the delivery room by the staff without Florence being allowed to see her. The cremation and internment were arranged by the hospital. Florence was eventually discharged from hospital to get on with her life.

Subsequent years saw the final breakdown of her marriage, the death of her father, years of caring for her mother who eventually died, and a move away from the family home.

Florence's natural grief for her baby was complicated by several factors:

- **As she was not permitted to see Pauline, and knowing about her condition, she wondered if her baby had been, to use her words, a 'monster'. She still had nightmares about this.**
- **As her baby was stillborn, Florence was not allowed to legally register her name.**
- **Although Florence knew that her baby's ashes were interred at the local crematorium she felt unable to initiate enquiries about exactly where they were. She had tried to do so, but had simply been handed a map and told to find the place herself.**
- **Her parents had seemed unwilling to allow Florence to talk about her bereavement because, presumably, they felt that this might make things worse. Her husband had blamed her for the situation. In addition, she felt that, throughout her life, she had never been allowed to say what she felt about anything.**
- **In 1982 there was no bereavement support following stillbirth or neonatal death offered by the hospital or wider health services.**

I suggested to Florence that one way of working through her grief might be to create a 'treasure box' containing items to remember Pauline by.

I realised that Florence was also grieving for her Dad who had 'rescued' her from her abusive marriage and taken her and her children back into the family home. We talked about Pauline and Dad being 'together' and she decided to include memories of him as well. As we worked on the treasure box, Florence brought in a soft toy and a guardian angel figurine as well as a photo of her Dad and one of his trophies. She knitted a small blanket to line the box and decorated the inside with baby stickers. I researched microcephaly and found a suitable picture of a microcephalic baby as well as a diagram to demonstrate the condition. I was able to reassure her that, whilst her baby would have looked different, she was by no means a 'monster'. During this time Florence was able to recount the events leading up to and surrounding Pauline's birth. She also talked about her Dad, how much he had meant to her, and how much she still missed him. It was clear that Florence was preoccupied with where her daughter's ashes were interred. With her permission I phoned the crematorium during a session and was able to obtain the necessary details as well as information about a newly opened Children's Garden of Remembrance.

We negotiated a visit the following week to identify where Pauline's ashes were interred and to lay flowers. We also visited the Garden of Remembrance sponsored by SANDS (The Stillbirth and Neonatal Death Society). The garden contains a wonderful statue of giant hands holding a baby with benches nearby for quiet contemplation.

Any parent who has lost a child is invited to paint a memory stone and place it in the garden. Florence decided that she wanted to do this. At her request I took photographs of the garden for her treasure box.

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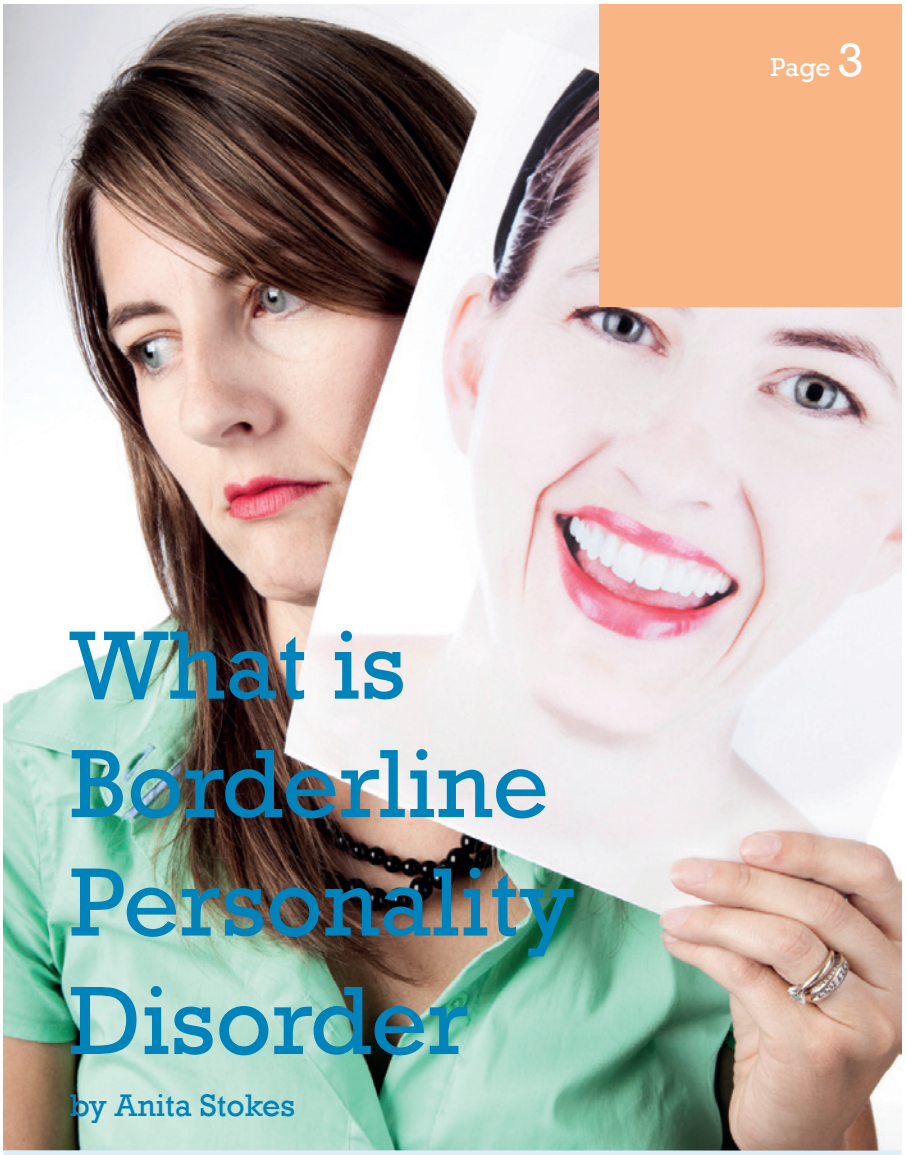
As she painted the memory stone Florence continued to process her grief about her baby. She added a doll and a hand-knitted cardigan to the box, as well as the photos. I encouraged Florence to speak to her church minister about the possibility of holding a small memorial service on what would have been Pauline's 30th birthday. This took place in the Garden of Remembrance and was immensely meaningful for Florence.

Florence has also begun to talk to family members about her baby. They had not realised the weight of grief which she had carried for so long. Having returned to church last year after many years, she has begun to build new friendships and a wider support network. Florence is learning to be more assertive and recognises that her feelings, and their expression, are valid. It has been a joy to watch her work through her grief and come to a place where she can lay some of her unresolved past issues to rest. She will never 'get over' her baby's death but Pauline now has a place in the present where she is acknowledged, remembered, and loved.

Note – This article is written and published with the full knowledge, consent and approval of 'Florence'



What is Borderline Personality Disorder

by Anita Stokes

Senior accredited Psychotherapist Anita explains how Borderline Personality Disorder can be recognised and offers advice for those who have contact with sufferers of this complex psychological condition

If you are involved in pastoral work, mental health or psychotherapy you will, no doubt, come across the term Borderline Personality Disorder. (BPD) If you are, or have been in therapy, your psychiatrist or psychotherapist may have included BPD in your diagnosis. But what exactly is BPD and how does it affect the lives of sufferers?

One of the difficulties with BPD is that it is a cluster of symptoms rather than one easily measurable problem. To add to the confusion, anyone can have 'borderline moments' in fact, it is a natural part of our development. When you examine the criteria listed below you will probably recognise some of them in many teenagers. Problems occur however, when borderline traits are no longer transient but persist into adulthood and affect the way in which an individual relates to others.

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According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) 2000, BPD is defined as

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, (characteristics) as indicated by five (or more) of the following:

1. *Frantic efforts to avoid real or imagined abandonment.*
2. *A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.*
3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
4. *Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).*
5. *Recurrent suicidal behaviour, gestures, threats, or self-mutilation behaviour.*
6. *Affective instability due to a marked reactivity of mood (e.g. intense Dysphoria*, lasting a few hours and only rarely more than a few days.)*
7. *Chronic feelings of emptiness.*
8. *Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).*
9. *Transient, stress-related ideation or severe Dissociative** symptoms.*

*An unpleasant or uncomfortable mood such as sadness, anxiety, depression, irritability or restlessness.

**Distancing oneself from reality to protect the mind.

BPD can be very difficult for sufferers. As indicated above, conflicting feelings epitomise this condition. The desire to be with others but scared of being let down, not trusting others but falling deeply into relationships too quickly and then feeling let down when such relationships are not reciprocated, a desire to self-harm and even commit suicide believing that others will be better off as a result.

As a friend or relative of someone with BPD you often feel as if you are 'walking on eggshells' and that you can never 'get it right'. You might feel overly responsible for his or her well being and at times want to give up trying. You often end up doing things that you wouldn't do for anyone else.

However, it is important that you put limits to demands made on you by keeping your boundaries firm.

Saying 'No' to certain requests from a BPD sufferer with whom you have a close relationship can help bring about a realisation that 'No' does not mean total rejection.

You may also notice that your friend or relative has a way of attracting chaotic situations, 'stuff' always seems to happen to them and others respond to them in a reactionary manner.

I am now imagining that you are looking at the above list thinking "Oh, I think 'so and so' might have this" If you recognise these traits in someone you know, it is important that you don't play psychiatrist and diagnose the 'patient' however tempting this may be. BPD is a very serious condition so if you know someone who seems to display some of the criteria listed above, it is important that they are cared for in a professional way. Your friend or relative will need your support and it can be very helpful if you are aware of the personal struggles this person is experiencing. Encouraging him or her to visit a GP will hopefully ensure referral to an appropriate specialist.

Long-term psychotherapy has been proven to be beneficial for BPD sufferers since it enables them to explore some of their internal struggles in a safe confidential environment leading them towards a more balanced life. Such individuals benefit from a support network but helpers also require supporting too. People with BPD often go undiagnosed for a very long time and they may have more than one mental health issue that adds further confusion. BPD is a vast and complex area, I hope that this article will help readers to recognise those who may be sufferers.

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Anita Stokes is a Senior BACP accredited practitioner and a Society of Analytical Psychology trained Supervisor. She has been Head of Counselling at The Counselling Centre in Tunbridge Wells for 8 years. She is now a freelance psychotherapist, supervisor and trainer. As a trainer, Anita has taught at certificate and diploma level on BACP accredited courses for 10 years. She has also co-facilitated pastoral counselling training within Surrey Borders NHS Trust and has delivered workshops across the South of England. She can be contacted by e-mail at Anita.counselling@gmail.com

Learning to Live With Loss

by Grace Hempstock

Willows Counsellor and Trainer Grace offers a realistic, yet reassuring, insight into a journey that all of us will take during our lifetime. Grace describes herself as a fellow traveller on that journey.

There are two things in life that we can be absolutely sure of. Each of us, without exception, has a time to be born and will have a time to die. In spite of this reality, death is often treated as being a taboo topic. Part of the experience of being human however, means that sooner or later we will be faced with both bereavement and a growing sense of our own mortality.

Whatever the circumstances through which our bereavement comes, learning to *live with* loss is an apt description of the journey that subsequently unfolds.

The days that follow bereavement will be very new territory and adapting to the impact of such change may feel like living with 'L-plates on'. This may be a more demanding time for some than for others and particularly so with the loss of a partner or a child. The level of support received from family and friends, our earlier experiences of loss, the quality of the relationship with the one who has died and our own patterns of coping will all be relevant.

When you lose someone you have been deeply attached to, you cannot avoid the pain of loss.

Since bereavement is a journey that involves a grieving process, it helps to 'normalise' something of what that entails!

In *Grief Counselling and Grief Therapy*, William Worden describes four 'tasks' which he recognises as a necessary part of the grieving process, although these are not seen as a "fixed progression".

Task 1: To accept the reality of the loss: The person has gone - physically - and they are not coming back. This can often take some time to fully register!

Task 2: To work through the pain of grief - physical, emotional and behavioural pain. One of the aims of grief counselling is to help facilitate people *through* this difficult task so that they don't carry pain and unresolved grief with them throughout their life.

Task 3: To adjust to an environment in which a loved one is missing. Worden suggests three areas of adjustment: External, Internal and Spiritual. Life has changed and there may be a need to adjust to a new sense of "Who am I *now*?" - perhaps involving coming to terms with being single rather than part of a couple. Death, Worden writes, "can shake a person's spiritual foundations and the bereaved person searches for Meaning in the Loss …. in order to make sense of it and regain some control."

Task 4: To emotionally relocate the loved one who has died and move on with life. Essentially this is about finding an appropriate way to keep a loved one *"with us"*, whilst still going on with life. For some, this is achieved in the form of charitable work that allows the loss to be given full expression and to tangibly *'remember'* in a way that helps others.

How long is a bereavement journey likely to take? Each bereavement journey has its unique set of circumstances. Certainly the first year will usually be very testing with birthdays, anniversaries, Christmas and holiday times accentuating loss.

Bereavement is not something one *'gets over'* rather it is something one *learns* to *live with* – and this takes time. Some 'benchmarks' might be adapting to new roles, regaining an interest in life and feeling more hopeful.

Worden draws attention to a sense of mourning – or grieving - as a "life long process" with an acknowledgement that there will be *"bad days"*. Pain, he says, will return, but one will be able to remember the *"in between times"* better! There is a tension here which Worden, I feel, addresses appropriately: *"We find a place for what we lose, but we also know that we shall remain inconsolable."*

Learning to live with loss can be an incredible journey and knowing that someone understands this and is willing to accompany us on the journey can help enormously. As a fellow traveller on life's journey, I have come to believe that. In God's economy, nothing we go through is ever wasted when it is placed back into His hands – and nothing - absolutely nothing can separate us from His love. (see Romans 8:v38)

How will NHS Reforms Affect Patients?

by Dr Tim Ballard

With the Health and Social Care Bill high on the political agenda, Dr Ballard highlights some possible pitfalls of this proposed legislation arguing for a more flexible approach to implementing the new system.

The plans of the Coalition government are causing much comment and concern across the whole of England. The proposed changes will not affect Wales or Scotland. At the heart of these changes is the desire to move the commissioning (the planning and arranging of care) away from Primary Care Trusts (PCT's) and for these responsibilities to be given to individual practices. There is some experience of PCT practice led commissioning carried over from the last Conservative administration in the form of practice fundholding. This enabled individual practices to take control of limited aspects of their budgets and to control patient referrals to specialists, based on a limited range of pre-negotiated services. The proposed changes are much more ambitious than this, with practices needing to form groups serving around 75,000+ patient populations. This will necessitate a more strategic approach to service development and provision since a great many existing practices serve local populations of much less than 75,000.

There are some significant threats associated with an upheaval of this magnitude. Firstly, public health departments do not appear to be a major part of the new process. Practice groups will need to make sure that public health departments are integral partners in this new vision of care rather than simply a bought-in service. Nationally, there needs to be a co-ordinated approach to service delivery which transcends common conditions. An example of this is the current debate that centres around availability of children's heart surgery units. Both proximity and the desire of hospitals to offer such a service needs balancing with the volume of work required to maintain clinical excellence. In this brave new world, it is not clear who will make decisions like this. There is also the need for practice groups to work closely and flexibly with hospital colleagues to design appropriate care packages, not necessarily determined by established structures or historical patterns of working.

The second major threat relates to key individuals and organisations needing to spend time on the process of structural reorganisation at a time in the economic life of the country, when all hands need to be on the pump to improve the efficiency of care delivery.

A third threat relates to the ability of GPs to take up this challenge in a consistent and uniform way. Previous and current experience in implementing new NHS systems has been gained by those keen to accept a challenge. However, there are no current plans to run any pilot trials for this new system. In addition, there will need to be a source of help and support for GPs and practices during the commissioning process; currently there is no clear mechanism for this to happen. I believe that the Royal College of GP's should take an active lead in this area.

Finally, many of these NHS reorganisation plans revolve around the marketing of healthcare in England to a much greater degree than has happened in the past. If the planned benefits are to be harvested, it will be interesting to see how the Government deals with hospitals and practices within such a new system who fail to perform to the required economic and financial standards. Will they be bailed out, leaving the whole new approach undermined, or will they be left to go under?

These proposed changes are certainly exciting and have the scope to deliver improved outcomes but there needs to be flexibility over the next few months and years as the new system evolves, rather than a dogged fixation to an ideology.

How important or necessary is Forgiveness?

by Dr Madson Peter Gubi

Senior counselling lecturer and Moravian church ordinand Dr Gubi, advocates that we are not devalued by God if we are unable to forgive, particularly when we have suffered severe and prolonged childhood abuse by those closest to us.

Should a Counsellor, who is a Christian, facilitate a client towards forgiveness?

Is there a faith imperative to do so? Amanda *(a pseudonym)* was aged 52 when we worked together. She had been sexually abused as a child by her father; she was unable to forgive and couldn't contemplate the possibility of forgiveness because of the horrendous nature of what her father had done, and its ongoing psychological and physical effects on her life. I respected, possibly colluded with her inability to forgive, but it left me with the question, 'How important or necessary is forgiveness?' – from both a therapeutic and a faith perspective.

Surprisingly, there isn't much written about the concept of forgiveness in the psychological literature[1], but West[2] advocates eight guidelines for the facilitation of forgiveness.

These include the following:

- *Forgiveness is a process… This process may never end.*
- *Timing… is crucial… and should be offered tentatively if… at all.*
- *Resentment, anger, hurt and fear need to be faced and explored before true forgiveness is possible.*
- *Forgiveness may involve empathy on the part of the forgiver for those needing forgiveness.*

These guidelines are not prescriptive of how forgiveness should be facilitated, but merely describe aspects of it. What seems important is the notion that forgiveness is a process, not something that is necessarily reached in order to attain it. It is an ongoing process that takes time[3].

As a Christian, it would be easy for me to say that Amanda ought to forgive her father. I have not had to endure her sickening experiences, except empathically, and that was sickening enough for me. Although the theological and scriptural basis for forgiveness is unclear[4], Christian tradition teaches that forgiveness is an imperative to becoming closer to living the divine within[5]. Psychological theory[6], such as it is, promotes the healing qualities of forgiveness and indicates that it is something to aim for when the client is 'ready' in the therapeutic encounter, rather than something that can necessarily be achieved. Again, it is a process rather than an end-point. Therefore, to talk of closure, moving-on, and letting-go is a misnomer, because the notion of process indicates an oscillation whereby forgiveness will be harder to encounter on some occasions rather than others. However, as a therapist and a Christian, I want to promote forgiveness wherever possible.

In the case of Amanda, where forgiveness is not possible, nor desired by her, I want to acknowledge that she is still fully a unique Child of God who is unconditionally loved and forgiven by God in spite of, and because of, her pain and suffering.

Because of her shame, Amanda is already robbed of her dignity and sense of self-worth and value. She is already drowning in the cesspit of her past without any further unintended judgement from me over her inability to forgive. Although Patton[7] considers her inability to forgive to be a 'defensive strategy', having worked with Amanda, I am more prepared to define this as 'empowerment'. Forgiveness, for Amanda, is both secondary and irrelevant to her shred of power in an otherwise powerless existence. The task for me is to be alongside her in her woundedness, not using my own judgement or Scriptural/ Christian tradition, to state whether she should forgive, but empathically embracing and cherishing her pain and strength in not forgiving. Whilst reconciliation can be moving and beautiful in cases where it is arguably undeserved, in the case of Amanda, it places responsibility for change on the one who has had most to bear in the first place' . It is not conditional on the perpetrator acknowledging his wrongdoing and responsibility, nor does it place any necessity on him to change. Because Amanda has already suffered most, reconciliation represents a further injustice to be encountered and overcome prior to the attainment of forgiveness – all of this in addition to the original injustice that she has already endured.

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Should she, one day, seek to understand her father and begin that process of forgiving from a place of readiness, it would be a privilege to accompany her in that process not because I think that God is judging her in not forgiving, but because she has reached a place of deciding for herself where her greater sense of empowerment lies.

This is a greatly abridged version of a more in-depth exploration of the subject by Dr Gubi entitled: "Forgiveness in Counselling: Is it a Christian imperative?" published in 'Thresholds: The Journal of the Association of Pastoral and Spiritual Care and Counselling', Winter 2010: 9-14.

Dr Peter Madsen Gubi, PhD, BACP (Snr Accred), is currently a Senior Lecturer in Counselling at the University of Central Lancashire, and a non-stipendiary ordinand in the Moravian Church. He has a private practice in Counselling, Supervision and Spiritual Accompaniment in Cheshire.

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Training

The following courses are planned for the coming year:

- Level 2 Introduction to Pastoral Counselling – October
- Level 3 Course in Integrative Counselling – 5th September
- Level 4 Diploma in Therapeutic Counselling – 6th September

CPD Training Evenings:

- Monday 28th May – Closures and endings (briefly including attachment issues which could be present) showing "Endings Therapy" DVD
- Thursday 21st June – Assessing new clients and their needs – report and letter writing – contact with other agencies
- Thursday 19th July – Working through reviewing and contracting (underlying issues – facing challenges)

Saturday Workshop:

- Saturday 2nd June – Myers Briggs Type Indicators

The following Saturday training days will take place at The Harnhill Centre, Cirencester:

- 9th June – Family Systems Theory" Susan Tollington
- 7th July – "Attachment Theory" Mike Fisher
- 10th November – "Trauma and Dissociation" Mike Fisher

For more information on the above courses, please contact:
Avril Fray, Training Manager at Willows.
Email: **training@willowscounselling.org.uk**

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Gill can be contacted on line via **www.gillfood.wordpress.com**

How To Contact Us

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