

Perichoresis, Pot Plants, Prayer Cards and Poiesis: A renewed pastoral paradigm emerging out of care of those with a dual diagnosis and conversations with midwives and obstetricians.

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### **Abstract**

This research arose from my experiences as a curate in England's Northwest seeking to embody God's love in the pastoral care of men with addiction and mental health issues (dual diagnosis), reflecting a wider societal issue around the care of people with that combination of problems, and the under-recognised role of clergy as unofficial 'front-line mental health workers'. This is a role that clergy get little training to discharge effectively, and so the research methodology employed was that of a Constructivist Grounded Theory as I've attempted to use insights from a variety of disciplines to act as a 'scaffold' in order to work out what clergy could meaningfully and consistently offer. Treatment for those with a dual diagnosis is difficult and often unsuccessful because it requires a collaborative relationship between patient and carer where often there may be a lack of acceptance that the issues exist. Insights were sought then from a related, but different field, namely midwifery and obstetrics, engaging with intrauterine death – where the mother may not have completely accepted the realities that they face. Interviews were conducted with clergy in the field, midwives and obstetricians. Accounts of the experiences of dual diagnosed individuals were sought through existing evidence in the public sphere to minimise the risk of harm for research subjects. Analysis of the research data revealed that pastoral care in those situations of complex bereavement are about embracing the tension between absence and presence, and helping people through that liminality, to reappropriate their grief and expectations of what life 'should be' to 'how life is' and 'how life might be in the future'. The significance of the role of objects is explored with particular emphasis on 'memory boxes', and their nearest equivalents in the field of dual diagnosis. These insights are connected to the academic study of the Doctrine of the Trinity, particularly focussing on the work of Sarah Coakley, with a thorough exploration of the metaphor of dance that has evolved around the concept of 'perichoresis' with connections made between doctrine and modern insights from dance studies. The result is a renewed pastoral paradigm that is collaborative, dynamic, liminal, and with an acceptance that care is not simply about 'being present', but about resourcing people for 'absence' as well through a poiesis that emphasises the freedom of the cared for, whilst encouraging and seeking what will motivate them to enter into the liminal space, a movement through which will enable their greater flourishing. This paradigm has implications beyond those with a dual diagnosis, and can be extended into pastoral care in its widest sense.

## **Summary of Portfolio**

Preceding this thesis were four elements of a portfolio of work which include a literature review, a publishable article, a reflection on practice and the research proposal which together helped to focus and direct the work that follows. Each of these elements were grounded in three experiences that will be further unpacked in the light of the research now completed, at the beginning of Chapters Three, Four and Five. The pastoral care of those with a dual diagnosis has been central to this research throughout. The literature review outlined existing treatment methods for dual diagnosis, alongside an understanding of Prochaska and Diclemente's model of change. Definitions of pastoral care were explored. The importance of narrative and the challenges of relationship with those with a dual diagnosis were highlighted. The ethical issues around working with vulnerable adults and an outline of some of the research methodology options were covered. Here, I called for reappraisal of the dominant 'shepherding' motif of pastoral care, leaving open questions about: 'confrontation' as a technique to be employed in the care of those with a dual diagnosis; and how best to 'construct narrative' in the pastoral encounter.

The publishable article focussed on the pastoral encounter as a reflection of Jesus' ladder linking heaven and earth (John 1. 51), assessing historical approaches to ladders, and reappraising current 'treatment' models of care explored earlier in the light of the ladder metaphor used by someone with dual diagnosis. The dynamic quality of the pastoral encounter was acknowledged, as was a sense that the experience of life for those with a dual diagnosis was of constant movement between the cross and resurrection. Work at this point was almost entirely Christocentric, despite recognising that the social dimension of care was vital.

The research proposal outlines the methodology (expanded upon in Chapter two of this work), as Grounded Theory. This piece outlines the manner in which the ethical considerations around research involving vulnerable people would be negotiated.

The reflection on practice brings my own narrative more firmly into the research. It is in this piece that 'Motivational Interviewing' was identified as the dual diagnosis care 'style' having the most to offer clergy. The midwifery metaphor is explained. By this stage in the endeavour it is identified that the monkey metaphor (outlined in Chapter three) speaks of the experience of dual diagnosis, the 'ladder metaphor' (outlined in Chapter four) speaks of the experience of pastoral care from a dually diagnosed perspective, and that the midwifery metaphor speaks of the perspective of the pastoral carer, acknowledging the presence of grief in the encounter.

It is from this place, and with an open mind for new discoveries, that 'field research' was started, from which the thesis emerged.

## **Introduction**

It was an early summer evening in England's Northwest, when at a local community meeting all of the local stakeholder groups gathered to discuss community issues that needed to be addressed. Facilitated by the local council, and attended by the police, residents associations, representatives of the local NHS, Youth service, elected representatives and open to the public, as an open forum to plug 'any gaps' that the statutory agencies may have missed from bin collections to crime and public disorder. It did not take long for what had become the most visible issue to emerge in the discussions . . . 'street drinking'. There was, in that locality, a group of around a dozen people who would sit near one of the main thoroughfares in the area drinking cheap cider, or fortified beer from the early morning to late afternoon. Initially they would be peaceful enough, and as the day would continue they would get more and more animated, often fighting with each other, until eventually they would either pass out or disappear off somewhere to 'sleep it off'. The police explained that, whilst they could move them on, this would not solve the problem. Concerns were raised by local residents about their welfare. One by one the statutory agencies explained why they couldn't offer any meaningful resolution to the issues the street-drinkers raised, and then, slowly but surely, all eyes moved to me, as the only person in the room wearing a 'dog collar' to see what the church could offer.

Already offering outreach to a local probation hostel, and with one or two church-goers already offering practical support (clothes, food etc), the church was seen to be best placed to make connections with this group. Leaving aside the myriad safeguarding issues, I wondered what it was that the church could offer. Making clear that there were no guarantees in this, I agreed to look into the issue, and see what could be done.

Consultation with local mental health workers revealed that the 'street-drinkers' were part of a much wider issue – 'dual diagnosis' – those individuals were suffering from issues with mental health and addiction. This group were widely thought locally to be amongst the most difficult people to work with because of this combination of issues. In the centre in which they worked, they helped some people with a dual diagnosis, but many other centres wouldn't touch them because they were considered disruptive, and often put other centre clients off coming in to access services. This was backed up by conversations with staff at the Probation Hostel, who suggested that in fact most of their residents were dually diagnosed. Contact was made with a local hostel for homeless and mostly alcoholic men, and a befriending scheme was set up, to listen to what the men had to say – in the belief that these were the same group as those that were street-drinking. They were not. And, as we got to know these men, it became clear that in fact many of them also suffered from dual diagnosis of alcoholism and mental health issues.

Although the street-drinkers were known to the hostels, they were living out in the community. Some were homeless, but most had a small bedsit that they lived in. They were all single, and their gatherings on a park bench were probably their only social outlet. Although known to various agencies, many of them were not being 'helped' by any of them anymore. And so, having consulted widely within the community, questions still remained: What was to be done? How could the Church reach out to these people? Were we the right people to do this? Was anyone else in another community doing this in a way that was leading people like this to a healthier way of life? And so – a research project was born.

### **From anecdote to evidence . . .**

I shall begin with a definition of 'dual diagnosis', then move on to some of the reasons for the challenges in the treatment of those with a dual diagnosis, before moving on to outline some statistics on the prevalence of these issues and the role of the clergy within communities in relation to those with mental health and/or substance misuse problems.

The NHS Confederation (2009) defines 'dual diagnosis' as 'the term used to describe people who have concurrent mental health and substance misuse or alcohol problems'. Other terms are used in place of 'dual diagnosis' – including 'co-morbidity of substance misuse and mental illness' (Baldacchino 2007, Weaver et al. 2002 as cited Centre for Mental Health et al. 2012); Kelly et al. 2012), or simply mental illness and substance misuse (Cleary et al. 2008). For the purposes of this paper I will refer to those issues using the term 'dual diagnosis'.

One reason for the complexity of treatment of a dual diagnosis is that the nature of the relationship between the mental health conditions and substance misuse is complex. According to the NHS Confederation (2009, 1) possible mechanisms can include a primary psychiatric illness precipitating or leading to substance misuse; substance misuse worsening or altering the course of a psychiatric illness; intoxication, and/or substance dependence leading to psychological symptoms; or substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses'. Another issue further complicating matters for treatment is that historically the provision of mental health and drug and alcohol services has evolved separately (NHS Confederation 2009, 1). At around the same time that I was beginning to recognise the full extent of the prevalence of these issues in my then context, an 'All Party Parliamentary Group on Complex Needs and Dual Diagnosis' (APPG) was being established (APPG 2014, 1). The APPG (2014, 2) state that 'data on the complex needs people face is not generally recorded by

government . . . [and] this means that although there is much anecdotal evidence, much needed statistics are lacking’.

Statistics that are cited include the fact that four out of five prisoners who are drug dependent have two additional mental health problems (NHS Confederation as cited APPG 2014, 2). The NHS Confederation (2011, 3) state that between 22-44 percent of adult psychiatric inpatients in England also have a substance misuse problem. There are higher rates of dual diagnosis in urban areas than in rural areas, and despite the fact that over 60 percent of patients in high secure facilities have a history of substance misuse, only 20 percent are receiving treatment specifically for their substance use (NHS Confederation 2011, 3). Certainly as of 2011 (NHS Confederation 2011, 3), the dual problem of mental ill health and substance misuse remains a challenge for mental health services, with one of the biggest problems remaining that staff working in these services are inadequately trained to deal with substance misuse. Approaching this from the ‘substance misuse’ side, 75 percent of users of drug services and 85 percent of users of alcohol services experience mental health problems, with 38 percent of drug users with a psychiatric disorder receiving no treatment for their mental health problem (Centre for Mental Health et al. 2012, 1).

These statistics (all for the UK) are consistent with those cited by Cleary et al. (2008, 226) for Australia who state that over 50 percent of people with a severe mental illness also use illicit drugs and/or alcohol at hazardous levels. Substance misuse leads to higher rates of treatment noncompliance, relapse, suicide, incarceration, hepatitis, HIV, homelessness, and aggression (Cleary et al. 2008, 226). Likewise in the US, 53 percent of people who abuse drugs have at least one comorbid mental illness (Baldacchino 2007, 148).

These statistics serve to reinforce my perception that the prevalence of dual diagnosis was indeed high. Given the complexities of treatment, and the historical issues around how those different treatments originated (mental health as averse addiction treatments), what is the best way forward as regards treatment and/or helping this group of people?

Kelly et al. (2012, 14), from an American medical context, suggest that ‘[e]ffective treatment for [dually diagnosed patients] often combines using different therapeutic “technologies”, i.e. psychotherapy, pharmacotherapy, and behavioural treatments and these different technologies exert a synergistic effect on treatment’. Kelly et al. (2012, 1) suggest that Motivational Interviewing has robust support as a highly effective psychotherapy for establishing a therapeutic alliance which is critical because retention in treatment is essential for maintaining effectiveness. This is echoed by Cleary et al.

(2008, 227) who state that 'one small motivational interviewing study provided the main support for alcohol use reduction and another for increasing participant attendance at their first aftercare appointment'. In combination with Cognitive Behavioural Therapy, motivational interviewing also improved mental state, life satisfaction, and social functioning (Cleary et al. 2008, 227). Drake and Mueser (2000, 111) are also positive on the importance of motivational techniques, and argue for more integrated services (where mental health and addictions are treated together under one administration), citing evidence from the United States, where these programmes have been more widespread for some time. These integrated programmes are not yet widespread in the UK (Centre for Mental Health et al. 2012, 3) and research continues on how addiction services and mental health services understand such concepts as 'recovery' (Roberts and Bell 2013, 76).

Within the UK, support for people with a dual diagnosis is frequently inadequate (Centre for Mental Health et al. 2012, 1). There are few if any areas where mental health provision and addiction provision is integrated (Centre for Mental Health et al. 2012, 2). The Centre for Mental Health et al. (2012, 2) also cites a lack of coordinated services; several areas had no agreed dual diagnosis strategy as of 2008, with less than half of the regions having assessed training needs of staff, and even within the prison system services are not well organised to meet the needs of dually diagnosed inmates. The situation is worse for those with less severe mental health conditions alongside a substance misuse problem where provision is described as being less developed (Centre for Mental Health et al. 2012, 2). All of these issues, which are structural, and well beyond the control of a dually diagnosed potential patient, further hamper efforts to enable people to access services that could over a period of months or years bring people towards recovery.

### **So what can clergy offer those with a dual diagnosis?**

Both Wood et al. (2010, 228) and Leavey et al. (2007, 557) conclude that religious leaders are often the 'first port of call' for many in their communities, and are working as frontline mental health workers – especially in poorer areas. This happens in isolation often, without referral to or from local medical and mental health professionals (Wood et al. 2010, 777). There are other issues as well in this role.

Leavey et al. (2007, 557) state that many clergy, 'lacking resources and knowledge feel unprepared, vulnerable and intimidated' by people with mental health issues. Leavey et al. (2007, 537) suggest that clergy may be poorly trained in any aspect of counselling or the management of mental illness and . . . . appear to respond to demands for mental

health support with caution and sometimes, rejection. This rejection seems to stem from fear. Leavey et al. (2007, 553) state that:

Despite an obvious sympathy with the plight of mentally ill people . . . the interviews revealed a fear of such individuals, views similar to the stigmatising stereotypes and fears that appear commonly among the general population. These views are expressed candidly and quite unselfconsciously by various clergy . . . despite the undoubtedly high level of contact that some clergy have with the mentally ill, it is only those clergy who have had personal-familial experience or with professional training who appear to have a more 'relaxed' relationship.

For some, this stems from a 'fear of violence perceived to be a correlate of mental illness' (Leavey et al. 2007, 553). For others, there is a sense 'of inadequacy' about their response to the mentally ill (Leavey et al. 2007, 554-555) stemming from not feeling well prepared for the tasks of caring for the mentally ill. The biggest source of anxiety in pastoral care for clergy identified by Leavey et al. (2007, 552) was 'people with [dual diagnosis], with the management of such people provoking conflict and 'feelings of guilt . . . concerning the charitable ethos of the church and the need for self-protection'. Here we glimpse the pressing need for this research.

Within our explorations of the issues around dual diagnosis, there will be a focus on three of what Osmer (2008, 12) describes as 'episodes', which are incidents or events that emerge from the flow of everyday life that evoke explicit attention and reflection. From these episodes, the situation (defined by Osmer (2008, 12) as the broader and longer pattern of events, relationships, and circumstances in which an episode occurs) will be elucidated, before exploring the context as part of the task of practical theological interpretation. The context is defined as the social and natural systems in which a situation unfolds (Osmer 2008, 12).

Osmer (2008, 4) suggests that there are four core tasks in practical theological interpretation, which include:

1. The descriptive-empirical task (involving the gathering of information that helps in the discernment of patterns and dynamics in particular episodes, situations or contexts)
2. The interpretive task (drawing on theories of arts and sciences to aid in understanding and explaining why these patterns and dynamics are occurring).

3. The normative task (using theological concepts to interpret episodes, situations or contexts, constructing ethical norms to guide our responses, and learn from 'good practice').
4. The pragmatic task (determining strategies of action that will influence situations in ways that are desirable).

(Osmer 2008, 4)

A primary aim of my research was to bring into conversation in a safe and acceptable manner the voices of people with addiction and mental health issues (the 'dually diagnosed') with the academy. Initially this seemed fraught with difficulties, not least questions about credibility, truth, and the myriad ethical questions associated with interviewing vulnerable adults. However, taking their voices seriously is imperative in efforts to understand what appropriate pastoral care might look like; standing in the pastoral tradition of Anton Boisen (Nouwen 1968, 49; Ward in Graham 2007, 78) whose phrase 'the living human document' refers to 'the life turned into text, which is reflexive of practice and reflexive of self, . . . embedded in dialogue, with words and thoughts going between self and others in an ongoing conversation which is both internal and external'. Stam (1989, 8) a film theorist, in his analysis of the work of Bakhtin, suggests that dialogue is material. Drawing on Stam's work, Ward (2005, 137-138) states that 'It is not as if voices float around in the ether, but that every dialogue, every conversation takes place in a real situation, in a real context between real bodies, between embodied self and embodied other'.

At the heart of this research are three encounters, or three conversations which will be explored each in turn, but each brought into wider conversation between those who may have been involved in similar situations themselves, theoretically. These three encounters are three living human documents, which will be brought into conversation with ten other living human documents, and five documents arising out of the experiences of recovery amongst dual diagnosed people. Thus, these eighteen living human documents are brought into what Miller-McLemore refers to as the 'living web' (1999, 90) within the thesis. The living human web mitigates against the individualistic leanings of Boisen's metaphor (Miller McLemore 1999, 90). The three initial living human documents will be briefly explained within the introduction, with more in depth exploration in the main body of the thesis. Alongside these conversations, relevant academic voices will be brought into conversation, at key points, to relate the findings of these conversations to the fields of theology, practical theology, philosophy, dance studies, and health and social care.

The first episode arose out of my work as a curate entering into men's hostels in the parish in which I lived and ministered. The first of these hostels was a probation hostel in which lived a group of men at high risk of reoffending. This was a very fluid community, with men coming and going all the time. Many of the men had issues with addiction, and several had diagnosed mental health issues. Some had both. Others had as yet undiagnosed mental health issues. Most of them had a history of violence. My role there was to facilitate a group discussion once a week, nominally on the topic of religion, at the request of the Hostel Manager, who was keen to instil in the residents something of the benefits of spirituality. Over time, relationships with the men would develop and deepen, albeit always tempered by the transitory nature of the place, and the ever-present threat of violence (mitigated by the presence of CCTV, and the distribution on arrival of panic-buttons to all those entering the hostel). Questions quickly arose out of this work though as, when faced with the enormity of their human needs, the depths of their despair and grief, and the skewed thinking of the addicted mind, I began to wonder what 'good pastoral care' might look like with these men. Is it appropriate to challenge addictive behaviour? How could I model God's love to people who are not being honest in how they relate to me? Or where trust is lacking? Clearly many of the men had fallen through the cracks of a system, what would be appropriate care for these men? In an area where 'street drinking' was prevalent, what was an appropriate social response?

The incident in the Probation Hostel began in a conversation about 'fear', I was struck by a particular exchange with a young man in the group. He began:

Michael: Well, we're all a bit like monkeys really . . .

Myself: Go on.

Michael: Yeah, well . . . we're all a bit like monkeys who live on a cliff face rather than in the wilderness . .

Myself: Is that because you like the danger of the cliff face?

Michael: No, no, because it's safer on the cliff face than in the wilderness where all the predators are.

Following this exchange, the group descended into silence. Their truth had been spoken in a most creative and powerful way by someone the majority had disregarded as irrelevant. An alcoholic, Michael had spent much of his life homeless. Michael struggled with depression. In medical terms he has a 'dual diagnosis'. In a group that ranged from anarchic behaviour, to odd flickers of truth, via much manipulation and

game playing, this was a rare insight into the minds of those who sat in front of me. Was his truth the same as the others? The sudden silence of the rest of the group suggested so.

This led to investigations into the nature of treatment into dual diagnosis, addiction and mental health issues, and I completed a literature review into that area of study, picking up on resonant theological themes along the way. Although helpful, as a Priest in the Church of England, about to move into parish ministry, I realised that I would not be able to offer that level of pastoral care alone, alongside the pressures of a busy parish.

The second episode came several months later in the hostel for homeless and mostly alcoholic men which I normally entered weekly with a group of three retired nurses seeking to engage whoever was available in conversation by way of seeking to befriend the men. This episode took place outside of that normal routine after a late evening phone call from a concerned staff member. Peter was showing suicidal tendencies, and has asked for 'that Vicar that comes in'. It was late evening and I entered to find Peter in a distressed state, staff unsure what to do. I sat with him, unsure what to do myself, and listened for any signs of attachment to anything in this world, trying to motivate some hope in this despairing man. He spoke of multiple bereavements, regrets, threats from others in the community. Eventually, he agreed to see me in the morning, to accompany me to a day centre locally for people with mental health issues. Hope enough for the moment I thought.

Several months after this initial encounter, I was moving on from my curacy to a first incumbency and Peter stopped me, determined to thank me for what I 'did' that night. It had been a significant moment. He said that 'it was like you came down a ladder to where I was at, and kept pointing up. And then you accompanied me, when I was ready up each step to where I am now'. Peter also struggled with an addiction and a mental health issue. He had been prescribed anti-depressants, but had not quite recognised his addiction to alcohol at that point.

This incident was critical in that here I seemed to have precipitated a change of outlook. He later went on to volunteer at the day centre, and move on to sustain a tenancy. There had been, effected in that encounter, some modicum of healing. This felt highly significant, and merited further thought. In my uncertainty, it felt like I had stumbled on something that may be of use to others in the field. A publishable article was written looking at Peter's metaphor of the ladder scripturally, historically and in terms of some of the models of care I had unearthed during the research stemming from the first episode involving Michael. The voices of those with a dual diagnosis were held as important and

significant, and the insights of a dually diagnosed theologian (Carter Heyward) were incorporated into the study.

But there were other questions emerging. Yes, there had been some 'healing' affected through this encounter, but what about the countless others where no discernible difference had been seen? In what sense was I modelling God's love there? What is the purpose of the pastoral encounter? Are clergy there to bring that sort of healing? Peter had been at a low point, and he was brutally honest with me, what about those encounters where that is not the case? Where things are masked/hidden? Where the person is trying to act like nothing is wrong? Where the danger of the cliff face is preferable to the 'predators' in the wilderness? Where hope cannot be found? The encounter with Peter took a couple of hours, and more time the following morning. How sustainable is that for parish clergy given ever larger parishes and decreasing clergy time?

The third episode was at the Women's Hospital. A call came through for me to attend labour ward to see a family who had lost their baby. On arrival at the ward, I discovered that unusually, my task this time was not to bless a baby that had already been born, so much as to persuade the mother to go through with the birth. She was convinced that a miracle could happen and that the baby would be ok, that in going through with the birth she could in fact be murdering her unborn child. This reminded me of an incident in my childhood, growing up on a farm. My father and I had had to remove a dead calf from its mother's womb, and so I had a clear insight into the urgency of the situation (see symptoms outlined below). After some discussion, and using the scriptural image of Hannah giving Samuel to God in the temple, the mother was persuaded to go through with the birth. Seeing the care that she received through that process made me realise how different her experience was in grief, to the experiences of most of the men I had encountered in the hostels. Here was another person in time of crisis, a change affected, but who would be accompanied intensively through that most challenging and difficult period in their lives. The local Women's Hospital was a centre of excellence for care for those who suffer an intrauterine death and as the one common link between the settings of the hostels and the hospital the contrast in the care offered was striking. Although medically the issues were seemingly different, underlying both settings and sets of issues was a form of complex grief that could lead to a physical deterioration of the person bereaved. The health risks associated with stillbirth, in particular when the foetus has not been discharged include septicaemia, blood poisoning, sterility and possible death of the mother as well. Substance addiction can lead to much the same fate, albeit possibly much more slowly. The alcohol (or other drug) poisons the body, causing eventual organ failure.

Through my encounters in the Women's Hospital, I had come to understand that the staff there were well trained for the care of those who had suffered an intrauterine death, particularly as it was a place where such issues arose not infrequently. With the benefit of space and time for reflection, the idea crystallised that there were enough parallels to warrant placing the two areas side by side to see what could be learned from the care offered by midwives and obstetricians to those who have suffered an intrauterine loss by clergy offering care to those with a dual diagnosis. There was the initial commonality of complex grief. There also was the same struggle to come to terms with the reality of loss experienced by both those who suffered an intrauterine death and those in the throes of addictive behaviour. Both groups were often struggling with other health issues (physical health issues for the mothers and mental health issues for the individuals with a dual diagnosis). And a similar challenge to be fully 'present' in the situation, indeed the theme of presence and absence is key as the comparison is explored. It is this theme of presence and absence that is central to this thesis, and there is much to learn from midwives and obstetricians about how the tension between presence and absence is negotiated that can be brought to bear in clergy care for those with a dual diagnosis.

And so, questions began to arise for me about what clergy could glean from the knowledge and learning of midwives and obstetricians? What procedures were used for the pastoral care of women who had suffered an intrauterine death? Could any procedures be translated into clergy practice? What might this look like in cases of people with dual diagnosis, and complex grief? In increasingly busy parishes, what is realistic for clergy in their offering of pastoral care to the actively addicted or the mentally ill? What can clergy offer that others cannot?

### **On not being of one substance**

Every metaphor has its limitations, and the metaphor of the situation of offering pastoral care in intrauterine death for the care of those with a dual diagnosis is no different. First there is the issue of personal freedom and choice. The families in a situation of intrauterine death did not choose to be in that situation (certainly not if pastoral care is being sought from local clergy). This is a situation that largely has been thrust upon them, sometimes quite suddenly, and with no warning. The situation for those with a dual diagnosis can often be more subtle, more gradual, although mental ill health can deteriorate rapidly, addiction certainly can take longer, and initially involves some more or less conscious decision making on the part of the addicted person. To say that addiction is a choice though is going too far. Nobody chooses to live like some of the men in the hostels I entered. They may opt to stay in that lifestyle, but as the first

episode with Michael reveals, fear compels them to stay; they may well have choices, but they feel compelled to stick with what they know rather than risk a change.

The second major limitation of the metaphor of intrauterine death as compared to dual diagnosis is that there is a time limitation on the mother coming to terms with having the baby. Her body will, naturally, expel the dead foetus normally. Biologically, there is a process that must happen – although emotionally the wounds will take much longer to heal. The biological process will happen over a couple of days usually, as physical deterioration occurs. Physical deterioration as a result of addiction takes much longer, is more subtle, and is easier to deny initially.

A third limitation is that the grief involved in both processes, coming to terms with addiction and a mental health issue and coming to terms with an intrauterine death as experienced by a midwife/obstetrician is often expressed differently. For couples suffering an intrauterine death, the initial response of the parents will often involve anger, normally directed at the hospital staff. There may be litigation coming from seeking to blame someone for some perceived fault. The emotions are often raw, openly expressed. This contrasts with the emotions of those with a dual diagnosis. There are moments when they may erupt. However, often the true emotions lie hidden. The issue of the addiction will also be hidden initially, from others, and eventually from themselves through shame, and stigma. A diagnosis of a mental illness also will be kept hidden for fear of the stigma attached to it.

A fourth limitation is the nature and duration of the engagement between clergy and those with a dual diagnosis, and the bereaved families and their engagement with midwives and obstetricians. There is a definite beginning and end point to engagement with midwives and obstetricians and families bereaved through an intrauterine death. This can contrast markedly with the sporadic, and often not inconsequential input of chaplains and parish clergy with those with a dual diagnosis, who can relapse at any point, even if they come off what it was that they were addicted to. The actively addicted can be very sporadic and unpredictable as to when they will turn up seeking support.

However different the emotional expression may be in that moment, the overarching issue is one of grief, grief over the loss of a child, grief over the loss of the hopes and dreams associated with a future that will now look very different, or grief over all that has been lost through addiction, broken relationships, frustrated ambitions, moving house seeking to escape problems. All of these are forms of grief. All of the emotions associated with grief and loss are associated with both groups of people; shock, denial, anger, depression all feature in both situations at points. It is, in both cases a

complicated grief, on many levels. Although almost impossible to disentangle, this is the principal commonality.

The other commonality is that of biologically not being of one substance. Sadly, both the foetus and the substance to which an addicted person has become addicted are both toxic to the body, and there is a process of acceptance of that toxicity that must occur for healing to be effected. Other addictions (work, sex, etc) also lead to health issues when untended. Mother and baby, whilst the baby lives, are of one substance, but when one or other dies, they cease to be of one substance, and one becomes physically toxic to the other.

A further commonality is that both the families suffering intrauterine death and those with a dual diagnosis usually are all supported to greater or lesser degrees by a number of people. For the families suffering intrauterine death a clergy person may or may not be called, but midwives, obstetricians, family support workers will all be present. For those with a dual diagnosis that I encountered, support workers, health workers were all involved, albeit in a less structured way, in much the same way that chaplaincy support was less structured. A significant difference often was in how willing and accepting of that support the different groups were. There is a question around awareness of the presence of that support with those with an active addiction. This will vary depending on the level of intoxication of the addicted person, and in their openness to the idea that there is a problem. For those with a dual diagnosis the addiction can be a form of 'self-medication' for the mental health issue. Although that 'self-medication' may be effective initially for the mental health issue, as far as the person themselves is concerned, clearly this is not tenable as a long term solution for the issues, often compounding the situation. There may be family members at their wit's end still maintaining some form of contact with those with a dual diagnosis. The breadth of support for the various facets of the biological, emotional and spiritual aspects of the issues being confronted is essential.

Given the commonalities, I decided to explore what clergy may learn from those who support families suffering intrauterine death to better support those with a dual diagnosis.

### **Structure of the thesis**

Following on from this introductory chapter, the next chapter will outline the methodology of the research project. This will include unpacking its constructivist origins. Explanation will be given of some of the challenges faced in the research endeavour, and how those challenges were overcome or embraced. \_

Chapters 3 and 4 will begin to explore some of the results of the research, introducing some of the initial data, and touching on some of the academic connections. Chapter 3 explores areas of the pastoral encounters where absence predominates and forms an exercise in 'naming absences'. This is not to say that there is no 'presence' there, for there must have been for the data to have materialised, but as a starting point, I will begin in this chapter to analyse some of the areas where 'absence' is dominant. Chapter 4, by contrast, will explore areas of the pastoral encounter where 'presence' predominates. Again, this is not to say that there are no 'absences' within those areas described, simply that 'presence' dominates those particular elements uncovered. Both chapters begin with a basic unpacking of the etymology of the words 'absence' and 'presence'.

Chapter 5 by contrast to the previous two chapters will begin to look at more liminal areas where the tension between absence and presence is writ large, and moves the endeavour into conversation with academic theology of the Trinity, looking primarily at the work of Sarah Coakley who connects the Doctrine of the Trinity to the practice of 'contemplative prayer'.

Following on from an initial exploration of the Doctrine of the Trinity, Chapter 6 sees the exploration expand out to the idea of 'perichoresis', reflecting on the dynamic quality of the pastoral encounter. Taking the idea of 'perichoresis' as 'divine dance', reflections on insights that can be garnered from dance studies are brought into conversation with both the doctrine of the Trinity and 'Motivational Interviewing', which is described as having a 'dance-like' quality. Connections are then made between Motivational Interviewing and 'poiesis', looking at 'poiesis' from its broadest and most original meaning.

Within the initial Literature Review, I surveyed a range of options for the care of people with a dual diagnosis. These included 12 step programmes (the Recovery Model), the Biopsychosocial model, The Trans-theoretical model, Cognitive Behavioural Therapy and Motivational Interviewing. For the purposes of this research project I have taken the decision to focus primarily on Motivational Interviewing. This is for two main reasons: the first relating to the multi-faceted role of clergy, and the second relating to the relative complexity of the other approaches.

The role of the Priest in the Church of England is most classically summed up in the 'ordinal' which states that:

Priests are called to be servants and shepherds among the people to whom they are sent. With their Bishop and fellow ministers, they are to proclaim the word of the Lord and to watch for the signs of God's new creation. They are to be messengers, watchmen and stewards of the Lord; they are to teach and to admonish, to feed and provide for his family, to search for his children in the wilderness of this world's temptations, and to guide them through its confusions, that they may be saved through Christ for ever. Formed by the word, they are to call their hearers to repentance and to declare in Christ's name the absolution and forgiveness of their sins.

With all God's people, they are to tell the story of God's love. They are to baptize new disciples in the name of the Father, and of the Son, and of the Holy Spirit, and to walk with them in the way of Christ, nurturing them in the faith. They are to unfold the Scriptures, to preach the word in season and out of season, and to declare the mighty acts of God. They are to preside at the Lord's table and lead his people in worship, offering with them a spiritual sacrifice of praise and thanksgiving. They are to bless the people in God's name. They are to resist evil, support the weak, defend the poor, and intercede for all in need. They are to minister to the sick and prepare the dying for their death. Guided by the Spirit, they are to discern and foster the gifts of all God's people, that the whole Church may be built up in unity and faith.

(Archbishops Council

2015, <https://www.churchofengland.org/prayer-worship/worship/texts/ordinal/priests.aspx> )

Within 'God's people', those with a dual diagnosis account for a relatively small proportion and although part of the Priest's role is to 'support the weak, defend the poor . . .and . . . minister to the sick', the task of caring for the dually diagnosed person is but a relatively small part of a much larger role. Any approach to the care of the dually diagnosed person needs to be simple for clergy who have to engage in all sorts of areas as part of their ministry.

12 step programmes, the biopsychosocial approach, the trans-theoretical model and CBT all have issues associated with them that would preclude them from use by clergy themselves. This is not to say that they are not valid approaches to the care of people with a dual diagnosis. Indeed it should be encouraged for clergy to refer or signpost the dually diagnosed individual on to a 12 step recovery group were that appropriate, or to a GP for referral on to Cognitive Behavioural Therapy or some other medical intervention as part of their care. Given the other pressures on clergy time, signposting or referral is by far the best option for these approaches as they would not be viable for most clergy

to be able to offer alone, and nor should they when others are available who can offer these things as part of their roles in the community (ideally).

Chapter 7 brings together these insights in pursuit of a renewed pastoral paradigm, a hybridization of 'autopoiesis' and 'theopoiesis', the meanings of which are explored thoroughly as the thesis is explained.

Having come to a renewed pastoral paradigm, the conclusion comes with a 'creative flourish', taking the form of a letter to myself 6 years ago, at the inception of the research endeavour, offering advice and encouragement, not just to my younger self, but to anyone seeking to embark on the pastoral care of people with dual diagnosis, and highlighting and gently challenging some of the structural issues in society that compound the issues of those who are dually diagnosed and offering alternative possibilities that might alleviate their plight.

## **Chapter 2: Methodology**

From the outset of this research, I have sought to take seriously the insights of those with a dual diagnosis, and as such any methodology used needed to allow for that aim. This was because one of the reasons why the situation of 'street-drinking' had arisen stemmed from social marginalisation, and fundamental to the situation being remedied, such marginalisation needed to be overcome. Swinton (2000, 33), an academic theologian and former psychiatric hospital chaplain, with his background in psychiatry, takes seriously the perspective of those suffering from psychiatric illness, raising concerns about the limitations of the 'medical model' of approaching treatment.

Swinton (2000, 33) states:

the medical model's approach, while perhaps necessary, is certainly not sufficient. Though biology tells us some things about the mechanics of human beings and the technicalities of mental health problems, it tells us nothing of what it means to be human and to live humanly even in the midst of our particular difficulties. The danger with oversomaticizing mental health problems is that it tends to individualise the problem, thus drawing attention away from the critical socio-relational dimension that . . . is fundamental to the process of oppression in the lives of people with various forms of psychological distress.

Swinton (2000, 33-34) suggests that the medical model's individualisation of the problem enables society to abrogate responsibility for the oppression and disablement of people with mental health problems. For Swinton (2000, 34), mental health problems are much more than biological defects that requiring fixing or controlling by specialist interventions. They are human experiences that happen to unique individuals within particular circumstances. They are social experiences in that a major part of the individual's difficulty lies in the society within which a person experiences his or her difficulties (Swinton 2000, 34). Therefore, the insights of clergy caring for those with a dual diagnosis, outside medical settings are key, as are the various facets of care offered (which move beyond the technical/medical care offered to women suffering an intrauterine death) by midwives and obstetricians.

The underlying philosophical assumption that underpins the way of doing this research is the perspective of constructivism (Lincoln and Guba 1994, 110). For Swinton (2001, 96), constructivism offers a perspective on truth and knowledge and the ways in which they are perceived by human beings and human communities. Rather than assuming that truth is something that is somehow 'out there', accessible in a pure, uninterpreted form via objective approaches within which the researcher distances him or herself from the object of research, this approach assumes the presence of multiple realities, and the

inevitable involvement of the researcher in the research process, not simply as an observer, but also as a participant (Swinton 2001, 96). Observation in a constructivist research endeavour is assumed to be an interpretive process (Swinton 2001, 96). For Lincoln and Guba (1994, 110), realities are apprehend-able in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature (although elements are often shared among many individuals and even across cultures), and dependent for their form and content on the individual persons or groups holding the constructions. Constructions are not more or less 'true', in any absolute sense according to Lincoln and Guba (1994, 111), but are simply more or less informed and/or sophisticated, and thus are alterable, as are their associated 'realities'. Within a constructivist paradigm, the investigator and the object of investigation are assumed to be interactively linked so that the 'findings are literally created as the investigation proceeds' (Lincoln and Guba 1994, 111). As a methodology, there is an element of dialectics, some form of association which in some sense is a social methodology.

Latour (2005, 7) defines 'social' as a very peculiar movement of re-association and reassembling. Latour (2005, 7) is determined that the notion of the 'social', has to be much wider than what is normally called by that name, yet limited to the tracing of new associations and to the designing of their assemblages. Within the constructivist paradigm, the methodological framework within which the exploration of the midwifery metaphor for pastoral care has taken place is that of a Constructivist Grounded Theory. Drawing initially on the work of Mills et al. (2006, 6-7) who compare and contrast the different strands of Grounded Theory as a methodology, I was attracted to the work of Charmaz (2006) as a methodology because it makes explicit the connection between theory development from the prior experiences of the researcher as this strand of the Grounded Theory spectrum 'was most explicit about the epistemologically subjectivist' nature of coding and the interpretation of qualitative data (Mills et al. 2006, 6). I approach this from a perspective as Parish priest, thus as a Christian by faith, who believes that all are made in the image of God, and that nothing is beyond redemption. Charmaz (2006, 10) posits that we construct our Grounded Theories through our past and present involvements and interactions with people, perspectives, and research practices. Thus research participants' implicit meanings, experiential views – and researcher's finished Grounded Theories – are constructions of reality (Charmaz 2006, 10).

This element of 'construction' was particularly central to this project. The element of 'care' for those with a dual diagnosis was not already going on, and an understanding of what 'appropriate' pastoral care might look like from a clergy perspective was lacking. In keeping with Charmaz' methodology, and drawing upon my experience of pastoral

care in another context (namely a local Women's hospital), the decision was taken to explore pastoral care of those with a dual diagnosis via what Strauss and Corbin (1990, 90) call a 'far out comparison'. Strauss and Corbin (1990, 90) state that 'analysts usually stay as close to their substantive areas as possible when making comparisons, fearing that they can't possibly learn anything that can be applied to their area by making a far-out comparison. That assumption is not true'. The use of this 'far-out comparison' has allowed triangulation from a recognised place of good practice (the care of people who have suffered intrauterine death in a centre of excellence) into an area where the appropriate care of people is less thoroughly researched. The rather 'generalised' perspective of 'dual diagnosis' which reflects people with any addiction in combination with any mental health issue is deliberate, as this reflects the nature of many callers at the door, at various points on the spectrum of awareness of their issues, pre-diagnosis, in denial, to diagnosed and sober.

Another distinctive element here is that the research represents an artificial social construction. The clergy, the dually diagnosed people, and the midwives and obstetricians have, by and large, never met. The common factor in this research project is I the researcher, and my quest to determine what 'appropriate pastoral care' looks like from a clergy perspective for those with a dual diagnosis. It stems from my recognition of the highly valued, and well respected care offered in the local Women's hospital (a recognised centre of excellence), and how little was offered to the men of a local Alcoholic men's hostel. I wondered what could be learned from one context (the hospital) by the clergy working with those in the hostel, but also with others out in the community (primarily street drinkers). I did not enter this research with a 'hypothesis' to be tested, simply with an open mind to the possibilities of what could be learned by bringing these disparate voices together and listening.

Within the midwifery metaphor, there were four groups of people who were involved: clergy, those with a dual diagnosis; midwives and obstetricians; and those who had suffered an intrauterine loss. As the focus of the research benefit is those with a dual diagnosis, it felt inappropriate to even consider soliciting the perspective of those who had suffered an intrauterine loss, and so this fourth group were not taken further because they would not benefit directly from the project and could be potentially harmed through it. I as clergy person had a network of people I knew from my time as assistant chaplain at a Women's Hospital who could give some insights into the care given there, and a network of clergy who I knew had some experience of caring for those with a dual diagnosis, even if they weren't familiar with the terminology.

The aim of the research then is to bring into constructive conversation these three groups of people: Those with a dual diagnosis bringing their experience of recovery,

sharing what had been significant in their movement towards recovery; the midwives/obstetricians sharing how they care for those who are suffering an intrauterine death; and the clergy sharing their experiences of care for those with a dual diagnosis, and more generally for those who have suffered a complex bereavement. Complex bereavement is a significant real connection between the two groups of: 1. those with a dual diagnosis and 2. those who have suffered an intrauterine death. It is hoped that by bringing these three groups together, subtle contrasts and similarities can be highlighted that might inform and improve the pastoral practice of clergy in the field. Each group has something distinct to contribute. The 'population' (Arber 2001, 59) to be interviewed was then clergy from a range of social settings selected based on their perceived experience of working with people with a dual diagnosis (or exposure to people with a dual diagnosis), and those involved in the care of women who have suffered an intrauterine death (whose baby had died in the womb), namely midwives and obstetricians.

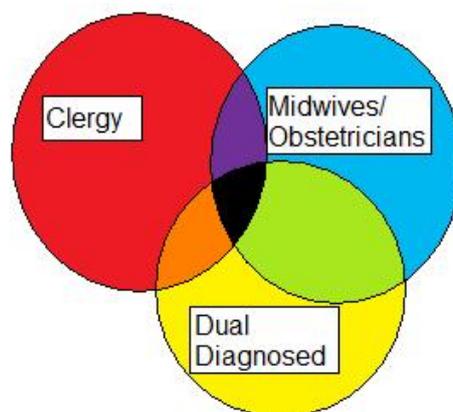


Figure 1: Populations to be researched.

The sampling system used for both the clergy group, and the midwives and obstetricians group was 'network' or 'snowball' sampling (Arber 2001, 63). The individuals selected from the clergy were known to me. They worked in contexts where 'dual diagnosis' was more common (urban settings, prisons or hospitals). This gave more meaningful data based on their broader experience of relevant practice than could be achieved by other sampling methods. The midwives and obstetricians were contacted within my current parish where I encountered some of them. A further two were known to one of the participants who made the introductions on my behalf. She selected them based on her knowledge of their being open to matters of faith. Ethical

permissions were not solicited from the NHS, because the research would not be of benefit to these individuals particularly.

Informed consent (Bulmer 2001, 49) was obtained from each of those interviewed, with the purposes of the research explained, and assurances given that data would be held as confidential. A signed consent form was obtained from all those who were interviewed.

Name of Participant	Role	Means of gathering their data
Eileen	Obstetrician	Interview
Hayley	Hospital Midwife	Interview
Julie	Community Midwife	Interview
Mary	Community Midwife	Interview
Emily	Obstetrician	Interview
Kevin	Hospital Chaplain/former midwife	Interview
Sean	Minister with Dual Diagnosis	Interview
Liz	Parish Priest and former midwife	Interview
Carla	Prison Chaplain	Interview
Jim	Parish Priest	Interview
Brian	Individual with dual diagnosis	Online testimony
Catherine	Individual with dual diagnosis	Online testimony
Patrick C	Individual with dual diagnosis	Online testimony
Val	Individual with dual diagnosis	Online testimony
Tim H	Individual with dual diagnosis	Online testimony

Table 1: Participants, the populations they represented (role), and how they participated in the research.

For those with a dual diagnosis, their vulnerability required alternative arrangements. In devising the methodology for this research project one of the primary considerations was that of the ethics of this project. According to Silva (1995, 15 as cited Liamputtong and Ezzy 2005, 203), a vulnerable person is an individual who experiences 'diminished autonomy due to physiological/psychological factors or status inequalities'. Based on Silva's definition, Moore and Miller (1999, 1034) contend that vulnerable individuals are people who 'lack the ability to make personal life choices; to make personal decisions, to maintain independence, and to self determine. Therefore, vulnerable individuals may experience real or potential harm and require special safeguards to ensure that their welfare and rights are protected'. Those with a dual diagnosis fall into that category; as do those who care for them. Quest and Marco (2003, 1297) refer to the vulnerable as people with 'social vulnerability'. They contend that some population groups, including unemployed, homeless, and drug addicted people, and ethnic and religious minority groups, face particular social vulnerability (Quest and Marco 2003, 1297). According to Stone (2003, 149), the vulnerable are 'those who are likely to be susceptible to coercive or undue influence'. Thus those with a dual diagnosis need special care from researchers when involving them in research.

Warr (2004, 586) says that as researchers, 'we must make every effort to ensure that the research we undertake among the disadvantaged and disenfranchised makes a positive difference in the lives of those it touches'. This was a primary concern for me in this research endeavour. And the words of Graham et al. (2005, 67) unpicking the work of Paul Ricoeur were salutary:

Within this enthusiastic embrace of storytelling, however, there lies a disturbing tendency to assume that the redemptive power of narrative can always bring healing and release, that discordant elements can always be reconciled within a life story properly told. Clearly this is a dangerous assumption as some experiences, particularly of trauma and abuse, cannot be so easily synthesized into narrative form.

In an interview setting, narrative would be key, and there was a strong chance that the questions around 'appropriate pastoral care' would bring up stories of trauma and abuse. Alongside this there was a lingering question over how beneficial, if it were to be beneficial at all, the research was going to be. I therefore took the decision to 'analyse' scripts detailing the experiences of those with a dual diagnosis that exist in the public domain online on an American based website for a dual recovery anonymous group rather than conducting interviews with that group. Practically speaking, I as researcher had not had formal mental health training, and am not a specialist in the field of

addiction treatment or diagnosis, and as such there would be difficulties in my being able to identify with certainty whether or not someone was suffering as a result of my questioning during an interview, or indeed whether they were actively under the influence of some mind-altering substance (it is not always clear). However given the focus of the research as being on the care of people with a dual diagnosis, I was keen that the voices of those with a dual diagnosis should be included in some way within the research project. Hine (2008 as cited Bold 2012, 117) warns of bias occurring because of the sample used; for example, those who are willing and able to access a computer may join in, but others will be excluded. However as the alternative was no input from those with a dual diagnosis, this seemed the best approach given the circumstances.

But is it possible to 'dialogue' with a text? Certainly Swinton (2001, 102), drawing on Gadamer, seems to think so, in that he states that 'in order effectively to interpret a text, it is necessary to enter into a dialogue with the horizon of the text. Out of this dialectical movement, fresh insights and new interpretations emerge which may even transcend the meaning originally intended by the author (Swinton 2001, 102). For Swinton (2001, 103), the task of the researcher is to enter into a constructive, critical dialogue with the text within which a fusion of the two horizons is brought about. Understanding occurs when the horizons of the scholar intersect or fuse with the horizon, context, or standpoint of the objective enquiry (Swinton 2001, 103). This requires a radical openness to the experience of the other and a respect for experiences that transcend one's own horizons (Swinton 2001, 103).

### **Interview Process**

I chose to conduct one to one interviews with those who gave consent because of the need for an 'open question' data gathering exercise, the relatively small number of candidates to be involved, and the nature of the 'far-out' comparison to offer reassurance that what was being offered in the interviews was both relevant and helpful. A series of eight questions were asked of each candidate, with the added benefit, when the need arose, of being able to add supplementary questions where necessary. An interview schedule was produced, and shown to each person interviewed beforehand. Responses were recorded on a tape recorder for later transcription, and as interviewer, I took copious notes during the interview to aid in the transcription process.

Interviews were carried out at the location of choice of the interviewee. Most took place in my home (which was local to most of those interviewed) but one of the obstetricians hosted me in her home for the interview. Of the clergy, one was in his church, one at a neutral venue, and one in her home, whilst the other two were in my home. This was so

because I was keen that research participants were not inconvenienced more than necessary, and so gave them freedom to choose interview location.

All of the candidates for interview were quite comfortable throughout, with one interview stopping briefly for clarification about confidentiality. The interview then continued after reassurances were given (a reassurance that could not have been given via posted questionnaire) as part of my duty of care to participants as researcher.

As the conversations continued another interesting phenomenon arose. My three clearly defined groups 'eroded' to some extent, in particular the clergy group. There were five clergy interviewed, as there were five scripts of those with a dual diagnosis analysed, and five interviews conducted of midwives/obstetricians. Within the 'clergy' category, two turned out to have been midwives prior to ordination, and a third turned out to be dually diagnosed and in recovery. This was not planned as such. However the dually diagnosed clergyperson did serve to mitigate some of the inherent power imbalance within the research design, sharing willingly something of his experience of recovery, and how that informed his ministry now. The boundaries though between the three groups then, collapsed to some extent, but I don't believe that the research was weakened for that, rather the opposite. I believe it may have strengthened it, for although the conversation lines may be blurred (See Figure 1), a greater understanding across the three groups was facilitated, and there became less of a cultural divide to be traversed between them. The interview with the dually diagnosed clergyperson was marginally longer as a result of his 'double perspective'; likewise one of the midwife-clergypersons gave a slightly longer interview in part because of her understanding of midwifery and pastoral care of those with a dual diagnosis. Interviews ranged in length between 30 minutes and 90-120 minutes in length. This varied depending on the confidence of the person being interviewed on the subject matter.

The clergy were drawn from a range of contexts, from parishes to chaplaincies (hospital and prison) and were a mix of male and female, ranging in age from late 30's to late 50's early 60's. This was done in part to avoid bias due to gender or age, but primarily they were chosen based on experience and the context in which they work. One of the clergy midwives was male, which helped slightly as the midwives and obstetricians were all female candidates, ranging in age from late 20's to late 50's and were a mix of community based and hospital based midwives with two obstetricians in the mix as well. The scripts for those with a dual diagnosis (non-clergy) people were selected from the website on the basis of length and amount of detail about their history and movement towards improved health. Some of the scripts were scant of detail and all too brief for my purposes, and so the lengthier scripts were selected. The scripts were relatively

anonymous, in keeping with the ethos of Dual Recovery Anonymous, but it was possible to discern the gender of the people described, and a mix of male and female were used.

### **Data Analysis**

Having conducted interviews with the midwives/obstetricians and the clergy, the interviews were then transcribed, and then the coding of the texts of the interviews, alongside the texts of the scripts obtained regarding the journey towards recovery could then begin. Initially the data was subjected to line by line coding. This categorised segments of data with a short name that summarised and accounted for each piece of data (Charmaz 2006, 43). This marked the beginning of the qualitative analysis of the data, defining what the data is about, and was completed for each script. The completion of line by line coding of *all* scripts as an area of methodological variance with the system of Strauss and Corbin (1990, 72-72) who advocated line by line analysis of initial interviews and then moving on to using categories as the basis of what to focus on in the next interview. This was done to mitigate against bias towards the ideas and experiences of the first interviewees. I was concerned that Strauss and Corbin's methodology may lend more emphasis on those initial interviews, with their suggestion of only line-by-line coding the initial interviews.

After this initial stage of line by line coding, some thematic analysis was required in order to make sense of the large number of initial codes that were generated (Attride-Stirling 2001, 386). Initially, themes were identified and abstracted from the coded text segments (as per Attride-Stirling 2001, 391-392). The themes that clearly emerged quite quickly were those of 'absence', 'presence', and 'a tension between absence and presence', summarised as 'absence/presence'. This procedure allowed me to reframe my reading the text, and enabled the identification of underlying patterns and structures, and in fact determined that the three themes were common across all three groups. These more focussed codes were consistent with what Strauss and Corbin (1990, 96) call 'axial coding'. These 'axial codes', or 'thematically grouped codes' were then mapped out diagrammatically to see where codes overlapped or not between the three groups of participants (Figure 2).

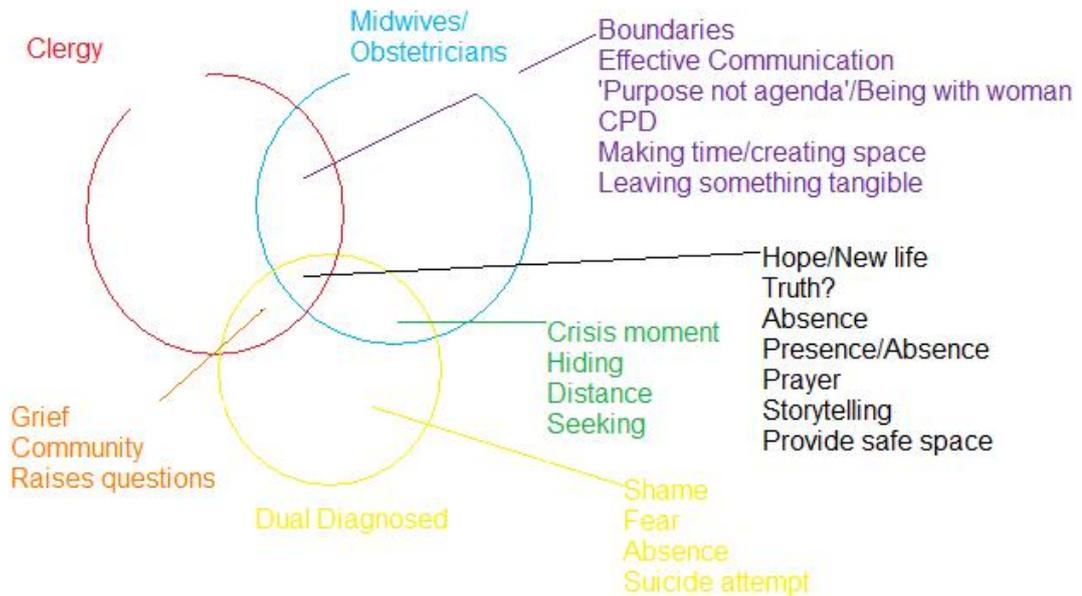


Figure 2: Diagrammatic illustration of some of the grouped codes mapped out. Where codes overlapped between two groups, the blend of the two colours is used in the typing to denote this.

The 'thematically grouped' codes were connected by three themes: absence; presence; and the tension between absence and presence (coded: absence/presence). The absence/presence theme quickly became the overarching or 'global theme' (Attride-Stirling 2001, 392). The 'global theme' (Attride-Stirling 2001, 392) was determined for the whole of the endeavour to be 'absence/presence' which was very much found to be the 'nexus' of the pastoral endeavour. Within that code were several other codes within a thematic network (Attride-Stirling 2001, 393). This included things like 'memory-boxes' (given to bereaved families containing objects that speak of the fact that their child existed and became a focus for their grief and loving attention). To completely unpack the global codes, their etymology was explored – by way of fully exploring the capacity of the words for the thematic networks, and ensuring that the maximum number of initial codes could be connected together. For Swinton (2001, 105), these themes are not objects of generalisation, rather they are like knots in the web of our experience, around which certain lived experiences are thus spun and thus lived through as meaningful wholes. Themes do not necessarily represent the experience as initially interpreted and understood by the person themselves, but are a constructive product of the fusion of the researcher's horizons with those of the participants as together they embark upon the quest for meaning and understanding.

### **Deviations from the initial Grounded Theory method**

Grounded theory was the obvious choice of methodology for this piece of research as it offered a way into what was a relatively unknown area, little researched and in which I the researcher had limited experience. However, the intersection of the three populations proved to be a place in which few people could speak with confidence, if indeed they could speak at all.

As noted within the introduction, clergy 'lacking resources and knowledge feel unprepared, vulnerable and intimidated' by people with mental health issues (Leavey et al. 2007, 557). Certainly amongst my clergy group there was a lack of confidence about answering questions relating to dual diagnosis, and the care of people with a dual diagnosis (with the exception of the clergy person who was himself dually diagnosed). This lack of confidence was echoed by the midwives and obstetricians in their talk of spirituality. This echoes research carried out by Savel and Munro (2014, 276-277) who state that 'Spirituality can be an intimidating topic for nurses and other clinicians; for many of us this is unexplored territory, and we simply are not trained well to talk about it.' These issues were coupled with the ethical limitations of not interviewing individuals with a dual diagnosis and led to a deviation from the normal grounded theory methodology. After the initial purposive sampling of clergy, midwives and obstetricians and individuals with a dual diagnosis, line by line coding took place, and through diagramming and mapping out those initial codes, an overarching code was quickly identified (presence/absence). The nature of that code, and what lay behind it highlighted shortcomings in the initial literature review. These included an overemphasis on one to one pastoral encounters, not taking into account others offering care to those with a dual diagnosis outside the Church, and no real engagement with issues of bereavement, and the role of objects in pastoral care – all of which emerged strongly within the initial data set.

The decision was thus taken not to carry on with theoretical sampling, amongst the participants, but rather to return to the literature and drawing in further relevant insights from the academy. This mitigated against further disempowering the individuals with a dual diagnosis by not prioritising insights from the other 'populations' (clergy and midwives/obstetricians), and also enabled me to draw from those who could speak with greater confidence into the areas of insight that had been drawn out of the initial interviews. Whilst the midwives and obstetricians could speak with great confidence on the practicalities of what was done for women who had suffered an intrauterine death, they could not speak with confidence on the theory behind some of that provision which would be of greater value for my purposes, seeking a means by which to transfer some of the essence of that good practice across to the care of those with a dual diagnosis.

This also served to de-medicalise the research to some extent. Orford (2013, 200) describes the dangers of focussing on the individual as the locus of attention well as 'a formulation of what has gone wrong which puts the failure of the individual to control his or her behaviour at the centre of things and to push to the periphery concerns about supply and social structure' in talk of addiction, and cites 'the dominance of the psychobiological or medical model' as bearing 'much of the responsibility for the field's blindness to power issues' in society as being the cause of many such issues. This echoes strongly Swinton's sentiments from the perspective of someone working with those with mental health issues described earlier. The research endeavour then would need to be broad in terms of where insights were sought to mitigate against this. Further research was completed around the Doctrine of the Trinity, Actor-Network theory and the New Materialism, and Poiesis, for reasons that will come clear in the following chapters.

### **Chapter 3: Movement into absence**

This chapter will begin by unpacking the etymology of the word 'absence', followed by an analysis of the first of the 'episodes' that have been explored in this research, and then looking at how the different meanings of the word 'absence' came up within the data gathered from those with a dual diagnosis, clergy and midwives and obstetricians.

Even a cursory look at the etymology of the word 'absence' and its derivatives (Harper 2014, <http://www.etymonline.com/index.php?term=absence>) highlights four forms of absence:

- a. Absence as loss and lament, the trigger for grief. This could include loss of self.
- b. Absence as the verb, to absent, separating oneself, making a choice not to be present, and the consequent loss of community.
- c. Absence as loss of potential or hope.
- d. Absence as loss of the physical presence of a physical body/substance.

The first episode, a fragment of conversation between myself and Michael, a man who is dually diagnosed in a Probation Hostel during a group session on 'fear'.

Michael: Well, we're all a bit like monkeys really. . .

Myself: Go on.

Michael: Yeah, well. . . we're all a bit like monkeys who live on a cliff face rather than in the wilderness. . .

Myself: Is that because you like the danger of the cliff face?

Michael: No, no, because it's safer on the cliff face than in the wilderness where all the predators are.

I want to return to my encounter with the man in the probation hostel, because in effect what he describes here sums up the situation of the actively addicted. There is writ large through this metaphor 'absence' in almost every sense of the word

Within that dialogue Michael touches briefly on absence as grief, when I ask him if he likes the danger of the cliff face, he responds 'No, no'. There is limited pleasure in living on the 'cliff face'. There is grief for the lack of security to be found in the wilderness. Underlying this is a lost innocence which stems from an (unknown to me) childhood trauma. There is described in this exchange a very definite 'absenting'. He chooses to live on the cliff face rather than in the wilderness. He has opted out of the wider

community, opting for the 'community' of the Probation Hostel, at best a transitory place. There is a loss of hope that the 'wilderness' (here read the wider world) could ever be a safe space to live and flourish. And gradually, the loss of Michael's physical presence with us, as alcohol slowly erodes his ability to articulate himself, epitomised by pauses in his speech (denoted by the spaces in his speech) and in his deteriorating health. There is also a sense of a 'loss of self' in his self description as a 'monkey', probably one of the more striking images in the whole metaphor. He was clearly not a monkey, but there was a man with low self-esteem, who saw himself in some sense as 'less than human'.

### **Insights from those with a dual diagnosis**

If Michael sums up the movement into absence, then he has summed up the feelings and experience of many of those who have experienced dual diagnosis prior to treatment. The five scripts of those with a dual diagnosis in recovery contained many references to absence, many of whom echo Michael's experiences leading to his sitting in a probation hostel, which he describes as one of the best places he's ever lived.

Brian, like Michael, had experienced childhood abuse. He explains:

When I was eight years old, I was walking down the street when I was grabbed by two young men. I would say they were about 18 or 19 years old and they drug me into an apartment and sexually abused me. Back then you didn't talk about stuff like that or you were a bad person. They told me if I ever told anyone that they would come back after my family and me, so I kept everything in. I remember watching my dad literally bounce my brothers off the walls and I was scared of him. Him and my mom would get into arguments especially when he drank, so I leaned toward my mom for protection. Little did I know that I needed protection from her as well. I got to a point where I just kept all the sexual, mental, and physical abuse inside of me . . .'

There is grief in this description for the loss of childhood innocence, the lack of safe space, and the origins of a learnt behaviour to hide/mask the hurt. Although lacking in metaphor, the sense of absencing is revealed in this description as Brian has hidden the truth of the pain of what he was experiencing from those around him, driven by fear of the repercussions from the initial abusers in part, and also fear of attracting further physical abuse from his father. There is an absence of hope, that there was anyone to whom he could reach out, as his father was also abusive, and his mother seems to have been complicit in some way (not sufficiently explained to be clear).

Abuse is common amongst those with a dual diagnosis. Katherine also describes a situation of having been abused, although in her case this did not precipitate her mental health issues. She explains:

At some point I went out with the first and only man who was really bad for me. I was convinced that he was perfect and therefore I had to come off my medication to be good enough for him. He was, it turned out, the only man who ever wanted to know me after I had been hospitalised for five months, and when I got sick again, he threw me down the stairs and out of his flat, leaving me to wander the streets all night during long psychosis'.

There may be two sides to this account, and so I should name the silence of the partner in this incident. What Katherine did or did not do to precipitate this outburst whilst psychotic is not described. However, Katherine was nonetheless thrown down the stairs in what can be seen as a situation of domestic violence and physical abuse. There is within this passage a clear sense of the struggles of the mentally ill to be present to her partner. In her desire for a true encounter, Katherine comes off her medication, which she perceives to be masking the truth. However Katherine's perceptions of truth in encounter and her partner's will more than likely have been markedly different. Low self esteem, a thread that ran through Michael's description of himself as sub-human is present here in the sense that Katherine perceives her partner as 'perfect' and that in order to measure up to his vision of perfection she needed to come off her medication. There is a symptom of the stigma of mental health here, a sense of shame at having a mental health issue. Is her coming off the medication about denial of having an issue? A struggle with learning the medication was necessary? Or a struggle to recognise that her perceptions of life were more accurate on medication than off? There are a number of questions here created in part by the limitations of the data, but what is clear is that the resultant psychotic break does in some way precipitate a complete relationship breakdown (whether he had been abusive before that is also not clear), and results in Katherine being alone and wandering the streets in a 'long psychosis', grieving her relationship to her 'perfect' partner, absent in the sense of being separated from her support network, and separated from her medication which allowed her to relate and be more easily present with others.

For Katherine, her absence was imposed upon her by her partner; she was, in a sense, sent into 'exile'. For Patrick C, Val and Tim H, absence was something that each of them at points of ill-health desired. This would manifest itself ultimately in thoughts of suicide, or indeed suicide attempts.

Patrick C began to have thoughts of death as a relatively young child. Patrick used alcohol as a mask for 'the negative feelings inside [him]' as an adult. He goes on to say that 'I could still "act happy" but the only time I felt happy was when I had a drink in my hand, or lines of cocaine on my mirror'. Although Patrick would be physically present with people, his true feelings would be absented by the alcohol and drugs he used to mask them. As a relatively young child, Patrick suffered with anxiety, and learnt to hide it because of the responses he saw from people to his older brother who also suffered from mental health issues. He explains:

When I couldn't wear the mask, I isolated. It was always one or the other. I isolated a great deal. I remember a pattern develops in second grade where I would wake up and know that I just couldn't go to school that day. I was just too scared even though I couldn't put my finger on why I should be scared. I just was. And so I would tell my mother I was sick and stay home and stay in my room. I would do this for a stretch of a few days and then go back . . . . And I remember beginning in fourth grade praying to God to just let me die. I couldn't bring myself to kill myself but I wanted to die so badly.

Similarly, Val describes life changing when she obtained a driving license:

And I was able to hide for hours alone in a field or in the woods. I started to obsess about death and dying and created elaborate plans to commit suicide. I wrote poetry about my feelings and would burn the evidence before I returned home. I was popular in school and work but wanted to be alone. . .

This continued later in life as Val describes:

I spent the next 8 or 9 years running from one job and one State to another. I would typically last a year in one place until I was sure that I would be discovered. I would leave my belongings and tell my employer an elaborate story of why I had to leave . . . . One day I put my car in the garage, shut the windows, stuffed my tailpipe and started the car. Through the grace of God, my attempt was interrupted . . .'

Tim H's suicide attempt came as a result of the absence of hope for an appropriate treatment for his symptoms. He explains:

Numerous medical tests were conducted, but didn't provide any clear explanations or directions for appropriate treatment. I became convinced that suicide was more attractive than the possibility of living a diminished quality of life – especially if the symptoms I was experiencing would grow steadily worse.

I made a suicide plan, wrote out goodbye letters; I had the means and a location picked out where I wouldn't be interrupted. I was calm and at peace with my decision. My plan was interrupted . . . '

Both Patrick and Val describe intent about their self-isolation. This was deliberate. For Patrick the motivation was his fear and anxiety, fear of rejection, of not being taken seriously, of being viewed as abnormal as a result of watching his brother and the responses he got from those around them. Val suffered with depression and anxiety. Fear drove her to some extent, and crippling low self esteem (she speaks elsewhere of feeling 'ugly' and 'dirty'). For Tim H, the absence of hope led to his desire to absent himself from the world. Suicide is probably the most extreme form of 'absenting' described by those with a dual diagnosis. Patrick would mask his true feelings of anxiety from his classmates as a child, and this was echoed in the 'lies' to his mother about feeling physically sick. Val equally did not reach out for help initially, resolving instead to remain independent, keeping her feelings hidden by expressing them in poetry which was then burned before returning home. Geographical relocation was a later technique for Val, running away from her true feelings, and the risk of being discovered for who she truly was. There was again an issue around low self-esteem for Val, a self loathing even. As the illusion of self-control was shattered, Val would move again to try again. Self-control underlies some of what Patrick describes in his desire to commit suicide, to take ultimate control of his suffering. Patrick though had at least attempted to reach out for assistance. It was only that that assistance couldn't rectify the situation to the standard he'd hoped. What is clear across all three episodes is their isolation, loneliness, the absence of community around them, particularly in that moment, but often a decreasing sense of community in the run up to those thoughts.

Carter Heyward (1999, 21), a dually diagnosed theologian, speaks of loneliness as a theological and ethical problem, particularly 'as shaped in the modern world and exploited today by capitalism'. She goes onto explain:

As a socially constructed alienation from ourselves and one another, an alienation that is indispensable to the global political economy, our experience of loneliness becomes both 'normal' (just the way it is) and often unbearable (without drugs, dependencies, or violence). There is nothing sacred or creative about this 'capitalist spirituality' in which loneliness is either a problem to be solved and removed, or a troubled state of being to which we sadly and resentfully resign ourselves. (Heyward 1999, 21).

For all three who describe suicide attempts, or thoughts of suicide, the experience of loneliness is a feature – driven for Patrick and Val in part by anxiety around the stigma

associated with mental health issues. The stigma and anxiety are things that Patrick and Val can do nothing about, much as Tim can do nothing about his experiences of suffering.

This powerlessness echoes an assertion by Rowan Williams connecting powerlessness and violence (suicide after all, also being ultimately an act of violence against the self). Williams (2007, 171) explains:

May [, an existential psychologist,] connects violence with powerlessness: it is aggression directed in the first instance against a self that is felt to be without worth because it is without power. It is, paradoxically, both an assault on the self and an affirmation of the self, 'a unity of the self in action'. Violence is irrational assertion, a creation of power out of nothing; it may be an authentic overcoming of powerlessness, the opening of a door to a higher self-evaluation, or else it may be an intensifying of real long term powerlessness. Which it is depends on whether the act of assertion harnesses the processes of reality, whether it is in some significant way a breakthrough into a participation in the way things work, or whether it remains at the level of pure protest against reality.

For all those who are attempting suicide, there is then the perceived absence of power, and an attempt to try and create power out of nothing. The paradox of 'assault on the self' and 'affirmation of the self' described by Williams is at its height in this form of violence. However the difficulty for all three stems from their inability to harness the processes of reality; there is irrational assertion in these episodes, and an 'intensification of real long term powerlessness', and a 'protest against reality'. For many of them, this marks a turning point, stemming from that intensification of powerlessness.

The distinctions that Williams makes here between an 'authentic overcoming of powerlessness, the opening of a door to a higher self-evaluation' and violence as 'an intensifying of real long term powerlessness' is reflected in a distinction that Heyward (1999, 21) makes between loneliness as an ethical issue stemming from a socially constructed alienation from ourselves and one another, and 'loneliness that is not basically alienation, not at root a product of capitalist spirituality'. Heyward (1999, 21) goes on to explain that she is:

Referring to a loneliness that reflects an emptiness at the heart of God, a void that, try as we may, we cannot fill. In God's image, the most we can do is learn; with the help of our friends and God working through them, to accept this lonely spot as a sacred space, a fully divine and fully human creaturely place of mystery and awe and fear and hope, and of a yearning for love that is beyond all

love. It is a place in us of an insatiable desire that cannot be met except in 'intimations and glimpses' on the road we experience together as life'.

The 'emptiness' in God stems from the yearning for justice, compassion, solidarity and friendship (Heyward 1999, 21) epitomised by Jesus' calling out 'My God, My God, why hast thou forsaken me?' (Mark 15.34b) on the cross. There is an irony in the fact that there is a need for community in order to be able to name the Void that is 'Holy Absence' – sacred space, the emptiness at the heart of God, denoted by Heyward's (1999, 21) description including the need for 'The help of friends and God working through them', and in her description of the 'insatiable desire that cannot be met except . . . on the road we experience together as life'.

Probably the key difference between 'sacred void' and the sort of void or absence that reaches its peak of intensification in a suicide attempt, or thoughts thereof, is in acceptance of that lonely spot. Simone Weil (1997, 56) states that 'to accept a void in ourselves is supernatural, echoing Heyward's (1999, 21) statement speaking of accepting 'this lonely spot as a sacred space . . .'. Can it simply be that addiction is the vain attempt to fill that Void? To quench the 'insatiable desire that cannot be met' (Heyward 1999, 21)? To fulfil the 'yearning for love that is beyond all love' (Heyward 1999, 21)?

Ford and Hardy (2005, 113) in a discussion about 'shame' state:

In extreme shame, we are deprived of self respect and of the recognition and affirmation of others and of God. It can be seen as the implosion of respect, in which those energies which should be taken up into that ecology of praise and blessing, as respect finds its proper form and goal, are instead turned against oneself. This negates what one lives from, and so it is a state of living death. It is a picture of ultimate rejection and horror, with the joy and hope of life drained away, and the energies of living turned against themselves.

This mirrors Val's description of herself as feeling 'ugly' and 'dirty', and may well have underlain the 'masking' described by Patrick. Shame silences the 'ecology of praise and blessing' (Ford and Hardy 2005, 113). Ford and Hardy (2005, 113, 115) outline 'right' and 'wrong' shame. Right shame is a recognition before God of being in some wrong relationship or false position (Ford and Hardy 2005, 113). Wrong shame is the result of the most powerful drives and processes of self and society being used to destroy joy, dignity and all that goes with them . . . [caused by] slander, fear, violence, deceit and the perversion of goodness and trust' (Ford and Hardy 2005, 115). Swinton (2000, 26 and 2007, 221) highlights that Jesus sat with those marginalised by society and with no access to cleansing rituals of the temple; they were condemned as sinners

in the eyes of the religious authorities, with no obvious way out of that state. Rather than condemn them, Jesus offered them friendship, especially to the marginalised, stigmatised and the demonised (Swinton 2007, 221). Swinton (2000, 26) describes this sitting with oppressed people as a 'radical act'. Mercadante (1996, 173) states that 'sin is a breaking of the relationship with God' while 'grace is a restoration of that covenant'. For Mercadante (1996, 172), 'grace is God present for us in Jesus Christ through the Holy Spirit. Grace as God's presence also implies relationship. Although it is accepting, it must also be accepted'. Mental health problems rather than being defined in terms of biology or diagnosis, are an ultimately indefinable combination of pathology, personhood, and community; the three aspects are inextricably interlinked (Swinton 2000, 27). It is notable that recovery rates from schizophrenia are considerably higher in Third World countries than in industrialised Western Capitalist economies (Swinton 2000, 19) and this is linked to social cohesion, and the ability of families and extended families to offer a closer, less stressful, and more accepting environment, which is conducive to recovery. Swinton (2007, 103) speaks of the need for the silence of the sufferer to be 'heard into speech'. What we have here then is two forms of silence: the silence of the silenced (the absence of their voices); and the healing silence of God, listening, accepting, and loving. Swinton (2007, 101) describes the silence of Jesus on the cross as a 'liberating force that reveals God's solidarity with the sufferer, not in unrealistic platitudes or false expectations, but in total identification and solidarity'. The silence that can lead to suicide attempt is a silence borne of shame, stigma, and despair. The silence of God is altogether different but borne of experience of these self same emotions. The silence of God invites us to bear witness to those emotions perhaps in lamentation but also through prayer.

### **Insights from midwifery/obstetrics around resisting absence**

Intensity of grief also occurs in a situation where there has been an intrauterine death. In a situation of intrauterine death, the void within parallels the 'sacred space' that Heyward speaks of, but in the moment in which the news of the death is delivered, acceptance is rare indeed.

Hayley, a hospital based midwife explains that:

What is really difficult sometimes [is that] you're dealing with somebody who might actually be totally shell shocked, they're not taking it in, they're in denial, they don't know what's going to happen, it's so many mixed emotions that that person is contending with . . . . She may be screaming to have a caesarean section because how could she give birth to a child when it's going to be dead. So there are all the things that you've got to talk through and listen to. And

maybe take that in stages, at the pace that that lady wants, appreciating that that lady might not want to deliver straight away, they might want to go home . . .

Here is described an intense expression of grief: shock ('totally shell-shocked'), denial ('not taking it in'), anger ('screaming to have Caesarean'), pain ('how could she give birth?'), all of which precede acceptance. Acceptance will likely not be seen in the hospital setting. Eileen, an obstetrician, has the role, often, of breaking the news to the family of what has happened. She explains that there is a great deal of 'initial emotion, apart from extreme sadness, which is anger, which is normally directed towards [midwives/obstetricians] without them intentionally meaning to, but they feel angry and have to be angry at something . . . it's like the initial stage of grieving when you become angry and need someone to blame almost. Invariably the women blame themselves, . . . they search for something they have done wrong, or not done properly'. There is a subtle difference in how the grief is expressed by the women though from their partners. Eileen goes on to explain that:

their partners blame lack of care, or us, or anything else really. "Maybe if the midwife had noticed a problem when we saw her last week", or "we phoned the GP with a query", or "we shouldn't have gone and had a meal there and she got an upset tummy", you know, they try to rationalise it and look for someone else to blame'.

The women affected, turn their anger inwards to themselves, whilst their partners project their anger outwards, generally, although in some of what Eileen describes, there is a sense of self blame for making certain decisions, so the distinction is never entirely clear.

When delivering the news, Eileen explains that 'by the time you say "I'm really sorry but I can't find a heartbeat", they have stopped listening to you then, so you usually have to give them a period of space once you have delivered that news, and leave the room with the midwife who is normally present with you and just give them some space to deal with their initial reaction'. Absence here is expressed in a form of 'absenting' on the part of the midwives and obstetricians, coupled with an understandable denial of the reality that has just been set before them in the case of the parent(s). Later, the absenting of the midwives/obstetricians will be mirrored by the family, as, having begun to comprehend the news of their unborn baby's death, 'very often some want to get out of the hospital as soon as possible', according to Eileen. She goes on to explain:

We are in agreement with that because they've just had possibly the worst news that they've ever had in their life and they often just need to get away from the place that they've just been told that and let it sink in before they can start

making informed decisions about the rest of their care . . . . Most of them just want C-section because they just want it over, but in fact we have to act in the interest of the mother and for the mother to go through an operation is not in her best interests.

The mother (and often her partner) seek to absent themselves as they physically remove themselves from the place where the news they did not want to hear has been given. Understandably, they would seek to get through and out of that situation as quickly as possible, and so superficially, they seek to absent themselves as physically painlessly as possible by going for a Caesarean section. However, the reality of a Caesarean section is that there would be permanent physical scarring without the joy of a live birth to give more positive associations with that scarring.

The absenting of the mother from the hospital mirrors the phenomenon of moving around common amongst those with a dual diagnosis, who often move frequently when the symptoms of their mental ill health and addiction begin to be undeniable in their current location. The intensity of emotion is often moderated by an active addiction, but when the addiction ceases to be sated, these emotions soon re-emerge with a similar intensity.

Denial also manifests itself in several more subtle ways. Julie, a midwife, describing a hospital birth of a stillborn baby says that 'there's a very sombre atmosphere, there is not much eye contact, not much talk, . . . '. Here we glimpse a subtle attempt to absent from each other, to not engage with each other. There is discomfort.

Likewise, in the process of giving birth to a stillborn baby, the mother may be 'covered up' because 'a lot of the time they don't want to see the baby straightaway, so there's none of the involvement of Dad having a look, "Mum do you want to touch the baby's head?", because we're trying obviously to wait until baby's born and then decide what they want to do', according to Julie, a sentiment echoed by Eileen and Hayley.

Denial as a form of absenting is a strong theme across both groups within those with a dual diagnosis in the form of denial of the mental health issue, the need for medication, the addiction, the issues stemming from addiction. Within the parents, denial manifests itself primarily in this issue of whether or not the death has even happened, that the birth must happen, that the baby really exists, that the situation is in any sense real, that the void is real.

The tangibility of the 'void' is more obvious for the midwives and obstetricians because the absence of life in the child comes through most poignantly in the silence. Hayley describes the atmosphere at the birth as having 'no joy, there won't be the sound of a

baby crying. There will probably be the sound of a lot of tears and a lot of that happening, but there'll be no baby crying, so it is very quiet'. They would be more keenly aware of that silence, accustomed as they would be quite regularly to the noise of crying baby in a 'live' birth.

Derrida, the French philosopher, speaks poignantly on silence, quoting the work of Bataille (2001, 167), he explains 'Silence is a word which is not a word, and breath an object which is not an object'. Derrida (2001, 332) goes on to explain that

if the word silence 'among all words', is 'the most perverse or the most poetic', it is because in pretending to silence meaning, it says non-meaning, it slides and erases itself, does not maintain itself, silences itself, not as silence, but as speech. This sliding simultaneously betrays discourse and non-discourse. It can be imposed upon us but sovereignty can also play upon it in order rigorously to betray the meaning within the meaning, the discourse within discourse. 'We must find,' Bataille explains to us, in choosing 'silence' as 'an example of a sliding world', 'words', and 'objects' which make us 'slide' . . . . . Toward what? Toward other words, other objects, of course, which announce sovereignty.

The 'silence' of the baby announces sovereignty, the sovereignty of God. It is an uncomfortable announcement. The child reminds us of the void within. Derrida (2001, 332) goes on to say that 'In speaking at the limit of silence', we must organise a strategy and 'find [words] which reintroduce – at a point- the sovereign silence which interrupts articulated language'. It is that fumbling search for words that many clergy will identify with. In a sense this is 'presence' speaking of 'absence'; the beginnings of negotiating that tension between the two. How do we find words that speak of God in this situation? Often we fail, but the search continues. For many working in this field, there are no answers to the inevitable questions that arise out of this situation. Because the answers we seek are ones that bring consolation, comfort, and the only words that could do that are words that speak of life. Thus articulated language is 'interrupted', as Derrida puts it.

### **Clergy on 'absence'**

This 'interruption' of articulated language, may account for the lack of talk of 'absence', to be found within the clergy interviews. It can feel like clergy are 'failing' to offer effective pastoral care when we cannot find appropriate words of comfort. Carla, a prison hospital chaplain spoke of what happens when a death occurs on a hospital ward, and touches on that sense of 'not knowing' in that setting:

Care of the other patients [on the ward] is important and I would go on the ward and gather the patients together for informal memory, for them to tell their stories, because it's very hard for people sometimes to be faced with a death on a ward, especially if it's sudden, so they're there one day and the next minute they're not. And it raises all sorts of questions for them. Particularly if it raises some anxiety for them around what medication can do to people's physical health. That's a real anxiety for them, is it going to happen to me? They're very anxious to know on those occasions why somebody died. And of course, I very often don't know.

Here, Carla alludes to questions for which there may be no answers, as well as the fears elicited in many when someone dies an untimely death, and with them the recognition that things may not always be 'ok'.

Jim, a priest in an inner city parish, when discussing caring for people with dual diagnosis recognised that his role is not 'to try and solve their problems. Because I'm pretty clear that those are beyond me to solve'. Jim has a rule not to get drawn into 'people's chaotic situations' because of the feeling of absorbing 'a degree of that chaos and skewed thinking into [himself]'. He is wary of this because of his observations of a former colleague who got drawn into trying to solve the problems of a couple of individuals getting in 'too deep and having significant problems' . . . culminating in his being 'murdered by one of the individuals'. Concerns had been flagged up with the then Bishop but nothing was done. Jim then went on to say:

So the system, as with many pastoral crises, the system doesn't really know what to do, because the big secret about the system is that there ain't no system which is why protecting yourself as a sole provider of a service is such an important thing. So we are not accountable in a professional way, we are not as with psychiatric/social workers will sit round at the start of the week, run through their cases (well ideally), talk to one another about what they're doing with individuals, there are checks and balances, they have supervisors who have access to their case records, they are writing down what they are doing, why they are doing it, when they are doing it, and none of that is in place in parish ministry for good and historic reasons, but you know, we do need, when working with people with such profound and complex needs, we do need more training, more support available.'

Jim describes here absence on a number of levels. Absence of 'answers' for those with a dual diagnosis and those slipping into 'chaotic behaviours'. There is a sense of peering into 'the Void' (to coin Simone Weil's term) in being present to these individuals

at that point. But also, an absence of support/safeguards, highlighted by the untimely death of a colleague. There is here a reminder of the inherent dangers of 'problem solving'. If as Williams (2007, 171) suggests, violence is connected with powerlessness, then perhaps the violence directed at the carer stems from feeling disempowered by the care offered; that rather than being allowed/empowered to solve one's own problems, the person offering pastoral care in a manner that solves problems for the person is in effect further disempowering that person, leading to the violent reaction. Certainly on those occasions where my own life has been threatened, I have been involved in 'problem solving' behaviours. The absence of support/accountability is one of the key differences between the situation of midwifery and clergy. Certainly in the situation of an intrauterine death there is a very definite 'team' involved in offering care, and collaboration across that team. Within this one comment, there is an absence of answers (the 'interruption of articulated language' again), an absence of support and safeguards, which led to the 'absence' of a colleague, the absence of system, and of an appropriate accountability within that absent system.

Jim describes life after violence, a withdrawal, a reassessment of what is offered and done. Carla, in her ministry in the prison hospital describes life after violence for the perpetrators of violent crime, where that crime has been 'motivated' by a 'psychotic break'. She explains:

The inmates have lost their families, many of them because of what they have done . . . .when people first come to one of our big hospitals and they're on one of our admission wards for assessment . . . .so very often there will have been a crime committed, and sometimes it's pretty horrendous, and could be connected to family or, when they begin to get better, and they are then faced with what they have done and that is a very, very critical time for their care, because they are facing the reality of what they have done in a way they didn't when they were very unwell, and so . . . bereavement hits them again in another way. You know, 'I've killed my family'. And so they've lost their buffer to that, in their journey to getting better. They've lost their unreality which kept them, in a sense I suppose, protected perhaps.

Here we see ministry in a relatively unique hospital setting, with the after effects of violence lived out. This also is a setting in which there are a number of patients with a dual diagnosis, although with clearly defined boundaries in place to confine and restrain the effects of 'chaos'. This is a fairly extreme form of therapeutic environment. Again, there are no words to be offered that will bring comfort in that situation, save those of forgiveness, offered over and over again. The absence of a buffer echoes strongly the experience of those coming off an addictive substance. Addictive substances can often

be used as a buffer to numb painful experiences of grief, abuse, some other trauma, or the effects of a mental health issue.

This has certainly been the case for Sean for whom stopping drinking meant that the bipolar disorder manifested itself more clearly. He also describes the disappearance of a 'circle of people. . . these were all friends at the time that [he] would drink with and when [he] did get clean and sober it seemed like they all just disappeared'. This account shows the implications of making such a significant change in life for an addicted person. This is reflected in a change of lifestyle and a shift in social circles. The old friends absent themselves, having less in common with the reforming alcoholic than they otherwise would have done. Another form of absencing occurs 'in dealing with [his] depression, . . . [Sean] might have a tendency to want to isolate from other people', explaining that 'that's not necessarily the most healthy response'. He is not alone in that response, and continues to use that insight in his pastoral care of others in that situation.

Sean, along with many of the clergy also manifests this idea of 'not having all the answers'. Indeed, he sees this as important. Sean explains, 'I place a lot of importance on not giving the impression that I have all the answers because I don't . . . I'm very willing to acknowledge that I don't have all the answers, but I would certainly use resources to try to find out the correct answers'. Liz, also echoed this sentiment. Indeed, it is that sense of not having answers that has motivated this research project.

Dual diagnosis and grief prompted by an intrauterine death are not mutually exclusive categories. Liz, a curate in an inner-city parish who cares for men with addiction issues (many of whom are dually diagnosed) explains:

I think particularly with the men I'm working with now, many of them have got loss of a child. And unless you've lost a child you can never imagine the pain that that must be, because of the loss of expectations, and we all dream for our children whether we're whatever we wanted to [be], we have this life expectancy that we'll die before our children do, and when that normal sequence of events is interrupted, it's very difficult for people to make understanding of it really.

Here Liz touches on the realities of dual diagnosis, addiction to alcohol and depression, loss of a child (pre- or post- natal) and the lack of answers that clergy feel in that situation, as do those suffering. Liz highlights the same absence of potential, hopes and aspirations that parents would have for an unborn child as Hayley (a midwife) highlighted. However, Liz goes a step further in alluding to the absence of the potential for that child to fulfil the parents own unfulfilled potential or expectations in life. There are many parents who live vicariously through their children, and so the loss of a child in

that situation would reverberate in grief for absent potential both ways on, with the child and the parents. Liz goes further highlighting an area of absence within the dually diagnosed people, especially where there is an active addiction:

The deskilling of people . . . it's actually being with people, and listening to how skilled they were at one point in their life. So master joiners, musicians, people working on oil rigs who have now lost their employment because of their addiction, and then part of that diminishing health because of drinking, raising potential mental health problems.

Addiction limits the potential of someone to live a healthy and fulfilling life. One difficulty of addictive behaviour is that sense of un-fulfilment. An addicted person will never have enough of whatever it is they are addicted to. In trying to find fulfilment through their addiction, they lose their potential in other areas of life. They cease to realise their potential in the sphere of employment, in relationships, and in other areas of their lives. Particularly where alcohol is concerned, the absence of hope often comes with increased consumption as alcohol has a depressive effect on the brain.

### **Naming absences – insights from the academy**

Suicide attempts, foetal loss, dual diagnosis, the absence of hope, the absence: of answers; of potential; of family; of 'articulated language'; of acceptance; of even the 'sacred' (according to Heyward); of power 'leading to violence'; of self-esteem; of a community. Having explored 'absence' as seen through the data gathered, I shall return to the academy, to see what insights can be gained to assist us in carrying the significance of this data forward in the task of exploring the pastoral care of those with a dual diagnosis.

The act of naming these absences is a 'spiritual' task. Swinton and Pattison (2010, 231) defines 'spirituality' as tending to function as 'a way of naming absences rather than presences'. Swinton and Pattison (2010, 231-232) see spirituality as 'related to issues of meaning, hope, purpose, connectedness, love and so forth', the implication being that these things are perceived as missing or downplayed within current approaches to care and treatment. This is not dissimilar to Marcella Althaus-Reid's (2004, 114) description of a 'community of women' amidst 'death squads and the politics of hunger and dehumanisation, which produces infinite forms of little everyday deaths in the life of the poor'. There, these women enact a 'theology of memory, counting crosses and resurrections' (Althaus-Reid 2004, 114), in which 'dead dreams and plans for a better future are resurrected by a community of women remembering'. Althaus-Reid (2004, 114) speaks here of the experience of the women of El Salvador, who are part of a wider community of Latin American women who are still claiming the bodies of their

dead, such as the Madras de Plaza de Mayo in Argentina and the widows of Guatemala. The Theology of Memory is a methodology, a metaphorical walk which starts with the silenced history of the poor women in Latin America, and finds in them 'that of 'God' present (what we can call resurrections, that is the presence of God in the memories of life and death) (Althaus-Reid 2004, 115). The women remind us that the resurrection was also a community event: women and men witnessed how Jesus came back from death, walked among them and continued the dialogue which existed before his crucifixion (Althaus-Reid 2004, 113). Every death changes the life of the survivors, because some humanity is removed from them, so it is legitimate to think that, starting with Jesus' resurrection, a whole community of people who suffered his loss when he was crucified came back to life again (Althaus-Reid 2004, 113 and Swinton 2000, 131). They highlight that the death took on another meaning; the resurrection became the paradigm showing us the durability and indestructibility of life and justice (Althaus-Reid 2004, 113).

Throughout this chapter, we have sought to 'name absences', in many ways to 'count crosses', to stare into the 'Void' that is the daily lived reality of those who suffer dual diagnosis, foetal loss, and the situations in which midwives, obstetricians and clergy are offering care. By virtue of the fact that these absences can be 'named', speaks of presence, the presence of those that remember, the presence of those who live to tell the tale.

Swinton and Pattison (2010, 232) go on to describe 'spirituality' as a 'point of resistance against particular inadequacies that have been, albeit inchoately, perceived or sensed . . . and that people wish to resist'. And so, having named absences within the data, the next step is to look at some of those presences. The need to do this is particularly acute, if Hammond (2003, 33) is correct, as she (quoting Miller and Thoresen 2003) suggest that 'religious spiritual practices have a beneficial effect on people's health'. Hammond (2003, 35) goes on to quote McKivergin and Daubenmire (1994) who state that 'therapeutic presence involves being with [a client] spirit to spirit, whole being to whole being, centred self to centred self, such as openness, centring, intuiting and connecting.' Moltmann (2004, 123) describes the origins of this therapeutic presence when he states:

In the self-help groups of the bereaved, consolations in grief are discovered mutually, in conversation. This is very much in line with the old concept of the religious communities, which Luther took over . . . the mutual consolation of the brethren. As brothers and sisters, men and women enter mutually into the situations of others, and combine the trust which loosens dumb tongues with respect for the intimate mystery of the other person. Here no one talks down to

anyone else. People speak or are silent, weep, and laugh with others in the same situation . . . the important point is not to be theologically correct but to be personally concrete . . .'

Here, Moltmann speaks about the experience of grief, and the grieving finding consolation. Speaking more specifically about those with mental health issues, Swinton (2000, 36) states that the Christian community has a vital contribution to make to the care of people with mental health problems in actively countering the wider interpersonal and social forces that act to stigmatise, alienate, oppress, and exclude many people with mental health problems from full social inclusion.

The relationship of 'friendship' is primary here for Swinton (2000, 37) based on the friendships of Jesus. The priority of friendship is the personhood of the other and not the illness, thus rehumanising those who have been dehumanised. Swinton (2000, 39) sees some of the distinctive features of Christian friendship as being socially radical in that it transcends the relational boundaries that are constructed by contemporary tendencies to associate with others on the basis of likeness, utility or social exchange. Then it seeks out those whom society rejects or marginalises, offering them unconditional acceptance, solidarity with the poor and marginalised, and total commitment to others even unto death (Swinton 2000, 43). For Swinton (2000, 26), understanding is therapy. This will be unpacked in more detail in Chapter 7. For now though, we turn from naming absences, to naming presences, and some analysis of the processes at play within those present.

## **Chapter 4 Presence**

This chapter will begin by unpacking the etymology of the word 'presence', followed by an analysis of the second of the 'episodes' that have been explored in this research project, and then looking at how the different meanings of the word presence came up within the data gathered from those with a dual diagnosis, clergy and midwives and obstetricians.

Again, as with the etymology of 'absence', a quick look at the etymology of 'presence' reveals several meanings to be explored:

1. Presence as the fact of being present.
2. Presence as a divine, spiritual, or incorporeal being felt as present.
3. Presence as the verb 'to present', to bring into the presence of, including formally or ceremonially including in prayer.
4. Present as a noun, a present or gift, a thing offered.
5. Present as in 'the present', a reference to this point in time.

(Harper 2014, [http://www.etymonline.com/index.php?term=present&allowed\\_in\\_frame=0](http://www.etymonline.com/index.php?term=present&allowed_in_frame=0)  
<http://www.etymonline.com/index.php?term=presence> )

All five of these meanings can be discerned in the encounter with Peter.

Peter is showing suicidal tendencies, and has asked for 'that vicar that comes in'. It's late evening and I enter to find Peter (who I had spoken to on and off for about 6 months at this point) in a distressed state, staff unsure what to do. I sit with him, unsure what to do myself, and listen for any signs of attachment to anything in this world, trying to motivate some hope in this despairing man. He spoke of multiple bereavements: lost children, a broken marriage; lost contacts with his father; the death of his mother; regrets; threats from others in the community. Eventually, he agrees to see me again in the morning, to accompany me to a day centre locally for people with mental health issues. Hope enough for the moment I thought.

Several months after this initial encounter, I was moving on from my curacy to a first incumbency and Peter stops me, determined to thank me for what I 'did' that night. It had been a significant moment. He said that 'it was like you came down a ladder to where I was at, and kept pointing up. And then you accompanied me, when I was ready, up each step to where I am now.'

If the first encounter was a description/metaphor for absence, this encounter was all about presence: being present to each other; representing a higher power for Peter;

presenting (to bring into the presence of Peter) hope (as gift); in that moment in time, the present. As an Anglican priest, I represented something of God to Peter, or at the very least pointed him in that direction. Yes, there was the naming of several significant absences, and in a sense, within the absences I was seeking some potential presences (broken relationships can be healed, lost contacts can be re-established, new friendships can be made, healing effected).

This encounter would also fit well within McKivergin and Daubenmire (1994, as cited Hammond 2003, 35) framework as a 'therapeutic presence', with what clearly was an unusual degree of 'openness, centring, intuiting and connecting' going on throughout. Peter's use of the metaphor of a ladder was also significant, a seemingly not unusual metaphor throughout the Christian tradition. This is a metaphor explored by Coakley (2013), Soelle (2001), Benedict of Nursia, Gregory of Nyssa, Jesus Christ in John's Gospel, and in the book of Genesis (Jacob's Ladder).

It is in John's Gospel Chapter 1, verse 51, that Jesus describes himself as a ladder connecting heaven and earth, an allusion to the story of Jacob's ladder in Genesis 28. Suggit (1993, 40-41) explains that:

The theme of ascending and descending is used at a number of levels in the Gospel [of John]. Here it is angelic beings who ascend and descend upon the Son of Man. In the majority of instances it will be Jesus who is presented as descending from heaven, and ascending into heaven . . . , the narrator also uses these words for Jesus' itinerary. Often Jesus is portrayed as going down or going up to a geographical area. The use of the same verbs in these instances functions as a constant reminder of the celestial katabasis (descent) and anabasis (ascent) of Jesus.

Celestial katabasis and anabasis encompasses the incarnation, crucifixion, resurrection and ascension, and, factoring in the references to geographical movement as well, will encompass most, if not all, of Jesus active earthly ministry. The allusion to Jacob's ladder is a reference to Israel (Jacob as was before the name change) finding hope, as well as Nathanael (disciple of Jesus called in Chapter 1), the 'true Israelite' finding the fulfilment of the hope of Israel by coming to Jesus (Suggit 2003, 19). Thus the image of the ladder in scripture is a powerful one, alluding to the entire narrative of Jesus from incarnation to ascension. It speaks ultimately of salvation, but also of struggle (Jacob wrestles with an angel, his hip put out of joint in the process in Genesis 32. 24-31).

Soelle (2001, 77) describes Jacob's ladder as the Biblical image for the soul's ascent to God, drawing on Johannes Climacus ('ladder to paradise'), Bonaventure ('Pilgrimage of the soul to God'), and Walter Hilton ('Ladder to perfection'). Touching on the theme of

'presence', Hasidic Judaism uses the ladder as a favoured image of community. Occasionally the tzaddik (leader of the religious community) is perceived as the ladder, but more often every person of higher or lower estate is pictured as one of the rungs (Soelle 2001, 160). Soelle (2001, 160) goes on to explain that this should not be seen in terms of a 'hierarchical power arrangement', but instead as 'a repudiation of spiritual arrogance of every sort, signifying the humility of equals, no one is dispensable on the ladder.'

The ladder imagery, through the ages then, has always had a dynamic quality about it, indicative of ascent and descent. Swinton (2000, 50) describes friendship not as a 'social status or a static human relationship', but rather as 'a dynamic activity within which we seek to live virtuous lives worthy of being called truly human'. The dynamic quality of human relationships is a key issue to be worked through, in particular with those who are struggling with dual diagnosis, where there can be times of intensity of engagement, followed by long absences, where *anabasis* and *katabasis* can be very rapid indeed. We glimpsed in the last chapter the importance of community, of relatedness, and here, we see just how much that has been valued by Peter at this point. Swinton (2000, 139) states that 'Committed friendship that reaches beyond culturally constructed barriers and false understandings and seeks to 'resurrect the person' – who has become engulfed by their mental health problems – is a powerful form of relationship. It offers hope and new possibilities to people'. Thus, the image is a good one; however not without its issues.

Concerns about hierarchy permeate the work of Sarah Coakley, a feminist theologian, who draws on the work of Gregory of Nyssa and his metaphor of ascent. Gregory traces Moses' steps from the light of the burning bush (which he interprets as the light of the incarnation) through cloudy darkness in the wilderness, to the thick darkness of the peak of Mount Sinai – the climax of the ascent (Coakley 2013, 286). Coakley (2013, 286) explains (quoting Gregory of Nyssa):

As the soul makes progress . . . , and by a greater and more perfect concentration comes to appreciate what the knowledge of truth is, so much the more does it see that the divine nature is invisible. It thus leaves the surface appearances , not only those that grasped by the senses, but also those which the mind itself seems to see, and it keeps on going deeper until by the operation of the Spirit it penetrates the invisible and incomprehensible, and it is there that it sees God. The true vision and true knowledge of what we seek consists precisely in not seeing, in an awareness that our goal transcends all knowledge and is everywhere cut off from us by the darkness of incomprehensibility'. Thus, the classic Platonic goals of light and clarity and achieved perfection are

extraordinarily reversed by Gregory into darkness and obscurity and a perfection that 'never arrives' (as he puts it in his treatise 'On Perfection'). Now we see that the goal of the Christian life is a very particular kind of loss of control.

Here, Coakley's ladder connects with Veil's Void. Coakley shows an apophatic sensibility, elucidating the ultimate 'unknowability' of God, the mystery that interrupts words. Coakley (2013, 319) goes on to explore the notion of 'hierarchy' in this imagery, rethinking hierarchy in the light of insights from Dionysius who states that 'the aim of hierarchy is the greatest possible assimilation to and union with God'. Coakley (2013, 319) contends that:

Hierarchy is a holy order and knowledge and activity which participates in the Divine Likeness', and that 'where hierarchy simply means order, then it is not at all clear that feminism should oppose it. Anyone who has worked in circumstances of institutional chaos knows that some such order, organisationally speaking, is preferable for everyone; it is worldly sexed subordination that feminism opposes.

This is an important point when dealing with those with a dual diagnosis. Peter could see his life had slipped into the darkness of isolation and chaos caused at least in part from his drinking, relationship breakdown, and his perceptions of life as viewed through depression arising through grief. A 'holy order' would bring some 'healing' to Peter. Cook (2006, 180), an addiction specialist, echoes this sentiment when he states that 'created order is to be desired as penultimate, not ultimate, it is to be desired as that into which the reality of God in Christ has come'.

This encounter led on to Peter settling into a more structured lifestyle, volunteering at a day centre for people with mental health issues, sustaining a tenancy, eventually seeking to start his own business, and re-establishing a connection with his father. There was plenty of mystery still surrounding Peter, particularly around various relationship breakdowns. Reconciliation with his father; beginning to offer practical assistance to others; and being able to support himself; all feel like signs of the establishment of a 'holy order'.

Ford and Hardy (2005, 121) speak not just of order/disorder but also of 'non-order'. They state:

Those who lay great stress on order as good like to describe all that is not order as disorder. Within their own terms they are sensible, because non-order is indeed a threat to them. Dictators fear laughter and good jokes as much as guns. Non-order thrives in the arts too, particularly in our era. It has constantly

been under attack there because of its threat to order – for example, abstract and other forms of modern art. Most creativity has an element of non-order, without which it is impossible to transcend the old ordering and produce something new . . . . Non-order is not just a means of producing new order, but is to be valued in itself, whatever its practical consequences.

For Ford and Hardy (2005, 124), affliction is 'the worst perversion of good order and of non-order together. Jesus meets it with a dimension of non-order: overflow. He suffers it for others, identifies completely and gets sucked in. 'My God, my God, why hast thou forsaken me?' is the result. In the vindication of the resurrection this becomes the essence of the new free order' (Ford and Hardy 2005, 124). Jesus is present as the new reality of order and non-order, word and spirit together and faith is letting this become our reality and so irresistibly rejoicing in freedom from shame before God, others and ourselves (Ford and Hardy 2005, 124). I suspect that 'holy order' and 'non-order' may in fact be one and the same thing. Certainly the establishment of a time of 'non-order' seems to be part of the 'therapeutic' task if it entails a movement towards 'rejoicing in freedom from shame'.

Moltmann (2004, 70) also reflecting on the transformative power of Christ's death and resurrection, speaks of Christ's solidarity with those who suffer. Moltmann (2004, 70) states that 'Jesus entered into his humiliation and his forsakenness by God and human beings so that he could be a brother to the forsaken, and be beside them as their friend in their time of need'. Peter's use of the ladder in his metaphor suggests that I may have entered that space of solidarity on some level. I left there with a great concern for him, and as such entered into his suffering to some extent. But I did so, always with an eye to seeking to guide him beyond that despair and isolation towards at least a glimpse of 'resurrection life'.

One of the areas that I had been reading about prior to my encounter with Peter was 'motivational interviewing' (MI). MI is a non-confrontational technique (introduced by Miller and Rollnick 1991 as cited by Watkins et al. 2001, 9) stressing self-efficacy and self esteem. This method is based on a collaborative relationship between those with a dual diagnosis and the pastor which includes respect for the dually diagnosed person and acceptance of their limitations, a non-threatening approach and a vision of wellness tempered with cautious realism (Watkins et al. 2001, 157). The dually diagnosed person is seen as expert on their experience of illness, and the pastor must have the flexibility to work compatibly with the client's view of reality (Watkins et al. 2001, 157). MI relies on identifying and mobilising the clients intrinsic values and goals to stimulate behavioural change rather than using coercion, persuasion, constructive confrontation and the use of external contingencies (such as threatened loss of job or family) (Miller

and Rollnick 1995). MI then is about mobilising hope. That hope was the gift that Peter took and accepted graciously. The collaborative approach required Peter to take an active role in his recovery. I could not do that for him, I could not solve his problems, merely provide an alternative viewpoint that Peter could take or leave. This encounter did not lead on to threats of violence. Had I not moved on to another parish, I expect that the pastoral relationship would have been sustained over the long term as a sustainable presence. The journey towards recovery was not smooth. There were relapses, periods of depression, and a lack of acceptance that he was indeed addicted to alcohol at times. For Peter though, the intensification of all that was going on that evening allowed him to embrace the way of humility enough to raise his feelings (that presumably were there relatively consistently) and make himself vulnerable in that way. This echoes Benedict of Nursia's use of ladder imagery in his Rule in which he describes us descending 'by exaltation and [ascending] by humility' (Benedict as quoted Chittister 1992, 62-63). When Peter exalted himself, he would almost inevitably descend into 'unholy chaos', and when Peter reached out for help, and was open to what was offered, he could begin to ascend. As with many dually diagnosed people, the road to recovery is rarely smooth.

### **Beyond Peter: Presence amongst those with a dual diagnosis**

Amongst the scripts of those with a dual diagnosis examined as part of this research, 'presence' featured far less as a code than for the clergy and the midwives and obstetricians. When it did occur, presence was usually associated with recovery; specifically the dually diagnosed person's attendance at a 12 step group was significant for both Katherine and Tim.

Tim details a progression from being 'unable to stop or control' his use of drugs to accepting the truth 'that [he] needed the help of other people'. After a period of treatment, Tim 'went on to live in a halfway house for additional support in [his] early recovery'. After a further period of difficulty with unpredictable and difficult to diagnose mental health issues, Tim went on to found a Dual Recovery Anonymous (DRA) group. He says:

I arrived in Kansas City and arranged for medical care. The neurologist and psychiatrist who helped me still do not fully understand my symptoms of chronic visual disturbance or periods of auditory hallucinations . . . . While they have no clear answers or cures, my doctors can help me manage my symptoms with appropriate medications.

My next task was to locate a 12 step program for people who experienced dual disorders. I was unable to locate any such group. The only reasonable next

step would be to start one. I arranged to use a room in the church that my parents attend, and on June 27<sup>th</sup> 1989, the first meeting was held that was to gradually evolve into DRA.

Within the material from dual diagnosed people, the presence of medical professionals, therapists and eventually friends are all significant, offering alternative viewpoints from a position of at least partial understanding, (noting the absence of answers relating to some of Tim's psychiatric symptoms), and enabling a 'presence to the self' for those suffering from mental health issues.

For Sean, the clergyperson who is himself dually diagnosed, finding presence as a representation of a 'higher power' in his recovery came from a doctor, who pointed out a few 'home truths' regarding Sean's spirituality when he was in rehab. Sean describes the situation this way:

I feel that when I was first in rehab, that I would argue with the doctors who told me that I needed to work on my spirituality, and I would argue with them and I would say I'm very active in my church, and I'm very religious. And they would come back to me and say, 'That's the point, you're very religious, but you're not very spiritual!' And it was a differentiation that I needed to discover.

Swinton (2001, 37) states that a person's spirituality manifests itself in thoughts, behaviours and language that can, to some degree, be observed, understood and nurtured, as they are the outward manifestation of the longings inspired by their experiences of their spirit: the search for transcendence, meaning, value, hope and so forth. Spiritual need has an outward dynamic as the spirit reaches beyond the boundaries of the self and connects with others and with God (Swinton 2001, 37). It is possible to get so caught up in the activity of Church life that those spiritual longings get squeezed out. It is prayer, the act of prayer, in its fullest sense that can be missed in the hubbub of church activity, and yet it is prayer that could be the beginning of a cure for the numbing addictions of the secular world (Moltmann 2004, 83). For Moltmann (2004, 83):

When we pray, what we are seeking is not our own wishes; we are seeking the reality of God, and are breaking out of the Hall of Mirrors of our own illusory wishes, in which we have been imprisoned. That means we wake up out of the petrifications and numbness of our feelings. We burst apart the armour of the apathy which holds us in an iron grasp. If when we pray we seek the reality of God's world (as with the first petition of the Lord's prayer), then prayer is the exact opposite of 'the opium of the people' . . . . In prayer we wake up to the world as it is spread out before God in all its heights and depths. We perceive

the sighing of creation; and hear the cries of the created victims that have fallen dumb. We also hear the song of praise of the blossoming spring, and feel the divine love for everything that lives. So prayer to God awakens all our senses and alerts our minds and spirits.

What both Moltmann and Swinton are suggesting is that a 'health-giving' spirituality will extend us beyond ourselves and into a greater awareness of the world around us, God, or those in our social networks. That doesn't necessarily mean that life will be instantly rosier and pain free (although Swinton 2001, 89 does cite research into the healing properties of prayer), as Moltmann (2004, 120) states 'through love we come alive, and make other people alive, but love also makes us vulnerable for disappointments and hurts, and ultimately for death . . . . If we want to avoid the pain, we reduce our capacity for happiness too.' As we relate more, we are more open to pain. Moltmann (2004, 120) compares those numbed by death and pain to having died a living death, spiritually speaking. For Sean, his 'religion' had not led to him being alert to the fact of his dual diagnosis, and I suspect it is that fact that led to the doctor's 'third' diagnosis of a lack of 'spirituality'.

There was little mention of 'higher power' in the material from those with a dual diagnosis. Only one described a significant moment of 'spiritual awareness' closely allied to his suicide attempt.

Tim wrote:

My plan was interrupted because my vision became so disturbed that I was unable to drive my car to the designated location. I sat up all that night, sincerely hoping that by morning I would be able to drive my car and carry out my plan. During the night, I experienced a change within me. I hadn't wanted to change. It simply took place. The feelings of fear, shame, guilt and hopelessness faded out. The desire to die . . . faded. Instead, I became filled with believable hope. I felt a sense of positive energy and motivation. I came to know that on the inside I was still the perfect person that I was when I was born . . . I came to know that I was a part of something, though I did not know what that something was at that time . . .

Tim later founded a dual recovery group, and never attempted suicide again. This was a pivotal moment on his journey towards 'healing'. Although not named as being 'of God', it certainly has a positive impact on Tim and causes a dramatic shift in his perceptions as to a way forward. The presence of the group would have the effect of holding him to account, supporting him, and offering him an opportunity to support them.

Could it be that Tim had an 'encounter' with God as 'Absent One'? Rubem Alves (1990, 99) describes God as 'the absence which saves'. For Alves (1990, 99), the Eucharist is 'an empty, silent space for our dreaming, before the Absent One' . . . . It is not the presence which performs the miracle. The miracle is performed by the power of the absence. Certainly this sentiment parallels Tim H's experience, sat waiting for clarity to return in order to carry out his planned suicide. The transformation could be described as miraculous. Does this mean that God is wholly Absent? Not according to Tim H, who, even without naming God, sees himself at the end of this 'encounter' as 'part of something'. And so there is some mystery here.

Feminist theology can help us with this mystery to some extent. Marcella Althaus-Reid and Lisa Isherwood (2007, 1 as quoted Walton 2014, 156) state that:

One of the many strengths of feminist theologies has always been the ability to include many voices within the debate . . . . This is not the same thing at all as having no method and no cohesion, it is, however, about creating space for diverse voices to express what they experience about the divine among and between us. It is about respect and an overwhelming belief that the divine cannot be contained by any one group whoever they may be and however blessed and sanctioned they believe themselves to be.

And so, it may be that Tim H simply did not have the language to articulate this as being 'of God', or it may be that having that space allowed him time to rethink for himself. But nonetheless, his experience was one of transformation, and that transformation is consistent with the sort of transformation that can come through divine encounter.

Consistent with the absence of talk of 'higher power' in the scripts, is the absence of talk of 'prayer'. Only one person, Patrick, describes praying to God, as a child, and that was a prayer of request to die. Later in life, Patrick prays to his 'Higher Power' to show him the way out of the vortex of addiction and mental health issues to which he had succumbed. However, the form of 'presenting' was strong in scripts from those with a dual diagnosis in relation to joining a group – not unsurprising perhaps given that the source of the scripts is a website for a 12 step group for people with a dual diagnosis. Katherine, Brian, Val and Patrick all describe joining and 'throwing themselves' into Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Dual Recovery Anonymous (DRA) or a 'Clubhouse' where they can be more open about the struggles of addiction and eventually mental health issues. It is here that they are brought into community living. Patrick describes well the act of 'bringing into the presence of' the group, information. At a first DRA meeting, a group that Patrick helped set up, Patrick:

Read 'Chapter 2 – Hope and Healing a Comprehensive Approach' [from the Dual Disorders Recovery Book]. We finished the Chapter and there was quiet for a minute and then everyone started talking at once.

There is an echo of the moment Michael offered the 'monkey metaphor' (Chapter 3 of this text) to his group in this description. The moment of silence, the pregnant pause, the brief, fleeting absence while thoughts are formulated, information is related and assimilated within experience, and the recognition of shared experience, shared feelings is common across both passages. But the difference is that here, the information offered is shared, open and overt in its honesty. It is not veiled in metaphor. Here the act of bringing the information about dual recovery into a setting where previously people have either looked at addiction, or mental health issues in isolation but never together before was particularly illuminating, and therapeutic.

For those with a dual diagnosis, the therapeutic gifts received are not necessarily tangible things, although Sean describing his time in rehab does recall that 'there was not one day that would go by when I wouldn't have either a visit, or a plant delivered, or received a card, or a letter of support.' For others, it is emotional and psychological gifts that are manifested through the groups. Tim explains that 'DRA has offered [him] . . . believable hope and steps to apply to both [his] chemical dependency and [his] psychiatric illnesses. It also offers [him] a way to heal the emotional and psychic damage that I experienced as a result of [his] dual disorders'. Val focuses on things such as 'acceptance' and 'support' from her employer; the gift of being told that she 'had a story to tell and something to offer other people' by her psychiatrist; and 'love', from the community with whom she works. The DRA fellowship has taught Val 'that if [she goes] to meetings and becomes part of a group [her] life will get better'. Here Val echoes Tim's sentiment of receiving 'believable hope'. Having been contemplating suicide, it is easy to see how this 'hope' must be like 'manna from heaven' for those in recovery.

It is Moltmann (2004, 89-90) who states 'the present and the future, experience and hope, initially clash in Christian faith. Between them is the remembrance of Christ crucified by the powers of this world. It is only beyond the cross that we can see the first daybreak colours of God's new world. This means that Christian hope is a hope against hope', or a hope where there is nothing else left to hope for'. For those who have contemplated suicide, that sense of being 'crucified by the powers of this world' would be quite live. Having grasped that 'believable hope', they have moved beyond the crucifixion into a form of resurrection life. They have become 'present' in a different, transformed way. Having considered the dually diagnosed people's reflections on

'presence', we focus now on the clergy, and see what they can add from their perspective.

### **Clergy perspectives on 'presence'**

Having been quite 'thin' in references to 'absence', the clergy interviews did focus a lot on 'presence' in all of the meanings unpacked from the etymology of the word.

The idea of 'being present' was central to several of the clergy interviews. Nearly all clergy interviewed spoke of 'being present'. Liz, when asked about her role as curate, explained:

The role is actually being a presence, being a listener, and a confidante, supporting people in exploring what the issues are, giving them the time and the space, and then when they're ready, offering them the chance to explore through prayer or through listening, through Christian listening, issues particularly around loss, issues which have damaged them, so that would be loss through relationships, bereavement, employment, but very much being alongside them.

Liz references 'being alongside people' several times, indeed on three separate occasions she references 'being with', or 'being alongside' people as an integral part of her role, mostly listening, but also 'until they can actually feel that they can ask for confession or absolution'. This highlights the need for trust to grow in that shared presence, which can take time with someone who is struggling with an addiction. There is a sense within her understanding of her role, that Liz is 'counting crosses and resurrections' with those she meets, to coin Marcella Althaus-Reid's phrase again. She is present, but offering as a 'present' (gift): space (i.e. an absence), in which can be placed the absences (created by loss, grief, and/or broken relationships).

Carla, in comparing the clergy role with that of medical staff on the wards of the prison hospital explains that 'our presence differs from other staff: . . . because . . . there can be a more immediate trust level, perhaps a slightly higher trust level, because [the patients] know that we don't write them up. Carla sees her role as being more about caring. She explains:

I think a warm human heart is the way I operate, and an awareness of all the issues that are raised around bereavement, loss, grief, anger, anxiety, so an understanding pastoral heart . . .

This description reveals this is not a dispassionate 'being present', but rather a compassionate being alongside the other person, the bereaved, no matter what has

happened in the background. Carla uses the language of an 'understanding pastoral heart', a language of the body. Davies (2001, 252) traces the origins of the word compassion back to the words '*hesed*' and the root '*rhm*' which both signify the bonding relations within close kinship groups – with '*rhm*' being cognate with '*rehem*' – or womb – which signifies the notion of physical inwardness ('moved in the bowels', moved with compassion). For Davies (2001, 253), compassion stands at the heart of the Christian response to God because the presence of God with us is known to us through his acts of liberating compassion.

Carla comes back to this point later in the interview:

I want to say that essentially one human being, walking the human journey with another, with all the vicissitudes of being a human being, the experiences of relationships, dealing with disappointment, and helping people discover their own . . . gifts. I think self-worth in mental health is hugely important for people because many people that I see have none at all.

Carla works in a context in which the same people can be worked with over a longer period of time, which is reflected in the description of 'walking the human journey with another'. Kevin, a hospital chaplain, alludes to the same concepts; however working in a context in which people move through more quickly, Kevin uses the word 'encounter', denoting the fleeting nature of many of the relationships he has with those he sees. Carla's description reflects McKivergin and Daubenmire's (1994 as cited Hammond 2003, 35) description of a 'therapeutic presence', albeit a presence that will take time to recognise fully the 'healing properties' that are possible, even in that setting. It is more difficult to ascertain the depth of presence that Kevin can manage in a hospital setting although he explains that he does 'encounter patients with mental illness, depression, addictions as part of the work of the general hospital', again affirming his 'being present' with the patients, respectfully listening without assuming anything. He also spoke of 'being present in a sacramental way, in communion, prayer or silence . . .'. This touches on two of the meanings of 'present', present physically present and present as gift, offering prayer, communion or space/silence'. Compassionate action, if it is consonant with acts of liberation, can be seen as being a significant part of what it is to be a 'therapeutic presence'.

Sean recalls how the church congregation were present with him when he was coming off alcohol. As a pastor, Sean is 'always completely honest with [his] congregations and colleagues about [his] own addiction issues and about the fact that [he is] in ongoing recovery'. The response he has had from this is 'that they have felt that [he] was much more real and that they could relate with [him] and that they actually trusted [him],

because [he] trusted them in disclosing [his] situation to them'. As with other clergy, there will be increased trust, and yet having been relatively open with the congregation (although he is reticent to disclose his mental health diagnosis because of the stigma around mental illness) this engenders even greater trust, and a resulting greater likelihood to disclose issues around addiction. This does highlight how making ourselves vulnerable in being present can be beneficial in a pastoral relationship, when managed carefully.

For clergy, the second 'type' of presence, as 'a divine, spiritual, or incorporeal being felt as present' was much more explicitly discussed than amongst the scripts of those with a dual diagnosis. After all, for clergy, talk of a 'higher power', or 'god talk', is more expected. There was some variation though in how open clergy were about that, although context may account for much of that variation. Those who worked in parishes could be more explicit than those based in hospitals. Liz, saw herself as 'offering God's love to them through whichever medium, through prayer, poetry, sometimes just reaching out to them'. In speaking of her work in an alcoholic men's hostel, Liz says:

I go in personally with no expectation really; that what happens on a particular day is very much led by the Spirit. So I think prayer is particularly important, prayer before you go, sometimes prayer when you're there, and having the confidence to offer prayer to an individual whether that's open or one to one or whether there's other people around really. And not being afraid to pray for someone.

Having said all that, Liz does not suffer from a delusion of 'being God'. She is quite pragmatic and goes on to explain:

We can't do everything, we can be there and we can pray and we can be that presence of God with that person, but a lot of 'skilled technical things, . . . for example CBT, . . . there's certain things we can do, we can find things out, we can pray with them, but a lot of the skilled things we need to realise that there's other people that can do that.

Liz sees herself as a part of a wider community addressing the needs of those in her care. She elaborates that 'we haven't got all the answers [as clergy], there's times when we can offer these things which we're carrying which are difficult, . . . to God and that may not take the pain away at that time . . .'. For Liz, 'prayer' is about that relationship and that conversation with God in themselves', and so that offering to God of what is difficult, is key for all those concerned with dark and painful situations.

By slight contrast with Liz's explicitness about prayer, Carla and Kevin, working within chaplaincy settings and employed by healthcare providers, cannot assume that explicit prayer will be part of their pastoral encounter. Carla sees her role as bringing 'some humanity into the clinical setting, and that . . . arises out of the gospel message really . . . that everyone is of infinite value.' Kevin, likewise, spoke of 'being present in a sacramental way, in communion, prayer or silence . . .', but also describes his spirituality as 'resourcing of what [he's] meant to bring, whether it's named or not'. So for Kevin:

It is not automatically assumed that it will begin or end with prayer or communion or scripture, but it may involve that. Neither does it take the form of a counselling interview. [I] describe it . . . as coming with purpose but not an agenda . . . , purpose to reach hopefully points of redemption and sacrament, reconciliation . . . with others and with God.

There is underlying this comment an understanding that what clergy offer is distinct from a counsellor, and also that however present a clergy person may be, the other person in the encounter may not wish to be 'fully present' with them, and so the encounter may or may not be 'redemptive', or indeed therapeutic – as McKivergin and Daubenmire would define it. There also needs to be sensitivity to the wishes of the patient in a hospital setting. There is no formal threshold, like a front door, through which a patient can choose to either let the clergyperson in or not. Chaplains need to be quite attuned to the social cues of the patient, and respond as appropriate, be that in explicit prayer, sacramentally, or by engaging in a brief conversation and moving on.

Jim spoke of a different form of prayer in his description of setting up a 'memorial service' for those who have died on the streets over the past year in his city. Rather than simply 'praying for people', Jim seeks to

'involve . . . the service users, as much as we can in the service. So if people have a musical talent they use that, so if people can read a piece of poetry or scripture they do that. We have some kind of participatory event, you know, you might write the name of somebody who you've known and want to grieve at this service, on a luggage label which is put on a balloon which then gets released. And also besides street people who have died and are being mourned by the group who are there, it's a time, as we do at memorial services, where we remember others, a relative who may have died a long time ago, but whose death might be an unresolved grief, or there might be an unresolved issue, and any names that the group who is there . . . want to bring into that service, they can bring those names. It's a point at which people can be real about some painful things in their lives'.

This illustration is not so much about 'praying for', as 'praying with', facilitating the prayer lives of those with a dual diagnosis (many of those on the streets are dually diagnosed). In a sense, this 'praying with' is a form of being present, showing in activity, rather than having that activity done for them. There is empowerment in this, a being empowered to speak for themselves, a being encouraged to participate in some activity that more than likely will be therapeutic.

There is the same tension here as between the two different ideas of the ladder in the Hasidic tradition, namely those who see the 'spiritual leader' as the ladder, the connection between heaven and earth, and those who see the Church/religious community or even wider community (as is happening here) as the 'ladder'. There will be a wide variety of understandings operative in both hospital and memorial service settings. People who don't wish to participate, or who are unable to participate, and others keen to participate in a communal act of remembering. Is one understanding more therapeutic than the other?

God is not the only 'higher power' represented by the clergy. The Church, (and to some extent also a hospital trust in the case of a Chaplain) is also represented by clergy in the field. Liz picks up on that representative function, and expresses the importance of communicating something of the pastoral work (within the bounds of confidentiality) to the wider congregation. She states:

We communicate what the Spirit is doing . . .so there's a connection between the Church and what is happening, because otherwise it can be seen as 'your work', so it's how we then encourage other people to see their calling and nurture them into answering God's call to be involved.

She describes inviting a choir of former drug addicted people in 12 step services into the parish to sing, 'bringing all those people who've been in addictions and . . . their spirituality in to meet with ours and having that common ground'. As a representative of the Church, Liz has been able to effect that meeting between these two, largely separate groups, enabling them to begin to be present with one another. This is an important point, particularly in the light of Sean's experience of coming off alcohol and the role played in supporting him through that difficult period. The clergy are not alone in that task of representing God, or rather should not be alone in that task!

Kevin highlights a different facet regarding the importance of prayer, the importance of prayer for the clergy themselves. Here he uses metaphor to communicate this:

Picture of not being a well but a channel, and not being a bucket but a sponge. So in terms of what you give while you are a channel in terms of what you do

with what you have at the end of the day if you are a sponge it can be squeezed out into the bucket and the bucket keeps it.

Prayer then, is the means by which Kevin means to prevent the challenges and difficult situations he enters into in his ministry from festering within him. The 'well' and the bucket' into which the channel and sponge flow are God. The channel and the sponge are the clergyperson, or lay person offering ministry to those with a dual diagnosis, or indeed others in difficult situations.

### **Present as 'gift'**

When considering what is offered by the clergy (the present or gift), one thing is a quality of relationship, or the space of encounter. Jim spoke of 'honouring the dignity and the humanity of people who have led very difficult and troubled lives'. Kevin spoke similarly of 'respect for them as an individual' and offering support in the form of 'continuing relationship . . . in the context of a caring community or group'. Liz spoke of 'giving [people] time and space, . . .'. Carla spoke of 'caring for the whole of people, . . . body, mind and spirit'. In a situation of complex and extreme grief, Carla describes 'helping people discover their own things to hope for, their own gifts, . . . helping them to discover that they matter, that they are valuable and priceless human beings'. For people who are on the margins of society, these things, space and respect, are precious gifts indeed, if they are in a position to accept them.

The second strand to what clergy present (or offer as gift) in a pastoral encounter, mentioned in three out of five scripts, was to 'leave something tangible'. At its most basic this was expressed by Liz who spoke of 'leaving a prayer card . . . something tangible that [the bereaved person] could reflect on'. Often the tangible objects in an act of worship can become a focal point for prayer. Liz described lighting 'a candle, one that [she'd] used on Easter morning' in an art class. Sean described how important during his period of initial recovery from addiction, tangible gifts had been: 'a plant . . . a card . . . a letter of support . . . they were there to support me and to lift me up . . .'. After the people had gone, these cards, plants and letters were tangible reminders of that support and care.

Plants feature in another element of this strand. Both Carla and Liz described efforts to build 'a spiritual space . . . in the garden', or 'a memorial garden'. For patients in prison hospital, a memorial garden will be a place where:

If patients can't go to the funeral, they can go to this garden and plant a flower, . . . . There will be a feature there. There will be a bench. And then once a year [they] will have a memorial 'something or other' for staff and patients that have died that year, for patient's relatives'. So it will be a place, a focal place where they can go . . .'

Liz described much the same idea for the men of the hostel she works in, creating a space in which those who have died can be remembered within that community. The physical presence of something tangible has an enduring effect on those who receive these things, acting as a semi-permanent reminder that someone cared enough to come and see them, thought of them, and thought them worthy of their time.

### **Present as 'moment in time'**

The concept of time is an interesting one for clergy working with those with a dual diagnosis. Jim made an interesting observation. In speaking of those with a dual diagnosis he explains:

It's a group of people stuck in time, stuck in a sort of revolving door of their own lives, and there have been some time in hospital, there may have been some time in rehab, but they notably come around again. Like I say, it's very different from just, you can have somebody with a mental health issue who goes through a crisis, gets sorted out, gets the right medication, gets stable, you know is then able to rebuild their lives, but you can have somebody with a drug or alcohol issue quite entrenched who hits rock bottom, who somehow finds within themselves or somebody else helps them to take a step upwards, get into a 12 step programme, ideally and they are able to rebuild their lives very successfully in terms of moving on, and salvation comes to their house. And this dual diagnosis group is such a difficult group because they seldom in my experience actually are able to have their needs properly addressed and to find salvation. . .

Jim alludes here to the heightened difficulties of 'treating' a dual diagnosis. Historically those with a dual diagnosis have bounced between addiction services and mental health services. This can be an ongoing problem, with one group refusing to offer treatment because of the presence of the other issue (mental health services refusing to prescribe medication until addiction is resolved for example). If grief has precipitated these issues, those with a dual diagnosis can be focussed on their loss, without any sense of hope for the rest of life being worth living in a full and meaningful way because of the pain of grief.

For clergy, the idea of being present, in the present, and not being consumed by the chaos or grief of those with a dual diagnosis came up several times. Liz spoke of the fact that there are 'certain things we can do . . . being with your own boundaries . . . knowing your limitations.' Carla spoke of how she had 'developed a way of not taking things out the gate with [her]'. Jim spoke of trying 'to be a reliable person, a person who actually has some boundaries . . . because I think those are quite good for people who often don't have boundaries'. Sean is also clear that change, if it is to happen, has to be initiated by the dually diagnosed person, particularly in relation to the addiction. He states that it is 'that person [who] needs to make the decision first and foremost to want to stop, and it's that person's decision, it's not my decision'.

The presence of the clergy must be a sustainable presence. Whilst ministry is costly, the needs of other parishioners must always be held in tension with those in a crisis. Clergy must always have an eye to the broader pastoral requirements of the present moment, and what it is that they can and cannot offer to those whose needs can easily be 'all consuming', particularly in the absence of structures of support (like supervision).

And so we turn now to the insights of midwives and obstetricians, having considered the manifestations of 'presence' elucidated by the clergy and those with a dual diagnosis, before we look at those areas where absence and presence were indistinguishable.

### **Midwives/Obstetricians perspectives on 'Presence'**

As with the clergy, for midwives particularly, 'being present' is central to the role they have in relationship with the women they support during childbirth. Indeed, Hayley explained that midwife means 'being with woman' and says that 'ultimately that's what it is about'. For Hayley it is pivotal that the midwife is 'able then to communicate maybe just not verbally, but by being there, just touching, and making sure that you are actively listening and hearing'. Hayley explains that the midwife is 'there . . . to support and really listen to what [the family] want'. For Hayley, the midwife is there to support the mother 'through her choice, through her pain and through however she delivers'.

Mary, a community midwife (as compared to Hayley who is hospital based), explains that there is 'supposed to be, as a named midwife, to have a bonding, and a liaison and a communication, and a continuity, so that you do follow the same people when they've had the baby'. In a situation of intrauterine death, Mary explains that after the birth, the midwives are 'just around', and that:

Possibly our job is not very clinical at this point, you're going through: Is she comfortable? Is she bleeding? Is she in pain? You're going through those few things, but you're not emphasising them anymore because their mental needs

are greater. And quite possibly you're only going to sit there as a friend because someone else is doing all the arrangements anyway.

Julie, another community midwife, echoes Mary's experience saying 'People that do accept us to visit [after the birth], we'll sit and talk for hours and discuss everything and anything with them.'

For obstetricians, Eileen and Emily, their role is slightly different to that of the midwives. Eileen explains that her role is to 'support the midwife in the role of achieving a normal birth'. And so, Emily states that 'high risk women . . . are monitored more thoroughly'. In a situation where a stillbirth has occurred, according to Emily there is 'a lot more compassion in it, so whenever they want to leave, they can leave. Whenever they're ready, everything is at the woman's pace'.

Julie sees those mothers who come into the ward, or who she meets in the community as if 'that could be my friend, that could be my sister, and got very close'. However as Eileen highlights, it's not just the presence of the midwife that is important to acknowledge in the situation of intrauterine death. After giving the mother the space to absent herself from the hospital, the mother will be present for the birth. Given 48 hours before labour is due to be induced, 'some come back the next day and just want to start the process'. Eileen also raises the issue of contact with the baby. 'Some women want the baby with them', according to Eileen. Mary explains that:

[The hospital staff] are quite good, they would do the birth and give them the option to, . . . the baby is not whizzed away, and all the Catherine Cookson books that you read, you know the baby is put in a shoebox under the bed and that's it. They are very, very sensitive and do believe in a lot of contact with the baby. There's a very logical thing to say that your mind has to tell you that this thing has happened, and this is the evidence that this has happened.

The presence of the corpse of the baby is evidence that there was a life; that the baby existed with all the hopes and expectations of the parents and those close to them. A lot of effort is taken to ensure that there is something present to remind the parents of their child's having existed, having been present. Hayley describes what goes into a memory box: 'the footprints, the lock of hair, the baby bands, the cot card, the photographs, anything that they can, that establishes some memory . . .'. All of these things, done as a matter of routine now, seek to give an ongoing physical evidence of the existence of the baby – the fact that the baby was present. Often after the family are discharged from hospital there is a funeral to be arranged, either by the hospital or by the family. Mary explains:

They still have the funeral, even though the baby has not got a birth certificate. Then they've gone from the house because they've wanted to take the baby home, and to take the baby round to the room, to say 'this was your room' and then the funeral has gone from there, but the baby never survived at all.

It is clear from this account just how significant the presence of the corpse is for the family. It takes time to make the mental adjustment to the new reality, and here the corpse aids during that interim period.

The presence of the dead body though is a disturbing one. Ewa Domanska (2006, 342-343) describes the 'politics of dead bodies' in a discussion about the Argentinean 'Mothers of the Disappeared' (Las Madras de Plaza de Mayo) and their debate over whether or not to disinter the human remains of those killed by the regime of the time. Some of the mothers were in favour of the exhumations of the bodies in order to demonstrate that they had been tortured to death and in order then to seek justice (Domanska 2006, 243). The others were against the exhumations, unable to accept the death of their loved ones (Domanska 2006, 243).

Although there are significant differences between the situation of an intrauterine loss and the disappearance of a much loved child at the hands of a brutal regime, there are also some parallels. Domanska (2006, 343) states that 'the liminality and "monstrosity" of the disappeared, of whom we do not know whether they are dead or alive, prevents the trauma of loss from being healed by means of rituals'.

The ritual of a funeral, of spending time with the dead body is vitally important for healing the trauma of the loss. The reality is that not all who suffer an intrauterine death are able to 'face' the grim realities of losing a much hoped for child, thus some do not attend the funeral, and a few do not acknowledge the presence of the dead body.

The presence of the baby also lives on in the minds of others. Julie, a midwife, explains that 'that little face is always on your mind'. The physical presence of the baby is very significant in an intrauterine death, and continues to be significant long after the trauma of the birth. Particularly at the end of the working day, thoughts about what they've experienced in the hubbub of the day come back. Emily explains that:

When you're in the hospital in that environment you are quite hard, it is later on either when you've got time to think or if you're on your own, or if you are at Church or wherever you go, if you're quiet or still, it can affect you then.

In that space where we are able to think beyond our individual tasks about others around us, we begin to consider the implications of what it is we do each day. We are part of something bigger.

For the families that are being cared for by the midwives and obstetricians, it is a matter of routine that there be 'a lot of spiritual talk', as Julie states, 'There's a lot of talk about wanting to have the baby baptised, you know like a little blessing . . . , what funeral they're going to have, . . . a lot of the time they ask 'Why me? Why do you think God's picked me?'. Hayley describes what usually happens well:

What [we] can do is discuss if they are religious, or what they would like, maybe they might not be religious, and sometimes that happens. However they feel that they would like somebody to come in and say a prayer and bless the baby so that baby goes to heaven. You know and they talk about may be the afterlife and maybe what's happening and so it's there, and we should be able to get somebody that they would want to be able to do that.

It is not just human beings that represent the divine or the spiritual for families. Hayley continues:

As much as we can, we get a little blessing card, a little medal, something that means so much to them, that's why a lot of our babies when they go to the mortuary, they'll have holy water, they'll have medals, a little cross, a prayer card, they've got something spiritual, something that's close to God, close to the baby, that's so important, that's as if when the family aren't there the baby is being watched over, and that the baby is safe.

At any point 'before, during, or after the birth they can have a priest or vicar or whatever their religion is, they can have their religious leader come and do blessings or that kind of thing', according to Emily. This is offered as a matter of routine for this group of people. And the perceptions of the midwives and the family is that this is reassuring, and a reminder that the baby is close to God ('our little angel', as Julie quoted several families saying). Here at this intensely painful moment, many families are reaching out either in lament and/or in pain to their 'higher power', to God, and to anything that represents or can be construed as representative of God.

### **Present: as bringing into the presence of, in prayer**

There was less talk of prayer in response to questions about intrauterine death from midwives and obstetricians than there was from clergy. However there were three main

ways in which 'presence' as a verb 'to present' occurred amongst the responses of midwives and obstetricians:

1. Presenting the bad news of an intrauterine death
2. Presenting the baby to the family
3. Prayer for the family

All featured in their responses.

It is usually the obstetrician who presents the bad news of an intrauterine death to the family, as the one called in to perform final tests on the bodies of the mother and baby to attempt to detect any signs of life.

Eileen describes what happens:

Normally when a woman attends labour ward, she may actually feel she's in labour, or she may attend . . . usually with intrauterine loss she's not felt foetal movement over a period of time. And in that situation, the midwife may try to locate a foetal heartbeat. If they can't perform, I would be called to perform ultrasound scan to try and locate a foetal heartbeat. Unfortunately, sometimes you can't, and I have to communicate that to the woman, her partner, or the family who may be present. And in that situation usually you have to give the information and I try to give them it as straight and honestly as possible. You can't dress it up to be anything other than what it is. Usually by the time you say 'I'm really sorry,' they've already come suspecting something is wrong . . . . They have stopped listening to you by then.

So Eileen presents only the most basic of information at that initial point. That is all that the family can take in. Later on, other information and care is presented. Eileen goes on:

Immediately, at time of delivery, medical care is needed [as there is an] increased risk of post-partum haemorrhage . . . . Also, the other physiological process is that she will start to lactate, so you have to give her certain drugs to stop lactation from happening. Then there are all of the administrative things that need to be done. They need to have information about a post-mortem and how they obtain a death certificate, then the process of that child, where the baby will go . . .

Here the obstetrician is presenting much more information, setting expectations regarding the 'process' of what will happen after the birth, as well as during the birth. They do not do this alone. Alongside them throughout is the midwife. Hayley describes

the midwife's role in that situation. She places great emphasis on constant communication, ensuring that 'the woman fully understands what will happen'. The midwife liaises with the mother about where she wants the baby delivered to. Some mothers wish to see the baby, and others don't at first. As Hayley explains:

It's making sure . . . 'does that lady then want her delivered onto her chest? Does she want the baby right to her? Those are the things you need to plan for as she's coming up to delivery, because it might be that actually she wants that baby taken away, washed, dried, dressed and then given to her. Or as I say, it might be that she wants that baby immediately so that she's got hold of that baby, so that she can see for herself that it's got no heartbeat, that it is not moving, that she needs to acknowledge that.

How the baby is presented immediately after birth is a key concern in these emotionally charged situations of intrauterine death. A great deal of care and reverence is taken over how the baby is introduced to the mother and/or her family. Flint (1986, 158) explains that it is important for parents to see and hold their stillborn baby, and are to be offered the opportunity. Not all parents can cope with this though, so the freedom is there to accept or refuse this option (Flint 1986, 158). The other thing to prepare before the baby arrives, according to Flint (1986, 158) is a cosy nest-like place where he or she can lie once born.

Prayer did feature in two of the interview responses of the midwives and obstetricians in a variety of ways. Eileen explains that it is at the families 'request whether they want the baby blessed, what type of service they'd want', which relates to prayer. The expectation is that this would be completed by the clergy/chaplaincy usually. Emily suggested that with friends 'who are Christian, there's a lot more prayer about their births, their experiences of their births . . . that nothing goes wrong . . . ' This is prayer by the families before the birth for a safe delivery. Only one person described overtly praying for the families themselves and for the decisions taken on that shift.

Eileen explains:

Often I will pray at the end of a shift; that night I will pray that I've made the right decisions, pray that I will be able to deal with next time around and pray for the woman and her family . . . that whatever the reason behind [intrauterine death] is something that they can learn to deal with.

### **Present as 'gift'**

When detailing those things that are offered 'as gift', or 'presents' to the families in this situation, Hayley describes the role of the midwife as to 'provide support, advice, and to be an advocate for the mum, the baby, and the partner and ultimately the family, to provide a safe, comfortable environment that meets the woman's needs'. The aim of the team, according to Hayley, is to 'deliver the highest possible care, meeting the individual needs of that mother and the partner, or the extended family. This will include the reduction of self-blame through constant reassurance'. Eileen says 'whatever they request they can have'. Probably the one item that came up several times would take on the greatest significance for the family as the reality of an intrauterine death begins to manifest itself and that is the 'memory box', explored in more detail in the next chapter.

### **Present as 'moment in time'**

'Present' as reference to 'time', the present moment in time, came up a few times in amongst the midwife and obstetricians scripts. Eileen refers to the moment when the initial information is given of the child's death, followed by a period of space (around 20 minutes or so), and then their going 'back in after a period of time'. Hayley spoke of 'giving them that time' and of 'being there at all times for them' as a midwife, recognising that (in her words) 'you've got a vulnerable human being there that needs you at a time of crisis in their life'.

After the crisis moment, Hayley referred to debriefing, firstly 'for the mum . . . initially after delivery, and then possibly six weeks down the line . . . maybe a few months down the line'. Mary describes the community midwives going in to 'see them up to a month afterwards'. Eileen referred to the fact that the community midwife would aim to go to see the mother 'on the day that they go home and a few days after and will keep contact with them . . .'. Hayley also made reference to staff debriefing, before they go home in order to provide an opportunity 'to talk about it, not to take all that baggage out the hospital with them'. There is then a sense of the staff team being present with each other – caring not just for the family but also for each other as they face that difficult situation together.

Having considered now the various forms of 'presence/present' within the data, we move now in the next chapter to consider the significance of the tension between 'absence' and 'presence' within the pastoral encounter.

## **Chapter 5: Living the tension between presence and absence.**

This chapter begins with consideration of the third 'episode' which was formative in the development of this thesis, before moving on to consider those areas in the data where the tension between 'presence' and 'absence' was most sharp, and the insights to be gained from Trinitarian theology for the pastoral encounter, and the reality of the tension between 'absence' and 'presence' therein.

It was evening when the call came through to me to attend the Labour ward to see a family who had lost their baby. On arrival at the ward, I discovered that unlike other occasions, my task this time was not to bless a baby that had already been born, so much as to persuade the mother to go through with the birth. She was convinced that a miracle could happen and that the baby would be ok, that in going through with the birth, she could in fact be murdering her unborn child. Influenced by a theology that suggested that if we had enough faith, God could do anything, she was determined that through a bit more prayer this baby would be ok. When I discovered what it was I was to do, I was put in mind of an incident in my childhood, growing up on a farm where my Father and I had to remove a dead calf from its mother's womb. The process of decomposition due to the body heat of the mother was well advanced, and later led to the sterility of the mother. And so, I had a clear insight into the urgency of the situation.

As the conversation unfurled, it became clear that the mother was strongly influenced by a Pentecostal spirituality, and 'recognising that I needed to use the scriptures in order to justify my insistence that she proceed with the birth, used the scriptural image of Hannah giving her much longed for son Samuel to God in the temple. The mother was then persuaded to go through with the birth. If Michael's metaphor was about 'absence', and Peter's about 'presence', then this experience of offering pastoral care is actually about the tension between 'presence' and 'absence'.

The mother and I were both physically present with each other, however the mother was also 'absent' to the reality of her situation. Her child had died, and so, whilst the corpse was present, the life of the child was absent. The mother was in denial of this reality, and thus was in that sense not fully present, although there were theological issues clouding her denial, or in a sense creating that potential for denial in that she could still hang on to the possibility that God could effect a miracle for her child even at this late hour.

In another sense, I was not entirely present, reliving as I was the memories of a childhood encounter with intrauterine death, and trying to consider how to convince this woman to go through with the birth. In a sense my gift to her was a biblical metaphor for her situation that revealed God's hand in this situation, albeit not a comfortable

metaphor. It served its function in that present moment, which was the primary concern at that point. Her pastor would be on hand to deal with the after effects of the situation further down the line.

In the background, although absent at this point, were the midwives and obstetricians, and present, though despairing slightly at this point were her partner and translator (as English was not their first language). I could be present for the moment, and absent after the task I had been set was complete. When I later attempted to visit, I was politely rebuffed. Others would be present as events unfolded as I had neither the skills nor the wherewithal to cope with that.

For that present moment, I was as 'therapeutically present' as I could be, gradually, fumblingly, finding that point of spiritual connection, using both English and French. After the event, I would spend about half an hour in the staff common room, gently debriefing with the staff present at the time. My efforts had enabled the progression of the birth to happen, the work of the midwife and obstetrician could continue. Death and grief needed to be 'embraced' in order for 'healing' to be effected.

The fact that my physical presence was not welcome after the event does not make that encounter any less 'therapeutic'. At the end of the encounter the mother was fully present to the reality of her loss, as evidenced by the cry of lament that was uttered, coupled with her partner's instruction to 'fetch the midwife' to begin the delivery of the baby. In that brief moment, we were as present as could be, a fleeting presence before I was absented due to the necessity of privacy for what was to come.

This moment was very much a liminal moment. Van Gennep (1960, 20) compares such liminal moments to standing on the threshold between separation from a previous world and the incorporation of a new world. Van Gennep (1960, 21) describes rites of separation as preliminal rites; rites executed during the transitional stage 'liminal rites'; and the ceremonies of incorporation into the new world as post-liminal rites. Separation involves moving away from ordinary life and becoming aware that things are going to be done differently (Miles-Watson 2009, 161). In effect this 'separation' is a form of absenting. During the liminal phase social hierarchy often becomes flattened, there is a giving over of the self, surrendering to a higher power, and there is a deep bonding of people who otherwise might have been strangers ('*Communitas*' – Miles-Watson 2009, 161). '*Communitas*' is a profound transformative bonding with people who those in the liminal phase may not otherwise socialise with (Miles-Watson 2009, 161) – which accords well with McKivergin and Daubenmire's description of therapeutic presence. The final stage, reincorporation, involves moving back into society and taking up the

new status or role that comes as a result of having completed the rite of passage, and negotiated the tension between absence and presence.

Within this encounter, I believe the mother was moved through the preliminal phase and firmly into the liminal phase. The midwives and obstetricians would move her through the liminal phase and into the post-liminal phase where hopefully her pastor would see her through reincorporation into the wider community. The *communitas* was formed with her husband, the translator and the midwives/obstetricians over the hours that followed.

When I look back over the process of naming absences and presences with the 'data' of this research project, one thing that was clear was that the clergy were less comfortable speaking of absence than of presence, being present. Many clergy spoke about embodying God's love to those we encounter in the encounter, primarily through our presence. There is very little accounting for our absences as clergy – the times we are not there, mentally, physically, emotionally. In what sense do we embody God's love then? Do we embody God's love then? Can we ever be truly present?

Derrida (2005, 173) states:

When you speak to someone, to a friend or an enemy, does it make any sense to distinguish his presence or absence? In one respect, I have him come, he is present for me; I presuppose his presence, if only at the end of my sentence, on the other end of the line [au bout de fil]; at the intentional pole of my allocution. But in another respect, my very sentence simultaneously puts him at a distance or retards his arrival, since it must always ask or presuppose the question 'are you there?'

Even within a conversation, there is the possibility of 'absence', even given the assertion of 'presence' and of 'being present'. And so, we come to the stage of needing to look at the theological underpinnings of the pastoral encounter. One thing that is clear from the midwives and obstetricians is that they do not perceive themselves as working alone. That in itself challenges my initial starting point. Initially, I looked at various examples of Jesus' ministry by way of examining how He offered pastoral care in his earthly ministry within John's Gospel. Within that Gospel, images from shepherding (John 10. 1-18, John 13. 1-35, John 21. 4-14) to healing (John 5. 2-9 and John 9), giving space (John 8. 1-11 and John 18. 33-38), to therapeutic presence (John 6. 1-15) were all considered. What I didn't consider, was Jesus' collaboration with the Father and the Holy Spirit. There are several moments in that Gospel where Jesus makes reference to not being alone in his ministry.

Indeed John's Gospel is peppered liberally with references to his interrelationship with the Father (John 6.44, 6.57, 6.63, 8.16-18, 10.18, 10. 29-30, 10.38, 12.26-32, 12.50, 13. 1-4, 14. 11-17, 14. 26-28 amongst others!). This places the form of pastoral care firmly into the realms of the Trinity, a community of loving relationship. And here there are divergent views. Emmanuel Levinas speaks of God as 'the absolutely Absent' (1996, 60) for example. And this contrasts markedly with Paul Fiddes (2002, 42) who argues that God can only be but present, abandoning talk of a dialectic of 'absence' and presence', and rather clarifying 'the nature of a 'hidden presence'. However, looking at life from the perspective of dual diagnosis, hiding is a form of 'absence', leading to broken relationships, and the perpetuation of pain and suffering. So is hidden presence really presence? In practice that is going to amount to the same thing as an absence. What we are touching on here is an age old discussion about the nature of God – summed up in the terms apophatic theology and cataphatic theology. Apophatic theology speaks of what God is not and is synonymous with the Eastern tradition of the Christian Church. Cataphatic theology speaks of what God 'is', and is synonymous with the Western tradition. The Apophatic tradition, is explained well by Catherine Mowry LaCugna (1991, 326):

The mode of *apophasis*, while it may appear at first to be a downward spiral into emptiness, is actually an ascent through the economy. The darkness of 'unknowing' is not a kind of disbelief but a type of knowing. The *via negativa* leads not into absence or nothingness but into the presence of God who surpasses thoughts and words and even the desire for God. Moses' vision of God at the top of Mt. Sinai took place in the cloud of darkness (Exod 20. 23, 34). Greek patristic writers favoured this text to describe the utter brilliance of God, the effulgence of God's glory, that can appear only to us as darkness. Even words like God and Creator do not designate the essence of God as it is in itself; these are terms of address. From the standpoint of apophatic theology, the terms 'person', 'relation', or 'communion' are also terms of unknowing and cannot be applied literally to God. *Apophasis* requires letting go of every controlling concept or image for God so that the living God may enlighten the darkness of our minds.

The parallels here with the metaphor of the 'ladder' imagery are clear. The seeming 'spiral downward' being actually 'an ascent', the surrendering of 'control' being the means to a deeper relationship with God, parallels the recovery process from addiction. The goal of the Christian life is a very particular kind of loss of control (Coakley 2013, 286). Drawing on the thoughts of Gregory of Nyssa, Coakley (2013, 286-287) states 'the human person becomes a 'receptacle created to be filled with the life of God and in

response to pour forth that life both to God and neighbour'. At the heart of Gregory's thought is that 'this type of loss of control, [is] a yielding to the unknown in God in a desire without end' (Coakley 2013, 278). There is a surrender involved in this, which is uncomfortable, but which will appear a more comfortable option to an addicted person who has reached a chaotic low point, where the status quo is most certainly leading to an early, lonely and futile death. But the question underlying all of this is: how does this work? How are we incorporated into the 'divine'?

### **Contemplative Prayer as the quest for Divine Incorporation**

Coakley (2013, 59) explains that it is 'in the "impossibility" of the prayer of contemplation, in which the Spirit cracks open the human heart to this new future, divine desire purgatively reformulates human desire'. Derrida (2001, 333) says that a fundamental principle is expressed as follows: 'communication' cannot take place from one full and intact being to another: it requires beings who have put the being within themselves at stake, have placed it at the limit of death, or nothingness. In embracing silence, we are opening ourselves up to an alternative, a new way of being, an 'other' idea, an 'other' perspective.

But how do we know that that perspective is of God, if God is indescribable? Gregory of Nyssa seemingly did not shy away from trying to explain God, and the Trinity. Gregory uses a range of images of God to describe and seek to define the Trinity. According to Coakley (1999, 134), Gregory's favoured analogies for the Trinity stresses the indivisibility of the 'persons' and even a certain fluidity in their boundaries. Gregory treats the imagery of 'three men' with great caution (Coakley 1999, 134). Gregory uses a range of other images, ranging from 'a spring from which water gushes forth in a continuous stream', . . . [to] the 'analogy of the rainbow' (an analogy which stresses the incorporative, reflexive flow of the divine 'person', as well as the indeterminate boundaries . . . of the 'persons' distinctness) – stating that pictorial 'analogies' such as this do better justice to the matter in hand than strict dogmatic definitions' (Coakley 1999, 134-135).

At times, these images 'mutually bombard one another in a flood of inter-corrective ideas', a deliberate ploy, as Gregory does not wish us 'to fixate on one set of images, but to allow all of them to be permeated by the profoundly apophatic sensibility that propels us from one to the other' (Coakley 1999, 136). No one image is perfect, no one image ideally sums up the totality of God. Each image has its limitations.

This use of a 'range of images' parallels well what I am doing here in seeking to explore the pastoral encounter with those with a dual diagnosis. Could the need to use multiple

images be an indication that we are nearer divine incorporation than we first believed in the mass of absences and presences we have so far named? I believe so.

That God desires our incorporation into relationship with God-self is a promise filled with hope, for someone at the precipice of embracing the contemplative journey into divine darkness. Having considered very briefly some of the imagery, or hallmarks of the imagery used by Gregory, as quoted extensively by Coakley, let us consider afresh the contemplative journey.

Coakley (2013, 84) explains that “the silence of contemplation is of a particular . . . form: it is not the silence of being silenced. Rather it is the voluntary silence of attention, transformation, mysterious interconnection, and (in violent, abusive, or oppressive contexts) rightful and divinely empowered resistance: it is a special “power in vulnerability””. This is a vital point when we consider the marginalised and silenced voices of those with a dual diagnosis. Silencing abuse, would not be therapeutic, rather simply a further compounding of what has already gone on. Contemplation engenders courage to give voice, but in a charged, prophetic key (Coakley 2013, 85). For Coakley (2013, 87), if Christian contemplative practice is working correctly (‘purgatively, transformatively, and with its full social implications manifested’), it:

Has the following dimensions: . . . Spiritually, it involves a progressive – and sometimes painful – incorporation into the life of God (the ‘likeness’ of the Son) via the ‘interruption’ of the Holy Spirit, as desire is gradually purified, and anger metabolised into the energy of love (the Prelude). In gender terms, it involves a rendering labile of gender to the workings of divine desire, a loosening of the restrictions of worldly presumptions about gender as selfhood expands into God and is thereby released for the same great work of love’. . . . In feminist and political terms, it involves an intensification of attention to the ‘other’ in her specific social conditions, a guarding even against the imposition of imperialistic (Western) feminist agendas. This contemplation, in all these aspects, promotes a concern for the common good beyond the boundaries of narrow ecclesiastical or national interests: it fosters what the early Christian Fathers called *leitourgia* (‘liturgy’; public service) in the best theological sense, as service to the world in humility and hope.

The driving force within the Trinity for this transformation, purgation, and social mindedness, is the Holy Spirit. Coakley (2013, 67) describes the work of the Holy Spirit as ‘interruptive’, or ‘purgative’, ‘drawing the believer progressively into the life of crucified and resurrected “Sonship” – as the Spirit responds to the “groaning of all creation straining towards its final goal”’ (Coakley 2013, 84). The language of purgation,

interruption, socialising, parallels the language of recovery or movement towards sobriety from active addiction.

Coakley (2013, 114) unpacks the 'Cosmic significance' of prayer using 'Paul's account of prayer in Romans 8' – 'the whole creation "groaning" to its final Christological telos in God'. For Coakley (2013, 114):

what this underscores is the extraordinary ripple effect of prayer in the Spirit – it's inexorably social and even cosmic significance as an act of cooperation with, and incorporation into, the still extending life of the incarnation. It gives the lie, by implication, to any falsely 'privatised' or 'subjectivised' associations of prayer with self-cultivation which may have accrued in the modern period.

The other particularly striking element of this passage is the metaphor that Paul uses for this 'whole unfolding event of cosmic gestation . . . figuring the entire Christic event as the groaning of a woman in labour Romans 8. 22-23' (Coakley 2013, 114). It is particularly interesting for this project as it is possible to read the role of the Holy Spirit as that of 'midwife' to this cosmic event – attending, guiding, communicating, being with, listening attentively, advocating for creation . . . .

Ford (2007, 216) states that 'a characteristic mark of tragedy is the embracing of contraries in tension'. There are various ways of formulating the tension: between ultimate sense and nonsense, between two ideals (a conflict in the very ethical nature of reality), between contradictory aspects of human nature . . . between protest and acceptance, or between the contingencies of life and their meaningful coherence (Ford 2007, 217). Within both the situation of intrauterine death and of dual diagnosis, there are these tensions through all those concerned. Those tensions are most poignantly and pointedly expressed in the tensions between absences and presences within those situations. Some of the most therapeutic responses were beautiful ways of encapsulating that tension.

### **Memory Boxes**

We see the tension between presence and absence most vividly expressed in the situation of intrauterine loss in the response of the team surrounding the birth. For each stillbirth, a memory box is produced. Within this box, evidence is placed that the baby existed. Photographs are taken, footprints, handprints, a lock of hair, any other items that were brought in for the baby, are placed carefully in a box which the family are given to keep. The absence of the child is in tension with the presence of the box, and all of the evidence that the child existed, that the child has been present, and as such is a part of their story which can be shared with loved ones, and those around them if they

choose to. The presence of the box speaks of the absence of the baby. The memories of the child speak of the absence of the child. The presence of the parents speaks of the absence of the baby; the presence of the midwives and obstetricians speaking of the absence of the baby. Gibson (2004, 292) states that 'through death, the most mundane objects can rise in symbolic, emotional and mnemonic value sometimes outweighing all other measures of value – particularly the economic. Even before bereavement, objects closely associated with dying family and friends are either becoming memorialised or are already memorialised.' For Gibson (2004, 291), the transitional nature of human corporeal existence is both compensated for and replaced by representation and objects.

I wonder if there are not parallels between the memory box and the sacrament of the Eucharist. Alves (1990, 50), in a discussion about medieval sacramental theology speaks of transubstantiation. Alves (1990, 50) explains:

Under the scrutiny of objective criteria of knowledge, bread remains bread and wine remains wine. As medieval theologians said, the 'accidents' remain the same. And yet they affirmed that by the power of the word an imperceptible change took place: a new 'substance' is there, in the place of the old: the body and blood of Christ.

But which word is this, with such a magical power? Is it not the word which announces the absence? Is not the Eucharist a meal before the Absent One? 'Eat and drink in remembrance of me' (1 Cor 11. 25). If it is done in 'remembrance' it is because something or someone is absent. Bread and wine are physical entities. They serve to nourish the body . . . . But when certain words are pronounced, a great void is opened inside our bodies, . . . and our bodies are transubstantiated by the power of the absence'.

Walton (2014, 185) approaches this from a slightly different perspective. Quoting Schmemmann, she states that 'for contemporary Orthodox theologians, the material world can be viewed, the world can be seen as the material of 'one all embracing Eucharist' in the process of consecration and reconciliation'. At the heart of the 'memory box' is the act of remembering – a significant theme. Swinton (2000, 127) describes the first task of effective liberating care is to 'remember those being cared for'. Swinton (2000, 127) states that 'to be remembered by God is to realise that we are of eternal worth and value in God's sight. Thus in remembering someone we acknowledge the person as worthy of memory, and acceptable as a full person.' Swinton (2000, 127) reminds us that the word 'remember' means 're-member', that is, to put back together that which has been broken', and that the opposite of remembering is 'dismembering' or taking

apart, alluding to the issues of the 'medical model' of care highlighted in Chapter 2. Alves (1990, 85) describes remembering as 'the awakening of what was sleeping, the resurrection of what had been buried'. The object is the sensible presence of what was alive in us as an absence (Alves 1990, 85).

So what is the equivalent in the care of those with a dual diagnosis? Leaving aside the memories of conversations had with clergy, memories of encounters, for the moment, because the memories are not prompted by anything tangible, anything externally physically present (like the memory box), there were some examples amongst the clergy practice of equivalent tensions between presence and absence. Liz, Sean, Jim and Carla all gave examples of an equivalent practice, although this is not universal amongst the clergy. My own practice has not extended to this (yet!), and Kevin does not make mention of this.

Liz gave the example, when visiting someone, of leaving them a prayer card. This was highly significant for the person she visited because it meant that she had something tangible that she could reflect on.' It is a simple enough gesture. But I would extend Liz's rationale further. That card speaks of the fact that Liz had been to see her; it speaks of Liz's presence in her absence. Sean spoke of a similar experience as he engaged in recovery from his addiction. He explained that while he was in hospital going through rehab there was not one day that would go by when [he] wouldn't have either a visit, or a plant delivered, or received a card, or a letter of support.' For Sean the visits, the actual presence of someone supporting him was probably most valuable in terms of showing him he wasn't in that situation on his own, but the presence of the plants, cards and letters of support spoke of the presence of that support even in the absence of the people sending them. Latour (2005, 69) argues that objects can be accepted as full blown actors, justifying this position for two reasons:

1. Because the basic social skills provide only one tiny subset of the associations making up societies.
2. Because the supplement of force which seems to reside in the invocation of a social tie is, at best, a convenient shorthand and, at worst, nothing more than a tautology.

Latour (2005, 71) defines an 'actor' as 'any thing' that does modify a state of affairs by making a difference. This is to say that the 'community' of 'non-human actants' symbolise in loco parentis the community of human support and love surrounding Sean at this time. It is perhaps no surprise that Sean in his own ministry sends cards regularly to those who are ill amongst his congregation.

Another example of an object having a profound effect on a person with a dual diagnosis was found in Daniel Miller's book 'The Comfort of Things' (2008, 168), in which Miller describes a dually diagnosed man, Dave, for whom Miller is 'convinced . . . that it was things that saved Dave, and one thing above all: the house', which Miller describes as 'a refuge . . . that keeps him afloat'. 'When things were not so bad, he could rummage around and find the remaining foundations upon which he rebuilt memory and some sort of narrative of his life that could shore him up and provide a spine around which he could fit his errant parts' (Miller 2008, 168).

Another area where the tension between presence and absence is expressed amongst clergy respondents was in gardens. Three of the clergy: Liz, Carla and Jim mentioned gardens as being part of their response to grief or in a therapeutic response to the issues of dual diagnosis. Both Carla and Liz spoke of creating memorial gardens as discussed in Chapter 4. Liz is looking towards building a 'sensory, spiritual space in the garden so it becomes a place that people want to be, to sit and be quiet and reflect, and for others to do that with them'. Again, the gardens in this situation become a space in which they are reminded of the presence of those now absent, helping those with a dual diagnosis, and others, to acknowledge the absence, but also that those loved ones have been present, and are entwined within their stories. The presence of the garden speaks of the absence of the loved ones.

Jim also spoke of a garden, although the garden he speaks of has a slightly different purpose. Working with a group of people who are vulnerably housed, the garden he spoke of was 'a little allotment', done in partnership with another agency working with homeless men, many suffering from addictions and mental health issues. The purpose of this is seen to be to 'give the men a sense of purpose and continuity . . . outside . . . that they're invited in. . . they are involved in . . . finding food . . . that they make themselves. And they're following that through . . . having grown it, harvested it, cooking it and the rest'. That sense of continuity is important in a situation of homelessness where lives can become very fragmented. Here we imagine a garden that speaks of those who tend it even when they are not present. The garden here reminds the men that they are present, distracting them from that which blocks out, obliterates, and leads to absence, alcohol, drug misuse, whatever their addiction may be, building up self-esteem, enabling them to help themselves, encouraging them gently into some form of relationship again, with their plants and plot of land.

These are very practical ways of enabling that tension between absence and presence to be expressed in a manner that is both healing and empowering. These responses are therapeutic because they encourage contemplation and gradual coming to terms with loss and the realities associated with loss.

**Importance of social support: present community remembering absences**

Althaus-Reid (1998, 407) states that:

Re-membering is the Christ-act of final reconciliation of God with the world, in the sense of making God's people one body and also keeping a permanent memory of the passion of Christ when he confronted the structures of power of his time.

From within the field of dual diagnosis treatment, there has been a growing acceptance of the multifactorial nature of mental illness and substance use disorders, leading to the articulation of a biopsychosocial perspective (Watkins et al. 2001, 3), meaning that these disorders have roots in some interplay between biological, psychological and social factors. Biological issues may include genetic brain chemistry problems that could underlie both disorders (Watkins et al. 2001, 3). The psychological dimension could relate to factors stemming from early developmental experiences, personality traits, emotional states and cognitive styles that result in habitual patterns of perceiving, thinking, feeling, and acting that are related to the disorders (Gorski 1994 as quoted Watkins et al. 2001, 3). The social dimension may refer to factors such as poorly developed social skills, family dysfunction, poverty and membership in oppressed or commonly rejected groups that may contribute to the etiology of mental illness and substance abuse and to problems that develop in work, social, and intimate relationships as a result of the disorders (Gorski 1994, as cited Watkins et al. 2001, 3).

Social support is also seen as key in the trans-theoretical model of change – including providing an alternative social environment to those that contribute towards dysfunction, and the provision of helping relationships (Watkins et al. 2001, 6-7). 12 step programmes also include group support as foundational to recovery (Evans and Sullivan 2001, 15). Certainly, recovery amongst all scripts from dually diagnosed individuals was associated with a movement towards community, generally speaking the DRA group, but also the 'Clubhouse' in Val's case.

Social support underpins the psychological support necessary. Patton (1989, 30), describes the Church as 'a community of anamnesis, or remembering, the Church is challenged to remember as an act of caring'. Patton (1989, 30) defines anamnesis as not simply memory of a past event, but as the 're-presenting of something that is not absent but alive and active in the present – epitomised in the Eucharistic liturgy which binds past, present and future together. Drawing connections with the work of Freud and the German pastor and psychoanalyst Joachim Scharfenburg, Patton (1989, 31) describes the process of psychoanalysis as the analyst helping the patient to rediscover their memory, by reconnecting with their life story and making a new one freer from

denial, by seeking to discover a more integrating form for the past by disclosing and reinterpreting painful memories which have been unnoticed or repressed. This echoes a second movement, within the healing process for those with a dual diagnosis, and that is a movement towards freedom and truth, albeit a renewed sense of truth, a truth connected to a future and the present, not just rooted in one perspective on a past. In order for this to happen, the dually diagnosed person must be willing and seeking to be freed from the chains that keep them 'frozen' in the past as Jim put it. Heyward (1999, 170) echoes this when she says that 'forgiveness is spiritual liberation from the shackles of the past. It frees us to go forward, 'not to shut the door on the past', and to know peace. Knowing ourselves forgiven by the spirit of life itself – empowered to go forth, unstuck and able to live each new day with a sense of personal grounding in the Spirit – we ourselves become God-bearers, agents of forgiveness, to others. Heyward speaks as a dually diagnosed theologian (alcoholic and bulimarexic – 1999, 170).

Alongside the movement to freedom and deeper truth, and the movement towards community associated with recovery from dual diagnosis, is a movement to order, the establishment of a routine. For Val, Brian and Sean, this includes sustaining employment; for the others, this includes regular and sustained contact with a DRA group. Both of these elements (sustained employment and sustained contact with a group) show 'a concern for the common good', or '*leitourgia*', using the terms of Coakley (2013, 87) – which Coakley suggests stems from an interruption of the Holy Spirit', an aligning of human desire with Divine desire, as human will submits to the 'Higher Power' of the Trinity. This third movement is the result of the other two movements, rather than a precursor to them.

For Patton (1989, 35), remembering and being remembered are key elements in care and in the development of community'. Patton (1989, 35) posits the entire pastoral exercise within the framework of the Christian community by saying:

The power of pastoral care rests in the fact that it is the care given by the community, not by the individual pastoral carer alone. The pastoral carer goes out with the strength and blessing of the caring community and with a conviction that because she, the carer, is cared about, she can offer the community's care to others. Care of self and care of others go together, and perhaps most important, care and community are somehow together in the memory of God.

All then that is done in the name of the Church is done on behalf of the Christian community – as part of the care of that community – which in itself reflects something of the care/love of God. And so finally, we need turn our attentions to the inner-workings of God as Trinity, to ensure that the care being offered is reflective of the Trinity, by

means of one of the more 'controversial' metaphors for the Trinity, which has stemmed from the rather vexed term 'perichoresis'.

## **Chapter 6: Perichoresis**

Having begun to understand care of those with a dual diagnosis as in some way reflecting the inner relationships of the Trinity, I want to spend some time looking at one of the more 'dynamic' metaphors for that inner dynamic summed up in the term 'Perichoresis'. The term will be looked at initially from a theological perspective and then, in keeping with Osmer's 'interpretive' task (Osmer 2008, 4) insights will be gained from the field of dance studies, before looking at MI as a potential source of 'choreography' for the pastoral encounter with those with a dual diagnosis.

Perichoresis, a Greek term, is a word used to express something of the nature of the interrelationships of God. Johnson (2007, 220) suggests that as a word it 'signifies a cyclical movement, a revolving action such as the revolution of a wheel' – and evokes 'a coinherence of the three divine persons, an encircling of each around the others'. Johnson (2007, 220) goes on to unpack the Latin translation of perichoresis, which can give a more static sense of the term – *circuminsessio*, meaning 'simply dwelling or resting within another' – from the Latin words for sitting and seat (*sedere, sessio*), the meaning preferred by Aquinas according to Fiddes (2000, 71). Or it could indicate more dynamically an interweaving of things with each other (from *incedere*, 'to permeate' or 'encompass'), the meaning preferred by Bonaventure according to Fiddes (2000, 72). The impact of these metaphors gives strong support to the idea that each person encompasses the others, is coinherent with the others in a joyous movement of shared life, without superiority or inferiority of one to the other (Johnson 2007, 220).

In the middle ages a metaphor came to be applied to describe perichoresis, the image of a divine dance (Fiddes 2000, 72). Fiddes (2000, 72) goes on to explain:

The word perichoresis is not actually derived from the root of the verb 'to dance around', perichoreuo (related to 'choreia', 'dance', with which we are familiar in the English word 'Choreography'), but the play on words does illustrate well the dynamic sense of perichoresis. In this dance the partners not only encircle each other and weave in and out between each other as in human dancing; in the divine dance, so intimate is the communion that they move in and through each other so that the pattern is all-inclusive. In fact, I suggest that the image of the dance makes most sense when we understand the divine persons as movements of relationship, rather than as individual subjects who have relationships.

The actual origin of the word perichoresis stems from the *perichoreo* which signifies cyclical movement or recurrence (Johnson 2007, 220). Johnson (2007, 220) goes onto stipulate that the origins are very similar and that it is in fact possible to portray this

motion in the form of a divine round dance modelled on the rhythmic, predictable motions of a country folk dance to portray mutual indwelling and the encircling of God's holy mystery. Johnson (2007, 220-221) extends the metaphor one step further when she says:

I would extend the metaphor further to include the art form created by modern choreographers in their drive to express the anguish and ecstasy of the contemporary spirit. Dancers whirl and intertwine in unusual patterns; the floor is circled in seemingly chaotic ways; rhythms are diverse; at times all hell breaks loose; resolution is achieved unexpectedly. Music, light and shadow, colour, and wonderfully supple motion coalesce in dancing that is not smoothly predictable and repetitive, as is a round dance, and yet is just as highly disciplined.

Seeming chaos, diverse rhythms, unexpected resolutions, anguish and ecstasy all echo the experience of pastoral care. For Johnson (2007, 221), also casts the metaphor in another direction:

We can say that the eternal flow of life is stepped to the contagious rhythms of spicy salsas, merengues, calypsos, or reggaes where dancers in free motion are yet bonded in the music. Perichoretic movement summons up the idea of all three distinct persons existing in each other in an exuberant movement of equal relations: an excellent model for human interaction in freedom and other regards.

If modern dance sums up the realities of the pastoral encounter, then perhaps 'spicy salsas, merengues and calypsos are where the pastoral encounter aims to get to at its best, because this would reflect a movement from sadness and grief to animation, life, and a 'positive energy', not to mention the bonding between those involved within a free dynamic not unlike the ladder metaphor with its movement of *katabasis* and *anabasis* – but free-er, with more vitality.

The metaphor of dance bears greater reflection. Indeed, the next step is to bring reflections of Trinitarian relations as dance, into conversation with the field of dance studies as a movement towards the embodied human reflection of what we have discussed, to see what insights can be brought to bear on our understanding of the Trinity, and also of the pastoral encounter with all the absences and presences more generally (modelled on the aim of reflecting God's love in the world).

Very quickly we see the same challenges facing 'dance studies' as those studying the pastoral encounter. Lepecki (2004, 6) states that:

This body, visceral matter as well as socio-political agent, discontinuous with itself, moving into the folds of time, dissident of time, manifests its agency through the many ways it eventually smuggles its materiality into a charged presence that defies subjection. Dance as critical theory and critical praxis proposes a body that is less an empty signifier (executing preordained steps as it obeys blindly to structures of command) than a material, socially inscribed agent, a non-univocal body, an open potentiality, a force-field constantly negotiating its position in the powerful struggle for its appropriation and control.

The description of the body as material, socially inscribed agent echoes Swinton's ideas around social responsibility for exclusion of those with mental health issues and also the material body damaged by alcohol or drugs, yet having open potential, constantly negotiating for their position in the struggle to gain control, albeit powerless in the face of addiction though. The scars of the body signify past events, moments of pain, possible abuse. And yet, the continuing life of the body signifies 'open potential' for good or ill. If the 'body' and 'presence' are not necessarily the same, within dance, then what constitutes 'presence'? Lepecki (2004, 127-128) describes 'presence' thus:

Dance as elusive presence, dance as the fleeting trace of an always irretrievable, never fully translatable motion: neither into notation, nor into writing. Inscription fails the test of a new regime of perception, which announces and pursues a new ontological grounding for the presence of the dancing body. Within this new visual regime and this new metaphysical ground, what tests both vision and inscription to their limits is presence: presence unfolding as a mode of being whose temporality escapes scopic control, presence as haunted by invisibility, presence as sentencing to absence.

The ontology of performance of dance then is that 'manically charged present' announcing itself at the very moment presence plunges into disappearance (Lepecki 2004, 132). Could the same be said of the pastoral encounter?

Lepecki (2004, 4) states that 'it is one of dance studies' major premises to define dance as that which continuously plunges into pastness – even as the dance presents itself to visibility'. Lepecki (2004, 3) divides body and presence –suggesting that 'it is nothing else than the positing of an interval between one and the other that allows choreography to announce and enforce its project of regimentation and inscription of bodily movements'. For Lepecki (2004, 3), presence and body are no longer necessarily isomorphic; one does not necessarily imply the other. This echoes both the pastoral encounter and the human encounter with God beautifully, where one may be present on some level, and yet there will always be an element of mystery there. According to

Feuillet (as cited Lepecki 2004, 3), the presence of the body is always preceded, always prefaced by, always grounded on, an open field of absence. Within dance studies, the question of the presence of the dancing body becomes a matter of delicate excavation, as dancing body releases layers of memory (Lepecki 2004, 4). Questions arise as to how to approach the visible body as its dancing presence lunges it into the past, into history into a representational field that is perhaps too excessive to be regimented, contained, tamed (Lepecki 2004, 5). Likewise a pastoral episode, when studied, is essentially a study of a historical incident, a 'present moment' that is no longer, and as such is now 'absent' and more than likely never to happen in exactly the same way again. This is a reminder that however much I theologially reflect on a pastoral encounter, I may yet not be ready for a next encounter in which similar issues arise again. No two encounters are the same because of the almost infinite configurations of factors that could lead to a particular situation developing in a particular way. Likewise, the dance, when studied could be done in infinitely different ways depending on the movement, interpretation and mood of the bodies involved.

This is but one tension highlighted between presence and absence within dance studies. Valerie Briginshaw (2001, 2) highlights a further tension in the 'conjunction of bodies and space' in that 'in dance, the limits and extent of subjectivity are actually and metaphorically exposed when and where bodies meet space'. Mouths, lips, tongues, ears and noses are both inside and outside the body as is skin (Briginshaw 2001, 3). These are liminal areas where the internal and the external meet. Briginshaw (2001, 3) highlights here the blurred edges of the presence of the body suggesting that 'seeing edges of bodies and space as both inside and outside in this way allows for ambiguities and ambivalence'. There is transgression, both in actuality and metaphorically because of the bodily and spiritual 'intimacies exchanged' (Briginshaw 2001, 3) – a potential issue in pastoral care.

Within dance, according to Briginshaw (2001, 3), 'at these limits and extremes of bodies and space, at the edges and in the border zones, meanings which contribute to ideas about subjectivity are continually being negotiated'. Briginshaw (2001, 4) sees spaces 'as a construct, a human or social construct, and so it cannot be explored without reference to human subjects'. For Briginshaw (2001, 5-6) then, dance 'presents representations of bodies in spaces, their relations to the spaces and to other bodies and . . . . is a most pertinent arena for exploring questions of subjectivity', which for our purposes are key concepts in the pastoral encounter. Is the dual diagnosed person the object of pastoral care? What does it mean to be 'subject'? For Briginshaw (2001, 6) being a subject entails being an 'I', a 'you', a 'he' or a 'she'. In other words subjects are constructed and positioned by and through language and discourse (Briginshaw 2001,

6), and thus bodies and humans are 'subjected'. Briginshaw (2001, 6) goes on to elaborate:

In the discourse of dance, when the limits of bodies, where they meet and interact with the surrounding space and with other bodies, are the focus, attention is drawn to the bodies' similarities and differences. . . . The similarities and differences of dancing bodies point to the kinds of subjects performing. They are seen as 'gendered', 'racialised', 'sexualised', and in terms of their ability . . . . Within the context of certain strands of postmodern theory the differences in subjects are recognised, so that subjects are seen as fragmented or split. This allows for subjects to be both the same and different from one another, to be both gendered and racialised, to be both agents with power to act on the one hand, and subjected to the rules and laws of language on the other. Seeing subjectivity as constructed in these ways importantly means it is open to change, it is in process, fluid and mobile rather than fixed.

There is then hope in this when we considered those 'subjected' as dually diagnosed (having at least 2 labels in their diagnosis alone!). To be 'both/and' is a significant part of the process of recovery for those with a dual diagnosis, who for years have been victim of 'specialisation' within the health service, bouncing between mental health services and addiction services. But this discourse goes further, encouraging us to think of those with a dual diagnosis as whole people, embodied, more than their diagnosis. Briginshaw speaks of the 'problem of in-between bodies and in between spaces', quoting post-colonial theorist Homi Bhabha, she states:

Hybrid hyphenizations . . . emphasize the incommensurable elements as the basis of cultural identities. What is at issue is the performative nature of differential identities; the regulation and negotiation of those spaces that are continually, contingently, 'opening out', remaking the boundaries, exposing the limits of any claim to a singular or autonomous sign of difference – be it class, gender or race . . . difference is neither One nor the Other, but something else besides – in-between (Bhabha 1994, 219 as quoted Briginshaw 2001, 15).

That sense of continual movement, remaking the boundaries alludes to the notion of bodies being seen 'as becoming' and always in the process of constructing and being constructed – never finished . . . [and] is of particular use because it recognises the non-fixity and instability of subjectivity, such that the subject never reaches a stable state of being which can be fixed in a binary opposition . . . rather [it] has the possibility of fluctuating in the spaces in between' (Briginshaw 2001, 18). What Briginshaw describes here parallels McBeath's (2009, 152) description of liminal spaces when she says:

In the liminal space there is the possibility of change, of openness, of transition and of ambiguity. It is the now and the not yet, the living with both crucifixion and resurrection. It is the meaning behind the ritual of bread broken and wine poured that is so central to our worship together. In the liminal space is both the reality of pain and violence and the celebration and hope of restored community.

Here there is a very strong echo of the pastoral encounter, in that people are constantly in a state of flux, even if that simply means growing older with the consequent grief over loss of independence and the things one could once have done but cannot any more. The physical movement within dance can be used to portray this ongoing process of becoming well, and has been extended to the performance of significant life experiences. Franko (2004, 123) explains that 'the body . . . is marked by the event and becomes the mark of the event'. Franko (2004, 123) quotes Tatsumi Hijikata, writing about representations of 'death' and significant tragic events in dance, who states:

To make gestures of the dead, to die again, to make the dead re-enact once more their deaths in their entirety – these are what I want to experience within me. A person who has died once can die over and over again within me.

Franko (2004, 123) explains that Hijikata refers 'neither to mourning nor to witnessing[, i]nstead he describes the giving of movement to disaster as event'. This is the performance of . . . symbolic exchange: 'a death given and received, thus reversible in social exchange'. Here is an example of dance as a form of giving in the philosophical sense (Franko 2004, 121). Franko (2004, 121) suggests that the philosophical tradition underplays . . . the simultaneous self-donation required to render the giving efficacious, and which , in the absence of any object, fills the role of intentionality that Derrida sees as inseparable from the gift. To perform a response to an event is to bring forth the contradiction of the gift as a reappropriation of eventfulness (Franko 2004, 123). That reappropriation corresponds with the pastoral encounter in that often there is an event or experience that the person seeking pastoral care is seeking to come to terms with (to appropriate or reappropriate). It is, on occasion, the case that addiction stems from a failure to reappropriate some tragic event within their life story, likewise mental health issues can sometimes stem from an inability to do the same. Jim's comment about those with a dual diagnosis being 'stuck in time' highlights this phenomenon. What Franko describes here suggests that what we should be seeking in the pastoral encounter is something more 'performative' that touches the emotions that are often muffled by the addiction. But how does this relate to the Trinity? There are parallels here with the crucifixion and resurrection, and the re-presentation (re-appropriation?) of the events leading up to them in the Eucharist, in which these events are remembered –

made present – in a sanitised way, stripped of some of the horror of the original ‘event’ – in which body is made ‘present’ in the transitory act of remembering which Jesus leaves his disciples to do.

So what of the elusive ‘presence’ of the dancers? The historical nature of dance? And the transgressive liminality of the dancers? Here we see strong echoes of Coakley’s (2013, 286) expression of the nature of the Trinity – quoting Gregory of Nyssa’s description of the soul penetrating ‘the invisible and incomprehensible . . . [until] it sees God. The true vision and true knowledge of what we seek consists precisely in not seeing . . .’. Again, Coakley’s appeal to Gregory of Nyssa, to a figure from Church history echoes the historicity of dance – we know God because of an appeal to the discernment of God’s hand in the history of redemption. That same move can be seen almost throughout the scriptures, in particular in the ancient Israelite appeal back to the events of the Exodus in times of exile after that period in seeking hope for the future. Indeed in looking back upon those three episodes, I look back in order to learn ‘choreography’ or hints on pastoral ‘performance’ in the future. We look back to recognise common patterns.

Probably the most powerful human example of what Gregory of Nyssa describes is that of the Chilean ‘mothers of the disappeared’, described by Swinton (2007, 117). At the height of the Pinochet regime, groups of bereaved women, the mothers and wives of ‘the disappeared’, would gather together and simply dance in front of the police stations. In gestures of lament and protest, they would pin photographs of their loved ones to their clothes and dance with invisible partners’. This was a spiritual and symbolic act, dancing with the spirits of their lost ones and refusing to lie down before the evil forces that caused their grief, their dance powerfully binding them together in the midst of sorrow (Swinton 2007, 117). The absence of their partners was reappropriated in such a way as to reach beyond the individual and challenge evil at its very roots (Swinton 2007, 117). For Swinton (2007, 118), the personal, and the political, the individual and the wider community, were bound together in the outreach of the spiritual dance of lament. But what of transgressive liminality? The metaphor of midwifery, the Spirit depicted as midwife in Romans 8 with the Holy Spirit interceding with sighs too deep for words ‘within and without’. One can scarce imagine a more transgressively liminal state than that of the midwife guiding the woman through childbirth, as a person often little known to the woman giving birth is given access to liminal areas of the body where inside and outside meet, rarely opened to others.

Swinton (2001, 142), speaking of a mental health context, suggests that where the life-world and belief systems of those in need of care may be radically different from those

of the carer, the moving across of the carer into the life-world of the cared for is perhaps more akin to moving across cultures . . .'. Swinton (2001, 142) speaks of 'interpathy' as an expansion of empathy that relates to 'thinking with' and 'feeling with' a person whose cultural context is very different from one's own, and requires that one temporarily believe what the other believes, see as the other sees, value what the other values' as part of genuinely entering into the experience of the other and viewing their world view as if it was the only way in which the world could be understood. Augsburger (2014, 11) states that interpathy is intentional cognitive and affective envisioning of the thoughts and imagining the feelings of a truly separate other. Augsburger (2014, 16) describes interpathy between two people using a metaphor of those people standing 'on tiny bits of ground and are privileged to step over onto the turf of the neighbour for a moment; compared to ground that is shared in sympathy, or the adjoining ground of empathy. Interpathic boundary-crossing is risky because it creates a new world where little may be shared in common and where the contrast may, at times, challenge basic assumptions about person, situation, interaction, and their respective meanings (Augsburger 2014, 17). Augsburger (2014, 21-22) states categorically that one 'not attempt interpathy alone' but rather in a visible community of caregivers. Augsburger and Swinton's 'interpathy' is part of the pastoral equivalent of transgressive liminality embodied in dance, in Jesus' coming amongst humanity, and in midwifery. A similar technique to 'interpathy' is 'motivational interviewing', which we will turn to now by way continuing to explore the liminal interface between the 'cared for' and the 'carer'.

### **Motivational Interviewing: choreography for the pastoral encounter?**

Motivational Interviewing (MI) is 'a gentle form of counselling, . . . which has been found effective in fostering change across a wide range of health behaviours (Rollnick et al., 2008, 4). Rollnick et al. (2008, 6) describe MI as:

Not a technique for tricking people into doing what they do not want to do. Rather it is a skilful clinical style for eliciting from patients their own good motivations for making behaviour changes in the interest of health. It involves guiding more than directing, dancing rather than wrestling, listening at least as much as telling. The overall 'spirit' has been described as collaborative, evocative, and honouring of patient autonomy.

This form of counselling comes from the medical realm, and is designed for encounters between clinicians and patients. The 'collaboration' then is between patient and clinician, and relates to situations where 'patient behaviour change is needed' (Rollnick et al. 2008, 6). Instead of an uneven power relationship in which the expert clinician directs the passive patient in what to do, there is an active collaborative conversation

and joint decision-making process (Rollnick et al. 2008, 6). There is here the recognition that only the patient can enact change in the end. The process is evocative insofar as it seeks to 'evoke from patients that which they already have, to activate their own motivation and resources for change' (Rollnick et al. 2008, 6). The clinician seeks to help the patient find connections between what they care about and the health behaviour change that will be needed to realise their reasons for wanting to make a change. In honouring patient autonomy, there is a certain amount of 'detachment from outcomes', not an absence of caring, but . . . an acceptance that people can and do make choices about the course of their lives . . . ultimately it is the patient that decides what to do' (Rollnick et al. 2008, 7). Underlying this is the recognition that 'this is something in human nature that resists being coerced and told what to do' (Rollnick et al. 2008, 7), and that ironically, acknowledging the other's right and freedom not to change sometimes makes change possible.

MI has four guiding principles (Rollnick et al. 2008, 7):

1. To resist the righting reflex (the urge when seeing someone headed down the wrong path to get out in front of the person and say, 'Stop! Turn back!') which paradoxically encourages the person to rehearse the arguments against stopping, reinforcing those arguments in their minds, and hindering them in making a change. Rollnick et al. (2008, 8) explain that 'we tend to believe what we hear ourselves say. The more patients verbalise the disadvantages of change, the more committed they become to sustaining the status quo' (Rollnick et al. 2008, 8).
2. To understand and explore the patient's own motivations. It is the patient's own reasons for change, and not [the carers], that are most likely to trigger behaviour change (Rollnick et al. 2008, 9). Rollnick et al. (2008, 9) explain that the carer is 'better off asking patients why they would want to make a change and how they might do it rather than telling them that they should'.
3. To listen with empathy. For Rollnick et al. (2008, 9), good listening 'involves an empathic interest in making sure you understand, making guesses about meaning' (Swinton's interpathy).
4. To empower the patient. This principle is about 'helping patients explore how they can make a difference in their own health' (Rollnick et al. 2008, 10). A patient who is active in the consultation, thinking aloud about the why and how of change, is more likely to do something about this afterward (Rollnick et al. 2008, 10).

Within MI as a technique, Rollnick et al. (2008, 12) identify three communication styles: Guiding, Directing, and Following. The stance of the care giver in relation to the 'patient' is easy and less conflict ridden (Rollnick et al. 2008, 12). Rollnick et al. (2008, 12) describe it as: 'like dancing rather than wrestling'. The guiding style is suited to difficult conversations about behaviour change (Rollnick et al. 2008, 12). The following style is characterised by the predominance of listening and communicates 'I won't change or push you. I trust your wisdom about yourself, and I'll let you work this out in your own time and at your own pace' (Rollnick et al. 2008, 14). They also identify synonyms of 'following' as including 'permit', 'attend', 'allow', 'be responsive', 'understand', 'observe', and 'have faith in'. By contrast, the 'directing style implies a 'taking charge', an uneven relationship with regard to knowledge, expertise, authority or power (Rollnick et al. 2008, 14). Sometimes this saves lives. It communicates "I know how you can solve this problem . . ." and the expected complementary role is adherence or compliance' (Rollnick et al. 2008, 15). The guiding style is different insofar as 'a good guide knows what is possible and can offer you alternatives from which to choose, communicating "I can help you to solve this for yourself"' (Rollnick et al. 2008, 15).

A skilful practitioner is someone able to shift flexibly among these styles as appropriate to the patient and situation like a dancer (Rollnick et al. 2008, 17).

Within this 'technique' there is an emphasis on listening for 'change talk', as this will resolve the ambivalence that most people encounter when confronted with a need to change. Change talk is characterised by 'desire statements' ('I want to', 'I wish . . .', 'I like . . .'), talk of what the person considers to be within their ability ('I think I can . . .', 'I can . . .'), reasons to change, needs to change, a commitment to change, and then taking steps towards a change. All of these elements are to be affirmed and encouraged (Rollnick et al. 2008, 36-42). The asking of questions that encourage change talk is encouraged, as is a deep listening to the person concerned, and seeking the permission of the person before giving information.

Watkins et al. (2001, 157) affirm that this method is based on a collaborative relationship which includes respect for the client and acceptance of their limitations, a non-threatening approach, a vision of wellness tempered with cautious realism. The client is seen as expert on their experience of illness, and the clinician must have the flexibility to work compatibly with the client's view of reality (Watkins et al. 2001, 157).

Sciacca (1997) correlates the 'tasks' of motivational interviewing with the Prochaska/DiClemente stages of change. For clients in the pre-contemplative stage, the motivational interviewer should raise doubt, and increase the client's perception of risks and problems with their current behaviour. For clients in the contemplative stage,

the motivational interviewer evokes reasons to change, the risks of not changing, and strengthens self-efficacy. In stage three, the preparation stage, the therapist would help the client to determine the best course of action. When the client is in action to bring about change (stage four), the therapist helps the client to take steps toward change. In the final maintenance stage, the therapist helps the client identify and use strategies to prevent relapse (Sciacca 1997).

As an approach, MI seems synonymous with the sort of care given by God to creation. In other words, there is an autopoietic quality to the approach insofar as the wherewithal and impetus for change within this approach comes from within the dually diagnosed person. The same qualities have been identified by Gregersen (1998, 354, as cited Du Toit 2000, 520 and Thomas 2003), who states that God creates and transforms the world through supporting and stimulating self-making systems. The alternation between following and directing, alongside guiding is consistent with understandings of the Trinity in action. One could map onto these three forms the 'persons' of the Trinity (Father as Director, Son as Follower, and Holy Spirit as Guide). There is a freedom within the relationship between clinician and patient for the patient to take or leave advice given, and an acceptance that the patient will take ultimate decisions as to the way forward, rightly or wrongly! The fluidity of movement between the three styles echoes the interpenetration and unity of the Trinity. Could the 'dance of the clinician and patient' in MI be one and the same as that sacred dance of the Trinity?

As 'presence' within dance, motivation is as 'elusive' amongst those with a dual diagnosis. There is a fluid quality to it, motivation levels will fluctuate depending on any number of different factors, from grief knocking motivation to beginning to realise elements of hope spurring on greater motivation. There is also a historical element to the 'interview', a looking back over how things have been, over past events, and a gradual reappropriation of those events as the person resolves ambivalences and is encouraged to embrace a change (ideally). There is also a transgressive liminality to the encounter, as resistance is encountered, the 'interviewer' is encouraged to 'roll with it', entering into the reality of the 'client'. The 'entering into the reality of the client' reflects this approach being client centred, which in turn echoes Johnson's (2007, 220) vision of the Trinity as coinherent, without superiority or inferiority of one to the other. Transgressive liminality is also seen when intimate details are shared in explaining the full implications of addictive behaviours, or indeed the impact of mental ill health, or both. And there is the obvious sense of motion, as (hopefully) the 'client' embraces change, moves forward into a future. There is a dynamic quality to the encounter – and the interviewer needs to be responsive to that dynamic, resisting the urge to seek to control, direct, or dictate the rhythm.

As within dance, there is within MI a tension between absence and presence. There is the same open field of absence within which the two bodies of the interviewer and interviewee are located. There is the absence created by the detachment needed to watch an interviewee determine to make an unhealthy decision. There is also the absence of that which is not disclosed, the unknown, inevitable to a certain extent in any pastoral encounter, albeit hopefully mitigated by the open questioning encouraged by the MI approach.

**But can MI truly reflect something of the compassionate love of God?**

Oliver Davies (2001, 177) describes the normal speech-act as 'a triadic combination of addresser, addressee, and the message, in which it is the communicative intentionality of the addresser with respect to the addressee that governs the whole. If the communication is to be successful, then the words used must efficiently serve as signs to those things to which they refer (Davies 2001, 177). Davies (2001, 177) indicates that the functionality of language here is fundamentally one of service, requiring the transparency of the signifier with respect to the signified. Davies (2001, 177) distinguishes between normal and poetic language, suggesting that in poetic language, the focus shifts from the intentionality of the addresser within the communicative act to the message itself. Is the language of pastoral care using MI poetic? And if so what difference does that make?

The term 'Poetic' – stems from the Greek word 'Poiesis' meaning 'to make', and links material productivity to poetic construction (Walton 2014, 135). Davies (2001, 184) is interested in connecting theology and poetics, and begins to make that connection when he says:

As language that is 'set apart', mysterious in its genesis, enchanting in its effects and burdened with an excess of meaning, as language which appears to speak in a revelatory fashion to the heart of things, as a second world, as a way of speaking which defies any appropriation by imperatives other than its own, poetry appears to offer a real analogy to the language of Christians and, above all to the wisdom-speech that is theology'.

Davies (2001, 187) concludes that:

Poetics leads us to the threshold of theology but not beyond . . . . The poem does at some subtle level remain tied to the empirical realm; that is the foundation of its metaphoricity. But in general, the poem is a semiotic system, or 'world', which is set up against the realm of ordinary perception and

existence. Abstracted from the 'real' world, it is in an important sense other than it.

Whilst poetics may not cross the threshold of theology, it certainly has strong parallels with dance, and with an encounter with an individual with a dual diagnosis, particularly when using a person-centred approach like MI, where there will often be a collision of worldviews, and a 'making of shared space'.

Walton (2014, 180) picks up on this when she draws on the work of Lefebvre, the dialectic materialist, who explains that poiesis refers to the supreme, restless, transformative capacity of human beings to reshape their world and create meaning out of the mundane. For Walton (2014, 180), Lefebvre offers a vision of the everyday in which it is the site of revelation; a realm of mystery shot through with the tragic; a place of profound play secured by the marvellous grace of the poetic.

She also draws on the work of De Certeau, who sees 'everyday life as scattered with marvels and retaining space for a poiesis of microinvention in which we resist with 'sweet obstinacy' (Quoting De Certeau, Geard and Mayol 1998, 213 as cited Walton 2014, 183). Walton (2014, 183) goes on:

This may appear an outrageously optimistic vision but it is one borne from De Certeau's perception of the sufferings of the excluded, from the traumas of our wounded humanity and the mystical intensity of patient attention to particularity. It is only through these that we gain the wisdom to see beyond the confining boundaries of our current epistemological categories and marvel at the poetic revelation of the everyday. In a similar manner to Lefebvre, de Certeau would certainly argue that we cannot see ourselves as believing people, as Christians unless we do transgress these boundaries. Boundaries are the place of Christian work and their displacement are the result of this work (De Certeau in Sheldrake 2003, 32)

The parallels with the pastoral care of an individual with a dual diagnosis here are obvious. For years they have fallen between addiction specialists and psychiatric services. Many, if not all of them, have suffered traumas, existing on the margins of society, wounded humanity exemplified. Both of the initial metaphors used in this thesis (monkeys on a cliff face in Chapter 3, and the ladder metaphor in Chapter 4) emerged out of encounters with people with a dual diagnosis. This research endeavour has stemmed from initial insights gained from those with a dual diagnosis; it is 'client centred' then to use the language of MI. Citing the French Philosopher Ricoeur, Walton (2014, 144) suggests that a metaphor is not simply a figure of speech; it betokens an

imaginative capacity to create something new out of the meeting of different terms. Walton (2014, 144) states that metaphoric construction is what enables human beings to engage in transformative action in the world as they create new conjunctions that empower them to apprehend existence in fresh ways. This imaginative propensity to engage creatively with difference enables human beings to open themselves up to the existence and needs of others – to be challenged at their core by the alterity they encounter (Walton 2014, 144-145) which Walton describes as a poetic process ‘in the image of our Creator who drew chaos into form and light . . . we are capable of creating moral community amid difference however impossible such a task in fact appears’ (Walton quoting Wall 2005, 60). MI and dance therefore can be viewed as poetic.

Approaching this question from a quite different direction, using evolutionary biology, the same conclusion can be reached, albeit in a more specific way. Humberto Maturana and Francisco Valera (as cited Du Toit 2000, 514) introduced the concept of autopoietic systems to describe the nature of living as opposed to non-living systems and in this way explained the nature of life. The principle of autopoiesis is deduced from the operation of the cell which produces large numbers of complex chemicals which remain in the cell, but also participate in the actual production processes (Du Toit 2000, 515). The cell is an autopoietic system since it produces only itself through a process known in biology as mitosis. Autopoietic systems neither depend on any observer to determine their identity, nor do they depend on any observer to perform their functions (Du Toit 2000, 515). Although they do interact with the environment, the environment does not determine what will be the changes of the state of the system (Du Toit 2000, 516).

Du Toit (2000, 518) goes on to explain that humans can be viewed as autopoietic entities, as can human societies. As such, where is God in autopoiesis? Du Toit (2000, 520) cites Gregersen who sees God as not just ‘behind’ life-processes, but ‘present’ in them, as the moral inspirer of sentient beings including humans. Gregersen (as cited Du Toit 2000, 520) sees God as triggering cause, who is switching in and out in order to hold the course of history on track, not doing anything that replaces the ordinary operations of nature, but rather as the underlying causality that enables creatures to trigger themselves forth in their given setting (Gregersen 1987, 358-359 as cited Du Toit 2000, 520). Gregersen’s vision of God here suggests a God continuously upholding the reproductive and self-productive capacities of matter from the simplest to the most complex forms, the compassionate co-sufferer of the trials and errors, accomplishments and breakdowns of creatures (Du Toit 2000, 520).

In that detachment, described within the MI system, there is clearly an echo of autopoiesis, with the acceptance and appreciation that it is for the interviewee to find

motivation for change and then to make that change – or not. Within Gregersen's description of God working through autopoiesis, there is, despite the detachment, still space for compassionate love. Davies (2000, 233) quotes Edith Stein in saying that 'in compassion we know the suffering of the other secondarily (it does not as such become our suffering; rather ours is a 'suffering with'), but we know the subjectivity (or world-centredness) of the suffering other primordially'. And so, MI, in that sense, can reflect Godly love, compassionate love, and something of the relatedness of the Trinity.

And so, having considered the metaphor of 'perichoresis' as dance, alongside the MI approach to working with people with a dual diagnosis and the creative potential of that approach, the time has come to consider all of this in relation to midwifery and what can be offered by clergy to those who come to them who are dually diagnosed.

## **Chapter 7: Towards a renewed pastoral paradigm**

In the last chapter, we considered the metaphor of God as Trinity as Divine dance, and the metaphorically dance-like approach to pastoral care of MI and the creative potential of that approach, with its emphasis on auto-poiesis. In this chapter, we seek to integrate these insights with those gained from the research, to bring these insights into dialogue with insights gained from the midwives and obstetricians, and the lived experience of people with a dual diagnosis and to move towards a renewed pastoral paradigm.

In many ways, the insights of the midwives and obstetricians echo those of the MI approach. There was a strong 'guiding' element, a lot of emphasis on listening, and some 'directing' communication encountered within the data. Both come out of the medical field, and as such, the confluence of ideas is to be expected. There was an autopoietic quality to the ways in which the midwives respond to the woman in labour, summed up by Eileen, the obstetrician when she stated 'whatever the woman wants, she gets', and in the strong element of moving at the 'pace that that lady wants' highlighted by Hayley, a midwife. The application of MI is much broader than just for people with a dual diagnosis. Rather it can be used for anyone approaching a time of change for health reasons, no matter how absent or present they may be.

The reality that has emerged as the data has been unpacked is that each pastoral encounter is an embodied tension between absence and presence. Even Michael, the originator of the 'monkey metaphor' in Chapter 3, was physically present and striving to connect with me within the group setting in what was an exceptionally creative way, even if the metaphor pointed to the deliberate absences that have predominated his way of life for what will have been many years. Equally, several absences were noted with my encounter with Peter, in spite of the fact that his metaphor spoke so powerfully of our shared presence on that particular evening. Amongst the midwives, the descriptions of 'avoided eye contact', 'silence', 'wanting to leave the hospital', 'being allowed to leave the hospital', all point to absences in what was otherwise a time of 'presence' in a most compassionate way. Indeed, the care of midwives and obstetricians is the very embodiment of compassion, which, as Davies (2001, 252) points out, in the Hebrew roots of the word comes from *rehem*, or 'womb', denoting the visceral language of physical inwardness ('Moved with compassion', implying a 'suffering with'), embodied by the description from Julie and Emily of the persistence of the memory of what they had dealt with in their working day. As with the study of dance though, this reflection on the data, and sharing of insights gained from pastoral encounters is entirely historical (insofar as we can only reflect on encounters that have

been and not prejudice encounters that will be), and as such reflects entirely an 'absence', or rather 'presence resisting reproduction by embracing the realm of absence' (Phelan as quoted Lepecki 2004, 5).

What is clear from the data is that the midwives and obstetricians skilfully embrace the liminal space created by an intrauterine death, and guide the woman and often her family through the process of giving birth, attentively and at the woman's pace, and in the manner in which the mother seeks events to happen given the circumstances. There is a sense of co-creating the way in which the birth happens, within some limits (no caesarean for example), in an autopoietic manner, all with an eye to resourcing the mother for the reappropriation of her loss with the memory box which will persist afterwards, a means by which to negotiate the void created by the loss of her child, allow some modicum of control, choice, and freedom within the chaotic maelstrom of emotions that will swirl around at a time of trauma such as this. The skilful attention brings significant comfort to the family at a time of intense emotional turmoil and often deep sadness.

The 'constant communication' outlined by Hayley is characteristic of this. The inclusion within the memory box (often) of 'a little blessing card, a little medal, . . . a little cross', something spiritual, is seen to be of great comfort by the midwives, communicating to the family that even when they aren't 'there, the baby is being watched over, and that the baby is safe'.

The importance of those spiritual symbols is interesting. They become physical reminders of God's 'presence' in this time of trial, dominated by absence. Clearly not every family will want that, but it is routinely offered. There is a subtle echo here of the 12 step programmes with their emphasis on a 'Higher Power', often interpreted as 'God', and certainly where a dually diagnosed person is approaching a clergyperson, we can safely assume that there is some vestige of a spirituality there, or at the very least an openness to it. The importance of 'spirituality' was highlighted particularly by Sean in describing his recovery – as highlighted by his doctors. This is understandable, as Swinton and Pattison (2010, 231) highlight that 'spirituality is related to issues of meaning, hope, purpose, connectedness, love and so forth'. Swinton and Pattison (2010, 232) highlight research that perceives these elements as missing or downplayed with current approaches to care and treatment generally (Murray and Zentner 1989; McSherry and Draper 1998; Tanyi, 2002 as cited Swinton and Pattison). Swinton and Pattison (2010, 232) suggest that the term 'spirituality' is rather not 'meaning, hope, purpose, connectedness, and love', but relates to the 'quest' for these things and serves rather as a term to highlight the perceived absence of these things, and as such provides a 'point of resistance' against these inadequacies in care within the health

service (Swinton and Pattison 2010, 232). This quest for what is 'absent' is consistent with the spiritual quest for God described by Coakley (2013, 286) as she explores Gregory of Nyssa's ideas of the Soul's ascent towards the unfathomable Divine.

As may be expected then, prayer and spirituality are absent from the MI approach, and given the importance for addiction recovery given to spirituality, and the particular role of clergy, there may need to be some revision of the MI approach as given by Rollnick et al. (2008) for our purposes. Is an 'autopoietic system' enough? Or should we rather be striving for a 'theopoietic' equivalent? And what might that look like?

### **Theopoiesis: an outline**

Theopoietic pastoral theology, according to Zylla (2008, 132, 136 and 138) requires three movements:

1. The first movement of the Theopoietic: Numinous silence as our orientation.
2. The second movement of the Theopoietic: Radical engagement of complexity – Ministry as Disorientation.
3. The third movement of the Theopoietic: Ministry as Reorientation – The Birth-Hour of a new clarity.

Zylla, a Baptist Pastoral theologian, goes on to unpack these three 'movements' each in turn.

For Zylla (2008, 132):

The ontological centre of our existence, of our worldviews, of our churches, and of our very lives, is God. The deepest strivings of our hearts end in God's presence. The deepest longings of our souls require God's touch. The centre of all that we ask or imagine is found in God. 'Numinous' is the word we use for this unspoken longing. It beckons us to recognise that the deepest search we carry out as human beings is our search for communion with God. Mystery is the basis for our fundamental orientation in theopoietic pastoral theology.

Here we see silence as central to theopoietics, silence that is rooted in a deeper longing, that expresses that deeper longing. Walton (2014, 168) exploring the thought of Elie Wiesel, a Holocaust survivor, suggests that he 'expresses the . . . sense that on occasions when words fail and stories cannot be told, it is our duty to preserve the sacred silence of those who suffer, but in a way that communicates rather than obscures their pain'. For this, there must be a 'waiting with', a waiting with those with a dual diagnosis, which requires 'a posture of entering into the mystery of the situation

without all the answers, waiting for the Spirit of God to move over the deep waiting for the illuminating work of the Spirit to come to our chaos, our sorrows, and our hidden searching' (Zylla 2008, 133-134), and in that waiting is time for prayer, which Simone Weil calls 'absolute, unmixed attention' (Weil as quoted Zylla 2008, 134).

Regarding the second movement, 'The radical engagement of complexity', Zylla (2008, 137) explains:

At the root of every ministry situation are hidden realities, sufferings, brokenness, losses, disappointments. We try to maintain a consistent vision but the elusive nature of people's commitments and the roaring fires of diverse expectations continue to undercut sincere efforts for uniformity. We hope for clear outcomes but often we are left to contend with the stops and starts of life in all of its amazing colour' . . . . We must yield to the complexity, all the while opening ourselves to the prompting of God who invites our courage and our expectant participation.

Let it not be said that anyone striving to work with those with a dual diagnosis who are still actively addicted are in any way not radically engaging with complexity.

Elucidating the third movement, 'Ministry as Reorientation, the Birth hour of a new clarity', Zylla (2008, 139) quotes Rainer Maria Rilke:

Everything is gestation and then bringing forth. To let each impression and each germ of feeling come to completion wholly in itself, in the dark, in the inexpressible, the unconscious, beyond the reach of one's own intelligence, and await with deep humility and patience the birth hour of a new clarity'.

Zylla (2008, 139) goes on:

Only after the first two movements can the final stage be set for the hard work of theo poetic articulation. The 'founding Word' governs this movement to articulation. The silence of the first movement to prayer and the radical engagement with the real life experiences of ministry are brought into conversation with the Word of God. The task of articulation is the task of pastoral theological reflection.

And Zylla (2008, 139) quotes Henri Nouwen who states that 'the art of spiritual living is to eat the word, digest it, and incorporate it concretely in our lives . . . . The Word of God has to anchor itself in the centre of our being'. Which is fine for resourcing clergy in ministry, but actually in terms of resourcing a dually diagnosed person in 'becoming', if it

is the task of the clergy to articulate, at what point do those being cared for 'eat the word, digest it and incorporate it concretely in their lives'?

Keefe-Perry (2009, 596) quotes Mikhail Bakhtin who describes language 'as a living, socio-ideological concrete thing . . . [that] lies on the borderline between oneself and the other . . . . It becomes 'one's own' only when the speaker populates it with his own intention, his own accent, when he appropriates the word'. For Keefe-Perry (2009, 597), to engage in the theopoietic process is to begin to come to terms with the Gracious Presence that unites all things, even in this broken world, to learn to see spirit at work in the mundane, and to transcend modern alienation with a call to unite and serve. Theopoietics is a means of engaging language and perception in such a way that one enters into a radical relation with the divine, the other, and the creation in which all occurs (Keefe-Perry 2009, 597). Again though, Keefe-Perry does not engage with the question of encouraging others into this task.

Guyonn (2006, 2 downloaded July 2014) does engage with this issue from his perspective as a non-violence activist, who, quoting Alves states that 'the poetic word which opens up the infinite Space of Longing, in hope that the dead will become gardeners'. For Guyonn (2006, 2), theopoietics opens up a space for unanticipated dreaming in which the past, present and future are re-shaped as we recognise and even re-create our own stories and our relationships with others, the world, and the Divine. Guyonn (2006, 6) extends theopoietics beyond the act of writing to a 'practice of social hospitality', built on intention which invites others to participate'. It suggests a set of practices and attitudes, but 'how can one bring an intention into the public square hospitably enough to invite others into a process of change?' asks Guyonn (2006, 6).

Guyonn (2006, 6) proposes that theopoietic activists acknowledge the importance of piercing to the heart of ultimate reality, and raising questions which promise to tumble worldviews. For Guyonn (2006, 10) then, theopoietics is more than just a style of writing,

Theopoietics is a hospitable and elicitive stance – on the page (inviting more writing than speaking), in the streets (eliciting narrative rather than shouting answers), and in ritual/worship space (deepening each one's knowledge of self, Divine, world, Other). It is a style which tastes so good that one wants more – more revolution, more of the grace-filled Divine, more writing that tweaks and questions – more blossoms, more dreams, more loves. It creates enchantment which ultimately offers life to those dead in soul or spirit, a resurrection of the body and soul.

The strength of Guyonn's perspective comes in his breadth of application of poiesis – as 'making' – but I want to push this further. Returning to the medical sphere – Hitchcock

Scott and Ross (2006, 207) argue for the 'weaving [of] creative arts into the practice of trauma and addiction therapy [as providing] rich ground for gaining insight, catharsis, and the integration of a compartmentalised self and lifestyle. Using scripture as metaphor, they state:

Prior to recovery, addicts and trauma survivors wander lost, much like the Israelites initially futile wandering in the wilderness (Ochs and Olitzky 1997, 128). Though lost, many seek a more authentic connection to self and spirit. While the patient begins therapy in despair, . . . it is followed by revelation – a whole new way of seeing. And after revelation comes the long process of integrating the new perception (129). Art, like manna, the mysterious food sent by God to the Israelites, sustains the lost and seeking. Art feeds us during times when we are parched, hungry and tired. The act of creation, whether an art piece or a meaningful life, is one of faith just as the act of collecting food that fell from the sky was an act of faith for the Israelites. The act of faith it takes to draw, sculpt, dance, sing, or role-play may be the first step to 'the breakdown of old ways of viewing things' (128) and the start of a new life . . . . The creative arts have a unique ability to help trauma survivors and addicts navigate through life experiences and defences to the centre of the soul.

(Hitchcock Scott and Ross 2006, 208)

Here art is quite strongly connected to faith and change – both significant elements in healing for someone with a dual diagnosis – a movement out of the wilderness and into the Promised Land (to continue the 'Exodus' metaphor). Quoting Rollo May, an existential psychologist, Hitchcock Scott and Ross (2006, 213) build on that connection when they state that one of the eight essential processes for wellness to stem from art therapy is a sense of the 'transcendent' to emerge in the process of 'creating', stating that transcendence is the ability to transform self, others, or situations through a spiritual connection to a higher source, echoing here the ladder imagery of Chapter 4. May (1975, as quoted Hitchcock Scott and Ross 2006, 213) states that 'it is well documented that while producing art, many experience altered states of consciousness or hypnotic states. It is through the process of making art that the artist/patient embraces the cyclical process of creation, preservation, dissolution, and recreation'. May (1975 as quoted Hitchcock Scott and Ross 2006, 213) states that every act of creation is first of all an act of destruction. Hitchcock Scott and Ross (2006, 213) state that this process helps the artist accept the world in non-dualistic terms and gain acceptance of even the most difficult situations. In this description of the transcendent within art, we can see clearly how the process of creating art negotiates the tension between absence and

presence. It is not the therapist creating art that negotiates this, but the 'patient' themselves (remembering here the medical origins of this piece of research). Poiesis in the broadest and, in some ways, most original sense of the word then, shows great potential in the healing process of those with a dual diagnosis.

### **Beyond Theopoiesis . . . a 'quest' comes towards conclusion**

Drawing these last insights together then, I wonder if the pastoral approach to those with a dual diagnosis should be one not so much of autopoiesis, or simple theopoiesis (where that may entail too much 'directing'), to one of 'autotheopoiesis' – enabling people to come to experience for themselves 'God with them' in the absences as well as the presences – in a manner that invites questioning, a plunging into the mystery of God, to create a space of hospitality where all sorts of questions and metaphors can be explored by those who come to us as clergy and to enable those who come to lift all of that 'creative mess' before God in prayer, either silently ('numinous silence') or aloud. In an ideal world, because not everyone is 'good with words' there should be a great latitude in what form 'poiesis' should take. The 'arts' is a broad field, and perhaps this is a challenge to churches to facilitate creative expression in a variety of forms to facilitate as broad a cross section of people as possible to encounter transcendence in the 'act of creation that is first an act of destruction'. Jim comes close to this in the memorial services in which he encourages street drinkers to take as active a role as possible, less 'praying for' as 'praying with', co-creating rather than 'creating for'. A midwife does not 'give birth for' the woman, but accompanies her through the birthing process, moving at a pace and in a manner that the woman is most receptive to. Likewise, a midwife does not work alone, and in our task of 'autotheopoiesis', we need to be aware of others involved in the care of those with a dual diagnosis: doctors, social workers, often family members at their 'wits end', and possibly other clergy. Is there the possibility of collaboration? This will be dependent on the quality of relationships with those 'others', but could be a way to humanly emulate the relatedness of the Trinity.

In positing an 'autotheopoietic' paradigm, I want to suggest taking the best of MI, and integrating within it some of the insights of the theopoietic. There are great parallels between Zylla's three movements of the theopoietic and work with those with a dual diagnosis. Numinous silence calls for listening from the pastoral carer, to hear the silence, and to call forth the voice of the other. 'Ministry as disorientation' echoes the entry in to the world of the dually diagnosed person, which for many would represent a 'radical engagement in complexity'. 'Ministry as reorientation' represents the reappropriation of grief, the 'Birth Hour of a New Clarity'. There is within all three steps,

space for some of the three communicative styles elucidated in MI: listening, directing and guiding, but the emphasis in autotheopoiesis must be on the self-efficacy of the dually diagnosed person. They must have freedom in this, to make choices, with which the pastoral care-giver might agree or disagree, in much the same way as God must rejoice and despair at some of the choices made by us all.

For Michael and Peter, part of their 'poiesis' came in their use of metaphor, a tradition I have continued throughout this thesis. Levinas (1996, 36) sees metaphor as a 'reference to absence', which given his belief in a God who is 'absolutely Absent' (1996, 60), suggests a transcendent quality, an awareness of the 'Other', if not in a fundamental way, then as glimpsed in 'me'. For Levinas (1996, 36), the absence to which the metaphor leads would then not be another given but still to come or already past. Walton (2014, 146) speaking of 'imaginative forms [that] must be created that bear the unbearable into speech, 'includes metaphoric utterances . . . passed on by those who have been caught up in extreme circumstances'. Citing the work of Rebecca Chopp (2001, 61 as cited Walton 2014, 146), Walton writes 'Such discourse is an invention . . . [required] to refigure, refashion and reshape the world', and includes 'metaphor' in a 'poetics of testimony'. For a practitioner within the autotheopoietic paradigm, listening for such a refiguring, refashioning, and reshaping is a key task, that echoes, or perhaps constitutes the poiesis of reappropriation of past experiences that could lead to a renewal of outlook, or indeed the reality of 'salvation coming to [a dually diagnosed person's] house' – to paraphrase Jim.

I have touched on the significance of objects and their potential for ongoing communication in the absence of the pastoral carer (memory boxes, prayer cards, gardens etc). So too the face, the presence of the pastoral caregiver of the other holds significance. Levinas (1996, 60) speaks of 'the Other' proceeding 'from the absolutely Absent, but his relationship with the absolutely Absent from which he comes does not indicate, does not reveal, this Absent, and yet the Absent has a meaning in the face'. When Levinas refers to the Absent, he is referring to God. The face of the pastoral caregiver, the presence of the pastoral caregiver then, can have the effect of enabling the reappropriation of past hurts and perceptions. If nothing else, the presence of the pastoral caregiver mitigates against Heyward's (1999, 21) theological and ethical problem of 'loneliness' as normality. Certainly the movement towards being present is associated with healing amongst those with a dual diagnosis, with all five scripts referencing the positive benefits of being part of a dual recovery group, Peter speaking of how beneficial my encounter with him had been, and Sean describing the significance of his encounter with the doctor and church members. Sean probably describes that transition from active addiction and mental ill health to recovery most poignantly with his

movement from one group of friends to another (drinkers to church friends), which enabled him to negotiate that tension between 'absence' and 'presence' more smoothly.

Ultimately the 'poiesis' within this paradigm is seeking ways in which to ease that transition, whether that be through pastoral conversation (as with Peter), friendship (as with Sean), physical objects that enable the person to recognise and reflect on their new reality (memory boxes, gardens), objects that encourage reflection on someone having been present, and continuing to care in their absence (prayer cards, potted plants etc), or a memorable phrase or metaphor that sticks with a person, lingering in the memory – encouraging an ongoing connection, a hunger for more (in a positive way). Poiesis could involve giving people the means with which to plunge deeper into the mystery of God, to embrace the ascent into unknowing through meditation, or creative prayer.

Ultimately, the dually diagnosed person must be left in no uncertainty that they have the freedom of choice in this, that they can embrace what is offered them, or not, and where possible, the 'autotheopoietic' community will strive to continue in relationship as best they can, bearing in mind issues of safety and risk management. The harsh reality of this paradigm is that there will be times where we accompany people to the cross, and there will be other times where we accompany them to a form of resurrection, and for some it will be a recurring mixture of both. But in a sense, this is all part of the perichoretic movement, certainly as viewed through history as we have it in the Gospels. The pastoral carer can offer opportunities, can encourage, can guide, but cannot do it for the person.

## **Conclusion**

Dear Alastair,

So, you've just been asked to 'do something about 'street drinking'? Well, 6 years on from that point, I remember well the feeling of unease, fear and that sense of stumbling into a minefield well! To be fair to you, you are in good company amongst your clergy colleagues, the majority of whom feel the same way when confronted by similar people. The issues involved are many and varied, but engagement with them will transform your understanding of 'pastoral care' – and resource you in your future ministry. Be brave, step out in faith, your instincts are good, follow them through.

For a start, you wanted to listen to those who you think are the 'street drinkers' in the relative safety of the alcoholic men's hostel. Listening is key, meet them where they are. Don't rush to challenge them. Certainly don't go into this to 'problem solve' for them. It might feel right and good, but it will end in their disempowerment and tears ultimately. Encourage, reflect, but ultimately co-create with them their future in whatever direction that is to be found. Befriending them is more therapeutic than you would suspect at this point for them. As you do so, you will discover that, in fact, the men in the alcoholic men's hostel are not the same people as those 'street drinking' and therein lies part of the main issue, the 'street drinkers' are marginalised, disconnected from the wider community. Although they are not the same people, they do share common issues, as do in fact the majority of the men in the probation hostel you've been going into quite regularly by this point. They are 'dually diagnosed', which is to say that they suffer from a mental illness and an addiction. You are probably thinking 'Well, if they are ill, why don't they go to hospital? Can we not have them sectioned and a period of intensive therapeutic input given?' But it is not as simple as that. In the UK healthcare system, mental health services and addiction services have evolved separately, with two distinct and different traditions and so those seeking to access treatment for both have to set about it in much the same way as someone seeking treatment for a heart problem and a broken leg. You will be quickly realising that it is a major achievement to get some of these people to access one service with any consistency, never mind two, particularly when there is ambivalence over whether there is even a need to access an 'addiction service'. This situation is one major contributing factor to this social issue because it forms even a slight barrier to resolving the issues. There is a need then to agitate for change here. In parts of the US, there is provision of an integrated service, where both issues are treated together and seen as a conjoined problem. This is a much better approach to treatment.

But that is not the only issue to be overcome. The second comes in another 'disconnect' in society, between the health service and the clergy. What has become clear in recent times is that in 'inner city' areas, clergy are still seen by a significant proportion of the population as unofficial 'frontline mental health workers'. We have become a way to access 'help' without admitting mental illness, or that there is an addiction, or simply to avoid admitting that there has been some sort of relapse. This is a significant challenge because we are not given any specialist training for that role, and because we have no powers to access appropriate services for people, even if we were trained. This is particularly sad, as 'spirituality' is seen as a significant factor to be considered with a long history of being an integral part of assisting those with an addiction towards recovery. Stronger connections here could facilitate faster access into sustainable health care.

So what of the immediate social issues you face? Allow me to speak first of what I have done by way of research, and then move into the 'pastoral care' element of this project.

At the beginning of this research, I began with three metaphors, and a research 'hunch' that there would be some insights to be gained into the pastoral care of people with dual diagnosis from the area of midwifery/obstetrics where an intrauterine death has occurred. The metaphors emerged out of my practice as Curate in the Northwest of England working in a range of settings, but because of the make-up of the area with a high proportion of dually diagnosed people living locally. Following up on the 'hunch', a series of interviews were conducted of midwives and obstetricians and clergy and a grounded theory methodology applied to the data generated. The resulting overarching code was a tension between absence and presence, and the theory emerging from that being that the pastoral encounter is a lived tension between absence and presence seeking to reappropriate the experience of absence (principally grief) in the lives of those being cared for. Although there was some evidence of this being done by clergy (through prayer cards and memorial gardens), there was a clear understanding amongst the midwives and obstetricians caring for a family that has suffered an intrauterine death that part of the care 'package' should include 'memory boxes', which have the potential to assist in the reappropriation of the reality of loss (an understanding that the loved child existed and a focus for remembering and grieving). An emphasis on the role of 'objects' in facilitating grief, and of reminding the person being cared for that they are cared for is a key, but small part of the pastoral care of individuals with a dual diagnosis.

Some of the tension within the pastoral encounter derives from the fact that the clergy are encouraged to 'be present', and yet the dually diagnosed person seeking care is often going to be 'absent', in the sense of keeping some things hidden, masking symptoms, or the full extent of the issues arising from the symptoms, or possibly just

because they are afraid of admitting that they are ill through the stigma attached to mental illness or addiction, or because of a past trauma sustained by them, which may have triggered illness later in life. Herein lay just a few of the challenges facing those offering pastoral care, and those seeking pastoral care.

What is absolutely clear is that pastoral care is not about 'problem solving' for those with a dual diagnosis. Rather there needs to be clarity about the fact that the dually diagnosed person is free to make their own decisions about how they approach life, whether or not they continue in a destructive behaviour pattern. If they are determined not to engage with a 'healing relationship', then that is what will happen. All that can be done is to signal to them that the opportunity remains should they think again.

The principles of MI are also key within the pastoral relationship, and may assist in preventing a complete 'absenting'. What is clear through this technique is that 'challenging' should not form part of the 'pastoral repertoire' of clergy offering pastoral care as this is more likely to cause a breakdown in relationship than anything else. Encouragement, raising questions, alerting those coming to clergy of any discrepancies in what is said, rolling with resistance, these are all key techniques, alongside empathy, possibly 'interpathy', empowering those with a dual diagnosis, and not 'correcting' them when it is plain to see that they are 'hitting the self destruct button'.

Another element from the insights of midwives and obstetricians is that pastoral care in a situation of intrauterine death is not done 'alone', but as part of a team. This is quite different to how many clergy operate, often 1-1, and in many parishes with little sense of collegiality. For most clergy, the image of the 'Good Shepherd' predominates when discussion turns to 'pastoral care'. But, and without seeking to undermine the unity of God, there are 3 in the Godhead, and so exploration was made of the Doctrine of the Trinity where quickly a symmetry between the role of midwife and that of the Holy Spirit were found. The mystery within the Godhead mirrors well the element of 'mystery' – the ultimate unknowability of people coming to clergy for pastoral care. The emphasis on the social dimension of care is key. One of the most significant elements of the paradigm of care that has emerged is that, ideally, it should be a community effort. Swinton's assertions of the social dimension to the marginalisation of those suffering mental illness can only be 'undone' through a 'social' solution. Sean's description of transitioning from one group of friends to another was a large part of his movement towards recovery.

The pastoral encounter is a dynamic event, and nowhere is that dynamism more clearly envisaged than in the metaphor of the Trinity as 'divine dance'. An exploration into insights that could be gained from dance theory was useful. The idea of the 'body as

socially inscribed agent' added another perspective on the social issues underlying dual diagnosis, and served to increase awareness of these issues for anyone offering care. Another key insight was the historicity of dance, to reflect on dance is an act of 'remembering', and echoes the process of theological reflection on the pastoral encounter. The parallels between dance and the pastoral encounter also highlight the 'performative' dimension of pastoral care, and talk of 'transgressive liminality' is a key concept, that unites the pastoral encounter, midwifery and dance.

'Transgressive liminality' involves plunging into the mystery, the incomprehensible, the unknown, absences within the encounter. Raising questions, continuing to seek to know in the face of 'not-knowing', often simply waiting with the other until the mystery is resolved, or they are ready to share more are all part of the transgressively liminal encounter. It can involve meeting people in the madness, attempting to see the world as they do for a time, and seeking to understand why they see it that way.

For those for whom pastoral contact is infrequent or sporadic, the use of prayer cards, or other objects that transcend to some extent the periods of absence, and remind the person that they are cared for is a useful thing. Praying with people, and enabling people to pray for themselves is also useful – encouraging and resourcing them in their spirituality. Sometimes enabling stories to be told can be useful, and other times it may not be possible, and simply finding some creative outlet for emotional angst is the best way forward, in an ideal world moving people however briefly into an 'altered state of consciousness'. The arts have much to offer here as a vehicle for the facilitation of this sort of work. Metaphor, a significant part of this current research project, also designates a striving beyond the present moment, a reaching out to something outside of the self. We need to be alert to that. What is key in the use of the arts is that those with a dual diagnosis are not just left to do something, simply by way of keeping busy, but rather that people are alongside them, reflecting with them on what they are doing and what that 'creative act' might signify within them that is going to be therapeutic.

As we engage in that 'creative' work, we strive to emulate the creative work of a Creative God, a God as Trinity active in Creation, not as Divine dictator, telling someone what to do at each step, but working with Creation in its ongoing development and growth, or death. There must be freedom within the pastoral relationship for those with a dual diagnosis to move in a healthy, creative direction or not. What is a central and key aim is the continuation of the relationship and the facilitation of a form of conversation that does not simply lead to a rehearsal of reasons 'not to change'.

It would be a great help were the Church of England (alongside other denominations) to train clergy in the technique of Motivational Interviewing, by way of beginning to

resource clergy in their role as 'primary mental health carer'. It would be a step forward to forge connections with providers of mental health and addiction care, and for those providers to integrate those services (as currently is beginning to happen in some parts of the UK).

Keep alert to those moments when absences are reappropriated, when the tensions between absence and presence are renegotiated, perhaps through metaphor, through non-human actants, or through simple conversation and befriending. Any of these things have the potential to prompt change. The Church and you as a clergyperson have the capacity to enable these people on their journey towards recovery by providing resources to encourage people in contemplative prayer, silence and meditation, to move from the silence of 'having been silenced' to the silence borne of being 'heard into speech'.

There will be times when you wonder whether anything you are doing is worth the effort, when 'absence' seems to dominate your encounters. There will be other times when you feel a deep (albeit possibly fleeting) sense of connection. Through all of my research, what has come clear is that the pastoral encounter is a lived tension between absence and presence, as such embodying the inter-relationship of the Trinity, striving to reappropriate absence in a manner that effects movement towards recovery!

I wish you well in that striving!

Yours in faith and hope,

Alastair

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