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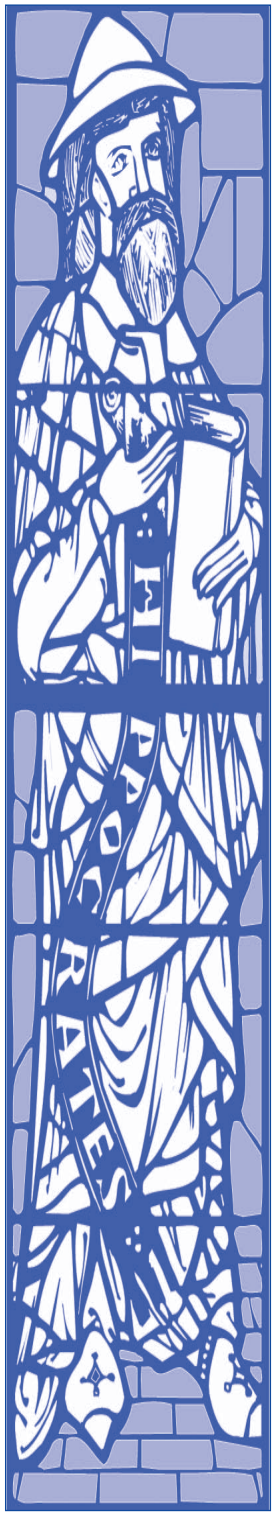

Volume 19, Number 1
ISSN 0895-5336

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Healing Ministry™

470 Boston Post Road

Weston, Massachusetts 02493

781-899-2702

Fax: 781-899-4900

E-mail: healingministry@pnpco.com

Web site: www.healingministryjournal.com

Healing Ministry™

Volume 19, No. 1

Healing Ministry, ISSN 0895-5336, is published quarterly by Weston Medical Publishing, LLC, 470 Boston Post Road, Weston, MA 02493, (781) 899-2702, FAX (781) 899-4900. Winter 2012.

Subscription Information

To subscribe: submit your complete name, address, and zip code, attention: ***Healing Ministry***, Circulation Department, 470 Boston Post Road, Weston, MA 02493. Please enclose check or purchase order. Subscribers wishing to notify the publication of an address change must submit an old mailing label and their new address, including zip code. No claims for copies lost in the mail will be allowed unless they are received within 90 days of the date of issue. Claims for issues lost as a result of insufficient notice of change of address will not be honored.

Subscription Rates

Individual:	US $86;	Canada, $106;	Foreign, $139
Institution:	US $150;	Canada, $173;	Foreign, $243
Library:	US $162;	Canada, $178;	Foreign, $252
Single issues:	US $50;	Canada, $60;	Foreign, $75

(Note: Prices US currency)

Manuscript Submittal - Author Information

Manuscripts should be submitted to the Editor-in-Chief, ***Healing Ministry***, 470 Boston Post Road, Weston, MA 02493 or may be sent to healingministry@pnpco.com.

Postal Information

Periodicals postage paid at Boston, MA, Permit No. 013-823.

Postmaster: Send address changes and Form 3579 to: ***Healing Ministry***, 470 Boston Post Road, Weston, MA 02493.

Printed in the United States of America.

Healing Ministry™

Healing Ministry Editorial Advisory Review Board

13145 7/17/12 Rev. b

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A practical guide to meet the needs of the mentally ill in the local church

Matthew Breuninger
Matthew S. Stanford, PhD

Abstract

Pastors and lay ministers are likely to encounter individuals and/or families in their congregation struggling with the effects of mental illness. Without the necessary training to competently treat serious mental disorders, a referral should be made to the appropriate licensed mental health provider. However, the congregation remains vitally important to the recovery process. When utilized/engaged effectively, religious involvement is associated with buffering against future relapses, effective coping with symptoms, faster recovery times as well as promoting and sustaining mental health. This article offers clergy and lay ministers practical tips and resources aimed at helping the local church to educate, support, supplement and provide continuing care to create a safe, loving environment in which those struggling with mental illness can find hope and healing.

Keywords: mental illness, Christian churches, practical, resources, clergy, pastors, family

Matthew Breuninger, Department of Psychology & Neuroscience, Baylor University, Waco, Texas.

Matthew S. Stanford, PhD, Department of Psychology & Neuroscience, Baylor University, Waco, Texas.

DOI: 10.5055/hm.2012.0011

Being a blind disease, mental illness does not recognize race, color, or creed. It touches everyone from the man on the park bench to the woman on Park Avenue—from the woman in the business suit to the man in the prison jump suit. Those afflicted with serious mental illness require the assistance of trained and licensed professionals. These individuals may need psychotherapy, medication, or a combination of both. Sometimes they require hospitalization to regulate and monitor their psychological health. The purpose of this article is to offer practical suggestions to congregations desiring to create a supportive environment for those struggling with mental health issues. This article is "not" intended to teach pastors or lay ministers to treat mental illness or to provide psychotherapy; such a task is the job of mental health professionals. Rather, what will be discussed are ways in which the local church can educate, support, supplement, and provide

continuing care to create a safe, loving environment in which those struggling with mental illness can find hope and healing. To achieve this goal, a mental health ministry, properly understood, should strive to integrate biblical truths with psychological resources. In doing so, the Christian community shares the burdens and struggles of fellow believers and becomes a visible incarnation of the Divine Physician.

The church has the gospel and gospel means good news

If you have been actively involved in a congregation as a pastor, an elder, a small group leader, or a weekly worshipper, then you have undoubtedly encountered either first-hand or indirectly someone struggling with a mental illness. Approximately 26.2 percent of Americans aged 18 years or above experience significant enough symptoms to meet criteria for a diagnosable mental disorder in a given year.[1] This means that in one capacity or another, many of us have been affected by mental illness. Perhaps we know a friend or family member who has struggled with a mental disorder. Maybe we, ourselves, have been diagnosed with a mental illness. According to the World Health Organization's[2] projections, in the next eight years, Major Depressive Disorder will become the second leading cause of disability globally among all ages and both sexes (calculated according to disability-adjusted life year [DALY]). This means depression will trump war, road traffic accidents, arthritis, paralysis, etc. as the number one cause of disability. According to the years lived with disability (YLD) calculation, it is currently the "leading" cause of disability between both sexes in the age category 15 to 44 years.[2] Furthermore, among adolescents and young adults, mental illness is already the leading cause of disability (DALYs), accounting for almost half of all disabilities in this age group.[3] Young children suffer as well. Between children and adolescents, an estimated one in 10 suffers from a mental or emotional disorder that causes significant distress or impairment in their daily functioning at school, with friends, or in their families.[4] Far from being immune to the effects of mental illness, families often bear the brunt of the confusion, sadness, and pain associated with caring for a mentally ill loved one. A recent study among Protestant denominations revealed that approximately one in three families was affected by mental illness.[5] Equally alarming was the fact that these families reported that their faith practices were negatively affected by the illness.

What is the point? What does this mean for the local church? The point is mental illness exists among us. It is in our homes, schools, and churches. It not only affects the life of the individual and the family unit but also shakes the very foundation of the congregation. Often congregant's personal relationships with Jesus Christ, a source of grace and comfort, are weakened, damaged, or destroyed by the direct or indirect effects of the mental disorders. Ignoring the problem does violence to the life of faith at the heart of each local church. However, the good news is that the church can be a source of comfort, support, and healing for those in its midst afflicted by mental illness.

And the last shall be first

When someone struggles with psychological problems or emotional distress, who is the first professional from whom they seek counsel and guidance? One would expect the answer to be their psychologist, psychiatrist, a medical doctor, or any other member of the mental health community. Those answers would all be wrong. When an individual is in psychological or emotional turmoil, they are more likely to seek help from clergy and pastors than from mental health professionals.[6] The counsel of those who are licensed and best trained to deal with such issues is sought after seeking guidance from a pastor or clergyman. The burden on pastors can feel overwhelming. Pulled for guidance

and effective solutions, the pastor may feel incompetent to deal with the psychological issue, but still desire to attend to the needs of the individual because they are a congregant. This tension may encourage the pastor to approach the problem from a perspective that is within his or her field of knowledge. Being comfortable with spiritual themes, he or she may deny or overly spiritualize the problem in order to feel a sense of competence in dealing with the issue. In this way, the ill individual is not only denied a supportive environment that can promote mental health, but also weakened in their personal faith as a result of the interaction.[7] How can a pastor, desiring to offer hope and healing, address the needs of a psychologically distressed congregant in a way that helps rather than hinders their recovery? The answer lies within the heart of the faith community.

The church: A healing salve-ation

The word salvation is rooted in the word salve, meaning to make whole or heal. For Christians, the salvation found in Jesus Christ certainly heals the soul, offering an eternal and spiritual wholeness for the believer. The church, however can be a fount of salvation in another sense—a small "s" sense of the term. Social support is a great source of psychological health. It acts as a buffer against the potential onset of mental illness as well as an important vehicle of healing and recovery from the symptoms of mental illness. As the mystical body of Christ, the church is called to be a unified body of believers in communion with one another. For those suffering with mental illness, this community can offer healing and wholeness simply by being a supportive community. The local church provides a person already receiving professional help with a loving, supportive environment that will foster and promote their recovery rather than hinder it. It is equivalent to when a friend or family member comes home from surgery. You strive to create an atmosphere that will help the loved one recuperate by giving them a quiet place to sleep, reducing their physical responsibilities, and maybe even putting in a ramp to help them get up stairs. St Paul instructs the Galatians, "Bear one another's burdens, and so fulfill the law of Christ."[8] There are those among us in the pews suffering the burden of mental illness. By simply being a church—offering a community that seeks to understand and lovingly share in the burden of those suffering from mental illness—the Christian community can assist in a powerful way in the care and recovery of those with mental disorders.

Stigma

Despite great strides in the mental health field, there is still a significant amount of misunderstanding and misinformation regarding the nature and causes of mental illness. Mental illness has been called the "no casserole disease" in some churches. This is because when a congregant has physical illness or ailment, church-goers usually rally to provide meals and other forms of support. However, with mental illness, a manic or schizophrenic episode usually is met with either abandonment or misunderstanding from the church.

Severe mental illness is a disorder of the brain. The brain, like any other organ of the body, has the potential to fail to function properly. When this happens, one of the results may be a mental disorder. Some of the most prominent stigmas regarding metal illness among Christian churches today are that these disorders are the result of personal sin, demonic influence, an insufficient prayer life, or simple character weakness. Some 30 percent of individuals who approached clergy regarding mental illness reported their interaction with the church as negative. Of those 30 percent, 60 percent were either abandoned or ignored by the church, whereas the remaining 40 percent were told that their illness was the result of either demonic influence or lack of faith/personal sin.[7] This overspiritualization represents a misunderstanding of the true nature

of mental illness. However, this is not to say that pastoral guidance/care does not have a place in counseling. It does. Not all cases of what might be considered depression and anxiety are in fact mental illnesses, properly speaking. There are cases in which individuals may be sad, depressed, or anxious because they are living/behaving in way that they know is contrary to God's law and not in accordance with their conscience. In such cases, pastoral or spiritual care may help the individual evaluate their priorities, align their life with principles of Christian discipleship, and dedicate themselves to prayer and other devotions. Such a remedy may cause the lifting of the negative mood states. However, these instances are different from true clinical depression, anxiety disorders, or other mental illnesses. An analogy might help. Let us look at type I and type II diabetes. In the case of type I diabetes, an individual's pancreas does not produce enough insulin. Therefore, the person may experience symptoms such as thirst, hunger, weight loss, or frequent urination. Type I diabetes results from the immune system destroying the insulin-producing cells in the pancreas. It is a genetically based immune system malfunction that does not depend on the person's lifestyle or food behaviors. Conversely, type II diabetes, while requiring a genetic predisposition, depends much more on the food behaviors of the individual. Obesity is believed to be the cause of type II diabetes. Mental illness is like type I diabetes. An individual's brain may produce excessive or insufficient amounts of certain neurotransmitters that are involved in thought, mood, and behavior. In a sense, the brain malfunctions. Pastoral and spiritual counseling deals with mood states and thoughts that are the result of a person's behavior (much like type II diabetes). The difficulty for many pastors is that individuals who may benefit from pastoral care often present some of the same symptoms as those requiring professional help for a mental illness.

The stigma surrounding mental illness has, however, made it difficult or impossible for individuals suffering with these disorders to share with the church for fear of being perceived as sinful or weak. As "one body in Christ," the stigmatization of the individual not only wounds the person but also infects the faith life of the congregation at large and tears at the seams of unity.

You have to A.C.T.

Creating an environment that is conducive to promoting and facilitating hope and healing for those receiving treatment for mental illness is simple, though not always easy. All you have to do is A.C.T.: acknowledge & accept, call to communion, and teach. This simple acronym will help you meet the needs of not only the individual sufferer but also families who may be struggling with a loved one afflicted by a mental illness.

Acknowledge & accept

Acknowledging the reality of mental illness and accepting those suffering as having a legitimate claim to worship in the church and bring their sufferings to Christ are essential ingredients in creating a hopeful and healing environment. Acknowledgment and acceptance begin, however, with the pastor. By openly addressing and discussing mental illness, the stigma that it must be relegated to the shadows of secrecy will fade. When mental illness is brought from the darkness into the light, it becomes less scary. What are some things a pastors can do to foster this environment?

Generally

- As a community, pray in a general way each week for anyone suffering from mental and/or emotional illness.

- Invite individual congregants struggling with mental illness to write down their particular spiritual and emotional needs. Read these during the weekly prayer intentions.

- Prepare sermons that incorporate and acknowledge the struggle experienced by those with mental illness. Sermon starters from NAMI FaithNet provide Scripture passages and sermon themes that are relevant to mental illness.

- Place an insert regarding a topic related to mental illness in the bulletin.

- Start a monthly collection of funds to subsidize or pay for mental health services for those who cannot afford it themselves.

- Invite a member of the church who has struggled with mental illness to witness to the congregation.

- Place brochures and other sources of information regarding mental illness and available resources in the back of the church or in the pews.

- Train ushers and greeters on how to be supportive and welcoming to all people. Also, train greeters to recognize signs and symptoms of severe mental illness, so that they are more attentive to the needs of individuals with mental illness. In this way, these individuals will feel wanted and welcome.

- Invite a mental health professional to speak or offer a seminar to teach that mental illnesses are brain-based disorders.

Engaging someone in psychological distress

- Do not be patronizing or disingenuous.

- Ask someone how they are doing and then "listen" to their feelings/response even if they are really sad, angry, or hurt.

- Do not tell someone how they should feel or what they should do.

- Be genuine. Be kind and compassionate, but honest. You can affirm and validate someone's experience without having experienced it yourself: "I don't hear those voices, but I believe you when you tell me that you do. That must be very scary and confusing for you."

- Help the individual remember that they are not an illness, but a person with an illness. Remind them of their strengths and gifts, not just their illness.

- Ask the individual what they want and what their needs are!

Call to communion

The Christian is called to bear one another's burdens and to share the sufferings and struggles of all Christian believers; it is a call to union and communion in Christ. The church, embodying this supportive community, has the opportunity and obligation to meet the material, spiritual, and emotional needs of its congregants. Here are some ways church leaders and congregations can answer the call to communion with the mentally ill:

- Put together a small task force and assess the needs of your congregation.

- Gather a group of individuals who is willing to make weekly phone calls just to say, "I'm thinking about you" or "I'm praying for you." This lets a person know that they have not been forgotten or abandoned. This same group can also send short notes or cards if the individual is not feeling well enough to communicate by phone.

- Involve congregants in programs to provide meals or clean the houses of those struggling with mental illness. A person may be too tired, fatigued, depressed, or generally overwhelmed to cook or clean for themselves if their illness is severe.

- For persons who are in the hospital, residential facilities or an unable to make it to worship because of their illness, make prayer blankets, psalm pillows or care packages to let them know that they have not been forgotten.

- If the mentally ill loved one is a child, consider creating a team of volunteers that supervises/cares for the child while their parents or guardians attend worship services.

- Provide respite care for family members of mentally ill individuals—watch a movie, perform a play, or take a field trip.

- Sponsor a drop-in center or social time (supervised if necessary) for individuals with mental illness to relax, play games, do project, or just talk.

- Provide opportunities for those struggling with mental illness to volunteer, sharing their gifts both in and outside of the church (eg, music ministry, reading Scripture, and committee member).

- Allow NAMI and other mental health support groups to use your space for meetings and educational courses.

  Create support groups for people and families affected by mental illness. Contact your local NAMI affiliate for resources and referrals.

- Sponsor an evening of structured discussion based on a book, DVD, or other material dealing with mental illness. Congregants can be encouraged to share about how mental illness may have affected their life directly or indirectly either in the past or in the present.

- Plan a candlelight vigil for *Mental Illness Awareness Week* or participate in activities during *May is Mental Health Month*.

Teach

It is only through educating yourself, your staff, and congregation that you can successfully meet the mental health needs of your people. Become familiar with the following Web sites and the resources, referrals, and recommendations they provide. You will find in these pages sermon starters, book recommendations, short videos and illustrations, educational material, bulletin supplements, and brochures.

- Take suggested books, videos, and literatures from the following Web sites and begin/supply your church library/resource section with information and materials on mental illness.

- *Pathways2Promise*

  An organization dedicated to helping faith communities develop their intrinsic capacity to be supportive, caring environments for those struggling with mental illness and their families. Offers program/ministry models, instructions for pastors faced with mental health crises, educational materials, and free liturgical resources.

- *Mental Health Ministries*

  A Web site dedicated to provide educational resources on mental health issues, as well as models of ministry that may be effective in dealing with mental illness in the local Church. Offers free bulletin inserts, brochures, and worship/liturgical resources on topics concerning mental health and faith communities. Also provides free video clips, DVD recommendations, and a list of helpful books on the topic.

- *Mental Health Grace Alliance*

  An organization dedicated to offering seminars and mental health trainings aimed at educating local

churches about mental illness. Provides Christ-centered counseling, as well as Christ-centered support groups (Grace Groups) for both those struggling with mental illness and their families.

- *Congregational Resources Guide*

  A resource guide for mental health ministries from the Congregational Resources Web site. This article offers annotated bibliographies on a large selection of audio and visual resources for individuals, pastors, and faith communities dealing with mental illness.

- *NAMI FaithNet*

  NAMI FaithNet is an outreach organization aimed at assisting faith communities in developing supportive environments for those suffering with mental disorders and their families. They also seek to promote the value of spiritual growth in those caring for loved ones with mental illness, while emphasizing the importance of spirituality in the process of recovery for those suffering from mental illness. Finally, NAMI FaithNet offers numerous educational materials concerning mental disorders.

Closing

In dealing with the inevitable reality of mental illness in the local church, allow the words of Christ to reverberate in your heart, mind, and soul: "Be not afraid." The local church can and ought to be a helper—a source of faith, hope, and love. It achieves this goal by offering those suffering with mental illness and their family's spiritual coherence and social support. Spiritual coherence occurs in the midst of the church encouraging helpful devotions, positive religious coping strategies and beliefs, as well as supplementary pastoral counseling. By offering study groups, home and hospital visits and educational trainings and resources, the local church creates a supportive social environment that fosters and promotes recovery from mental illness. The church instantiates the hope, healing, and help of the Holy Spirit, becoming a source of consolation and peace for those in her midst bearing the heavy burden of mental illness.

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Meditation and self-care for helping professionals

Noell L. Rowan, PhD, LCSW, CADC

Abstract

Taking care of ourselves as helping professionals is important in the ability to provide high quality service as well as to improve overall health. This article focuses on the application of self-care through practicing some forms of meditation and describes the use of centering prayer, movement meditation, and simple techniques for helping professionals in the alleviation of human suffering.

Key words: self-care, helping professionals, meditation

Introduction

The practice of self-care by professionals such as social workers, chaplains, nurses, physicians, and others in helping fields has begun to have some prominence in discussions about providing effective and healing service to others.[1-5] The use of meditation by helping professionals has been described as a practice that can be especially healing with various methods of meditation.[3,5-8]

What is it that is helpful about meditation? Is it the focusing of the mind and body on wellness? Is it the process of setting aside time to be present? Is it in the learning to be present? Is it about being still and quiet in the midst of hurried and busy inner and outer worlds? What about the practice of focus on one healing thought for several minutes? These are common questions. It seems that what is most important is the actual practice and the willingness to practice with some regularity.

Monaghan and Viereck[8] describe meditation as dealing with something that is already within us and seeing that a state of grace is possible. Meditation can be summarized by:

> "Meditation is not a religion. Meditation is not a doctrine. Meditation is not another 'good' that you acquire. Meditation can be objectless and consist of just sitting. Think of it as play rather than work. While you are playing, your mind is more open."[8(pxvii)]

The art of meditation is a process that can be simple, such as being still and quiet. It is typical to pay attention to breathing and focusing on a word or phrase

Noell L. Rowan, PhD, LCSW, CADC, Director, BSW Program and Assistant Professor, Kent School of Social Work, University of Louisville, Louisville, Kentucky.

DOI: 10.5055/hm.2012.0012

that has special personal or spiritual meaning.[9] Self-care in the form of meditation is truly an act of love and surrender as we allow ourselves to become still and listen and open up to whom we are and who we are meant to be.

Practicing mindfulness meditation as a form of stress reduction has been described as an emergent practice to enhance health for both practitioners and their clients.[3,5,10,11] Mindfulness meditation is a process of carefully attending to shifts that occur within the body, mind, emotions, and in the outer world with focus on kindness and having a nonjudgmental demeanor.[3,12] The process involves a practice of being still and learning to be aware of self and others.

Becoming generally more aware has been noted as key in the process of self-care and in meditation practice. As Kearney and colleagues[3] reported, a group of physicians dealing with clients at the end of their lives, were particularly prone to compassion fatigue and high stress and yet began practicing mindfulness meditation. Through the engagement in meditation, the findings demonstrated progress in the development of empathy for clients and lower levels of stress.[3] These and other findings[5,11] about the aid of meditation practices for helping professionals illustrate how the practice of various forms of meditation can enhance the lives of helping professionals and their clients.

One form of meditation: Centering prayer

Bourgeault[6,13] describes the practice of meditation through the use of centering prayer and chanting as contemplative exercises to deepen our capacity to heal ourselves. In ancient tradition, centering prayer is a Christian-based meditation that simply teaches to release thoughts as they enter the mind.[13] This practice has provided for much healing both mentally and physically by letting go of thoughts as a symbol to release and move more freely through life in general.[13]

When meditating using centering prayer, chanting, or some other form of meditation, there is an inevitable point at which the human emotions will emerge and as some refer to dark and deep-seeded issues may arise.[6,14] It is vital during these moments to allow for the full expression of these emotions and possibly to deal with the often unconscious issues with another healing professional. After all, being human and caring for oneself often involves allowing for fully expressing ourselves in a safe and supportive atmosphere. As is common for our clients, helping professionals may periodically or regularly seek the counsel of a safe and supportive therapist or other social support system to assist in dealing with emotional expression in a healthy manner.

Keating[14] provides a detailed discussion and guide to perform the centering prayer meditation. He presents the process in a simple step-wise process that includes selecting a sacred word as a symbol of one's intention to focus on the divine presence.[14] There is also an emphasis on sitting comfortably and closing the eyes in an effort to allow the body and mind to settle and to silently begin to focus on the sacred word or symbol.[14] Finally, Keating[14] discusses the normal human process to drift in one's thoughts and the gentle manner in which this centering prayer method involves gently refocusing one's thoughts back to the sacred word or symbol. The process of centering prayer allows for yet another way to practice meditation and to gain skill in letting go. Gaining skill in letting go of attachments can be healthy practice not only in the workplace but also in all human relationships. While centering prayer is one suggestion to add to the repertoire of self-care for helping professionals, other forms of meditation which involve movement are presented next.

Meditation in movement

There are many forms of meditation that involve moving the body. Some of these examples can be in yoga (in its many forms), dance, martial arts, and labyrinth walking. Sometimes simply taking a walk in nature

can soothe the mind, body, and spirit. In practicing meditation, consciously noticing how one's feet feel on the ground, in the grass, or in a shoe and how it is supported by the earth and focusing on breathing in and out slowly and calmly—this is a beginning to movement and meditation. Taking a walk in nature in silence can refresh the mind through a process of noticing the sounds of birds, the sunshine, the feel, and smell of the air. Walking meditation may also involve paying attention to the pace of one's walking in an effort to breathe slowly and evenly and at a comfortable pace to leave room for noticing and becoming aware of thoughts, feelings, and sensations. Trusting oneself to move gently and at ease with nature can bring about respite, can raise inner awareness, and be a tool to use to begin the day or at any time.

As Monaghan and Viereck[8] describe, it is important to choose a safe place to meditate and a time that is free of distraction as much as possible. When re-entering the world, within a sometimes hectic pace and a myriad of encounters, it is good to re-enter with some care as there may be new awareness and things to consider in decisions about money, relationships, and etc. In essence, taking care of ourselves through the practice of some form of meditation is a way of learning to "integrate the various ways of knowing and being, not an escape from ordinary reality."[8(p9)] Meditation is a way to become still, even if the form of meditation involves movement of the body. When we become still, then nature can have room to reinstate us to well being.[15]

Conclusion

Taking steps to practice self-care is vital for helping professionals. Having a toolkit of options can be especially helpful when our individual needs at one time may be very different from another. There are many forms of meditation and this article focused on only a few of these. Incorporating simple techniques such as the process of centering prayer, mindfulness meditation, or some form of movement meditation can bring about inner awareness, decreased stress, releasing of thoughts, toxins, and an overall cleansing of the mind, body, and spirit. Taking time to enhance our health and give to ourselves is a good rhythm to get into in an effort to ultimately be able to authentically give more to our clients and to all beings.

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Pastors, church members, and mental illness

The Reverend Don Allen Jr, PhD, LICDC

Seven years ago, I was given the opportunity of a lifetime. After more than 30 years of pastoral ministry and 19 years as a counselor in the substance abuse and mental health field, I joined the staff of Summit Behavioral Healthcare. (Summit is a part of the State of Ohio Mental Health Hospital System.) Many of my Christian friends and some pastors were shocked that I would accept this position. They felt I had sold out; that I had abandoned my core beliefs concerning Divine Healing, which is defined as "Healing through divine intervention as in response to prayer or because of faith."[1] They incorrectly concluded that I had conceded there were some people who are mentally ill and were beyond hope. They erroneously assumed that I had adopted the position that medication was the primary (or only) solution and that God was secondary. This assumption is totally inaccurate and unfair.

I am often amazed that some sincere, Bible-believing Christians will not hesitate to go to a hospital when it comes to medical problems such as heart attack, cancer, strokes, or diabetes. Everyone agrees that sometimes medical tests need to be run, X-rays taken, and surgeries scheduled. We all agree that compassion must be shown. However, when that same person goes to a psychiatrist, psychologist, social worker, counselor, or therapist, they often face criticism from believers who declare that such people are weak in their faith and need to "get over it." The truth is that mental illness, which is defined as "Any of various disorders characterized chiefly by abnormal behavior or an inability to function socially, including diseases of the mind and personality and certain diseases of the brain. Also called mental disease,"[2] is a serious problem. It is a real disease that causes real pain and afflicts many in our churches. Mental illness and emotional problems are not issues that can continually be swept under the rug in the vain hope that they will go away.

There can be various root causes for physical illness. For example, cancer can result from contact with asbestos or it can be

The Reverend Don Allen Jr, PhD, LICDC, Founder/Director of Through HIM Ministries; Substance Abuse/Mental Illness Counselor, Summit Behavioral Healthcare, Cincinnati, Ohio.

DOI: 10.5055/hm.2012.0013

inherited from a parent at birth. Heart attacks can be the result of a poor diet, stress, lack of proper exercise, genetically inherited tendencies, or poor development while the baby is still in the womb. We would never hesitate to call 911 if a family member fell and broke their back. We would do all we could to help. We would seek out the best surgeon and use any medical treatments necessary to reduce pain. In addition, Bible-believing pastors and church members would strongly encourage patients to pray to seek God's assistance in the healing process.

However, often these same people advise those suffering from mental illness to avoid seeking the professional assistance of the mental health practitioners who can help heal them. We pray for healing when people suffer from physical pain and encourage them to get medical treatment. Why do we pray for healing for emotional pain but discourage those suffering from mental illness from seeking professional assistance? It is a sin if I break my arm, go to the hospital and ask God to heal me. If I am clinically depressed, is it a sin to make an appointment with a psychologist to get better?

There is a wide variety of physical diseases that require a doctor's expertise to treat. There are many forms of mental illnesses, such as bipolar disorder, schizophrenia, and anxiety disorders, which we find a number of Americans suffering from, including those within the church community. "An estimated 26.2 percent of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year."[3] Let us look for just a moment at anxiety disorder, which generally list seven categories:

- **Generalized anxiety disorder:** It is a common chronic disorder characterized by long-lasting anxiety that is not focused on any one object or situation, generally characterized by fear or worry.

- **Panic disorder:** A person suffers from brief attacks of intense terror and apprehension.

- **Agoraphobia:** An intense fear of not being able to get out of some place or a need to be by the window or door.

- **Specific phobia:** Sufferers typically anticipate terrifying consequences from encountering the object of their fear, which can be anything from an animal to a location to a bodily fluid to a particular situation.

- **Social phobia:** Intense fear or panic of being in public or around groups of people, often resulting in the individual not leaving their home.

- **Obsessive-compulsive disorder:** Primarily characterized by repetitive obsessions such as distressing, persistent, and intrusive thoughts or images and compulsions such as urges to perform specific acts or rituals.

- **Post-traumatic stress disorder (PTSD):** Post-traumatic stress can result from an extreme situation, such as combat, natural disaster, rape, hostage situations, child abuse, bullying, or even a serious accident. It can also result from long-term (chronic) exposure to a severe stressor. I personally experienced individuals who were affected by the events of September 11, 2001, in New York City; they suffered from PTSD. They could not sleep, they were unable to go into buildings, or had other fears.

Some of these disorders, such as depression, bipolar disorder, schizophrenia, and even anxiety disorders, are caused by circumstances and events while others are caused by a chemical imbalance in the brain. There is some medical research that has shown that chemical imbalances in the

brain (such as a lack of serotonin or excessive levels of dopamine) can lead to problems with thoughts and behavior. However, there are also those who believe just as adamantly that chemical imbalance plays no role in mental illness.

Depression is a psychological malady that often afflicts church members, yet it is commonly overlooked. People suffering from depression are often accused of having weak faith. Consequently, the depressed church member may feel lonely, discouraged, and abandoned. They may see life as hopeless and—if untreated—that hopelessness can lead to suicide. When properly prescribed by a medical professional, medications such as Paxil or Zoloft can help depressed people cope with their feelings. Using these medicines in conjunction with time in counseling and/or support groups can be effective tools to address these issues. It is not uncommon that a severely depressed person (like a very physically sick individual) may need to remain on their medication for several years until they receive their healing. Please understand that I am not a proponent of medication only. I firmly believe that the church has a key role in helping people with mental health issues, just as we have a role in ministering to those with cancer, heart problems, and other physical maladies. Our role as pastors and church members is to pray, encourage, and support.

I have served the past 17 years with the Assemblies of God and recently returned to the Baptist church. I have many close friends within the Methodist, Church of God, and Church of Christ denominations. In all those fellowships, I have seen church members living in significant emotional pain and too scared to tell anyone. I spent time in New York City following the events of 9/11. I talked with believers who were at the World Trade Center that day. I spoke with police officers who lost partners. I talked with school teachers who watched—along with their students—the planes crash into the towers. All these people suffered real pain from an anxiety disorder known as PTSD. That pain ranged from mild to severe. When events such as 9/11 occur, some suffer from an anxiety disorder, whereas others may suffer from depression. Some of the children who lost family members face serious abandonment issues. Unfortunately, many within the church will tell them to simply pray about it and it will be OK. Would we give the same advice to someone with a broken arm?

As I have worked in Cincinnati's mental health hospital, I have had many men and women share their faith with me. They talk about their plans to get out and return to a normal life, reunite with family, and get back to church. Some have been in the hospital for years. One thing that saddens me is that the vast majority say that their pastor has "never" visited them. Every church I know today would be outraged if the pastor did not go to the hospital at least weekly to visit a dear saint with cancer. Yet we can go a lifetime without visiting a church member in the hospital with bipolar disorder or schizophrenia. This often has more to do with our misperception of the cause of the disease and our lack of personal understanding of mental illness. And, it is not just the duty of the pastor to minister to the sick. Laypeople should also visit those in hospitals.

I often work with treatment teams to discuss patient histories, review medical information, talk about brain imaging scans, and evaluate how medication has been working. Prescription medication can help stabilize a patient's mood after being discharged. That medicine can make all the difference when the patient returns to an unstable environment. Yet some people are willing to ignore medicine because of their faith. History has shown that the church has been one of the major hurdles that medical science has had to overcome. The mistaken belief system of many in the church remains one of the largest hurdles for the mental health community today. We in the church remain stubbornly

unshakable in our belief that we know best and that we know better than medical mental health professionals. Curiously, we do not take that approach when dealing with a broken arm.

Are mental illnesses curable diseases? Yes! God, in his infinite wisdom, can cure all forms of disease. However, we must acknowledge that God has the final say in whether he chooses to cure or help the individual maintain a functional life style through the safe and appropriate use of medication and treatment. Does it mean that we encourage people to leave disease untreated until he intervenes? I feel very strongly as a pastor, mental health professional, and human being that it is my job to encourage people to seek and find the help they need to cope with their life problems. If that means taking medication, being admitted to a mental health facility, attending support groups, seeing a psychiatrist or psychologist, people should receive the help they need. I must set aside my personal biases and help people get well.

What then can we do to help people with mental health issues? First, I recommend that we all learn what mental health issues are and how they are currently being treated. Second, I encourage all to not be closed minded when people in your church seek your help and prayers. Finally, compile a list of competent Christian counselors (including psychologists and psychiatrists) in your areas who are willing to help you help others.

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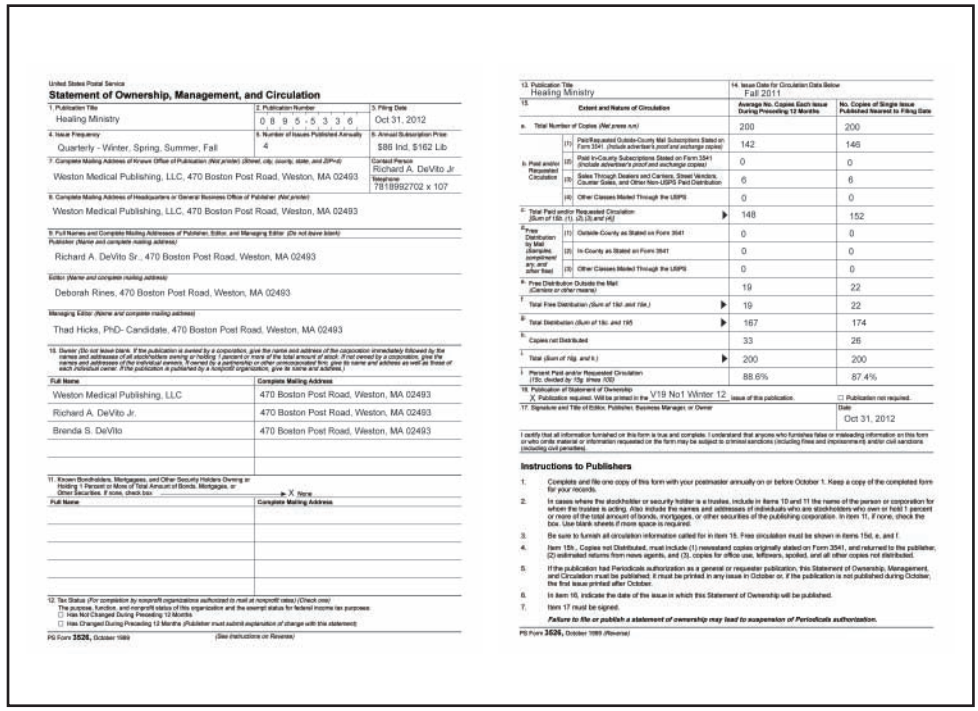

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication Number	3. Filing Date
Healing Ministry	0 8 9 5 - 5 3 3 6	Oct 31, 2012
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Quarterly - Winter, Spring, Summer, Fall	4	$86 Ind, $162 Lib

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4): Weston Medical Publishing, LLC, 470 Boston Post Road, Weston, MA 02493 — Contact Person: Richard A. DeVito Jr, Telephone: 7818992702 x 107

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer): Weston Medical Publishing, LLC, 470 Boston Post Road, Weston, MA 02493

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)

Publisher (Name and complete mailing address): Richard A. DeVito Sr., 470 Boston Post Road, Weston, MA 02493

Editor (Name and complete mailing address): Deborah Rines, 470 Boston Post Road, Weston, MA 02493

Managing Editor (Name and complete mailing address): Thad Hicks, PhD- Candidate, 470 Boston Post Road, Weston, MA 02493

10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)

Full Name	Complete Mailing Address
Weston Medical Publishing, LLC	470 Boston Post Road, Weston, MA 02493
Richard A. DeVito Jr.	470 Boston Post Road, Weston, MA 02493
Brenda S. DeVito	470 Boston Post Road, Weston, MA 02493

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → X None

Full Name	Complete Mailing Address

12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)

PS Form 3526, October 1999 (See Instructions on Reverse)

13. Publication Title: Healing Ministry	14. Issue Date for Circulation Data Below: Fall 2011	
15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)	200	200
b. Paid and/or Requested Circulation (1) Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. (Include advertiser's proof and exchange copies)	142	146
(2) Paid In-County Subscriptions Stated on Form 3541 (Include advertiser's proof and exchange copies)	0	0
(3) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	6	6
(4) Other Classes Mailed Through the USPS	0	0
c. Total Paid and/or Requested Circulation (Sum of 15b. (1), (2),(3),and (4))	148	152
d. Free Distribution by Mail (Samples, complimentary, and other free) (1) Outside-County as Stated on Form 3541	0	0
(2) In-County as Stated on Form 3541	0	0
(3) Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail (Carriers or other means)	19	22
f. Total Free Distribution (Sum of 15d. and 15e.)	19	22
g. Total Distribution (Sum of 15c. and 15f)	167	174
h. Copies not Distributed	33	26
i. Total (Sum of 15g. and h.)	200	200
j. Percent Paid and/or Requested Circulation (15c. divided by 15g. times 100)	88.6%	87.4%

16. Publication of Statement of Ownership
X Publication required. Will be printed in the V19 No1 Winter 12 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date: Oct 31, 2012

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Another view of aging

Marguerite Guzmán Bouvard, PhD

One has to be a scholar these days to read about the lives of older women for we have been banished from the media and politics and have been made invisible by our culture. In the rare instance, when older women are actually portrayed the images are negative. We are often ridiculed and stereotyped on television. In fact, the famous radio personality, Garrison Keiller, is 65 years old yet keeps make fun of older people on his weekly show. The small and alternative presses are our space, for old age is regarded with terror in a society that worships youth, good looks, and vitality. Even the standards of beauty are modeled on the very young so that we believe there is no such phenomenon as a beautiful older woman.

Marguerite Guzman Bouvard, PhD, Resident Scholar, Brandeis University, Waltham, Massachusetts.

DOI: 10.5055/hm.2012.0014

People wishing to compliment me tell me "You certainly don't look your age!" a comment I resent for I do not consider myself defined by my looks or that people my age are not supposed to be physically attractive. I remember Gloria Steinem's wonderful riposte to a supposed compliment by saying, "This is what fifty looks like!" As most of my friends who are also in their sixties and over, I do not consider my face a source of my identity, but rather who I am, what I have accomplished in my life. In other words, I do not like being segmented. I am a whole being.

I grew up in a culture where the generations mingled on a daily basis and where older women had a prominent role. I learned early on both that we have a term and that our older years can be a deeply satisfying period of life. My grandmother came to live with us from Trieste, in the North of Italy when I was 10 years old and by her very presence gave me an understanding of the human condition and a vision of what I could become when I became an older woman. From her, I learned what it was like to live through two world wars, to lose a great deal and begin again.

At a time when women were supposed to stay in the home, she strode through our town as if she owned it and everyone deferred to her. She was indeed striking; however, it was not her looks that made her so formidable but her character, her dignified bearing, and her unshakable self-confidence. She flaunted the social barriers confining older women by taking as much space as she needed and living with great intensity. She quickly picked up English by watching television and attending night classes at our local high school and taught me that it is always possible to revise one's life for

she was in her sixties when she joined us.

I found her company often preferable to that of my friends who played baseball after school because she would tell me such fascinating stories of her childhood and our family. I credit both her and my mother for unwittingly steering me toward a career as a writer, my grandmother for the hours she spent storytelling and my mother for allowing me open time to daydream. They were also my staunchest supporters as I bucked the tide before the women's movement eschewing marriage for graduate school.

Although my grandmother certainly was very pleased with her luminous beauty and charm, she did not take that side of her life very seriously. It was diverting, but she never gave up her freedom to remarry after becoming a war widow in her thirties. She had her own inner resources to draw on and preferred her independence, a lesson that remained with me: another person will never deliver us from creating our own lives.

My mother died in her mid-sixties, but as she aged, she seemed to enjoy herself more, to take risks, and dream of rearranging her career, which is exactly what she did. She took my niece Michelle to Japan on a lark before the time when traveling was a rarity. Most of all, she wanted to set up her own dress business in Hong Kong for she was fascinated by the Far East but my and my children's protests about being so far away from us dissuaded her. She also decided on a shift in her career just after she had recovered from a major heart attack, becoming a manufacturer's representative and creating clothing designs in her own apartment rather than working as a vice president of marketing in a dress firm. "This is so much fun," she told me. "I wish I had done this sooner."

She also told me rather frequently that she wanted "To die standing up"; despite her frail health, she loved going to the opera, the theater, and the museums. She did in a way, because the day she died of a second heart attack, her dining room table was filled with her drawings, she had spent the afternoon at the opera and was reading one of her favorite books in bed.

Both my grandmother and my mother were my mentors and walked before me showing me that a person can survive life's difficulties with grace. I still see my mother's very purposeful walk with her head held high with her designer's sample case in hand. I hear the kindness in her voice and her peculiar sense of humor that my children loved. I keep my grandmother's cane in my study because she continued walking until she was very elderly. I carry with me two substantial and vibrant persons who reached their peak not in middle age but in their last years. Thus, when I look at someone, I see the inner self reflected, not so much the facade.

Not only did I grow up with unusual role models but also my voracious reading exposed me to different ways regarding aging and to other cultures. I learned through novels that in certain parts of India, older women are freed from household chores and spend their time meditating and enjoying their privacy within a family context, being rather than doing. Plato introduced me to the concept that age qualifies a person for governing because that is when a person acquires wisdom. My reading in Native American culture reinforced the views I acquired as a child: In the Cherokee culture, the Beloved Woman, an older woman most likely a grandmother, advises the nation on important matters and many of them become spiritual leaders.

I happen to view age as a plus not a minus and find it a very enjoyable time of life. This is not to deny the grief of old age, of losing one's health, of losing friends. I live with three debilitating chronic illness, but I have found my age a very comfortable place to be, a time of peace and serenity, and, above all, perspective. Perhaps this is because so much of aging is filled with paradox or duality. It is our suffering that highlights the moments of joy that helps us to recognize and honor those times. There are few of us who have reached

old age without grief, loss, or illness. However, these experiences give us strength, a capacity for mining each day, and ultimately an acceptance of our particular circumstances.

I no longer care about things I once believed were so important, my career for instance, or public appearances. I understand that even if I had been able to have the job I so dreamed of, teaching in a large university that would have supported my research instead of in a small catholic college, it would not have been nirvana. Probably, I could not have handled the politics. However, it makes no difference in the long run. I have let go of so many useless goals and it has freed me to enjoy life to the fullest.

I am at ease with myself because I have not only let go of external signs of success but also have the good fortune to work at a distance from institutional infighting. Although no longer teaching because of my illness, I have maintained my ties with academia as a Resident Scholar at Brandeis University and enjoy being in a community of committed scholars and artists where I am free to participate as much or as little as possible and also to give of myself.

I cherish good friends, feel free to be very selective about whom I see, to turn down speaking engagements, to use the little time I have as I wish. Perhaps this attitude is a result of my illness, but I also feel that helping another person is of seminal importance. When I was younger, I was a radical activist and felt I had to change the world. Now I understand that the smallest gestures are of equal importance or rather that there is no hierarchy in trying to make a difference in this world.

My children are grown up and have their own lives. That they are happy in their families and with their choices is a source of deep satisfaction because both my son and daughter had some very difficult moments as we all do when we are in our twenties. I can let go of worry and simply enjoy them and their spouses now. I realize that I am very fortunate in this because many of my friends experience difficulty with their adult offspring and two of them have lost their children. My two nieces who are as close to me as my children have also grown into substantial and contented persons and this is a source of great happiness for me. It has given me a sense of completion that is a gift and that many older women may find in other ways.

I became a grandmother last summer, a high point in my life: my little grand-daughter, Ariel, has opened up a whole new world and also given me a sense of continuity. I see my mother in my daughter and my daughter in this new and fascinating person. My youngest niece had a little boy at the same time as my daughter. I consider him my grandson and find him a source of continual joy. Korean born and adopted, my niece has always struggled with her identity. Now I see her introducing Jae into a culture she is rediscovering, see with delight how much he resembles her. I feel that her son is a mirror in which she will find her roots. If on one hand I experience continuity, on the other I enjoy the adventure of learning about her culture with my niece. I have found that being a grandmother is the most joyous role, and I feel lucky to have the sense of completion that it brings.

I wish we older women would be regarded as a resource rather than being portrayed as burdens for we have so much to offer. As we age, we become more of who we are rather than dwindling as society would have us believe. Certainly, I am much more patient, but I am also more passionate about my writing than ever and find that there is no separation between my writing and my life. I have work to do and that is what matters to me, not whether it is visible or not. That work is not only my writing but also the very private work of listening to and helping people in distress. I also feel more intensely toward my family members as well as toward my friends and sometimes chance acquaintances.

What I have noticed is how much pleasure I take in the simplest things and that I take the

time to enjoy them. Where was I rushing to in my early and middle years? I do not remember stopping to think of all I had very often. Now, I have the time to meditate late afternoons and part of that meditation is a reviewing of the day with all its richness. It is not as if I have long days stretching ahead of me, for my illness means that I am able to work only a few hours a day but those hours are very precious. I feel as if I am walking through the landscape wide awake instead of rushing past so intent on my goal that the path is almost invisible.

Although brought up as a catholic, I have long been attracted to Buddhism and the lesson of mindfulness, of living fully each moment on the one hand and thinking in terms of eons on the other. Granted our lives seem so very short, but there is so much more than that brief term and it is all around us if only we take the time to see it. Old age has been a time of renewed spirituality for me. I am too much of a rebel to be comfortable with institutionalized religion. Instead, I read about all religions and find the sacred in the everyday rather than by participating in established rituals.

My practice of meditation and my writing have opened me up the vastness of inner space. Perhaps this is also because both my illness and my writing have imposed solitude on me. I have found that privacy is enriching rather than confining. Rather than a turning away, it invokes a clearer appreciation of the world. I take time to think, to dream, to just be, what seems like empty time in our fast-paced culture but is actually a source of creativity and problem solving.

I am not afraid of death. It has been sitting on my shoulder for so long for though my illnesses are not terminal, they are debilitating enough to remind me of my mortality. Looking back, I see how fortunate my mother was to die suddenly and in her own apartment rather than lingering in great pain. If I have fears, they are of living too long and becoming a burden to my children. I am also keenly aware that my life-long partner who is my best and deepest friend has a term as I do.

We are free now to spend quality time together taking walks, reading side by side, for I have an infinite respect for the present and have learned to cherish each moment. "It is all we have," a close friend confided to me.

Here is another paradox. I do not have that many years ahead of me, yet I have a field of memory to wander in and revisit with new understanding and have a sense of becoming and of inner strength. With the special insight that age brings, I realize that each life is a pilgrimage, a long process of self-discovery as well as an awakening to the world around us. Thus, it is the process that matters, our daily treks and interactions. We are all caught in difficult circumstances, but it is not so much the circumstances that define us but how we face them and what we do with our lives. If we have lived intensely, we will continue to do so, to revise our styles and choices as we age for there is no plateau in this journey.

Being there—When someone you love is seriously ill

Nancy Groves, MSW, CSW

Abstract

When a loved one becomes seriously ill, anxiety and feelings of helplessness often overwhelm the family caregivers. As health care professionals, we can assist families as they navigate these difficult times. Helping caregivers understand the needs of their loved one opens up new ways of relating and offering support. Instead of withdrawing, families gain the knowledge and insight to truly help their loved one and to make this journey together.

Most of us are well prepared for the occasional bout of sickness that leaves our loved ones under the weather. If a dear friend or family member is not feeling well, we are quick to respond with carefully selected cards, bouquets of flowers, and tender loving care. We expect the illness to pass, and in most cases, it does. We then celebrate the return of good health and life goes on.

As a medical social worker, I listened to people who shared their innermost struggles and fears as they faced a serious illness. I saw how family members and dear friends sometimes stayed away because their own feelings of helplessness brought emotional discomfort and were too painful to experience. From those moments together, my patients taught me that the sense of helplessness that others felt could be transformed to loving acts of kindness and support. When we understand the needs of someone who is ill, we then know how to respond. Instead of withdrawing, we can be a companion on this journey and truly help our loved ones as they face a serious illness. Therefore, we must become aware of the specific needs.

The need to know

When a serious illness is first diagnosed, the mind is filled with apprehensions about what to expect. There are a multitude of questions that surface about the disease, treatment options and procedures, and prognosis. We can assist our loved ones by obtaining as much information as possible in all these areas. With accurate information, better health choices can be made. The Internet can be an excellent

Nancy Groves, MSW, CSW, Medical Social Worker; author of Facing Illness, Finding Peace, *published by Pauline Books & Media, Troy, Michigan.*

DOI: 10.5055/hm.2012.0015

resource to find reliable and up-to-date information on any medical condition, if used with care. The Web sites of national and local health and illness organizations are a good place to start. Most of these organizations provide brochures and informational packets free of charge. They often offer support groups as well. Linking a loved one to a person or group of people who are facing the same serious illness strengthens coping skills and reduces fears. Using all these resources to provide information and support eases the overwhelming feelings of anxiety and enables caregivers to respond to the person's need to know.

The need to be heard

After the initial shock has subsided, there are many emotional reactions that surface. In many ways, dealing with an illness mirrors dealing with loss. There is grief and sadness because there are many losses associated with an illness. In addition to a loss of health, there can also be a loss of abilities, a loss of appearance, and a loss of identity. The most helpful response is to simply allow our loved ones to share whatever feelings they may be experiencing. We are often frightened of this, for we feel we must say or do something to relieve the sad or upsetting feelings that are being expressed. However, the best gift we can offer is to simply listen. If we take a moment to reflect on a crisis we have faced, we realize that comfort come from neither receiving advice nor other's efforts to diminish our emotional reactions. Rather, our comfort came from the loving presence of a friend or family member who simply listened to us and allowed us to freely express our thoughts, fears, and feelings. The burden on the heart is made lighter through the sharing of thoughts. Having someone available to truly listen enables our loved ones to work through their feelings, to experience emotional relief, and to know they are not alone on this journey.

The need to contribute

We all take pride in the contributions we make to our families. Our efforts to improve or enhance our surroundings are related to our self-esteem. When a serious illness is diagnosed, some activities may be curtailed because of loss of abilities related to the disease. In addition, well meaning family members may begin to take over many responsibilities to be helpful when in fact, this only reduces the sense of personal satisfaction. It is important for families and friends to encourage the person facing the illness to continue doing whatever is possible within the limits the disease imposes. Be creative, and think of tasks that can still be done with some modifications. Remember to include the person in decision making. If you are assisting with family maintenance tasks, such as grocery shopping, ask for the person's input in completing the grocery list. If you are making a meal, ask for menu suggestions. Focus on what can still be done, rather than what has been lost or changed because of the illness. Efforts in this area will reduce feelings of helplessness and will strengthen self-esteem.

The need to be valued

This need is related to the need to contribute. However, this need affects a person at a deeper level and impacts the sense of self. Meeting this need is crucial for maintaining good mental health and effective coping skills when facing an illness. Too often, people define themselves in terms of their abilities and their appearance. Facing a serious illness may include bodily changes and loss of abilities that can lead to a loss of self and feelings of depression, shame, inadequacy, and guilt. To effectively respond to these feelings, we need to ask our loved ones to see themselves beyond this narrow perception. Ask the question, "Do you really want to limit the meaning of who you are to only these two aspects?" and "What are other personal qualities that you still have, despite your illness?" Help the person see that qualities such as compassion, sensitivity, kindness, sense of humor, creativity, and love are unchanged. Reflect with

the person on what remains constant in spite of the illness and build a new sense of self based on these positive, valuable, and changeless attributes. As loving friends or family members, we must show our loved ones that we still see their innate worth so that a redefined and stronger sense of self will emerge.

The need to be hopeful

Hope is nourishment to our souls that keeps us going in the midst of distress. Hope is important for people with a serious disease because it can provide renewed energy to cope with the many difficulties an illness brings. Hope may center on the desire for a cure. By keeping abreast of current information and research, we can share in that hope with our loved ones. We can also provide smaller, daily doses of hope to encourage our loved ones. We can assist them in looking forward to a visit from a friend or to a short trip to a favorite place. Hope can focus on the desire to be among loved ones for the duration of the illness, and with a loving gesture, we can assure the realization of that desire. Being hopeful means that there are still many small pleasures that can be experienced on a day-to-day basis. We can help make that a reality for our loved ones.

The need to find peace

People of faith who are facing a serious illness often turn to God. A belief in God provides a constant, loving companion amidst the crisis of ill health. Many people find peace within their faith, recognizing that a true sense of inner calm comes from God's sustaining love and abiding presence. Our loved ones may request that we pray for them or with them, or arrange a visit from their priest, pastor, or rabbi. Reading their favorite hymns or passages of Scripture may also bring solace to our loved ones.

Nearly every one of us will have the experience of being with a friend or loved one who is seriously ill. Through an understanding of what our loved ones need, we will be able to lovingly support them and make this journey together.

Medicine and morality: Promoting the art of good patient care

Benedict Faneye, OP, MDiv, PhL, DHCE

At a recent encounter with a medical student, I introduced myself as a bioethicist to which the student had a quick and somewhat negative reaction. I asked the student to share her experience of bioethicists with me but would not say much. In the ensuing discussion, she mentioned that she had taken a course on ethics. She went on to describe the lecturer who taught the course and gave me the impression that the course had nothing to offer to those in the field of medicine. This was not the first of such experience for me. As a bioethics intern at a 400-bed medical facility, I heard nurses and medical residents refer to me and my colleagues who went on daily patient rounds with the care team as "ethics police." Besides, I have encountered healthcare professionals who simply disagreed with the idea of having ethicists "interfere" with the relationship between the healthcare provider and the patient. This is not to say that all healthcare professionals are wary of having ethicists around. However, the trend raises an issue of the need to stress the role of ethics in the practice of medicine.

Thus, this article will first address the issue of human conduct, which is the subject matter of ethics. Ethics focuses on the rightness or wrongness of human act, which presupposes making a judgment. The next issue addressed in this article is what I have designated as "modern medicine." Medicine in the present day is not what medicine of some 20 to 30 decades ago used to be. A distinctive feature of modern medicine is technology, whereby the relationship between the patient and the care provider is being redefined by how the care the patient receives is shaped by medical technology. The goal of medicine is health. For this goal to be attained, it is not merely enough that the care giver simply performs an act, either that of a doctor, nurse, or a laboratory technician, it is equally important that the patient is recognized as a person whose active participation is indispensable to the goal of medicine.

As mentioned above, I want to address the issue of human conduct, the subject matter of ethics, and its relevance for modern

Benedict Faneye, OP, MDiv, PhL, DHCE, Dominican Institute of Philosophy and Theology, Mt. Ranier, Maryland.

DOI: 10.5055/hm.2012.0016

medicine. Human conduct connotes activities generated by the human person, either alone or in our interpersonal relations. Human conduct is something practical as in when a doctor listens to a patient's complaints and does a physical examination to be able to arrive at a diagnosis. In the course of doing such an examination, the doctor makes certain judgments on which he embarks on a course of action, which is the treatment to be administered to the patient. Here, the action of the doctor is a manifestation of the judgment reached. Such judgment cannot be made arbitrarily in light of the fact that it is in relation to another individual, namely the patient. The rightness or wrongness of the doctor's conduct, which clearly manifests one's judgment, is determined not by what one does but by what one should do. This is where ethics plays an indispensable role for a profession like medicine. Ethics is a theoretical discipline that seeks to lay down principles and laws that govern how human agents achieve their goals, but it equally forms an essential basis for morality, which is the practical exchange we all experience in a doctor-patient relationship. What is of primary interest here is not what a person does but what one should do. Right conduct springs from knowing what one should do and acting in accordance with that knowledge. Addressing what one should do means being in agreement with certain action-guides without which one can hardly claim to be conducting the self rightly.

Fundamentally, the morality of an action is based on whether right reason (ie, human reason) approves of the action or not. This objective standard for determining the appropriateness of human conduct guarantees that a care giver's course of action, in the treatment of a patient, not only strives at restoring the patient to health but also respects one's dignity. Now, as the focus of ethics is the analysis of human conduct, ensuring that goals sought after are in accordance with established principles and laws, I would say that ethics should be considered as an indispensable tool for all healthcare professionals in the discharge of their duties. Simply put, it is a tool that helps to make healthcare delivery to each patient as personal as each individual condition requires.

The next focus of this article is the doctor-patient relationship. As I stated above that the goal of medicine is health, it needs to be pointed out that this goal can only be attained by the joint effort of patient and care giver. The care giver comes with a unique expertise that the patient lacks, but it is the patient who provides the facts that render the care giver's expertise operational. In Philosophy of Medicine, a distinction is made between illness and disease.[1] At the heart of this distinction is the fact that a patient's complaint is a life story, unique from any theories of disorder (ie, disease), which serves as operational principles for healthcare providers. Often, when a patient complains of back pain, this could easily be reduced to a condition such as bulging or herniated disk for which pain medication is administered. However, for the patient, it is not a mere physiologic problem. In the patient's complaint, there are also the added personal, social, and spiritual dimensions. The back pain could be the source of the patient's mental agony given how one may not be able to perform one's daily functions again; the pain could also have a social dimension in how one may have been cut off from friends and fellow workers who make up one's social network; and it might as well have its spiritual dimension given how one may consider the pain as a sign of divine disapproval for one's lifestyle. The above underscores the fact that the act of diagnosing entails not only an expert's ability to situate a patient's complaints within a given theory of disorder but also and, more importantly so, the patient's personal story and life issues. Regardless of the potentials presented to us by medical science and its technology, healthcare providers need to be aware of the fact that science is only at the service of humanity, not vice

versa. As such, learning to engage the human person in the clinical context, for the benefit of the individual patient, should be of utmost importance for every healthcare provider.

From the perspective of the patient, it is important that one realizes that medicine is not an exact science. It is not exactly given how there is no fixed dosage of any given medication with which patients are treated across the board. It is typical that after a doctor administers treatment to a patient, the patient is usually given a follow-up appointment, not only to determine the patient's progress but also to observe if there might be any adverse effects that may be peculiar to the individual. While medicine may have found certain cures for particular human conditions, it makes no claim that such cures could be administered with accurate precision as to their effects on patients. Patients A and B may be treated with the same dosage of a given prescription, and patient A may respond positively while patient B may prove intolerant. This underscores the difference in the constitution of both the patients. Such difference would only be known in the experience of each patient, which makes the individual's experience an invaluable element to be noted in the relationship between the patient and the care giver.

This means that the patient also has an important responsibility to observe and share the experience of such symptoms that may be associated with a condition and its treatment. It is often the case that patients in the African cultural context chose to defer to the doctor and his/her expertise out of respect. Such cultural phenomenon could jeopardize the patient's well being. I would argue that just as medicine has advanced greatly with modern technology, the stakes have equally risen significantly as far as the patient's safety is concerned. The safety and well being of each individual patient cared for in the modern medical system is significantly tied to the peculiarities of that individual. This means it is not just the care giver who has the duty to listen and be connected to the life story of each patient encountered, but that each patient too has a responsibility to play an active role in that healing relationship.

Finally, the art of good patient care is not a one-sided reality. It is about the care giver who realizes that to attain the goal of medicine both scientific theories of disorder and individual human experience of illness must be integrated. For the individual seeking wellness and good health, this means recognizing one's responsibility in not only presenting the self to the healthcare provider but also taking the time to share one's experiences of illness that are unique to each individual patient and without which the goal of medicine would be elusive.

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My story

Everyone has a story to tell. This section of the *Healing Ministry* journal allows individuals to tell these stories, to those best positioned to benefit from them. These personal tales can, and often do provide support, strength, and lessons for living.

My father's final lesson

The Reverend William H. Griffith, DMin

I have learned most of my lessons in my chaplaincy and pastoral care ministry from those who were grieving and dying. Some of those I have shared in my two previous books, but there was one that was very personal learning experience that I learned from my 95 year old dying father.

During his end stage Alzheimer's he was in a care facility in up state New York and I was living in Arizona. I visited him every three months and sent him a letter every week. In the letter I included a page with three pictures of our years together. My sister, his primary care giver would collect them in a three ring binder and those who visited him would look at it with him during their visits.

On my last visit with him before he died I learned from the staff how helpful it was for them to learn about his life by going through the pictures with him. When I arrived on the day of my last visit he was sleeping. I woke him up after learning from the nurse that he had not eaten lunch and they would see that he was served anytime he was ready. We went down to the dining hall and just the two of us sat together at the table. Few words were spoken. I wasn't sure he knew who I was. I took the picture book with me and he didn't seem to have any interest or recognition of the pictures. When the nurse brought the tray I put the book aside. She arranged his tray, opened his box of milk and put in the straw, unfolded his napkin and put it on his lap and turned and left.

Immediately my father bowed his head and closed his eyes. I knew what he was doing. He was offering thanks for his food. A tear came to my eye as I realized that although he didn't know me, he still talked with God. We sat together in silence throughout his meal and then went back to his room and watched a baseball game on television. I kissed him goodbye and on my way to the elevator I stopped at the nurses station to thank them for the care they were providing for him.

The nurse asked me, "How

The Reverend William H. Griffith, DMin, Chaplain, Hospice of South Central Indiana, Columbus, Indiana; Author of More Than A Parting Prayer: Lesson in Caring for the Dying*, Judson Press, 2004 and* Tears in a Bottle: Learning how to grieve well*, Xulon Press, 2010.*

DOI: 10.5055/hm.2012.0017

was your visit?" I told her we had little conversation, but then I said, "I was really pleased when he bowed his head and prayed before he ate his meal. My dad always prayed before a meal, whether at home or in a restaurant." I then added, "He also never failed to get down on his knees and pray beside his bed before getting into bed every night."

The nurse showed surprise on her face and turned to the other two staff members and said, "come over here and hear this."

I wasn't sure what she was getting at until she said, "Tell them what you just told me." So I repeated the story of my dad kneeling by the bed to pray.

They all looked at each other and said, "That explains it, doesn't it?"

I said, "Explains what?"

She replied, "Since you dad's room is just across from our nurse's station we would often look up and see him beside his bed on his knees and we thought he had fallen out of bed so we would go in and help him get into bed. We never found any bruises and thought that was strange. What you just told us fits perfectly with what we saw. He was praying.!"

I left that day, never to see my father again, but never to forget the lesson he taught me about the wholeness of the spirit that can still talk with God, even when dementia limits him talking to others.

Holy words

The Reverend Lauretta H. Halstead, MA, BCC

In the beginning was the Word, and the Word was with God, and the Word was God . . .

As chaplains, ministers, and spiritual care providers, we are often confronted with the deepest of existential questions, to include the most fundamental one of all, the question: "Why?"

Over the years, I have become aware of my own inner contradictions where my spirit is saying "trust in the Lord with all of your heart and lean not to your own understanding; in all of your ways acknowledge God and God will direct your paths. . ." (Pro 3:5) while my mind is simultaneously listing for me, all the ways in which my faith is irrational, and my situation impossible.

The Reverend Lauretta H. Halstead, MA, BCC, Bel Air, Maryland.

DOI: 10.5055/hm.2012.0018

It is clear to me now that the existential "why" is not merely a question in search of an answer at all. Instead, it is more of an invitation into the sacred space of what I now refer to as "holy words." May times in the face of human suffering and pain, patients and those who love them, look to us as professional chaplains to find some glimmer of hope, some assurance that the next hours will not contain anything that would confound Almighty God. We search our hearts and minds, for words of comfort at best, or at the very least, words of wisdom, healing and peace.

As believers, surely the perplexities of this life will challenge each of us, as we seek contextualization of some of life's most painful and perplexing experiences. If we walk in faith long enough, we will be confronted with the question, from within or without: "My God, my God, why has thou forsaken me?" Typically, we rush to explain, to comfort, and even convince some entrusted to our care, that when tragedy strikes, God does not then break a contract nor a covenant. As we journey with others we must always remember that God does not forsake us, even in the darkest of hours, or in the midst of inexplicable grief.

It is important to know that the role of the spiritual care provider is to be fully present; to hold a sacred space for holy words that beg to come from the wounded soul.

This presents a challenge in our culture, where pleasure and happiness is a social as well as economic goal. One popular commercial sums it up well: ". . . . haven't got time for the pain." Because of our hyper vigilance against pain and suffering, there is an array of attempts to "fix it," particularly as it pertains to the physical body. I invite you to

consider with me one of the unhealthy ways in which we do not always do a good job assisting with the emotional aspect of existential suffering.

During "grief talk" it is critically important to allow the suffering soul to express herself fully. Too often, an attempt is made—usually by well meaning family members, friends, or spiritual support persons—to encourage the individual AWAY from expressing some of the deeper and perhaps more poignant feelings. These instances may sound like "Don't speak that way," "stop thinking like that," "don't question God," "you don't mean that," or "stay on the bright side," "smile and the world smiles with you, weep and you weep alone," or don't be so negative." The list could go on and on so I will conclude with sharing from my personal list of the absolutely worst things to say to a suffering soul: *"It could be worse."* Is this good news?

What I now understand which I can only wish that I had understood 10 years ago, is that there are things which people in spiritual, physical, or emotional pain need to say, but are not given the permission nor the space to say.

We stamp some of life's most painful and discomfiting (not to be confused with discomforting) experiences with a huge stamp saying, "you shouldn't feel that way." The truth of the matter is we may not want to hear the voice of pain and suffering, but that in no way diminishes what a suffering soul NEEDs to say. The "need to say it" is a part of the isolating quality of suffering, which needs to be healed.

To hold space for even the most painful things to be spoken and heard, are yet a part of the conversation necessary to fertilize the spiritual soil, so needed for healing. To hold such space is a holy act. As I reflect upon the biblical account of Jesus washing the feet of His disciples and the resistance of Peter, I am reminded of the scripture: " . . . if I don't wash you, you are not mine." (John 13:8)

Similarly, the soul is metaphorically "washed" when those things are spoken that need to be spoken. The words that emanate from that inner space are holy words. The space into which naked words are spoken is sacred space . . . soul space. What we may want to hear is not always as important as what the hurting soul needs to say. May we all walk in greater awareness and humility as we journey with those who suffer so often through the silence imposed upon them, based on what we may not wish to hear rather than what the may need to say. Let us embrace the truth of Proverbs 18:21: " . . . the power of life and death is in the tongue. . ."

Why isn't life easy?

Judy Tatelbaum, LCSW

I do not think life was meant to be easy. If there were no challenges, what would we learn? How would we grow? Still, it is so human to want life to be easy.

There are many circumstances that make life difficult. The traumas and losses in our lives are most challenging; we also suffer over not having enough money or enough time and not having the job, partner, or living situation we want. However, it is not only circumstances that challenge us, though our circumstances can be fraught with difficulties. Often life is not easy because it does not fulfill our expectations.

Judy Tatelbaum, LCSW, Psycho - therapist and Trainer specializing in grief. Author of the books, The Courage to Grieve *and* We Don't Have to Suffer. *Website:* www.judytatelbaum.com. *E-mail:* jtmiracle@comcast.net.

DOI: 10.5055/hm.2012.0019

How our lives unfold is usually a mystery. We have so many ideas, plans, hopes, and dreams. Sometimes they are achieved, and sometimes they are not. There are always those unexpected bumps in the road, accidents, and turns that we never dreamed of. Life events and people do not turn out to be what we imagined. We pick a person to be our mate who does not notice us. We marry the person with whom we dreamed of sharing life, only to find they are flawed or different than we expected. Relationships we thought we would have forever do not last. We lose jobs we expected we would keep. We choose a career that becomes exhausting or unfulfilling.

When things actually do go our way, we may become complacent or even bored. Sameness can lead to boredom. The issue of being satisfied is a conflicted one for most of us. We tell ourselves if I had "A" I would be happy, but when "A" is not that great, we long for "B" but find "B" is not the answer either. One key way of having life be easier would be to choose to be contented at any moment, satisfied with life just the way it is right now.

Another reason life is not easy is because mastering our circumstances does not happen overnight. In many of our endeavors, if it is not easy, we assume our efforts are not worth it. We forget that the most remarkable things we accomplish in our lives usually were not accomplished overnight or without considerable effort. To master most things, we have to keep working them.

Mastery involves practice. A competent artist, writer, chef, teacher, or parent masters his or her craft by doing it over and over again, day after day. Satisfying relationships and jobs take work. That is the process in mastery; that is what is required

to succeed. Success does not usually fall in our laps. Millions of us may play the lottery, but very few actually win. It is the willingness to keep at our goal or dream day after day regardless of the result, whether there is evidence of success or not.

We need to keep going, even if we fail. My advanced creative writing teacher in college gave me a grade of C with a note that essentially said I had no talent and should not write for others. I was shocked and angry. At first, I thought I would stop writing, but I love to write, so I kept writing for myself—journals, thoughts, poems, and short stories. In time I published three books and hundreds of articles—all of this accomplished though I was told I had no talent. My most significant discovery is that the writing itself, more than the publishing, has been what brings me joy.

Whether we are aware of it, each of us is engaged in mastering one or several areas of our lives. We may be learning to face a difficult emotional or health challenge. We may be working on our relationships with our spouse, parents, children, or colleagues. We may be engaged in a meditation practice or exercise or a health program or on developing a creative skill. We may be working on managing our time or our finances. Our attempts to master the many aspects of living are what most of our lives are about.

The biggest pitfall in many of our life endeavors is to think we can handle something once and for all—be it overcoming a painful event, handling a job, a relationship, exercise, weight loss, or learning something new. Although we may aim to be done with things, most of living is in the practice.

Most likely true satisfaction comes from our continuing efforts. The most important things we do in life—our relationships, our jobs, our personal successes, and recovering from painful events all involve work. So, life is not easy. Still the work we do to achieve our goals is worth it. So many times it is in the process of accomplishing our goals that we find our satisfaction, rather in the result.

Before the browning of the leaves

Father Dn Thomas Johnson-Medland, CSJ, OSL

A cold breeze blows the aroma of prebrowning leaves across the surface of the lake. As I see the bright sun riding high in the clear blue sky and catch the wafting of the leaves in my nose, there is now no doubt, autumn is here.

The calendar has not yet marked the shift to autumn, but there is a knowing the soul has that marks shifts and changes differently than numbers and books. Just because we have not passed the line of the proper equinox or the dated threshold of a new season does not mean that change is not present with us.

This is a sort of ambling antenna that picks up signals about things based—somehow—on the frequency we have experienced the event in the past. However, I am also beginning to realize that there are smaller signs that are perceived and really just below the cognitive and conscious radars of the soul.

This detection device lives strong in the dying. Somehow the dying process heightens the abilities of the dying person's perception. They know which things are most important, which people need the most attention, and how much time they have left and what they must accomplish.

I know that part of this knowing is honed over the years. We live with people for years and we begin to pick up their subtle communications. Today she is happy, today she is angry, today she is tired—these kinds of things. We can figure out what is changing in the landscape by perceiving the events around us and adding up all the variables.

However, the dying have another knowing. It is a knowing that goes beyond the simple remembering of people's facial responses and personal moods. It is a knowing that borders a bit on the paranormal. A lot of the time, these special moments of grace or knowing are FANTASTICAL to the folks just beginning to work with dying patients. They make marvelous stories at cocktail parties and really open up people's inner ears to deeper truths.

Father Dn Thomas Johnson-Medland, CSJ, OSL, is the Chief Information Officer for Lighthouse Hospice Inc. He has worked in hospice care for 12 years. Tom is ordained in both the Greek and Russian Orthodox Church. He has written 8 books and over 40 articles. He lives in the Poconos with his wife, Glinda and two sons, Zachary Aidan and Josiah Gabriel.

DOI: 10.5055/hm.2012.0020

For the people who have been tending the dying for years, these things are common. Somehow, they have shaped our understanding of dying and also taught us to listen differently to the things of life and living.

I will never forget a woman I visited who was dying of Alzheimer's disease. She was still ambulatory and really in the pre-decline phase of the disease. She was about two hours from my home and living in a facility. I received an intake form and decided I would leave to see her the next morning. I did not call to make an appointment as this facility was huge and difficult to get through to; I knew she would be there.

In the morning, I had trouble starting my truck. The battery seemed to be getting ready to die. I worked on it a bit, went in to clean my hands, and left a half an hour late. When I arrived at the home, I introduced myself to Angel, the patient, and she said: "Having car troubles today?"

I looked at her in complete disbelief. I really had no idea what to think. I was new to hospice work so I really did not have enough of these experiences under my belt to recognize them as commonplace. WOW.

The rest of the session was difficult at best. She kept changing the conversation and steering things around to nonsense. I still had not become comfortable working with folks who had dementia-related disease, so it was driving me crazy. I was not sure whether I was supposed to pursue any of the conversations she started or just listen. I began to realize that the absurdity of our conversation reminded me a bit my early days of meditation practice.

There is a whole period of time at the beginning of meditation practice in which you have to become comfortable with the many shifts and variations of thought that arise and subside in a mind that is trying to become still. It is often called monkey mind because of the erratic nature of its swinging from cognitive branch to branch. Once I made this connection—well after this first visit—I was able to settle into the times I spent with her (and other patients) and overhear the process that was going on—despite the dementia.

Before I left, she looked me straight in the eye, and for a split second, she looked completely sane. She kept staring and said, "Don't worry. You'll get a house."

What she could not have known was that my wife and I had looked at a house the day before. We really liked the house and wanted to buy it until it was disclosed to us that there was a leaking oil tank in the yard. We had been all set to make an offer as this was not the first time we had looked at the house. When we heard about the tank, our hearts sank. We were so tired of looking at houses.

For the little old demented woman from north Jersey to have known, and offer me consolation was further out on any paranormal limb than I had ever gone or even dreamed people could go. There I was, thanking her, in utter shock; and feeling like she had somehow been spying on me. It was like the CIA had violated my privacy.

She was right; however, in two weeks, we had an offer accepted on a house around the corner from the leaking oil tank. We moved in while the patient was still alive. Within three months discovered that this house, too, had a leaking oil tank. Go figure. When I found out about the leak, I smiled and thought of Angel. I wondered if she knew that, too.

This sort of extra-sensory antenna is something that has come up over and over again in hospice work. How should we look at it, is there a way to bring some sort of order to the apparent chaos of its appearance, and is it a skill that we can hone in the nondying times of our lives? I am not sure.

I do believe that we can become much more perceptive in life than we are. I believe we can do this by opening up our inner awareness through stillness, meditation, and reflection. However, is there some veil or boundary that the dying cross and are able to come back and forth through just before they die.

In our Scottish heritage—and most of the Celtic experience—there are times that are called the THIN TIMES. These times are when there is a greater chance of communication between the spirit world and the physical plain. Things thin out around Halloween and again in the spring. In the mental health fields, we used to joke that things always got a little bit crazier around "full moons and holidays."

We have all cared for dying folks who have pointed to or spoken with some disincarnate entity that was in the room, but out of our sight. Most of us have had encounters with people who knew things that they really could not or should not have known.

Perhaps dying people are able to become more familiar with life. Just the same as when you can sense autumn's arrival because you have lived 48 of them already and sense or recognize the familiar pattern of prebrowning leaves. Maybe the idea of dying or just dying itself opens up some portal to being in touch with things that are going on and have been going on all around you.

I am saying all this, and pondering all this to get to one point and one point only. The dying, although the have many needs that we can assist them with—help them to accomplish before they die—really deserve to be listened to. The dying have something to teach us. The dying have something to say. As professionals who work with the dying, it is an ominous task before us to teach the people all around the dying to listen to what they have to say.

There is a lot of awkward posturing around death and around the dying. Because people do not know what to say or do, they avoid people or "do things around the dying" or "speak AT 'dying' people." We are called to model the behavior of listening to the dying. If we take what they have to say seriously, then we will teach friends and families to become more comfortable with dying and the dying and just sit down and spend some time with each other.

Then, and only then we may all hear the valuable messages that the dying have to offer. The messages about how important love is, the messages of how central forgiveness is, and the countless stories of how much meaning we have had in each others' lives over the many days we have spent together.

Visiting the ill: Learning lessons from sacred stories—Part 2: Four guiding principles to achieve a successful visit: Be there; be present; be a blessing; be gone

Rabbi David J. Zucker, PhD, BCC
Rabbi Bonita E. Taylor, DMin, BCC

In the previous issue of *Healing Ministry (Vol. 18, No. 4)*, we presented a sacred story about three rabbis that is found in the Talmud. In that narrative, there was a rabbi who was seriously unwell. He was visited by a colleague. When the ill rabbi declared that his suffering was intolerable, his visiting colleague held his hand and healed him. Then, the visiting colleague became ill. He in turn, was visited by a third colleague. When the new ill rabbi declared that his suffering was intolerable, the third colleague held his hand and healed him. This begged the question as to why the original rabbi-visitor who healed the first rabbi could not heal himself? The Talmud answered its own question by stating that "a prisoner cannot free oneself from incarceration." (Babylonian Talmud Berakhot 5b). The foundation for choosing the healing modality of touch is dialog, through which the visiting healer-colleagues could discern the impact of their colleagues' "sufferings." This is supported by a variation of this narrative where dialog with the ill person effected healing (Midrash Song of Songs Rabbah 2.16.2).

We suggested 12 lessons to be learned from those sacred stories, lessons that focused on the fact that at times, each of us may need help. We also offered some suggestions for how we might be with each other on those occasions when someone who is in our sphere is compromised either through illness, accident, aging, or chronic condition. We also addressed the value (and

Rabbi Bonita E. Taylor, DMin, BCC, Associate Director of CPE; Director of Jewish Chaplaincy Education, HealthCare Chaplaincy, New York, New York.

Rabbi David J. Zucker, PhD, BCC, Recently Retired Director of Chaplaincy Care, Shalom Cares; Shalom Hospice, Aurora, Colorado.

DOI: 10.5055/hm.2012.0021

dangers) of touch. There are further lessons to be learned from these stories. In Part 2, we address four guiding principles for conducting a successful visit. Some of these recommendations flow directly from the ancient narratives, while some are inferred. Stated succinctly, we might term them the four B's: Be there; Be present; Be a blessing; Be gone.

Be there

Plan a time to visit that is good for you and also for the person whom you are visiting. If this is a home visit, check that the person is able to get up to answer the door without causing undue strain.

Be aware that if you are making a home visit that their home may not be as clean or as tidy as they would like it to be for visitors. Certainly, always seek consent before visiting someone in their place of residence. Consider that they may find a regular telephone call—for example, every Monday at 2 PM or the first Tuesday of each month—less stressful and more spiritually healing. It would also give them something to anticipate. If the homebound individual has facility with such items as e-mail or twitter, consider using these vehicles of social media to offer community, camaraderie, and connection.

If you are visiting at a hospital or a long-term care facility, check on the routine of that establishment. You will want to avoid mealtimes and the person's test or treatment times.

Before you enter the ill person's room, take a breath and center yourself. The person you have come to see may not look at their best or may be intubated (have tubes connected to their bodies or running into their nose or mouth). Their wigs or toupees may not be situated. They may be embarrassed about their own frailty.

If you have set a time to be there, honor that commitment. Not to do so suggests that they have nothing else to do but wait for you to arrive. While this may be true, it may be experienced as disrespectful to behave as though it was true.

Be present

Being present requires your active attention. Focus on the person before you, not on yourself. Do not talk about your last appointment or what you need to do when you leave. Being actively present means listening twice as much as you speak. As people like to talk about themselves, encourage them to do so, even if you have heard their story before. Convey to the person that who they are is important and that their time on earth matters and makes a difference to you and to others. Let your responses be compassionate and emotionally empathetic.

During your visit, set aside your iPod®, iPad®, Blackberry®, and cell phone—even when it rings—until you have left. Letting your phone go to voice mail shows the person visited that you respect and are fully present to them.

Finally, if there is another visitor, do acknowledge the person, but remember that it is the patient (resident, client) that you have come to see. This is not a social occasion to catch up on the latest news with long-time-no-see family and/or friends.

Be a blessing

Sometimes, just being there with a kind word, your human touch, or even a little bit of silence is a blessing. In addition, using some of your time to pray for someone who is vulnerable and worried is also important. Your prayer can—and we would suggest should—be spontaneous, personal, and appropriate for the occasion. From personal experience as the recipients of spontaneous custom-made prayer, we can attest that a personalized direct-for-you prayer is much more emotionally and spiritually satisfying than a one-size-fits-all already-written and fixed institutionalized prayer.

Begin with "I would like to say a prayer on your behalf, would you be OK with that?" If the person says "no," wish them success with their treatment, surgery, current medical care, adjustment to new ways of living, etc. However, if they consent, say something like, "If you could feel God's presence here in the room, what would you like God to know?"

Your individualized prayer should be simple:

"Dear God (or simply, "Source of Being" or "Higher Power") I am here with _____ (the person's name) at _____ (his/her home; XYZ Hospital; ABC Long-Term Care Center, etc)

_____ (person's name) is not experiencing optimal wellness. He/she wants you to know that _____. Let _____ (person's name) feel your Presence, especially in terms of their _____ (heart, liver, leg, arm, internal organs . . . if you know this information).

Grant her/him the courage to face what comes next and the strength to endure it."

And together, let us say "Amen."[1]

Avoid the temptation to pray for a complete recovery. Realistically that may not be possible. Someone aged will not suddenly become young again. Your request for a complete recovery can leave a patient (resident/client) feeling that they have been "unseen" and "unheard." No matter how hard everyone wants it, asking for the impossible often leaves people disappointed in themselves, in the medical team for failing them, and/or in God for abandoning them. This is counterproductive; it is spiritually harmful.

Be gone

Do not overstay your visit. By the very necessity of the visit itself, you are acknowledging that the person is not experiencing optimal wellbeing. Someone who is "under the weather" or suffering from so many of the vicissitudes of aging that they need specialized treatment, may tire easily. Be attentive to what the compromised person says and what they do or do not do. Nonverbal body language conveys meaning. In general, a 15 to 20 minutes visit is the maximum time to spend with someone. This is true even if you have travelled a long distance to see them. Lastly, be respectful of the person's privacy. What you see or hear is not to be shared with others.

Some closing thoughts about what you may hear. . .

Affirm, or at the very least, do not challenge where the compromised person is in their relationship with God. This is not the occasion to persuade someone to your beliefs, no matter how sure you are that you are correct. You may—or may not—agree with the ideas expressed. Some persons find comfort in the belief that all that exists in the world, including suffering, is part of God's eternal plan. They take the position that we may not understand God's decisions, we may not like them, but that we must not question them. Rather we simply have to affirm God's presence. This response has similarities to the biblical book of Job. Job complains and questions, asserting his innocence. Finally, God answers Job. God essentially says, as mere mortals you cannot see, much less understand the big picture. This approach, that we should (or possibly we must) "let go and let God" does resonate for some people. If this is their belief system, we should affirm them in that thought, regardless of whether it matches how we personally approach the question of suffering and God's responsibility (theodicy).

Conversely, others believe and say that their suffering is unjust. They will question God's judgments or God's care for them. They may ask you directly about God's justice. Allow for their doubts. A clear message that comes out of the ancient rabbinic texts is the permissibility of doubt. You do not have to claim to know a meaningful response. You can honestly say, "I do not know." Further, God does not need you to defend divine decisions.

Sacred stories contain important lessons. Visiting those who are compromised by illness, accident, aging, or chronic condition is a blessing for them. While we would hope that we would always be the visitor, the time may come when we will be the ones visited. As we set an example for others, so in time we may be the recipients of someone else's kindness.

Reference

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