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C HICAGO HAS BEEN UNSEASONABLY WARM the past few days, making sandals and short sleeves the preferred dress; nevertheless, change is in the air, and the leaves on the oak tree outside my window are beginning to show autumn color.

CT also reflects seasonal change with a rotation on the editorial board. With this issue, Al Voorhis concludes his term, having left chaplaincy earlier this year to return to parish ministry. I am grateful for his service and pleased that he will continue to review books for these pages.

Earlier this year, Jodie Futornick and Mark LaRocca-Pitts accepted positions on the editorial board, and beginning with this issue, David Zucker joins them. Their willingness, along with that of their colleagues whose names appear on the left, to give of their time to review manuscripts assures a consistent level of quality.

Another change is planned for 2008 as CT will be offered as an "e-publication" beginning with the spring/summer issue. This will help to reduce printing/postage expenses as well as speed delivery to you and, perhaps more importantly, provide a more efficient way to access articles for reference. Although CT will continue to be available in printed form, I encourage all who are "e-literate" to elect this subscription method. Information as to how to effect this change will be provided after the first of the year. For now, I invite you to sit back and enjoy the wealth of information and reflection contained in the following pages.

Rozann

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Attention to Spiritual/Religious Concerns in Pediatric Practice: What Clinical Situations? What Educational Preparation?

Larry VandeCreek, BCC • Daniel H. Grossoehme, BCC • Judith R. Ragsdale • Christine L. McHenry • Celia Thurston

MEDICAL PRACTITIONERS AND RESEARCHERS CONTINUE to explore the association between spiritual/religious (SR) concerns and illness and medical care. Koenig et al. summarize over 1600 publications that describe this relationship.[1]

In a previous publication, we reported the statistically significant web of associations between the personal/professional characteristics of pediatricians and their attention to SR in clinical practice.[2] In summary, we found that older pediatricians who described themselves as religious and spiritual more frequently talked with patients/families about their SR concerns. These pediatricians reported that their own personal SR was important in their clinical practice and that the SR of patients/families was relevant to the care they provided.

This article presents results relative to the following:

- Clinical situations in which pediatricians perceive that the SR of patients/families plays an important role.

- The education pediatricians receive in medical school and residency that prepares them to respond to these concerns.

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Many pediatricians believe that spiritual/religious (SR) concerns of patients/families are important in some clinical situations. This project identifies these situations, the educational preparation of pediatricians to respond helpfully to these concerns and their interest in additional education. Pediatricians associated with three academic Midwestern pediatric hospitals responded to a survey by briefly describing clinical situations in which they regarded the SR concerns of patients/families as an important part of the clinical situation as well as curricular experiences that prepared them to respond. They deemed SR concerns important at the end of life, in medical crises and when medical management is impacted by specific religious beliefs. The most frequently sugested seminar topic was how to talk about these concerns with patients and families.

- Pediatricians' interest in continuing medical education that addresses the role of SR in clinical medicine.

Literature review

A few studies in the primary care literature suggest clinical situations in which physicians or patients/families find SR to be important. Monroe et al. report results from 476 internists and family physicians concerning their willingness to inquire about or be involved in spiritual behaviors in three clinical settings.[3] Approximately one-third (31 percent) would ask about SR beliefs in the office setting, 39 percent would inquire of hospital patients and 74 percent would ask dying patients.

Results from another study suggest that physicians address SR in the context of death/dying more frequently than in other clinical situations.[4] A third study produced similar results. Primary care residents (N = 247) indicated that they were more likely to incorporate SR into patient encounters as the gravity of the patient's condition increased.[5]

How does medical education prepare physicians to respond to these SR concerns? Some authors focus on how the medical school curriculum can incorporate attention to SR. The Medical School Objectives Project Report-Three includes learning objectives, educational strategies and outcome goals to ensure that graduating medical students recognize the importance and role of SR in healthcare.[6] Puchalski and Larson argue that medical students must learn how SR interfaces with healthcare because it is at the heart of learning how

to deliver compassionate care.[7] In another publication, Puchalski traces the increasing attention to spirituality in medicine, reporting that in 2006, 75 percent of medical schools report that they provide curricular attention to spirituality.[8] At least four other reports describe curricular efforts.[9] Additionally, the John Templeton Foundation continues to reward SR curricular efforts in medical schools.[10]

Other authors explore how attention to SR can be included in residency training. King and Crisp describe survey results from 101 family practice residency programs, reporting that 31 percent have a specific SR curriculum.[11] Wolkenstein describes his efforts, opining that "lectures, seminars and presentations alone to the residency cohorts and faculty are not as strategic as seeing their faculty asking questions about the component of spirituality in their precepting encounters with residents."[12] Silverman describes need assessments for an SR curriculum in a family medicine residency program before writing a curriculum.[13] Two additional authors report curricular efforts that involve healthcare chaplains in teaching and/or clinical roles.[14]

Still other reports look at how practicing physicians interact with the SR of their patients/families either positively or negatively. The Working Group on Religious and Spiritual Issues at the End of Life discusses three cases, providing a list of phrases to help elicit the patient's concerns, potential pitfalls in SR discussions and goals of such conversations.[15] Barriers to spiritual care experienced by physicians, the need to respect professional boundaries and the benefits

of taking a spiritual history also have been explored.[16] The Anglican Working Group in Bioethics discusses professional grounds for physician inquiries and how they may make inquires appropriately.[17] Todres et al. describe a training program in clinical pastoral education (CPE) adapted for clinicians.[18] Summarizing the first six years of the program, they describe the didactic and reflective processes whereby skills of relating to the spiritual concerns of patients/families are acquired and refined.

In the pediatric literature, only five publications describe clinical situations in which pediatricians believe that SR is important and/or their education/training has prepared them to discuss SR concerns. The American Academy of Pediatrics Committee on Bioethics has published recommendations concerning religious exemptions from child abuse statutes and religious objections to medical care.[19] These recommendations offer guidance to pediatricians as they provide care to the children whose parents espouse beliefs that conflict with prescribed medical care.

Siegel et al. describe six clinical situations of increasing severity, asking which medical conditions would warrant discussions about SR, e.g., health maintenance, birth of a baby, non-life-threatening bad news, emotional crisis, life-threatening bad news, death/dying situations.[20] Respondents (N = 165) reported that they gave increasing attention to SR as the clinical situations became more life threatening, e.g., health maintenance <40 percent, death/dying situations >90 percent.

The Brooks and Chibnall study of pediatricians (N = 61), observed

that "some pediatricians felt ill-trained for religious inquiry."[21] They quote a pediatrician who said, "We were taught not to discuss this kind of thing."[22]

In a study conducted by Armbruster et al., 46 percent of the faculty (N = 46) and 33 percent of the residents (N = 44) who responded agreed with the statement, "I am not adequately trained to address religious/spiritual issues." [23]

The project reported here gathers data from a large sample of pediatricians concerning clinical situations in which the SR of patients/families plays an important role, their educational experiences that prepared them to helpfully respond, and their interest in further training.

Methods

Participants

The authors surveyed all active pediatric medical staff members in three academic Midwestern pediatric hospitals after the institutional review board (IRB) of each hospital approved the study. The aggregate response rate was 58 percent (N = 737). Males constituted a slight majority (53 percent) of respondents. Age was reported in decades; most respondents were between thirty-six and forty-five years of age.

Respondents identified their faith groups as follows: Christian – 72 percent, Jewish – 12 percent, Muslim – 4 percent, Other – 12 percent. Seventy-one percent described themselves as "religious," and 83 percent indicated they were "spiritual." Approximately three-fourths affirmed that their personal SR was important in their medical practice (73 percent) and that the SR of patients/families was relevant to their practice (76 percent).

Instrument

The questionnaire included an item asking pediatricians to write a few words that described clinical situations in which, from their perspective, "the patient's/family's SR played an important role." A dichotomous item asked respondents whether they had received "any formal instruction concerning SR in healthcare" during medical school or residency. If they responded positively, they were asked to write a brief description of it. The second dichotomous item asked if they would "be interested in attending a Category 1 CME workshop on SR in healthcare." The final item asked them to name an SR related topic of special interest to them to be addressed in such a workshop.

Procedure

A cover letter, the survey and a return envelope were mailed to hospital-related pediatricians. After two weeks, a reminder postcard was sent that thanked responders and encouraged nonresponders. After two additional weeks, non-responders received a revised cover letter, the survey and a return envelope. The authors arranged for the transcription of the narrative materials and analyzed responses to the two dichotomous items utilizing the Statistical Package for the Social Sciences (SPSS). The brief written narratives from the pediatricians were analyzed manually by identifying themes in the material and placing each response within the appropriate theme. Unique responses were grouped into a miscellaneous category.

Results

Sixty-seven percent (N = 494) wrote responses that identified clinical situations in which, from

their perspective, the SR of patients/families played an important role (Table 1). One-third (33 percent) identified end-of-life situations, e.g., DNR decisions, removal of life support, the dying process and grief. Responses included the following:

- When the parents are facing life and death situations.

- When I need to discontinue mechanical ventilation in DNR situations.

Eighteen percent identified critical, serious, and severe medical situations:

- Coping with severe injuries, e.g., brain injury, spinal cord.

- Whenever you deal with a critically ill child.

Fourteen percent reported that from their perspective, SR played an important role when patient/family beliefs disallowed standard treatments. These pediatricians frequently cited specific religious groups whose beliefs/practices impinged on clinical practice, e.g., Jehovah's Witnesses, Amish.

Five percent pointed to medical situations that involve chronic conditions:

- When the patient is chronically ill and in much pain.

- When the child has a severe genetic disorder.

Twenty-five percent of the responses were deemed unique and placed in a miscellaneous category. For example, one respondent briefly noted situations in the pediatric outpatient office and another described "the willingness to

Table 1

Pediatricians' identification of clinical situations in which patients/families find their spirituality/religion to be important

Clinical Themes	N = 494	Percent
Terminal illness, DNR situations, dying, grief	169	34.2
Stressful crises in general	85	17.2
Special care requirements due to religious beliefs	68	13.8
Chronic illness/chronic care	26	5.3
Miscellaneous responses	125	25.3
Did not identify a clinical situation	21	4.2

N = 494 (67 percent of the total sample of 737)

Table 2

Spirituality/religion related educational interest

Educational Topics	N = 228	Percent
How to talk to patients/families about SR	93	40.8
Information regarding diversity of religions	52	22.8
When appropriate? When helpful? Boundaries?	22	9.6
Miscellaneous	61	2.8

N = 228 (31 percent of total sample of 737)

accept psychiatric treatment." This category also included responses that described patients/families rather than clinical situations. For example, a pediatrician wrote that SR of parents was important "when faith is central to family relationships and day-to-day living." Attempts to find additional themes in the large amount of material in this miscellaneous category were unsuccessful.

Twenty-one pediatricians (5 percent), who wrote a response but did not identify clinical situations in which patient/family SR played an important role, used such words as none, unsure and never.

A second questionnaire item inquired about SR training in medical school and residency. Eleven percent (N = 85) indicated that they had received some formal instruction. The follow-up question asking them to describe the instruction elicited such words as classes, lectures, seminars or talks. Miscellaneous responses noted attendance at a religiously-oriented medical school or participation in the Christian Medical Society.

A third item asked whether they were interested in attending a Category 1 CME concerning the role of SR in healthcare. Sixty-one percent (N = 429) answered "yes." A follow-up question then asked those respondents to suggest specific topics for such a workshop. Fifty-six of these pediatricians, however, while making a response, did not suggest specific topics. They wrote responses such as "not sure," "anything" and "leave it up to you." When these responses are eliminated, the usable responses are reduced to 31 percent (N = 228).

These 228 pediatricians most frequently suggested a workshop that explored how to open a dialogue with patients/families regarding SR concerns (Table 2). They wished to learn the skills related to talking about SR, how to approach it in a sensitive manner, how to address it without offending patients or families and "how to kindly and safely bring up the issue." One pediatrician wrote, "I don't really know where to begin since spirituality/religion or faith tend to be such personal things." Another described the goal of such a workshop as "overcoming physician discomfort in addressing patients' spiritual beliefs."

Twenty-three percent of those who responded to this item suggested that the workshop should provide an overview of diverse religious beliefs and practices and their relevancy to healthcare. One pediatrician suggested an "overview of other religious faiths, specifically case scenarios showing importance

of spiritual aspects in healthcare." A subset (N = 12) of these pediatricians requested a workshop that focused on beliefs of religious groups that impinged on and complicated treatment, e.g., Jehovah's Witnesses.

Nine percent of those who responded to the item suggested a workshop focused on whether addressing SR was appropriate or helpful and whether addressing SR transgressed legal and/or ethical boundaries. Comments included the following:

- When is this appropriate to discuss with families? How to introduce topic?

- Appropriateness in routine care … how to access this area in the context of caregiving.

- Spiritual assessment— how, when appropriate?

The miscellaneous category (27 percent) contained small groups of responses concerning such topics as the role of faith in healing (5 percent), attention to scientific studies examining whether SR was helpful in healthcare (5 percent), the role of prayer (3 percent), death and dying concerns (2 percent) and other suggestions that could not be classified (12 percent).

Discussion

As the responses make clear, pediatricians in this study believe that SR is important in serious medical situations (Table 1). This is defined as impending death or other highly stressful medical situations for patients and/or their families, including chronic conditions that will require years of attention. It ap-

pears that the role of SR increases as the suffering of patients/families increases, presumably because it offers support and comfort. These results suggest that pediatricians, like physicians in other specialties and medical patients, believe that attention to SR is appropriate, perhaps even necessary, in more urgent clinical situations.[24]

Fourteen percent (n = 68) of the respondents indicated that SR is important when beliefs/practices prohibit the use of usual clinical interventions. In such situations, the function of SR is turned on its head; instead of providing support and comfort, it may increase the patient's suffering and the possibility of death. Smaller percentages of respondents identified chronic medical and miscellaneous situations.

In summary, these results are compatible with Siegel's study described above and two qualitative pediatric studies of parents whose children died in a pediatric intensive care unit (PICU).[25] In the latter two studies, parents describe many spiritual needs.

The educational experiences that prepare pediatricians to helpfully interact with SR concerns appear to be limited. In the Armbruster study noted earlier, 46 percent of faculty and 33 percent of residents agree with the statement, "I am not adequately trained to address SR issues." In our study, only 11 percent (85 out of 737 pediatricians) acknowledged any formal training, most of which consisted of lectures, seminars and group discussions. The written responses to the item suggest that SR was briefly considered in the context of broader subject matter such as cultural diversity or biomedical ethics. One respondent summarized edu-

cational exposure with one word— "minimal."

Recent publications suggest that attention to the role of SR has increased in medical education. The long-term benefits likely will depend on the nature of these efforts. It is doubtful that lectures and other "talk about it" methods are adequate for learning the necessary skill sets. Like medical skills taught in internship and residency, interpersonal skills are usually learned by practice under supervision. Todres et al. describes such a clinical program that includes the process of actually providing spiritual care.[26] No respondent in this project reported participation in such a supervised program. Pediatricians likely will find it difficult to adopt this supervised approach because it challenges the fast-paced, fact-based and financially-driven practice of medicine.

A majority of respondents (61 percent) in this study expressed interest in attending a Category 1 CME workshop focused on SR and identified a wide range of SR topics (Table 2). While interest in such a workshop may fade in the face of other pressures within clinical practice or the appeal of other workshop topics, many want to learn how to talk to patients/families about SR. It is unclear whether they want to engage more competently in fact-finding concerning SR beliefs and practices that impact their decision making or whether they seek skills to provide spiritual care as clergy understand it.

For example, obtaining religious information is very different from responding to the SR concerns during diagnosis and treatment. The first constitutes fact finding with the goal of acquiring accu-

rate information; the second seeks to provide emotional and spiritual support from within the patient's/family's SR tradition. The first is best carried out with careful and skillful questioning; the second requires intense listening to and interacting with patients/families as they struggle with fear, hope, despair, and regret. The first can be accomplished within a limited time frame; the second should not be rushed and must follow the time frame set by patients/families. If pediatricians—and physicians generally—wish to learn how to provide spiritual care, then a clinical program similar to that described by Todres appears to be necessary.

Almost a quarter of those who suggested a workshop topic want information about the diverse religious beliefs that impact healthcare. While those who want help learning how to talk to patients/families as noted above desire increased clinical skills, the pediatricians in this category want information.

Nine percent want an educational context in which issues of clinical judgment are discussed. When is it appropriate to raise SR issues, to inquire about those issues? In what contexts is it helpful? And what are the professional boundaries? These pediatricians implicitly appear concerned that starting a conversation about SR could be problematic. Perhaps they believe that it may offend patients/families because SR is private or that it may lead to their involvement in discussing matters that go beyond their training.

Response to these educational interests appears to be limited. We found only one brief description of a CME course. Its author, a member of the Christian Medical Association, reports training "more

than 6000 healthcare clinicians."[27] We found no further publication describing this or similar efforts.

At least two limitations must be considered when evaluating the results of this study. While a majority responded to the items concerning clinical situations in which SR is important, many did not respond to the educational items. Thus, although these results provide more information on the educational aspect than was previously available, they should not be regarded as representative of the specialty or of physicians generally. Further, while pediatricians identified clinical situations in which they regard SR as important, it is unclear whether they make interventions in these situations, refer the patient/family to the chaplain, or take no action at all.

In conclusion, many pediatricians recognize that SR is important to patients/families in stressful medical situations. Most reported limited educational preparation for responding to these concerns. Further SR continuing medical education focused on SR skills and information is desired, but few opportunities appear to be offered. This merits attention from physicians, chaplains, and other healthcare professionals.

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Identifying Spiritual Needs in Patients Presenting with Chest Pain When Catheterization Reveals No Clinical Etiologies

Ann M. Osborne • Paul Derrickson, BCC

Patients presenting with chest pain who subsequently were ruled out for underlying disease were highly critical of their experiences. A pilot research project was approved by the institutional review board (IRB) to conduct interviews with twenty-five patients who were found to have no clinical etiologies indicating heart disease. Open-ended questions explored their feelings relative to a series of spiritual need categories. Areas which generated the most response included fear versus peace, meaninglessness versus hope and grief/loss versus reinvestment/reintegration. All participants voiced spiritual concerns related to one or more of these.

THIS RESEARCH EMERGED AS FOLLOW-UP to a clinical pastoral education (CPE) residency spiritual pathway project. It is designed to explore how patients experience a particular disease and to propose spiritual interventions that chaplains may make to respond to patients' spiritual concerns. Anecdotal evidence showed high levels of patient dissatisfaction with catheterization lab staff when patients were found to have no clinical etiologies indicating myocardial infarction. Rather than being pleased to learn they had no cardiac disease, many of these patients not only expressed dissatisfaction, they also returned to the hospital multiple times for additional testing in an effort to define the nature of their symptoms.

This research project identifies potential spiritual, social and psychological stressors that may have contributed to the patients' experienced symptoms. It is the hypothesis of this project that such patients may be suffering from spiritual, psychosocial and/or nonmedical stressors or may be the bearers of stress within stressed family systems.

Literature search

Stress cardiomyopathy (broken heart syndrome) results when sudden emotional stress causes severe but reversible heart muscle weakness often mimicking classic heart attack

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symptoms.[1] In 2005, Johns Hopkins' researchers found that when postmenopausal women experience sudden, overwhelming shock or emotional distress, they respond by releasing large amounts of adrenalin (epinephrine) and noradrenalin (norephinephrine) into the blood stream. The heart muscle is stunned, producing symptoms that mimic classic heart attack symptoms.[2]

The Minneapolis Heart Clinic conducted research over a thirty-two-month period on twenty-two women aged thirty-two to eighty-nine, 96 percent of whom were fifty or older. The report, published in 2005, concluded that reversible cardiomyopathy triggered by psychologically stressful events occurs in older women and may mimic evolving acute myocardial infarction or coronary syndrome. This condition is characterized by a distinctive form of systolic dysfunction that predominantly affects the distal left ventricular chamber and has a favorable outcome with appropriate medical therapy.[3]

Tako-tsubo cardiomyopathy, apical ballooning named for the distinct appearance of the end-systolic left ventricle in ventriculography, is a widely reported syndrome in Japan. Symptoms include acute onset of reversible apical wall motion abnormalities or ballooning, with chest pain; changes in electrocardiogram, such as ST elevation; and minimal release of myocardial enzymes with no significant stenosis visible on coronary angiography. These symptoms usually are preceded by severe emotional or physical stress. Various explanations under investigation include catecholamine-mediated cardiotoxicity, coronary artery vasospasm, microvascular injury, impaired fatty acid metabolism or transient obstruction of the left ventricular outflow.[4]

The study design

It was hypothesized that some patients who experience spiritual/psychosocial distress and/or stressful family system dynamics exhibit symptoms of ischemia but present no diagnostic results. Patients exhibited anginal symptoms and abnormal stress test results prior to catheterization.

The chaplain interviewed twenty-five patients who received normal cardiac evaluations for chest pain of uncertain etiology, assessing six categories of spiritual need. Only those experiencing chest pains and who presented negative clinical indicators for the disease following catheterization were included. Interviews took place immediately following the diagnostic cardiac catheterization and ranged in length from twenty minutes to one hour.

Eight open-ended questions, developed by the Hershey Medical Center Research Team, explored the level of spiritual and/or psychosocial distress existing in the lives of patients or within their immediate family systems. (See page 15 for a copy of the questionnaire.) Patients described their feelings concerning the following six spiritual need categories, which were originally identified by Claude V. Deal and Michael E. Gross at Duke University in the 1999 Deal/Gross Scale of Basic Pastoral Care:[5]

1. Loneliness vs. Community

2. Anxiety/Fear vs. Peace

3. Guilt vs. Forgiveness

4. Anger/Hostility vs. Resolution

5. Meaninglessness vs. Hope

6. Grief vs. Reinvestment/ Reintegration

A final question assessed patients' feelings of satisfaction about the interview experience itself.

The study group

The patient cohort included eight females and seventeen males ranging in age from thirty-five to seventy-two. (See Table 1, page 12 for detail.) All had ejection fractions in the range of 58 to 75 percent with a mean of 69 percent. All participants experienced strong feelings about one or more spiritual concerns. Many were the major stress-bearer within a larger family system that was in spiritual or psychosocial distress.

Eight of the twenty-five stated they had no religious belief or connection to a faith community. The remainder professed faith as follows: Baptist (2), Free Bible Church (2), Lutheran (5), Presbyterian (1), Roman Catholic (4), Spiritual (1), Wesleyan Methodist (1), Wicca (1).

They used a variety of rituals to cope with difficult or traumatic experiences in their lives. Twelve used prayer to God when dealing with traumatic circumstances. One person went to church. One person talked with family members who had passed into the spirit world. Six used secular rituals such as sports, hobbies, nature, and being alone when troubled. One expressed anger at God, and four stated they employed no rituals or spiritual practices. All but one of the twenty-five participants expressed satisfaction after the interview. Fourteen

asked that the results of the study be mailed to them.

Results

Ten major themes emerged concerning participants' spiritual concerns:

1. Grief concerning the loss of loved one(s), job, health, family relationships.

2. Why me?

3. God is mad/is punishing me.

4. I'm all alone; nobody cares.

5. Everyone depends on me.

6. I'm responsible for the happiness of others.

7. I'm aging.

8. I'm afraid of dying.

9. I internalize feelings/ worries.

10. I am the stress bearer in a chaotic family system.

Questions, which generated the most interest, related to the following (in order of preference):

1. Feelings of anxiety, fears and relationships.

2. Meaninglessness and hope.

3. Grief/loss and reinvestment /reintegration.

Discussion

The interviews offered noninvasive therapeutic care for patients presenting with no cardiac-related chest pain. Anecdotal results indicate a benefit to patient morale as

Table 1

Age and marital status of cardiac study participants (N = 25)

Age Group	Males (N = 17)	Females (N = 8)
Under 40 years	1	0
40 – 49	8	3
50 – 59	1	1
60 – 69	6	4
70 or older	1	0
Marital Status		
Single	3	0
Married	13	4
Divorced	1	4

they were encouraged to verbally explore their feelings around their major spiritual and/or psychosocial needs. It appears that such pastoral care intervention may benefit patients experiencing high levels of spiritual, psychosocial or chaotic family system stressors.

As a result of the benefits observed in this pilot study the catheterization lab staff now schedules individual pastoral services consults with patients who experience clean catheterization results with the express purpose of exploring spiritual and psychosocial concerns. Chaplains visit these patients to engage them in open-ended conversation around the six spiritual need categories previously referenced. As in the pilot, such visits range between twenty minutes and an hour, dependent upon the patient's engagement with the questions.

Limitations

This project was structured as a qualitative phenomenological study to verify observed phenomena through case study analysis. While the results underscore and

verify previous anecdotal data, the study did not have the benefit of a control group. The next step is to provide the benefit of blind controls to test for the Hawthorne effect. In addition to the group receiving pastoral care interventions, a second group would be visited by a nurse blinded to the research questions. A third group would receive no visits. Follow-up telephone calls would query patient satisfaction. Each individual's hospital utilization would be monitored for a year following catheterization.

Conclusions

The results of this project suggest that there are benefits in initiating pastoral care conversations with patients who believe they have experienced heart attacks but for whom catheterization shows no clinical findings of disease. This research indicates that both men and women experiencing high levels of stress have spiritual and psychosocial needs. Talking about feelings with a pastoral care provider offers a noninvasive method of support for such patients. It is anticipated

that this case study based research will serve as the basis for further exploration of pastoral care interventions that may serve to relieve patients experiencing high levels of spiritual, psychosocial or chaotic family system stressors.

Authors' note

Coinvestigators for this study included the following staff at Penn State-Milton S. Hershey Medical Center: Helen E. Zimmerman, MSN, CRNP, Paul Derrickson, MDiv, BCC, and Ann M. Osborne, MDiv. ♦

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Participant interview form – May 2007
Penn State Milton Hershey Medical Center

Participant #:   Date of Interview:

Age: Gender: Marital Status:

Length of Time Symptoms Experienced Prior to Procedure:

Religious Affiliation:

Religious/Nonreligious Support Systems:
(Circle all that apply)   Family   Friends   Faith Community

Other (Specify):

1. What people or organizations do you use to support you when you are in crisis?
    Are you a member of a religious community, e.g., church, synagogue, mosque, parish?
    Do you possess a strong family support system?
    Who provides the most support to you during times of personal crisis?

2. What feelings do you experience concerning your relationship to yourself?
    In relationship to other people?
    In relationship to God?
    Do you experience sadness at your lack of intimacy with self/others/God?

3. Have you recently experienced any particular issues, problems or stresses that have created worry or fear for you?

4. Are there concerns you have that cause you to feel guilt or other negative feelings, e.g., shame, blame, need for forgiveness?

5. Have you recently experienced any major losses, threats or events that have created deeply expressed feelings, e.g., denial, anger, hostility, acceptance or transition to a new place of resolution for you?

6. What creates meaning and hope for you? Have you experienced a sense of meaninglessness or despair over past, present or future life situations?

7. How do you deal with or express difficult or traumatic life events?

8. Do you practice any spiritual/religious rituals that assist you to cope with difficult aspects of your life?

The Chaplain as an Authentic and an Ethical Presence

David J. Zucker, BCC • T. Patrick Bradley • Bonita E. Taylor

ONE OF THE CORE TENETS OF PROFESSIONAL CHAPLAINCY is that pastoral/spiritual caregivers can ease the existential anxiety that confronts those who are vulnerable and compromised. Further, they connect these patients, residents, clients, or staff to Divinity, however they define it, and thereby, contribute to their healing. The authors acknowledge that their use of the terms Divinity and God throughout this article may not always be interchangeable.

Some chaplains are mandated to offer *religious* care, others to offer *spiritual* care and some to offer both. Spiritual, in this context, does not mean mystical. It refers to the experience of our souls as they engage the issues to which contemporary life exposes us. Spiritual is also different from religious although at times they overlap.

Working as a professional chaplain is often defined as "being present with people where they are, wherever that may be." Yet, from the perspective of both authenticity and ethics, is this a goal

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Chaplains often are called upon to minister to those of a faith tradition other than their own. This article differentiates between spiritual care and religious care. Drawing on the Common Standards for Professional Chaplaincy developed by six North American professional chaplaincy associations, the authors examine the role of the professionally trained, multifaith chaplain. They also provide guidelines for authentic, ethical spiritual care with differently observerant believers. The article includes suggestions for creating custom-made, spontaneous spiritual prayers.

that is truly beneficial either to the chaplain or to the compromised individual being served? When chaplains recite words to which they do not ascribe, are they spiritually harmed? When chaplains affirm religious truths that are not their own, are those they serve spiritually harmed? Are there no boundaries beyond which chaplains should go in their endeavor to be present with people "where they are," wherever that may be?

This article challenges the premise that as professionally educated chaplains, we can always be with people where they are. It also challenges professional chaplains to explore the following question: just because chaplains *could* do something, does it mean that they should?

Contrasting religious and spiritual

To begin, it is important to distinguish between the words religious and spiritual. Wesley L. Brun maintains that "'Religious' concerns are often defined as those issues that grow out of a person's relationship with an organized religious group or institutionalized religious expression. 'Religious' concerns often have to do with how persons understand themselves *in relation to* a religious or 'faith group.'"[1] Followers of religious traditions observe specific, primarily fixed, rituals to engage their belief systems.

In contrast, he writes that spirituality has at least four characteristics that define or give it scope:

1. [S]pirituality is deeply *personal*, sometimes to the point of being idiosyncratic. It sometimes defies precise definition in words,

but rather is described by use of metaphor, poetry, and/or story, which point beyond themselves to an "experience." …

2. [S]pirituality often connects a person with a "Being-greater-than-themselves," a "Being" whom they call by various names, God, Yahwah [sic] (Yhwh), Allah, Jehovah, Brahma, Shekinah, Sophia, Vashti, Gaia, the Great Spirit ….

3. Connection with the Being often gives the person's life a sense of purpose or order …. It also, often, gives the person a perspective on life and death.

4. Such spirituality often offers the person a sense of perspective in which they understand themselves, others and the world.[2]

The role of the professional chaplain

This article focuses on the work of professionally trained chaplains. In North America, chaplains seek board certification via one of the following professional associations:

Association of Professional Chaplains (APC)

National Association of Catholic Chaplains (NACC)

National Association of Jewish Chaplains (NAJC)

Canadian Association of Pastoral Practice and Education (CAPPE-ACPEP)

Chaplains need to understand their primary—or exclusive—mandate. Basically, there are two types of professionally trained chaplains: monofaith and multifaith. Two of the authors of this article are primarily multifaith chaplains and occasionally monofaith chaplains. The third is primarily a monofaith chaplain and occasionally a multifaith chaplain.[3] All of us are board certified chaplains with extensive and continuing professional chaplaincy education that helps us to determine when to fulfill which role. They participate in both monofaith and multifaith peer review groups to continue to differentiate their own needs from the needs of those whom they serve. As a consequence, they are grounded in their respective religious traditions. They know who and what they are—and are not—theologically, spiritually and personally. Each has some personal agreement and disagreement with the "normative theology" of their respective denominations. At the same time, each represents the larger body of their individual faith traditions. In addition, as part of the respective workplaces wherein they function, institutionally they represent the ethos of their specific agency/administrative centers.

Monofaith chaplains—Buddhist, Christian, Hindu, Jewish, Muslim, et al.—are conduits between the religions that ordain or endorse them and the persons of the same faith who are compromised. Visiting congregational and community clergy are invariably monofaith. These chaplains/clergy primarily offer religious as opposed to spiritual care. They provide significant religious resources, such as sacraments, rituals, excerpts from sacred literature, specific "God talk" and

prayers to those who find healing significance in receiving or otherwise engaging that particular religion.

Monofaith chaplains and the individuals that they serve share immediate religious connections, religious language, broadly common religious beliefs and a relatively shared denominational understanding of Divinity. In symbolic language, monofaith chaplains and the individuals with whom they interact form a closed system. They are linked by bonds that are nuanced and shaded in ways that are best known and appreciated by their believers. The rituals and prayers that they offer reflect these nuances.

Often, chaplains from other religious traditions think that they understand these nuances when, in truth, they are fundamentally unintelligible to those outside of the belief system. Frequently, this occurs when multiple religions share the same words but imbue them with different meanings and practices. For example, forgiveness or grace and how each may be achieved are very different within Christian and Jewish religious systems.

Multifaith chaplains, while usually ordained or endorsed by a specific religion, also have been educated to care for individuals who profess religions other than theirs. They offer a spiritual presence to those whose lives have been disrupted, e.g., by illness, accident, aging, substance abuse, physical and cognitive challenges, military service, imprisonment, irrespective of their religious backgrounds. Most of the individuals that these chaplains visit are either confined to acute-care institutions, e.g., hospitals, or long-term care facilities, e.g., nursing homes, hospices, reha-

bilitation centers, prisons. They also may be engaged with social service agencies, which serve homebound or other challenged individuals. These individuals may or may not be affiliated religiously. Some self-identify with a religion from which they appear to be disconnected; others self-identify with a religion with which they are deeply connected. Whatever their relationship with organized religion, they are often frightened, angry, sorrowful, disoriented, feel powerless and/or rightfully concerned about what the future holds for them. As such, they are compromised spiritually. Some may speak of their distress in words reminiscent of the biblical Job: "I will not speak with restraint, I will give voice to the anguish of my spirit; I will complain in the bitterness of my soul" (Job 7:11). Others may not give direct voice to their distress, but these emotions play out on their faces or in their eyes and are visible to the educated professional chaplain.

Multifaith chaplains empathically listen to the stories of these sufferers and actively assist them in exploring the current existential dynamics afflicting their spirits. They connect the religious, the secular, the affiliated and the unaffiliated to Divinity, however the sufferer defines this. Multifaith chaplains are expected to respect religious boundaries that are not their own.

The goal of the professional multifaith chaplain

Professionally trained multifaith chaplains begin their visits by introducing themselves and socially joining with vulnerable individuals as they assess their spiritual needs. Chaplains who meet with individuals in long-term care facilities

generally have time to develop relationships. Those who meet with individuals in acute care facilities or in any situation where jeopardy is present, often find that time is too limited to develop relationships. Chaplains take this time factor into consideration during their visits while they actively listen and assess. One of the significant differences between professionally trained chaplains and well-intentioned clergy is who listens to whom. Though often offered in jest, the fact is that it is axiomatic for chaplains to remember that it was with purpose that God gave us two ears and one mouth; we are meant to listen twice as much as we speak—maybe more than twice as much!

Chaplains describe themselves as the only official professionals who engage compromised individuals *without specific agendas*. If that were strictly true, what would differentiate professional chaplains from church, synagogue, temple and community volunteers or even candy stripers? The answer to that is a paradox. On one hand, during visits, multifaith chaplains have no agenda. On the other hand, they strive to be fully present; actively listen with empathetic ears, educated intellects and hearing hearts; perform spiritual assessments; attempt to get their own counter-transference out of the way while they encourage persons to speak from the depths of their distress; and offer appropriate prayers.

Some individuals ask chaplains for prayer. Some do not. Either way, chaplains are understood to be religious professionals who are specially connected to Divinity, even if it's to a "different" Divinity. In a silvering North America, people seem hungry to connect

to Divinity. Furthermore, there are more individuals who are in the midst of long-term challenges than in the past when many more people succumbed to their illnesses and died relatively quickly. Consequently, it is incumbent upon chaplains gently to invite individuals to connect to Divinity. One way to accomplish this is via prayers that are appropriate to the sufferers, whether or not these prayers are directly requested.

Vulnerable individuals are not surprised when religious professionals invite them to prayer; they are surprised when they don't. Compromised individuals who accept an invitation to prayer trust that chaplains will not violate their religious and spiritual sensibilities. The best way to accomplish this is with custom-made prayers that are composed spontaneously to reflect what a vulnerable person wants to say to Divinity in the context of a particular visit.[4] Suggestions on how to formulate these spiritual prayers will be found later in this article. Visits without prayers are important opportunities lost.

The authenticity and ethics of the multifaith chaplain

The Council on Collaboration, represents over 10,000 chaplains, pastoral counselors, and clinical pastoral educators in North America. On November 7, 2004, in Portland, Maine, the council approved a set of minimum standards for spiritual care professionals that representatives from each member association had collaboratively written.[5] American Association of Pastoral Counselors (AAPC) and Association for Clinical Pastoral Education (ACPE) joined APC, CAPPE/ACPEP, NACC and

NAJC in the ratification of four documents:

1. Common Standards for Professional Chaplaincy,

2. Common Standards for Pastoral Educators/ Supervisors,

3. Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students,

4. Principles for Processing Ethical Complaints.

Collectively, these documents describe what it means to be a professional, multifaith chaplain, a pastoral counselor or an educator. All board certified members of these associations now sign documents affirming their accountability to these basic tenets. Throughout the four documents, issues of ethics are elucidated and members are advised to incorporate a working knowledge of ethics appropriate to their pastoral context. For example, nine items in the Common Standards for Professional Chaplaincy relate to ethical issues, in particular, highlighting that the needs of those served are met by the spiritual care professional.

The message being sent by the associations is very clear. In all spiritual caregiving services, chaplains are to consider the needs of the vulnerable individuals being served above their own needs. Specifically, the associations affirmed the following:

• The right of each faith group to hold to its own values and traditions.

• Respect for the cultural and religious values of those served.

• Restraint by chaplains from imposing their personal values and beliefs upon those served.

• Counsel chaplains to seek advice from other professionals and to make referrals to other professionals whenever it is in the best interest of those being served.[6]

In other words, chaplains may not use or pray in the religious or spiritual language of their personal faith systems unless it matches the faith systems of the individuals that they are serving. Nor may chaplains seize these moments as opportunities to proselytize or to convert someone who may seem at loose ends religiously.

In reviewing these documents, it becomes clear that the writers were concerned that chaplains frequently do not understand when they are being disrespectful of other belief systems, when they are imposing their personal values upon others, when they are meeting their own needs first or when they should make referrals. The professional associations were courageous in addressing these issues which seem to be systemic problems in chaplaincy.

If chaplains may not use their own spiritual and religious language when serving individuals of other belief systems, may they use the spiritual and religious language of those they serve? It is our position that for caregiving to be authentic to, and ethical for, the person being served, chaplains need to acknowledge that there are boundaries around each spiritual and religious tradition. These boundaries should not be transcended by differently observant chaplains who are by

definition outsiders and, therefore, not privy to meanings that are inherent in the language and rituals of faith systems other than their own. Despite good intentions, such trespassing may inflict spiritual harm upon those whom they seek to serve.

It is, of course, easier if the chaplain and the person being served, e.g., client, resident, patient, loved one, share a similar religious tradition. It is easier still if they share a similar religious denomination. In both cases, they share a certain amount of theological understanding and language. There may be differences in nuances and practice, but a Lutheran chaplain may religiously or spiritually attend to another Lutheran reasonably easily. A Methodist chaplain knows language that is familiar to another Methodist. Matters become more complex when there is a chasm between the religiously spiritual traditions of the chaplain and person s/he serves. Even though they share the kinship of Christianity, it may not be possible for a Lutheran fully to attend religiously to a Baptist or a Methodist to a Presbyterian. It may be impossible for a Protestant fully to meet the needs of a Roman Catholic or a Roman Catholic fully to meet the needs of a Protestant. Likewise, it may be difficult for an Orthodox Jewish chaplain fully to serve a Liberal Jewish person or a Liberal Jew to serve an Orthodox Jew, despite the fact that they share the kinship of Judaism. An even more complicated situation occurs when the chaplain and the person being served are of different faiths.

Of course, some religious and spiritual practices have spiritual meaning for believers and also are partially accepted by members of other faith traditions. For example, meditation and yoga are part of Buddhist religious practice. Christians, Jews and Muslims may engage in these practices; however, this does not make them privy to the inherent significance of these rituals to a Buddhist. Many Christians celebrate Passover with Seders, but this does not make their Seders Jewish, nor do they understand or experience this ritual from within the emotional catharsis that Jews do. In a similar vein, although Jews can perform baptisms, they cannot embody the words of the ritual and thereby imbue it with holiness.

There are further reasons not to recite sacred words from other religious traditions. By their nature, formal prayers have certain rhyme or response patterns that are known to practitioners. Chaplains from other traditions are unlikely to be familiar with these subtleties, may mispronounce some of the words, and thereby, give offense. At the very least, these prayers will be heard as stilted and unprayerful.

Basically, we cannot be that which we are not:

> A Protestant cannot be a Muslim.
>
> A Jew cannot be a Native American.
>
> A Seventh Day Adventist cannot be a Jew.
>
> A Mormon cannot be a Roman Catholic.

As multifaith chaplains, we should not try to be.

In formulating standards for spiritual care professionals, the professional associations were emphatic about chaplains putting the needs of the person being served first. Nevertheless, they did not declare that chaplains are to be chameleons or that chaplains' desires to be empathic with those they serve are meant to leave them without a religious or spiritual identity of their own. It is our position that caregiving needs to have components that are authentic to, and ethical for, chaplains. Chaplains who come from traditions that proselytize and convert may have difficulty reconciling their personal authenticity with professional ethics. For such reconciliation to occur, chaplains need to acknowledge that there are boundaries around each spiritual and religious tradition—sometimes their own and sometimes those of the person being served—beyond which they should not engage.

Following are several scenarios that have confronted us or our colleagues in our efforts to offer authentic, ethical pastoral care.

Chaplain Bob, who is Roman Catholic, has a personal digital assistant (PDA) that includes several Jewish prayers, such as the *Sh'ma*: "Hear Israel, the Lord is our God, the Lord is One." (Deuteronomy 6:4). This affirmation of God's unity is as close to a creedal statement as may be found in Judaism. Should he recite it with a Jewish person?

Chaplain Hannah, who is Reform Jewish, has the words to the Lord's Prayer and the Hail Mary as well as a musical rendition of "Amazing Grace" on her PDA. Should she recite/sing them with a Christian person? If she were asked to perform a baptism or other Christian ritual, should she do it if it meets the "in-the-moment" need of the person before her?[7]

Chaplain Len, who is an Evangelical Protestant, has a book in his

office that contains various prayers "for emergency situations."[8] He visits an inmate named Mohammed. Should he recite words from the *Qur'an*? Alternatively, should he pray a generic prayer of healing and substitute Allah for God?

Chaplain Constantine, who is Greek Orthodox, is very devout in his personal practice. As a professional chaplain, he desires to chaplain all of the individuals in his care. A patient who self-identifies as a Satanist requests a visit from a chaplain and for words of comfort that would be religiously appropriate to him. How should Chaplain Constantine respond?

Just because you could, should you?

So, how *do* chaplains care for believers from other faith systems and also remain ethical to those they serve as well as to themselves? It is the thesis of this article that just because chaplains *could* do something, it does not mean that they *should* do it. Given this, how may chaplains authentically and ethically offer care to the individuals they serve?

General principles for offering authentic and ethical spiritual care with differently observant believers are listed on page 21. The following sections offer a few specific examples that we have gleaned from our efforts to offer authentic, ethical spiritual care to augment these general principles.

Non-Christians chaplaining Christians

Many prayers are embodied and made holy when their believers recite them and are secularized when non-believers recite them. If you do not ascribe to the religious truths inherent in these prayers,

do not recite the Our Father (*Pater Noster,* Lord's Prayer), the Catholic Blessing for the Sick, the Catholic Commendation of the Dying or the Hail Mary, to name a few.

Do not baptize someone if it is not part of your religious tradition as different Christian denominations have different rules about what constitutes an effective baptism. Rather, find someone who has been baptized to do the baptism while you offer spiritual care.

When you invite individuals to prayer, also invite them to add a few words of significance to them during or at the end of the prayer. If it is healing to them, they will add Jesus, Mary or the Trinity; you do not need to do so.

If an individual adds a name of Jesus, Mary, the Trinity, et al., and these names are not part of the religious system to which you ascribe, consider closing the prayer with words such as "May God hear your prayers." Do not end with "Amen" if you don't affirm the person's religious beliefs as to some people Amen signals agreement with and/or affirmation of all that has been said.

Sometimes a Christian individual tells a non-Christian chaplain that it is all right to say a particular Christian prayer. You should decide, however, what is appropriate for you based on the religious tradition that you follow.

Non-Jews chaplaining Jews

Do not mention or allude to religious entities such as Jesus, Mary, the Trinity, Allah or Buddha during a chaplaincy visit. A Christian chaplain once said that if he did not end a prayer with the words "in Jesus' name," it was like writing an e-mail and not pushing "send." Our response is that once the names of

any of these religion founders or other religiously significant individuals are added, it is like writing an e-mail and pushing "delete."

Whenever possible, remove crucifixes and other Jesus-related artifacts and language from the chaplaincy experience of a Jewish individual. It is undoubtedly true that the historical Jesus was benevolent; however, it is also true that Jesus' name has been used throughout the ages in non-benevolent ways. For two thousand years, Jews have been persecuted, martyred and murdered in the "name" of Jesus. Consequently, it is difficult for many Jews to see or hear representations of Jesus or other emblems of Christianity and not to associate this—consciously or unconsciously—with Jewish crisis and tragedy.[9]

There is no substitute in Judaism for the above-named religiously significant figures. Moses was not a founder of Judaism. He is not a substitute for Allah, Buddha, Jesus, et al. and should not be invoked in prayer.

Do not use Hebrew. While it is acceptable to some Jews, others find it patronizing—and you won't know which is which. If you're thinking about asking, remember that some will want to please you and that's not why you're there.

Do not engage in prayers that are outside of your own religious system. In transcending this boundary, you may be sending a message that you didn't intend. For example, for Jews the *Sh'ma and* Psalm 23 were discussed earlier in this article.

Perhaps you have reason to believe that a patient is dying. You know of the Jewish tradition of *Vidui* (confession when death is near), and you offer the patient a chance to say it. However, the patient still is hopeful that the treatment will

General principles for offering authentic and ethical spiritual care with differently observant believers

1. Spiritual care, without engaging a specific religion, is always appropriate.

2. Find out which monofaith clergy, chaplains and community visitors are available to make visits in your institution so that you may offer to make a referral, i.e., who celebrates communion; who anoints for healing; who offers Sabbath blessings; who arranges for Juma prayer?

3. When a religious ritual is essential for a differently observant believer, offer spiritual care and find someone more appropriate to perform the ritual from among the staff, loved ones, community clergy or visitors.

4. Do not offer to recite fixed prayers or liturgical readings from faith traditions that are not your own; this may include different denominational traditions. Doing so may distress the individual who

   - Does not know the prayer.

   - May not know all the words.

   - May not want to engage in formal prayer outside of the faith community, e.g., church, synagogue, mosque, temple.

   - May believe that it is inappropriate to say the prayer with a nonbeliever.

   - May consciously or sub-consciously attach meanings with which you are unfamiliar and you did not intend. For example, many Jews are familiar with the *Sh'ma* only as the prayer said either in synagogue on the Sabbath and Holy Days or at the time of death. Psalm 23 is another example of a prayer that many Jews associate only with funerals.

5. If an individual asks you to recite a fixed prayer or liturgical words from Scripture or prayer books for example, provide them with spiritual care and facilitate the requested experience for them with appropriate staff, a loved one, or a referral to another professional or community visitor (whose names and availability you have already ascertained).

6. Do not offer to perform rituals from another faith. You may be able to say the words and perform the deed, but you cannot embody the words—or make the experience holy—in the way a believer can.

7. Be careful not to use words that are important to you in the context of your faith tradition when they are not germane, and in fact may be alienating, to the person you are serving.

8. Spontaneously composed prayer that is custom-made for the individual served always is appropriate.

9. Do have available printed prayers of healing for as many faith groups as possible.

10. Do ask permission before contacting local clergy; many unwell individuals do not want their home communities notified. This also has HIPAA privacy implications.

11. Remember that chaplains' relationships with the individuals they serve are not mutual nor are they equal. Rather, they are hierarchical with the chaplain in the "closer-to-God" position. As such, many vulnerable individuals often give chaplains the answer that they think chaplains want to hear, even when they would prefer to say no.

be effective. Perhaps meaning well, you apply the same rules to offering Jewish confession as you do to Roman Catholic confession. In both cases, as an outsider to Judaism, you may send a message that you didn't intend.

Non-Muslims chaplaining Muslims

Sacred words are meaningful to their believers. Unless you are Muslim, do not recite such prayers such as the *Shahada*: "There is no God but Allah and Muhammad (peace be upon him) is His messenger."

Although Christians and Jews share common roots with Muslims through Abraham, it would be inappropriate for a non-Muslim chaplain to refer to Abraham as Ibrahim in a prayer.

Non-Native Americans chaplaining Native Americans

Native Americans/First Nations are a very diverse group. What is an appropriate prayer for a Lakota Sioux, may differ for an Algonquin, an Arapahoe, a Miwok, a Mohawk or a Navaho.

Chaplaining the nonaffiliated

An individual may self-identify as unaffiliated, unchurched or lapsed. These terms mean different things to different individuals. They do not mean that the individual is ripe for proselytizing or conversion.

Chaplaining the agnostic or the atheist

Individuals who self-identify as agnostic or atheist and also engage you in conversation for more than five minutes after you have clearly identified yourself as a religious professional, e.g., Chaplain, Reverend, Rabbi, Imam, Roshi, want something spiritual from you. This does not mean that when they leave the hospital or other insti-

tution that they will convert. It means only that in the moment, they are scared. We are reminded that the old saying that "there are no atheists in foxholes" also applies to hospitals. Offer these individuals spiritual care and a wish them success with an operation/treatment and/or improved health.

Chaplaining polytheists, Satanists

Chaplaining these individuals may or may not be different for you than chaplaining other individuals whose belief systems are significantly different than your own. It is a subject that you may want to consider engaging either alone, with a peer group or at a conference before you are faced with this situation.

If such individuals wish to recite something that is meaningful to them, encourage them to do so and help facilitate this, perhaps through written material. Remember, you do not need to affirm their truth.

To pray or not to pray

It may seem as though we are advocating against praying with those who believe differently. This is not so.

Fundamentally, there is no reason for chaplains who have accepted a multifaith mandate to violate either their professional ethics or those of the individual being served. Earlier, we wrote that connection to Divinity is a primary goal of a chaplain's visit. Prayer often facilitates this, and chaplains often are seen by those they serve as either presenting God, re-presenting God, or as representing God.

In view of the important role that prayer plays in healing among the multifaith, multiethnic populations that chaplains serve, the issue is not *could* a multifaith chaplain pray with all people but rather

how could a chaplain pray with all people?

Prayer is a special kind of conversation. Prayer is the individual's soul conversing with the Soul of the universe. We need prayer. Prayers are the deep and various longings of our souls expressing themselves. Sometimes, this expression takes place through reading familiar words in a prayer book. Yet, we know from experience that these words may not always match what we feel. Our human souls yearn to express what is most profoundly true for us at a given time. This is especially true in those moments when we are faced with the mystery of living and dying, of knowing and not knowing.[10]

The Bible reflects a longstanding intercessory tradition. In the Hebrew Bible, there are numerous examples of verbal intercessory prayers to God. In Genesis, Abraham prays for Abimelech. In Exodus, Moses pleads with God on behalf of the people, and at one point, in Numbers, he prays for the health of his sister, Miriam. Later, during the period of the prophets, in the book of Kings, Elijah and Elisha pray on behalf of people in their respective communities, and Job prays for his friends. In the Christian Scriptures, the Gospels are filled with examples of Jesus praying spontaneously for the ill and distraught.

Monofaith chaplains generally use denominational-specific prayer language that is both value-laden and formalized. In contrast, professional multifaith chaplains learn to use spiritual prayer language that is personal and specific to the individual being served. Commonly these are termed spontaneous and custom-made prayers.[11]

Custom-made spontaneous spiritual prayers

Custom-made prayer infused with spontaneous, heartfelt intention encourages our spirits to speak their truths in the moment.

Bonita Taylor explains that as a clinical pastoral education (CPE) supervisor, she teaches pastoral care students about the profound effects that custom-made prayers have upon those who are vulnerable and compromised. In Taylor's words:

> Ultimately, they must learn this for themselves during their pastoral visits. In my experience, students are often skeptical about the effects of this kind of prayer, preferring to stay in the comfort and security of fixed prayer. Invariably, at least one or two students return to class saying that they had intended to follow the guidelines perfectly, just to "prove me wrong." Instead, they return with stories about patients who became teary and, blessed them; or crusty and angry long-term care residents who opened up after prayer about their fears for the future; or social service agency clients who shared truths about themselves that they had not shared with anyone before.

There are five basic steps or guidelines to create no-frills, custom-made, spontaneous prayers.

1. Ask the individual if you may pray for him/her, e.g., would it be all right if I said a prayer for you? When individuals realize that they are not being asked to remember the words to a prayer, they relax into the connecting experience. Asking permission empowers individuals who are in a vulnerable state.

2. Ask the individual to identify a focus for the prayer in his or her body or spirit. Alternatively, ask what s/he would like to say to God. The prayer actually begins when individuals engage in the process of praying for themselves even if they don't compose the prayer itself.

3. Address the Divine and connect the individual to Divinity. You might address the Divine as though you were writing a letter, e.g., Dear God, Dear Source of Life, Dear Eternal. It is important that pastoral caregivers identify the individual being prayed for by name and location. This is not for God's benefit. It is for the benefit of distressed individuals who need to feel that God is focusing specifically on them, rather like a GPS—a **G**odly **P**ositioning **S**ystem.

4. Relate the individual's plight to the Divine. Blend the individuals' factual ordeals with any accompanying existential spiritual dynamics that you have helped them to explore.

5. Share with God what this individual needs. This intensely personalized prayer is composed primarily of what the suffering individual wants to pray for—yet it needs to be realistic in what is asked. To offer a hope for cure when it is out of touch with reality may leave vulnerable people feeling unseen and unheard. Worse, it may leave them feeling deserted by God, perhaps the most miserable feeling of all. The words, "Do not forsake us, Eternal God" encapsulate the essence of all prayer. Pray for courage, for strength and for endurance.[12]

Conclusion

This article contrasts *spiritual* or *pastoral* caregiving with *religious* caregiving. It brings into focus ethical boundaries that should be inherent in situations where chaplains and patients/residents/clients embrace different religious systems. It also highlights areas of respect that good-hearted, well-intentioned chaplains may inadvertently—and unknowingly—violate during otherwise compassionate and spiritually nurturing visits.

The article challenges the tenet that chaplains must always *be present* with the individuals they serve *wherever they are*. This is a particularly egregious motto when chaplains understand it as a mandate to become a *religious* caregiver for an individual of a different faith or when they understand it as an order to violate their own belief systems.

The authors reference the Common Standards approved by the Council on Collaboration. particularly those

sections that counsel chaplains to seek advice from other professionals and to make referrals to other professionals whenever it is in the best interest of those being served. They also present authentic and ethical ways for chaplains to interact with vulnerable individuals wherever they are on—or off—the faith continuum and include suggestions for how to pray with those of differing faith traditions.

Finally, we raise the question that just because chaplains *could* do something, does it mean that they *should*? We ask chaplains who take umbrage with our discussion to explore their own counter-transference around appearing to be able to meet all of their patients/residents spiritual *and* religious needs. Further, we invite chaplains to ask themselves how they would know if they were being perceived as disrespectful by patients who acquiesce to them out of vulnerability, politeness or a wish to please the chaplain who, after all, represents Divinity? ⚶

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[2] Ibid.

[3] Zucker is a Reform Jewish Rabbi; Bradley is a Roman Catholic Deacon; Taylor is a Conservative Jewish Rabbi.

[4] See Bonita E Taylor, "The power of custom-made prayers" in Dayle A. Friedman, ed., *Jewish Pastoral Care*, 2nd Edition (Woodstock, VT: Jewish Lights, 2005), 150-60. Though framed in a Jewish context, the concepts that Taylor enunciates have broad applicability.

[5] Rabbis Taylor and Zucker served on the NAJC Board during this period. Rabbi Taylor contributed to writing Common Standards for Pastoral Educators/Supervisors. Both voted in this historic international meeting.

[6] *Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students*, Preamble, 1.3, 1.11, 4.4, 4.5.

[7] See Phyllis A. Toback "A theological reflection on baptism by a Jewish chaplain, *Journal of Pastoral Care* 47, no. 3 (Fall 1993): 315-17 and George Handzo and Zahara Davidowitz-Farkas, (Journal of Pastoral Care 48, no. 1 (Spring 1994): 101-2. In their response to Chaplain Toback, Reverend Handzo and Rabbi Davidowitz-Farkas write that "As chaplains … [o]ur intent, in part, is to help patients recognize and use resources for healing that are theirs alone. … Their story is their own. We cannot join it; we can only share it. [In baptizing an infant, Chaplain] Toback has crossed an important boundary in relationship to the family … [S]he violated her own and the family's integrity … and trod on the sacred ground of a tradition she can never fully appreciate simply because it is not hers." (p. 101)

[8] For a critique of such volumes, see David J. Zucker's review of Mary M. Toole, "Handbook for Chaplains," *Vision* 16, no. 9 (October 2006): 19.

[9] See Bonita E Taylor and David J. Zucker, "Nearly everything we wish our non-Jewish supervisors had known about us as Jewish supervisees," *Journal of Pastoral Care & Counseling* 56, no. 4 (Winter 2002): 327-38.

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[12] Adapted from Taylor, "Custom-made prayers," 153-56.

Pilot Study:
Exploring the Relationship between Faith Development and Compassion Fatigue in Hospice Practitioners

Gretchen Thompson

Hospice work, with its ongoing exposure to death and dying, appears to create significant risk of compassion fatigue among nurses and possibly other staff.[1] This pilot study, designed to take an initial look at the relationship between hospice practitioners' spirituality and their levels of compassion fatigue, originated with my own experience as a chaplain in this field. Serving on three interdisciplinary teams has brought me into close contact with a variety of hospice practitioners: nurses, home health aides, social workers, bereavement staff and other chaplains.

Many in the hospice field appear to experience periods of significant difficulty that is not attributable to simple burnout resulting from poor working conditions, e.g., heavy caseloads, inadequate supervision, or from overall mismatch between job requirements and personal values.[2] This difficulty seems to be related to the challenge of continual compassionate engagement with individuals who are grappling with mortality; who suffer greatly, both physically and psychologically; and/or whose family problems have become exaggerated by the stresses of coping with terminal diagnoses. Too often, those professionals who cannot endure sustained exposure to these kinds of struggles leave hospice work altogether, resulting in the more organizational problem of rapid turnover. This, in turn, adds stress to those who remain.

In searching for some viable explanation for this phenomenon, I discovered considerable current research centering on compassion fatigue—variously termed vicarious trauma, secondary traumatic stress or secondary posttraumatic stress syndrome. Though the specific term used depends on the orientation or focus of the

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This study compares the faith stage of six hospice staff with their compassion fatigue scores utilizing a questionnaire adapted from James Fowler's faith stage interview and Beth Stamm's Professional Quality of Life Scale (ProQOL). Although the small study size presents obvious limitations, the results suggest the possibility that work which involves constant exposure to death and dying is related to spiritual development. The author maintains that this fact alone is reason for further study in this area.

researcher, the signs and symptoms seem fairly consistent: recurring intrusive memories; emotional numbness; impulse to silence or distance clients/coworkers through judgmentalism or detachment; heightened physiological reactions, such as jumpiness or sleep disturbance; pervasive feelings of exhaustion, hopelessness and discouragement.

Some approaches are medically oriented, assuming compassion fatigue to be pathological. Others focus on the individual as opposed to the group or to the environment. Laurie Ann Pearlman's definition of compassion fatigue, which she terms vicarious trauma, avoids both pathologizing and individualizing and acknowledges a spiritual dimension as well:

> Vicarious traumatization is a transformation of one's inner experience resulting from empathic engagement in others' traumatic material. It is important to emphasize that such responses on the part of the helper are not pathological… but rather, a normal reaction to stressful and sometimes traumatizing work …. There are several common features of vicarious trauma. First, its effects are cumulative; the impact of being repeatedly exposed to traumatic material may reinforce gradually changing beliefs about oneself and the world. Second, its effects are permanent, in that they may result in lasting changes in the way we think and feel about ourselves, others and the world. Third, its effects may be emotionally intrusive and painful …. Helpers may find their spiritual beliefs shifting,

including their meaning and purpose in life.[3]

This definition, which hinges on "transformation," and describes a cumulative, irreversible, permanent and intermittently painful change process, related to one's sense of meaning and purpose in life, also could be applied to spiritual development. The possibility that compassion fatigue may be related to spiritual growth does not diminish its legitimacy as a concern; but does distance it from the realm of assumed personal failure and opens a whole new set of possible interventions and assists for those experiencing it.

James Fowler, whose research in the area of faith development remains highly respected, construes faith not as human religiosity per se, but as something more universal: one's ways of relating to that which one holds as ultimate in terms of meaning and value, one's covenantal relationships with "centers of power and value."[4] Fowler's structured interviews of 359 individuals over a nine-year period indicated with powerful clarity that faith was developmental. His model is a synthesis of the work of Jean Piagett (logic and cognition), Lawrence Kohlberg (morality) and Erik Erikson (psychological growth).

Fowler's research revealed six distinct stages of faith, none of which necessarily correlate with biological maturation. For example, though late adolescence often brings an individual to stage three, there are certainly stage two individuals in their fifties and occasionally stage four individuals in their late teens.

Barry James and Curtis Samuels also have described these stages.[5] (See page 26.) For this inquiry,

I generated a similar set of developmentally apropos statements focused on compassion, defining that term broadly as the capacity to respond empathetically to the experience of another or others.

Stage 1: I have compasion because I will be punished if I don't.

Stage 2: I have compassion because I want you to reciprocate.

Stage 3: I have compassion because my community, e.g., family, faith group, neighborhood, tells me it is the right thing.

Stage 4: I have compassion because my own internal values tell me that it is the right thing.

Stage 5: I have compassion because of a deep loyalty to all humanity that extends, paradoxically, beyond all that appears to divide us.

Stage 6: I have no choice but to have compassion, which I am called to manifest through creation of justice. There is no division between us. We are all one and all sacred.

Although Fowler did not conduct research on what causes individuals to move from one stage to the next, he did offer reflection on that topic, often identifying a crisis or major life shift as instrumental in evoking growth. Using Fowler's model among others, James and Samuels researched the relationship of high-stress life events to spiritual development, i.e., the shift from one faith stage to the

next, and discovered that high-stress experiences—both negative and positive—do correlate with increasingly universalistic faith perspectives. It is as though individual frames of meaning, when cracked apart by stress or trauma, simply have to become more encompassing if one is to integrate difficult experiences into what one thinks one knows. What begins as pain and chaos, then, may indeed lead to growth. Thus, for hospice workers, or indeed anyone who swims daily in an ocean of suffering and death, the initially disruptive experience of compassion fatigue may well bring about a deepened, more mature and more resilient faith. With that possibility in mind, I set out to measure levels of compassion fatigue and faith development in a small group of hospice personnel.

Study method

For this pilot, I utilized both Fowler's faith stage interview and Beth Stamm's Professional Quality of Life Scale (ProQOL), a thirty-item questionnaire which is the most recently revised and simplified version of the Compassion Fatigue Self-Test (Figley, 1995).[6] The latter generates scores in three discrete areas, which are defined as follows:

Compassion satisfaction: pleasure derived from doing (compassion-related) work well.

Burnout: feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively.

Compassion fatigue: related to vicarious trauma and to work-related, secondary exposure to extremely stressful events.

Fowler's stages of faith as described by James and Samuels

Stage 1 – Intuitive-projective is episodic, fantasy-filled and imitative. Images of parents' formal religion and normal family life (including favorite stories and family rituals) give coherence and meaning to the child's life.

Stage 2 – Mythic-literal finds meaning in life through the teachings, symbols and perspectives of the individual's community. These are recognized in a rudimentary way and appropriated quite literally. Stage 2 individuals can describe religious or historical narratives but have little conceptual perspective of their meaning.

Stage 3 – Synthetic-conventional is a conformist stage, since the opinions and authority of significant others play a powerful role. Values, commitments, and relationships become central to identity and worth. Authority is located in traditional authority roles or in the consensus of a valued, face-to-face group.

Stage 4 – Individuative-reflective realizes that meaning is separate from the symbols and rituals which convey it. Two essential aspects mark this stage: realization of the relativity of one's world view and abandonment of reliance on external authority. It is achieved through a deepening self-awareness and the assumption of personal responsibility for making choices of ideology and lifestyle.

Stage 5 – Conjunctive faith is not usually reached before mid-life. The embrace of polarities in one's life, an alertness to paradox, and the need for multiple interpretations of reality mark this stage. Stage 5 individuals are genuinely open to the truths of other communities and traditions, and recognize that ultimate truth extends beyond the reach of every tradition. Importantly, Stage 5 is characterized by an interiority which brings "an opening to the voices of one's deeper self" (Fowler, 1981, p. 193).

Stage 6 – Universalizing faith is attained by a few exceptional individuals. They embrace the world as their community, have an all-consuming commitment to justice and love, and are devoted to overcoming division, oppression and violence.

This tool has been designed primarily for research purposes. It also claims to be helpful for individuals or groups seeking self-assessment and is targeted for professionals whose work includes exposure to trauma. It identifies individuals as being in low range (bottom quartile), medium range or high range (top quartile) on any given scale. Reliability and validity information are available through the Idaho State University Web site (www.isu.edu/~bhstamm).

Fowler's faith stage instrument consists of an interview that typically takes about two hours to conduct. Ordinarily, the interview is taped and then transcribed and scored for markers in seven different subcategories: form of logic, perspective taking, form of moral judgment,

bounds of social awareness, locus of authority, form of world coherence and symbolic function. As this study had limited scope and resources, I taped interviews but did not transcribe them, utilizing a scoring technique that included listening to each interview twice and recording markers on a grid. The quesionnaire adapted for hospice personnel from Fowler's original interview structure appears on pages 30-31.[7]

From the interview itself, one can identify an individual's faith stage or state of transition between stages. Although there are simpler, more facile instruments that measure faith stage, they lack the nuance of Fowler's interview and do not effectively detect individuals in transition.[8]

On the assumption that field staff at HealthPartners Hospice of the Lakes might want to learn more about compassion fatigue and its impact on their work lives, I began by offering all field practitioners the opportunity to take the ProQOL and to receive confidential feedback regarding the results. As practitioners work in teams, this offer was made team by team, without management present, for a total of seven teams. If team members chose to proceed, they were offered an hour-long workshop on compassion fatigue for one continuing education credit (CEU) and/or written materials on the topic. They completed signed consent forms agreeing to be research subjects and were asked to check a box at the bottom if they were also willing to be interviewed individually following ProQOL administration.

Teams tended to act as coherent groups. If one person on a team expressed interest in the ProQOL

or the workshop, team consensus tended to build quickly. I was careful to describe all participation as voluntary and prepared to work with individuals or parts of teams if consensus was not reached, but this was never the case.

All seven teams expressed a willingness to take the ProQOL; however, one team did not return test protocols. Overall, respondents averaged in upper medium range for compassion satisfaction, medium range for burnout and high range for compassion fatigue.

Four teams expressed interest in workshops, which included a discussion of the three sub-scores of the ProQOL, as well as the difference between burnout and compassion fatigue. Some found this distinction somewhat pointless, i.e., when you feel crummy, you feel crummy—who cares what it's called. Others found it useful, saying that it provided them with a means of teasing out which aspects they could influence positively, and which ones they might be better off ignoring.

All individuals on three teams volunteered for the follow-up faith stage interview, and I chose the first six whom I could schedule: two nurses, two social workers, a bereavement coordinator, and a chaplain. As the pace of hospice work is very intense and the interviews time consuming, I was grateful for a pool even of this small size, because it allowed me to schedule interviews with a shortened timeframe. To conduct interviews more than a few weeks past the administration of the ProQOL would have created a problematic time gap.

Results

All of the interviewees were open, engaged and extremely generous

both with time and with self-reflection. Assessment of their faith stages revealed three individuals solidly in the middle of a given stage, and three in transition.

I aligned each individual's assigned faith stage with his/her compassion fatigue score and then analyzed the resulting data for patterns. (See Table 1.) My hypothesis was that those in higher stages of faith development, whose capacity for compassion is arguably heightened, might be experiencing higher levels of compassion fatigue. As a result, I looked for a correlation between faith stage and level of compassion fatigue.

The faith stage range proved to be narrow with most participants falling in Stage 3, Stage 4 or transition between the two. This is less surprising when the ages of the interviewees—thirty-five to sixty—are taken into consideration. These are the most common stages for that particular age group.

It is interesting that three out of six interviewees—all with high compassion fatigues scores—were in transition. This opens the possibility that hospice work does indeed stimulate growth; however, this is an ambiguous finding as there is no way to examine causal relationships with such a small sample.

Discussion

While the limits of this pilot study are obvious, these results do suggest the possibility that work which involves constant exposure to death and dying is related to spiritual development. Further study is necessary to determine whether transitional phases of spiritual development cause states of heightened compassion fatigue or whether it is the reverse. Those who work

in environments of suffering and death tend to have special gifts, e.g., empathy, discernment of pain and ability to manage it well, high tolerance for being witness to loss and suffering, great capacity to listen and support non-judgmentally. Ideally, such individuals would be able to navigate through compassion fatigue utilizing the same tools that help anyone progress along a path of spiritual growth.

Impacting compassion fatigue through enhancement of spiritual development is neither expensive nor difficult. Supportive, understanding peers are among the most powerful agents in this regard (Catherall, 1999) and often the least utilized.[9] For example, the compassion fatigue phenomenon of sleep disturbance is not uncommon in hospice staff. I know of more than one practitioner who wakes up in the middle of the night and listens to work voicemail, filling this sleepless time with images of night call triage situations, only to reach morning a bit more exhausted.

Using the medical diagnosis and treatment mode may result in intervention via medication. From a spiritual development perspective, "treatment" may involve a discussion among supportive peers in which compassion fatigue may be respectfully processed—given the form of a story that others hear and honor. Though this is different from a prescription for sleep medication, it need be no less effective.

Anecdotally, it was interesting to watch the three Fowler-transitional individuals proceed with their work following the interviews. They all appeared to be more energized, more hopeful and, in general, less fatigued. Simply to be well heard invites spiritual resilience in a way that should not be underestimated.

Table 1

Comparison of faith stage and compassion fatigue scores

	Faith Stage	Compassion Fatigue Score	
Subject A	5	0	very low
Subject B	4 with some remnants of 3	10	low middle
Subject C	3	11	low middle
Subject D	Between 3 and 4	17	high
Subject E	Between 3 and 4	19	high
Subject F	Between 3 and 4	27	very high

Conclusion

Compassion fatigue may generate discomfort, job turnover, decrease of effectiveness with clients and coworkers as well as physiological problems such as sleep and eating changes, panic attacks, jumpiness, and/or flashbacks. Nevertheless it also may be an indicator of spiritual development. This changes the possibilities for choosing how to address it. As this phenomenon is inherent in the work of all who companion those in crisis, further research is warranted.

Author's note

Many thanks to all those at Hospice of the Lakes who supported this pilot project with their time, wisdom and guidance. ♦

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[8] Gary Leek, "Validation of faith development scale using longitudinal and cross-sectional designs" *Social Behavior and Personality: An International Journal* 31, (2003), 637-41.

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Fowler's interview structure adapted for hospice

Introduction: Specific questions about hospice work

1. About how many people do you see in a week?

2. How many of those visits are notably difficult, and in what ways?

3. How many are notably satisfying, and in what ways?

4. What is it about the work in general that most inspires or encourages you?

5. What about the work is most difficult for you?

6. How long have you been doing the work?

Part 1: Life review

1. Factual data
    Date and place of birth
    Number and ages of siblings
    Occupation of providing parents/adults/caregivers
    Ethnic/racial/religious identifications
    Characterization of class: childhood and present

2. Divide life into chapters—major segments created by changes or experiences, "turning points."

3. In order for me to understand the flow or movement of your life and your way of thinking and feeling about it, what other people or experiences would be important for me to know about?

4. Thinking about yourself at present, what are the things that make life truly worth living for you?

Part 2: Life-shaping experiences and relationships

1. At present, what relationships are most important to you? e.g., family, friends, work; may be positive, negative or both.

2. You did/didn't mention your father. When you think of him as he was when you were a child, what stands out? Tell me about him, e..g., work, religion, interests, challenges.

3. You did/didn't mention your mother (same as question 2)

4. Have your perceptions of your parents changed since you were a child? If so, how?

5. Are there other people from earlier times in your life who played a key role, or who have been significant in shaping your outlook? Tell me about them.

6. Lows: have you experienced losses or suffering that have shaped you in significant ways?

7. Highs: have you had moments of joy, ecstasy, or breakthrough that have shaped your life significantly?

8. What were the taboos in your early life, i.e., what were you taught to understand as absolutely forbidden? How have you lived with or out of those taboos since childhood? What are your own taboos now?

9. What experiences have affirmed or strengthened your sense of meaning in life?

10. What experiences have shaken up or disturbed your sense of meaning?

11. Who are the greatest heroes in your life? Why?

12. Who are the greatest anti-heroes?

Part 3: Values and commitments

1. Can you describe the beliefs or values that are most important to you? Why these, and not some others? In what way do they find expression in your life? Please give examples: e.g., times of crisis, risks/costs of commitment.

2. What is the purpose of human life?

3. Do you feel that some approaches to life are more "right" or "true" than others? Are there some beliefs or values that all people ought to hold and act on?

4. What symbols/images/rituals are most important to you? Why?

5. What relationships or groups are most important to you as support for your values and beliefs?

6. When you have an important decision to make, how do you go about deciding? Please give examples, if possible.

7. Do you think there is a "plan" for human lives? Are we, individually or as a species, shaped or defined by forces beyond our own control? Elaborate.

8. When life seems most discouraging or hopeless, what holds you up or gives you hope? Elaborate.

9. When you think about the future, what makes you most anxious or uneasy for yourself, for those you love, for society, for whole world. Respond to any or all.

10. What does death mean to you? What do you think happens to us when we die? Have you had some lifeshaping experiences related to death and dying?

11. How has hospice work changed your feelings and understandings about death and dying?

12. Why do you think some people (or groups) suffer more than others?

13. Do you feel that human life on this planet will go on indefinitely or is it about to end? Something in between those two extremes or different from them?

14. Where do you feel that you are changing/growing/struggling at the present time? i.e., what are your growing edges?

Part 4: Religion

1. Do you consider yourself a religious person? Why/why not?

2. What feelings come up for you when you think about God? Has this changed over the years? If so, how?

3. If you pray, what do you feel is going on when you pray?

4. What is "sin" or "evil" to you? Has this changed since you were a child? If so, how?

5. Some people believe that without religion, morality breaks down. What do you believe?

6. Do you understand your religious perspective to be "true?" If yes, to the exclusion of other religious perspectives? If no, elaborate.

Part 5: Summary

There may be important memories, thoughts, feelings, beliefs, or stories that have not come up yet. Please take a moment to reflect on your life, and add whatever would help me to understand your faith, using that word in the broadest sense.

Questions to a Hospice Chaplain

Bill Serdahely

In a response to questions asked by hospice patients and their loved ones, the author explores the dying process. Using examples from his ministry as a hospice chaplain, he details the difference between predeath visions and hallucinations. He also raises the possibility that dreams may provide a way for patients, whether alert or comotose, to prepare for death through resolution of remaining life issues.

As a hospice chaplain affiliated with a community hospital, I often am asked by my patients or by their loved ones to explain three phenomena: predeath visions, predeath dreams and the length of time the dying process takes. Specifically, my clients ask me about the validity of predeath visions; about the meaning of predeath dreams and why dying takes so long.[1]

Building on some twenty-five years of near-death experience research and eight years as a hospital and hospice chaplain, I set out to research three related questions in order to better serve my patients and their family members:

1. What is the difference between a predeath vision and a hallucination?

2. Do nonresponsive/comatose people dream, and if so, what are the implications?

3. Why is the dying process often so long and so unpredictable both for alert as well as nonresponsive/comatose patients?

Predeath visions

It is not uncommon to hear family members, and sometimes even a few hospice medical staff persons, report that the patient is hallucinating. On further inquiry, however, it appears that the patient actually is having a predeath vision. It is important to differentiate between the two, as hallucinations may be pathological or a side effect of medications, while predeath visions are generally healthy for, and helpful to, the patient.

As with hallucinations, predeath visions occur when a person is awake. They may be distinguished from hallucinations in several ways. Deceased loved ones are much more likely to be viewed in predeath visions than in hallucinations. Predeath visions, unlike

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hallucinations, may be spiritually transforming.[2] Further, they tend to be comforting rather than frightening to the patient.

Sarah's mother provides a typical example.[3] Sarah was extremely anxious about how to reply when her mother reported seeing her husband and son, both of whom were deceased. I assured Sarah that many dying people have predeath visions, and that these often are intended to convey to the dying person that their deceased loved ones are there for them. Sarah's anxiety level markedly decreased over the course of our visit, and she said she now felt much better about her mother's comments.

In a previous article, I reported on a series of predeath visions, collected over several years.[4] These were reported by secondary sources, mainly family members of the patient or hospice nurses. They appeared to provide loving help from the other side to the dying person.

Karen reported that her great-grandmother was very concerned about her affairs not being in order. A female "angel" (her word) appeared to this woman telling her, "Don't worry. Everything will be fine." The next day, Karen's great-grandmother died.

One evening after an extended period of coma during which she had not stirred, Brad's wife suddenly sat up, looked at the ceiling, extended her arms and died. To her husband, son and daughter who surrounded her bedside, it appeared that she had experienced a deathbed vision that helped her make the transition.

A hospice nurse described a male patient who had experienced several visions of deceased people from his past prior to having a very rest-less night. The following morning he was very alert and wanted cornflakes for breakfast. Soon after that, he sat up and looked past his sons. His eyes became huge and "trance-like." He said, "Let's go. Let's go," and he died within the hour.

A different sort of "sighting" occurred with Dan, who told me that when he lay down in bed, he would see the ceiling light fixture come down at him. I replied that I believed Dan was hallucinating. Adjustments subsequently were made in his medications, and this experience ceased.

Failing to distinguish correctly between predeath visions and hallucinations may have serious medical implications for the patient. If medications are decreased or stopped on the erroneous assumption that the patient is experiencing a predeath vision, there may be serious physical consequences. Conversely, treating the predeath vision as an hallucination may result in overmedication.

Predeath dreams

As with predeath visions, predeath dreams often are of comfort and of help in the dying process. They may be peopled by deceased loved ones who may communicate messages such as "I am here for you" or "It's not quite your time yet, but soon." Sometimes predeath dream imagry is more symbolic as described by a patient who frequently asked why hadn't he died yet. In a subsequent dream, he found himself almost finished doing an ineffable project. He shared his dream with me, and I suggested that perhaps this was the answer to his question. His dream seemed to indicate that his project, i.e., his life, was almost finished. He died shortly thereafter.

Occasionally, the dream of a dying person may even be prophetic. Stan, who was dying of amyotrophic lateral sclerosis (ALS), dreamed he was pushing a sailboat into the water by himself with the horizon before him while people stood on the shore behind him. We both agreed his dream was a metaphor for his impending death. He also said the time in his dream was "3 p.m. or 4 p.m.." Initially, the time reference seemed strange, but then he added that it was a time when there was not much daylight, which brought to mind the winter solstice. Dan told me about his dream early in December, and he died the day after the winter solstice. His wife told me Stan always hated the winter solstice because of the paucity of light. She believed that he held on long enough to see it come and go.

length of time to die

Often hospice patients tell me they are ready to die, but it is taking what seems to them to be an interminable length of time. Both they and their loved ones often ask why God doesn't "call them home" sooner rather than later.

As Pete lay comatose in our hospital hospice room, his dear friend, Tina, a steadfast companion and caregiver, asked me several times why he hadn't died yet. Everything seemed to have been taken care of, and Tina had told him he was loved and "could go." Yet he lingered.

Edith was admitted to hospice, and seven months later she was still alive and suffering, despite ongoing, attentive nursing care. Her daughter, Maria, was greatly distressed.

She had followed all the prescribed recommendations, such as telling her mom that she loved her and that she could let go. She also had made sure that her out-of-state brother, Ted, came to visit Edith. Still Edith lived, slumped over in her wheelchair with her head on her chest, able to speak but a few words and to sleep well only occasionally, despite frequent adjustments to her medications.

While I realize there are medical factors which determine the length of time it takes to die, I believe that spiritual and emotional factors also may come into play and interface with the pathophysiological variables. When the dying process seems to be protracted, I am inclined to wonder whose need it is that death come sooner rather than later. What has become clear to me is that the patient is not on the loved one's timetable. The loved one's agenda is neither the agenda of the patient nor of God.

Though it is impossible to say with absolute certainty what is transpiring for each and every person dying in a protracted way, some possible explanations may be offered.

Standing at the bedsides of such comatose and nonresponsive patients, I often wonder if perhaps the dying persons may be dreaming. Two renown experts on dreams independently communicated their professional opinions that dreaming is possible during the comatose/nonresponsive state of consciousness. Dr. Harry Hunt suggested looking for the rapid eye movements below the closed eyelids, which signal REM sleep.[5] Jeremy Taylor, who has conducted extensive research on dreams, maintains that considerable spiritual and emotional work is completed through dreaming. Thus, it is possible that comatose hospice patients may be doing dream work during this time.

It is also possible that the patient may be completing a life review while comatose. Life reviews are well-known phenomena for people having near-death experiences.[6] With hospice patients, the goal may be to bring the person back into spiritual and emotional balance prior to death.

Near-death experiencers and nondying comatose patients have occasionally reported having out-of-body experiences (OBEs).[7] Therefore, it seems reasonable to posit that during a prolonged dying period, the comatose hospice patient may be having OBEs.

Another extrapolation from near-death experiences (NDEs) is that of a mission or missions. NDErs often report that they were sent back to their physical bodies because they still have a mission or missions to complete. Their understanding is that once they have fulfilled these, they will be allowed to "return to the other side," i.e., they will die. Perhaps some dying hospice patients still have a mission to fulfill as well.

For example, in caring for a hospice patient, estranged family members sometimes are forced to meet, to talk and to make medical decisions together. Thus, the prolonged dying period may serve a greater spiritual good, providing time—and space—for estranged family members to begin to reconcile.

The dying patient may be using this time to take care of personal unfinished business. The patient cited above provides an example of this. During the last two months or so of her life, Edith talked repeatedly about cats: take care of the cats; protect the cats; give food to the cats; are the cats O.K.? Her comments were attributed to her mild dementia, but somehow they seemed related to unfinished business.

In conversation with her son and daughter, they told me that when she was a child, the youngest of nine and living on a farm, she loved animals and had about thirty pet cats. One day when she was away from the farm, her parents and most of her siblings drowned all of her pet cats.

Edith's adult children told me she had been badly traumatized by this incident. I came to believe that in the last two months of her life her concern about cats was a reflection of her attempt to accept and to make peace both with the loss of her pets and with the betrayal of her parents and siblings.

Conclusion

My goal as a hospice chaplain is to provide better answers to the questions of my patients and of their loved ones about predeath visions, predeath dreams, and the seemingly long period of time the dying process may take. Differentiating between predeath visions and hallucinations may help clients having the former better cope with their dying process.

Interpreting predeath dreams may provide them with salient information about the last phase of their life. Exploring possible explanations for a protracted period of dying may give some measure of comfort both to the patients themselves and to their loved ones. ♦

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[3] All names in this article have been changed to insure the confidentiality of my patients and their loved ones.

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5 Reverend Jeremy Taylor, e-mail to author, September 25, 2006.

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Touchstones: Tangible Spiritual Nourishment

Mang Tiak, BCC
Cindy Vanover

on holy ground

Throughout human history, tangible items have served as symbols through which we receive meaning and, often, comfort. Having something "to hold on to" such as beads, shawls or rosaries often provides insight, comfort and strength.

Observing this power of something to hold on to, the spiritual care staff of The Methodist Hospital System (Houston, Texas) began looking for something tangible to leave with patients at the end of the chaplain's visit. We wanted something without specific reference to any one religion or spiritual practice, yet something that that they could hold, see or use in meditation and that would act as a remembrance of the comforting words of chaplain, friends or family.

Ultimately, we decided on "touchstones," smooth rocks with words etched into them: serenity, peace, strength, grace and patience, to name a few. Rocks clearly have many metaphorical associations. In most faith traditions, rocks or stones have been used to convey meaning. The English language has many positive associations with stones and rocks. For instances, we refer to the stepping stone, cornerstone, and touchstone. The Psalms are full of references to rocks as illustrative of God as defense, refuge, salvation and foundation.

Still many of the chaplains were hesitant about the idea because they were unsure of patients' reactions. Often to their surprise, they discovered deep and powerful reactions by patients, who found the stones very comforting and spiritually helpful.

Reverend Mang Tiak, senior staff chaplain, tells the following story:

Last summer, I received a blue bag of touchstones from my department director. He said we were going to use these stones in a pilot project in our ministry with patients and families. My first reaction was less than enthusiastic. I was actually unwilling although I don't know why. Those stones were stuck in my office for several months.

Finally, in December, I began to use them in my visits. One of those was to a man I'll call Andrew, who was very weak and not expected to live.

I gave Andrew the stone engraved "Strength" and blessed him by saying, "May the Lord grant you both physical strength and spiritual strength." He shared with me his feelings of rejection from some faith communities, his loneliness in his spiritual life and his fear of dying. As I journeyed with him in his wilderness, he wanted to reconcile with God and renew his faith in Christ. I offered him a service of healing. He held his Strength stone tightly in his palm during the service. In fact, he held that stone every time I visited him. I was surprised and grateful for the comfort he received from this simple object. I wasn't the only one who noticed, however.

His physician told me that Andrew "seems to be so touched and strengthened by the stone you gave him. He holds it every time I visit. Thank you so much for your wonderful ministry with him."

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Toward the end of April, I was paged by a social worker. Andrew was actively dying and requested my ministry. Later, when I met with his mother and his partner they asked me to speak at his funeral. How could I refuse, knowing how rejected Andrew had felt? He died peacefully that night.

At the funeral, Andrew's partner came to me as I was approaching the coffin to say my farewell. He pulled the stone I had given Andrew from his pocket and said, "I will keep this stone on behalf of Andrew for the rest of my life. It helped to give him strength even when he walked through the valley of the shadow of death ...." He could not continue, and my eyes were filled with tears. All I could say from deep down in my heart was "Thank you God for those who brought these stones for me to use in my ministry."

It would be easy to hear such stories and attribute magic powers to the stones, but we know to do so would be to create idols. To attribute such powers to them would be inappropriate because the stones themselves did not provide comfort, strength and healing. The stones are merely objects—unless they are viewed as icons—as physical things through which we can receive spiritual strength.

As chaplains and people of faith, we recognize that God has provided us with an abundance of such stepping stones, gracing us with a bounty to nourish the spirit. To rely solely upon one source of nourishment is to create an easy path to idolatry. To take part in all that God has to offer allows us to lovingly embrace a diversity of passageways.

While it is comforting for the hospital patient to read spiritual prose, it is also comforting to hear an uplifting song or to eat a home-cooked meal prepared with love or to hold a warm, smooth stone. All of our senses can connect with symbols or objects to bring us spiritual nourishment. This happens most effectively and powerfully when we treat such symbols and objects as icons and, in that way, open ourselves to receive.

Without objects or symbols, we humans have nothing to focus on, nothing to interact with, and without focus and interaction, revelation is not possible. So we must speak, we must write, we must listen, we must read, and we must interact with the world of objects. In so doing, we must recognize that these symbols and objects are not in themselves divine. Rather these icons provide us with a medium for divine fellowship and communion. While they do not provide us with absolute certainty, they do provide us with a passageway—with stepping stones. ◊

Code Blue

"Code Blue, Code Blue"
Two words
I don't
like together.

I had seen him
that morning.
Too tired
to talk.

A covey surrounded him.

His roommate
was alone,
curtained off.

I shook his hand.
He responded,
"I like
Your grasp."

We talked about handshakes,
about Jesus.
His eyes
sparkled.

I clearly liked him.
Next visit...
"Was Jesus
God's Son?"

I liked him more.
Next visit...ICU.
Hand clasp.
I waited...

"Is it time to
let go?"
"I don't
know."

They say he died
Saturday morning.
I miss
Him.

Dick Millspaugh, BCC

Eleven Thirty-five PM

Reading poetry in bed
in a vain attempt
to replace imagines of a still tiny body
with thoughtful phrases that stir my heart.

As if chirping birds
and moonlit fields
could ever crowd out the memory
of the little pink feet
slowly turning white
while a mother pleads,
"My baby, my boy,
        Oh God, Oh please!"

Like partners in a macabre ballet
doctors, nurses, technicians dance
finding a vein, threading tubes,
compressing the tiny chest.
their music – a mother's wails.

I stand by helplessly
silently imploring God
to, just this once, allow a miracle.
Let this little one breathe!

But there are no miracles to spare this day.

No word, no phrase, no image
can erase the memory
of a mother's anguish
and two tiny white feet.

Some things cannot be forgotten.

Linda F. Piotrowski

poetry

In Memoriam

Across the keystone march the names,
war dead scored
in deep dark type
rank upon rank.

In memoriam each name borne
on Christ Church wall,
as stern to bow
penitents pray.

Thirteen born surrender their breath;
seven junior,
six first born worn.
Strong names, short shrift.

Robert W. Duvall, BCC

Grace

You're sitting there alone
on the bank of a rocky creek and God comes
and sits beside you,
takes off his shoes, dusty sandals really,
and sticks his feet in the cold, clear water.
Tiny fish swim around your toes,
silver and completely wild.
Somewhere nearby kids are lying in the sun
on the stone ledge of a waterfall,
eating watermelon, their hands sticky.
Suddenly butterflies in a cloud
surround them and land lightly
on their bright faces.

Capers Limehouse

Chaplain's Note: Haunted

All hospitals are haunted,
the long pale corridors, marked with signs
and with paintings of landscapes and houses,
no one sees
except as signs
to other signs, or, for a moment,
to life outside.
And all the old parts, the rooms turned to storage,
waiting like old women on a curb,
the shiny new units,
full of sun and luck, all are thick
with fluttering wisps and remnants
of spirits, too startled by their own deaths
to get themselves neatly beyond.
Voices, if there are voices, outside our range.
Even the endless florescent lights waver faintly
in the thin tatters caught on unsaid words
like filaments of fine cloth,
snagged on brambles in a thicket.
And maybe in the end
it's all of us – not one of us
making a clean break –
and those of us still mostly here,
the workers in their purposes, the grievers leaving,
the patients pushing their IV poles
down halls to the next nurses' station
and back in a hopeful, solitary marathon,
all of us still mostly here,
walking through this air,
never quite seeing, quite hearing
what is still there.

Capers Limehouse

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Quelli Sono I Mei Pantaloni

I am attempting to learn Italian
in the same way that I learned the care of souls—
one useful phrase
at a time,
one minor Intervention applied
to a thousand different cases.

Oh, I'm sure this is the point
at which you are expecting
me to say something about listening, but
listening never got me into trouble,
nor did "reflective response."

It was only when I offered some
original thought on the subject at hand that things
seemed to go awry, astray, out-of-kilter—"unhelpful" as they say in
the listening skills lab. I just don't have the wisdom
of Solomon, the eloquence of David, the fiery persuasiveness
of Jeremiah
(tho I have exhibited similar neurotic behaviors).

No, I learned the care of souls one phrase
at a time,
falling short
of perfection
in nine hundred ninety-nine
instances (perhaps more),
each error standing out like a lump of
coal on the living room sofa until
repeated failure alchemized each into
something diamond-like, and
like the facets of a diamond,
there glinted forth some heretofore hidden and
healing power—well, at least once.

As you might guess, I am still laboring
to find the gem-like quality in most of my
habitual pastoral utterances;
all of which explains my sputtering delight
when I happened upon "Quelli sono i mei pantaloni."
Where and how this phrase will be of use in my
encounters with some future Italian,
women and men of the bela figura,
I know not.

The vision carries me forward,
already anticipating the appearance
of that improbable phrase:
"Those are my pants."

R. Mark Grace

Jamie D. Aten, Jane E. Schenck. "Reflections on religion and health research: an interview with Dr. Harold G. Koenig," *Journal of Religion and Health* 46 no. 2 (Jun 2007): 183-90. • Harold G. Koenig is one of the best-known researchers in the medical world today who is working to disentangle and clarify the complicated links between religion/spirituality (R/S) and health. He has published widely in the fields of mental health, geriatrics and religion and has authored close to three hundred R/S and health articles in peer-reviewed literature. In addition, he has over thirty books in print or in press. This interview is wide-ranging, beginning with his attraction to psychiatry, which is where the power of religion first caught his attention. In caring for chronically ill, older patients, he found high rates of depression and sadness, but he also noticed that for many, religion was a major and valuable coping mechanism. As he trained in psychiatry, he also began studying religion in persons who were sick. He also started to talk to other doctors about what he was doing, which was not necessarily a wise career move during the eighties, but one which reflected his self-confessed rebellious streak. He talks about the current need for better research, about the topics he believes need to be investigated and about ways in which others might go about getting funding and undertake preparatory training.

Terry Badger, Chris Segrin, Paula Meek, Ann M. Lopez, Elizabeth Bonham. "Profiles of women with breast cancer: who responds to a telephone interpersonal counseling intervention?" *Journal of Psychosocial Oncology* 23, no. 2/3 (2005): 79-100. • The amount of research that has been done to investigate the use of telephone counseling to provide emotional support to people after their hospitalization is relatively limited. A notable exception is the work by Badger, the first author of this study. The purpose of this paper is to discuss the profiles of women with breast cancer for whom a telephone counseling intervention was beneficial for symptom management as well as for quality of life. The findings presented are based on the responses of twenty-four participants, who completed the telephone counseling intervention, as well as three measurements made over the course of the ten-week study. The typical participant was white, in her mid-fifties and married. Most had stage II breast cancer and were receiving chemotherapy as the primary treatment. The findings suggest that women in long-term marriages who reported no previous history of depression or cancer benefited most from the intervention. This group reported the least depression, negative affect, symptoms of stress/fatigue and improved quality of life. The authors suggest several theories, which may explain their findings and discuss the implications for future practice.

Christina Beardsley. "Not just a comic turn: clowns and healthcare chaplains," *College of Health Care Chaplains Journal* 7, no. 1 (Spring/Summer 2006): 2-11. • In the late 1960s, Heije Faber, a Dutch pastoral theologian, wrote a book in which he presented the clown as a model for healthcare chaplaincy. Since then, a number of chaplains as well as others in healthcare have written about the analogy between the clown and the chaplain. The most recent United States contribution was authored by Jason Cusick (*Chaplaincy Today* 21, no. 2 [Autumn/Winter 2005]: 12-18). Beardsley describes the origin of the analogy of the clown in the social and religious ferment of the 1960s, and then

in the literature

These abstracts have been selected from the database of *THE ORERE SOURCE*, a bimonthly publication of pastoral and related articles edited by W. Noel Brown, MDiv, BCC.

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asks whether Faber's three points of comparison between chaplain and clown are relevant today. Having provided a brief overview of the history of clowning, mime, and physical theater, she asserts that the analogy does indeed speak to some of chaplaincy's current concerns, e.g., the problem of transcendence, teamwork, professionalism, prophetic ministry. In this well-written article that is too brief by a measure, Beardsley's contribution, like Cusick's, provides a new perspective on the "foolish" work of hospital chaplains today.

Sarah Beckman, Sanna Boxley-Harges, Cheryl Bruick-Sorge, Becky Salmon. "Five strategies that heighten nurses' awareness of spirituality to impact client care," *Holistic Nursing Practice* 21, no. 3 (May/Jun 2007): 135-140. • "Professional practice standards mandate that spiritual nursing care is a responsibility, not an option." With that declaration, these nurse authors point out the gap between what nurses *should* do—be more aware and responsive to patients' spirituality—and what many *actually* do—give spirituality a low priority. They describe four experiential exercises, which may be offered alone or in a series, and make suggestions for questions to ask when interviewing patients about their spirituality. The exercises may be used in clinical pastoral education (CPE) groups, by chaplains with nurses or in educational groups in synagogues or parishes. Although none are new, and in fact most were being used thirty years ago, the authors correctly suggest that if nurses are to be more effective in talking with their patients about spirituality, they must have some

experiences that are more effective than attending a lecture or reading a book. Nevertheless, a case could be made that the focus of the four exercises described conveys too narrow an understanding of the richness of spirituality.

Diane J. Chamberlain. "The experience of surviving traumatic brain injury," *Journal of Advanced Nursing* 54 no. 4 (May 2006): 407-17. • This paper from South Australia presents the results of a study describing the experience of surviving traumatic brain injury (TBI), as related to the author by sixty individuals, one year after their injuries. She describes what she has found as "an individual and invisible experience," concluding that healing and resolution of grief continues to be problematic. There is very little in the literature on this subject, and the aim of her study was to learn how experiences of self within survival and recovery were described by survivors of TBI. She also wanted to learn how the individuals were making meaning of the experience of surviving. The most common themes included regret and grief within the self; the insensitivity of health professionals; the stranded self; and the recovery in self, which concerned stories that the survivors reconstructed when they saw their current lives. Chamberlain illustrates the themes with heartbreaking quotes from the persons she interviewed. Because of the reality of "invisibility," that is, the fact that so much of what needs to be attended to about these patients is invisible, chaplains will find this a useful exploration. The staff expectation is that once such patients have been treated and discharged from hospital, they will

simply move on with their lives. This kind of attitude in healthcare professionals may be appropriate for persons whose visible wounds or broken bones have healed. Recovery from a TBI tests our ability to fully understand and support wholistic recovery. In that regard, it is noteworthy that there is no mention of spirituality or religion in the article.

Peter A. Clark. "To circumcise or not to circumcise?" *Health Progress* 87, no. 5 (Sept/Oct 2006): 30-39. • Routine circumcision of newborn baby boys is the most frequent surgical operation performed in the United States. However, in recent years, there has been an increasingly widespread debate in the medical, ethical and, most recently, the legal community concerning the surgery's appropriateness. The recent discovery that the practice of circumcision may affect the potential for acquiring the AIDS virus has added a particular urgency to the current discussion. At first glance, the issue appears to be solely medical, but Clark suggests that further analysis of this practice reveals religious, cultural and even socio-economic implications. This article examines the medical and legal issues of newborn male circumcision, gives an ethical analysis of the current controversy surrounding the issue and determines if it is ethical for Roman Catholic hospitals to permit the procedure. Clark concludes that barring religious obligation, there is little to recommend routine circumcision of newborn males, adding: "if promoting the dignity and respect of every human person is a priority for the United States and for Catholic health care, then it is time

to better educate the public about this issue and to protect those who are the most vulnerable in our society. Doing so is not only of social responsibility; it is a moral imperative as well." (p. 38)

Rebecca Clarren. "Behind the pillow angel," *Salon.com* (9 Feb 2007): 5 pp. • Ashley is a nine-year-old girl with static encephalopathy, a very rare medical condition that causes permanent brain damage. Her parents have described her as having the mental capacity of a three-month-old; she cannot walk or talk. Last year, they asked doctors at Children's Hospital and Medical Center in Seattle, Washington, to perform what has come to be called the "Ashley Treatment." This involved surgically removing her breast buds, performing a hysterectomy and giving her high doses of estrogen for thirty months so that she would never increase in stature. One of the reasons for this request was to ensure that they would more easily be able to care for her than would be true if she continued to grow in size. She is presently four feet, five inches tall and weighs sixty-five pounds. She will continue to age, and with good physical care, she is expected to have a normal life span. News of the surgical intervention has caused a great deal of discussion; numerous articles have been written concerning the case and the ethical issues involved. Clarren has done her homework by going back to the start of this case in early 2004 and providing details of the process leading to the surgery. This information provides a deeper understanding of the values held by all who have been involved. Some of what she describes has not appeared in other reports, e.g., the

hospital ethics committee that gave support for the treatment included a chaplain. The original medical article by the lead physicians involved, "Attenuating growth in children with profound developmental disability: a new approach to an old dilemma" by Gunther and Diekema, appeared in the *Archives of Pediatric & Adolescent Medicine* 160, no. 10 (2006): 1013-17. Clarren's article may be downloaded. http://www.salon.com/news/feature/2007/02/09/pillow_angel.html

Natarlie deCinque, Leanne Monterosso, Gaye Dadd, Ranita Sidhu, Rosemary Macpherson, Samar Aoun. "Bereavement support for families, following the death of a child from cancer: experience of bereaved parents," *Journal of Psychosocial Oncology* 24, no. 2 (2006): 65-84. • This is the second of three reports by a staff group from the Oncology Total Care Unit of Princess Margaret Hospital in Perth, Western Australia, which has been looking at the bereavement support given families after the death of a child from cancer. In this study, they set out to identify the experiences and needs of parents who received hospital-based bereavement support. The study process, which included unstructured interviews with nine parents, six mothers and three fathers, is clearly described. Four questions were utilized. Tell me a little about your child's illness. (Prompt question: What about the last few days of your child's life?) Thinking back to the time after your child's death, what was that like for you? (Prompt questions: What helped you and your family during the immediate period of your loss? What wasn't helpful during this time?) Reflect-

ing back, what things were done by the ward or the hospital team in general that helped you and your family at the time? (Prompt questions: What other things could have been done for you and your family that would have been helpful? Was there anything the staff in the wards or the hospital as a whole did at the time that wasn't helpful?) Are there any other suggestions you can offer that may be of help in the future to other bereaved parents? An analysis of the interviews led to the identification of six themes in the parents' comments: personal grief, personal coping, concern for the siblings of the deceased child, hospital bereavement support, use of community supports and unmet needs. Each of these is discussed and illustrated. The take home lessons from this study, headlined here, but detailed in the paper include the following. Fathers and mothers grieve differently, which places stress on their relationship as they each do their grief work. A lack of understanding by relatives and friends as to what the parents are going through isolates them at the very time they need support. A number of parents reported that religious faith and "after death" beliefs helped them cope, suggesting that health care professionals need to develop an awareness and understanding of any parent's belief system. These parents commonly reported needing help in order to be able in turn to help their child's siblings with their grieving.

Nina Eikens. "Who'll win the life saving kidney?" *www.radionetherlands.nl* (31 May 2007): 2 p. • Does the end justify the means? On Holland's "De Grote Donor Show" (The Great Donor Show) a

terminally ill thirty-seven-year-old woman, identified only by the pseudonym Lisa, was placed before a panel of people, all of whom needed a donor kidney. During the program, she asked them questions about their lifestyle and their personal histories and conversed with their families and friends. Audience members were able to send her advice via text messaging, and at the end of the show, she decided who should get her kidneys when she died. The program was broadcast on June 1, 2007, on the Dutch public TV broadcaster BNN, stirring up great controversy both before and afterward. Although the program appeared to break no laws, it did cause considerable distaste, not only in Holland but also across Europe. Three days after the airing, the whole affair was revealed to be a hoax, albeit a hoax with a purpose. It had generated over 50,000 responses asking for information about organ donor cards. See http://en.wikipedia.org/wiki/The_Big_Donor_Show for the full story.

Brian Hughes, Mary Whitmer, Susan Hurst. "Innovative solutions: a plurality of vision," *Dimensions of Critical Care Nursing* 26, no. 3 (May/Jun 2007): 91-95. • This is a very good article on hospital chaplaincy, written jointly by a chaplain (the lead author), an experienced palliative care nurse practitioner and a clinical care nurse specialist in critical care services. Its intent is to showcase the potential of chaplaincy in critical care units. The need for, and the training process of, the board certified chaplain are accurately described as are the needs of ICU families and the potential value of interdisciplinary teamwork. The

need for teamwork is based on a Quality of Life model of care. "The spiritual component of this model addresses religion and spirituality, spiritual suffering, exploration of meaning, hope versus despair, the importance of ritual, and cultural diversity." In part, the authors conclude that "chaplains play an important role in the plan of care and decision making, enhance the interdisciplinary team and provide an invaluable bridge between the medical staff and the hospitalized patient and family." (p. 95) This paper would have value in enlarging the vision of some nurse managers or hospital administrators. Final factoid: In 2003, a chaplain at the center described in this article contacted the pastoral care department at every facility which had acquired Magnet status (a national recognition of nursing excellence) to inquire about chaplain staffing to bed ratios, i.e., chaplain FTEs versus average daily census. Of the 108 Magnet-recognized facilities at the time, 101 supplied figures. The as-yet-unpublished result was a ratio of 1:153.

Steven Laureys. "Eyes open, brain shut," *Scientific American* 296, no. 5 (May 2007): 84-89. • Up in the neuro-ICU, life gets increasingly challenging with every passing month as more and more people who have suffered brain damage are admitted. Even after surviving acute trauma, if the damage is severe, the individual may slip into a coma. The question then turns to whether the person will recover, and what will recovery look like? The case of Terry Schiavo put the spotlight on such situations. In this overview article, Laureys, who leads a research coma group, clearly

and succinctly presents what currently is understood about coma and the vegetative state. He shows how the two main components of consciousness can be completely dissociated, with wakefulness being intact, while awareness, which includes all thoughts and feelings, is lost. Thus, a person can be awake, but not aware. The wakeful patient has sleep/awake cycles, at times seeming to be awake with eyes open and wandering, and at other times eyes shut as if in sleep. In the latter, patients may even open their eyes and stir if someone touches or speaks to them. Chaplains who provide pastoral care to such patients and their families will gain a clearer understanding of what is happening and of the difficulties involved in determining who may regain consciousness and who will not.

Mary E. Madonald, Stephen Liben, Franco A. Carnevale, Janet E. Rennick, Susan L. Wolf, Donald Meloche, S. Robin Cohen. "Parental perspectives on hospital staff members' acts of kindness and commemoration after a child's death," *Pediatrics* 116, no. 4 (Oct 2005): 884-90. • This interdisciplinary paper, written by nurses, chaplain and doctor, explores the significance of different acts of kindness by staff members toward parents following the death of their child. Twelve parents whose children had died in an ICU at a tertiary care pediatric hospital were interviewed about their experiences. The purpose of the interviews was to explore their experiences of the death. Three themes emerged. Parents placed great importance on the hospital's memorial service and on staff members' presence at that service. While parents found

it hard to return to the hospital after the death, they all attended the memorial service, and some found closure as a result. The parents appreciated receiving cards and greatly valued staff members' efforts to visit or telephone and attend the funeral. Even after a significant interval, parents remembered positively those staff who had done these things. On the other hand, parents spoke of their disappointment when staff did not engage in such activities or were absent from memorial services.

Rajeev Mehta, Joshua Hauser. "Hospital chaplains reflect on spirituality in end-of-life care," *Healing Ministry* 12, no. 3 (Summer 2005): 35-43. • The objective of this study was to explore what a group of hospital chaplains believe is important in spiritual care at the end of life. The intent was to understand, in a nuanced way, the spiritual care that should be considered by all members of interdisciplinary teams for the benefit of their patients. Individual interviews were conducted with all six of the full-time chaplains of a midwest hospital. The chaplains were of Protestant, Catholic and Jewish backgrounds, and each had at least ten years of experience working in palliative care. The interviewer asked two open-ended questions in order to open discussion regarding each of three categories. May contact with religious figures be helpful? May contact with a religious figure or religious concerns in general be harmful? What is the role of specific religious beliefs for the chaplain and the patient? Using the methods of grounded theory, salient themes from the interview notes were assessed. The authors

present their findings in detail under the following headings: the positive outcomes of chaplaincy, chaplaincy for those without specific beliefs, negative associations with religion and the role of specific religious beliefs. Important factors uncovered by this study include understanding that the chaplain acts as a listener for the patient, helps patients avoid a sense of guilt and feelings of isolation and provides meaning and purpose for patients. The authors suggest that physicians should be aware of the patient's own spiritual resources. They also encourage referrals to hospital chaplains, as was prposed by Daaleman and Frey ("Prevalence and patterns of physician referral to clergy and pastoral care providers," *Archives of Family Medicine* 7, no. 6 [1998]: 548-53). They conclude that since studies have demonstrated that patients desire their physicians to be involved in spiritual matters at the end of life, the physicians themselves should be aware of how another important worker of the care team—the chaplain—sees his/her role. They remind physicians that they need to keep in mind that many hospital chaplains maintain a separateness from the hospital with its medical agendas and that this often is central to how they comfort patients. Such a boundary, they suggest, needs to be respected as a way in which the hospital chaplain is distinct from other health care professionals who are also involved in caring for the needs of the patient. They suggest that further work in this area should be done to understand specific ways that physicians and hospital chaplains might relate to one another concerning the religious and spiritual needs of their

patients. As a point of disclosure, the literature editor was one of the chaplains interviewed for this study.

David Mitchell. "The development of palliative care chaplaincy services in Scotland," *PowerPoint presentation* (2006): 13 slides. • Mitchell is a hospice chaplain in Glasgow, Scotland, where he is also a lecturer in palliative care. He describes how, over a ten-year period, hospice chaplains in Scotland developed standards and competencies for chaplains in palliative care and how these can be measured. The standards and competencies are clearly located within and consistent with the National Health Service government standards of the United Kingdom. (NHS QIS 2002) This presentation, titled "Building bridges with the medical community: palliative care in Europe and the spiritual health care giver," was given at a session of the consultation of the European Network of Health Care Chaplaincy, in Lisbon, Portugal, May 2006 at which chaplains and chaplaincy organizations from twenty-six countries across Europe were represented. Following Mitchell's presentation, the consultation adopted a statement on palliative care to be used by participants throughout the European network to strengthen the basis for spiritual and religious care of the dying. Mitchell's presentation, which is followed by a link to the statement adopted by the Network, may be downloaded. http://www.eurochaplains.org /060519_mitchell.pdf

Ann Neale. "Who really wants healthcare justice?," *Health Progress* 88, no. 1 (Jan/Feb 2007): 40-43. • This article is a "conscience work

exercise," designed by a member of the Center for Clinical Bioethics at Georgetown University. Neale suggests one reason that efforts to reform health care have not been successful is that we have not brought to those efforts sufficient reflection concerning the deeper values, attitudes and dispositions. Rather, the reform movement has been concentrated on promoting particular policy solutions. She created this exercise to help an individual or group examine the personal values, attitudes and dispositions that contribute to or inhibit efforts toward healthcare justice. The exercise comprises a one-page worksheet. Persons who undertake it are invited to share their findings with the author. Further details may be found on the Web site. www.chausa.org/consciencework

Christopher Newell. "Psychosis, spirituality and me," *bjr Newsletter* 18 (Apr 2007): 2-4. • Newell is a mental health chaplain. He also is recovering from a recent psychotic episode during which he was hospitalized. He courageously describes his experiences before, during and after his hospitalization. His story will be of value for those who wish to gain a deeper sense of what it is like to be mentally ill. He writes, "I want to speak of psychosis, of dream time, of inner voices that speak of the pantheon of embodied feeling, of terrors that undermine your very self and yet are strangely godly as well. What do I mean by that? What godly reason would there be for such seeming personal disintegration—disintegration to the point of death, or, at least the very serious contemplation of death—and that in order to save others too? Let me explain. You see, I was not sure I possessed a soul anymore …." (p. 3)

Louise D. Palmer. "Growing hope," *Spirituality & Health* 10, no. 1 (Jan/Feb 2007): 40-43. • How would you characterize or label hope? Is it a belief or an attitude, an inward disposition, or a gift? Anthony Scioli believes that it is most helpful to think of hope as an acquired skill. He believes that it is active, that one can tend and nourish it. He suggests that it is multifaceted, having fourteen distinct aspects, and self-perpetuating. Hopeful people tend to be more resilient, more trusting, more open and more motivated, so they receive more from the world, which in turn, confirms them in their hopefulness. A clearer understanding of hopefulness has been developing from early in the 1990s, through the work of Kenneth Pargament and the late C. S. Snyder. Now Scioli has developed his own Hope Scale, which, along with the theory behind it, provides an expanded understanding of the nature of hope. For him, hope is complex: its roots are in our deepest self, its foundation in our relationships, and it has a spiritual core. In his mind, hope determines our prospects for survival and health, sustains our intimate bonds and gives life purpose and meaning. Scioli has recently published a number of interesting studies, including one on the relative importance of age, hope and gratitude as predictors of well-being in a sample of seventy-five persons aged eighteen to sixty-five years. Using three different measurement scales, he found that a high level of hope was the most powerful predictor of well-being, no mat-

ter the age. In a second study, he found that hope appears to buffer anxiety about death and dying. He first showed a group of young people, a ten-minute segment from the movie *Philadelphia*, in which Tom Hanks plays a young man dying of AIDS. Scioli then measured the fear of death and dying in the young people who had viewed the film. Those with a high hope score showed less death anxiety than those with a low hope score. Finally, he completed a study to see if hope is reflected in the body-mind connection. In a study that included thyroid cancer and HIV-positive patients, he found that the hopeful participants reported better health and less distress/worry about their health. To get some external confirmation of the subjective reports of the patients, he interviewed each person's case manager and also did blood testing to determine patients' immune cell count (CD4). His findings strongly support the belief that hope affects general health as well as the condition of the immune system itself. The article includes a set of practices recommended by Scioli, one for each of the hope traits he has identified. For chaplains seeking to develop their own spiritual lives, there may be opportunity here. For the chaplains seeking to be doctors to the souls of their patients, there may be interventions here for future use. The article concludes with a copy of the Hope Test. The fourteen aspects of hope are included, with two questions for each aspect. See www.spiritualityhealth.com/hopetest for a copy of the test.

Eugene W. J. Pearce, Patti Lewis. "A hospice for the pre-born and the newborn," *Health Progress* 87, no.

5 (Oct 2006): 56-61. • Alexandra's House is a Catholic, charitable, perinatal hospice in Kansas City. The idea of perinatal hospice is not well known; the authors describe the philosophy behind its origins and the care provided. They describe how the medical management of perinatal death has changed from thirty years ago when the practice was to hide a baby who was stillborn. The reality is that parents bond with the fetus in utero as a member of the family. This means that proper mourning is needed following such deaths for the benefit of the parents, other family members and especially for the next baby. They describe in detail the care provided.

Jill Peltzer, Mary H. Leenerts. "Spirituality as a component of holistic self-care practices in human immunodeficiency virus positive women with histories of abuse," *Holistic Nursing Practice* 21, no. 3 (May/Jun 2007): 105-14. • Peltzer and Leenerts state they wrote this article to articulate the need for a holistic theory of self-care for women with HIV that describes and places spirituality as a primary component in their model of self-care. They suggest that, by making spirituality integral to self-care, nurses and other healthcare professionals will support and educate women who are HIV positive within a holistic perspective. They begin with some frightening figures about the increase in the number of women who are HIV positive, which nearly tripled between 1985 and 1996. Women account for 27 percent of those who are newly diagnosed with the disease. Almost 80 percent of the women diagnosed were infected

through heterosexual contact. In 2004, African Americans, who are approximately 12 percent of the U. S. population, accounted for half of the HIV/AIDS cases diagnosed. Almost 80 percent of the women in the country who are HIV positive are either African American or Hispanic. Research has shown that these women are typically out of touch with themselves, their own bodies and/or their own needs. The authors describe the possibilities for a holistic concept of self-care as a method of connecting to self through spirituality.

Christina M. Puchalski, Beverly Lunsford, Mary H. Harris, Tamara Miller. "Interdisciplinary spiritual care for seriously ill and dying patients: a collaborative model," *The Cancer Journal* 12, no. 5 (Sept/Oct 2006): 398-416. • Puchalski and her interdisciplinary colleagues—nurse, social worker and rabbi respectively—make the case that spirituality is essential to healthcare. In the clinical setting, spirituality may be manifested as spiritual distress or as resources for strength. Spirituality has an intrinsic element in that it underlies compassionate and altruistic caregiving. There is also an extrinsic element—learning a patient's spiritual history and making a spiritual assessment. Further, each member of the interdisciplinary team has responsibilities for providing spiritual care, and "the chaplain is the trained spiritual care expert on the team." The paper is comprehensive in scope. Following a case history, extended sections describe the role of the physician, the nurse, the social worker and the chaplain. The authors conclude: "Excellence in quality of care will depend on ad-

herence to a biopsychosocial-spiritual model of care that is practiced by all members of the healthcare team. Good ongoing communication between the interdisciplinary team members will ensure that the patient and family have the most comprehensive compassionate treatment plan and care."

John P. Slosar. "Father O'Rourke and beginning-of-life issues," *Health Progress* 88, no. 2 (Mar/Apr 2007): 39-44. • Father Kevin O'Rourke, OP, has been a significant figure in the modern world of healthcare ethics, especially in Roman Catholic healthcare ethics. This article is the fifth in a special section of Health Progress honoring his life and work, on the occasion of his eightieth birthday. Slosar highlights what he sees as two foundational elements in O'Rourke's approach to beginning-of-life issues. The first is his consistent attempt to make explicit the connection between the norms foundational to human procreation and the meaning of human sexuality and the ways in which these influence our personal and social lives. The second focuses on his arguments for the moral status of the early embryo. Slosar describes O'Rourke's understanding of these two foundational concerns to illustrate some of the practical guidance he has described over the years.

Mildred Z. Solomon. "Realizing bioethics' goals in practice: ten ways 'is' can help 'ought,'" *The Hastings Center Report* 35, no. 4 (Jul/Aug 2005): 40-47. • A familiar criticism leveled at bioethics is that it is more intellectual than practical, having too little application in the "real world." In this article, Solomon

replies to such critical voices and suggests how bioethics can keep its feet on the ground. She argues that bioethics must use the social sciences more effectively. She suggests that empirical research could provide a bridge between conceiving a moral vision of a better world and actually making that world a reality. She makes the following specific suggestions to facilitate the move from ethical analysis to ethically justifiable behavior. Gaps between espoused ideals and actual practice need to be documented. The nature of individuals' moral reflections and the level of their personal skill and ethical analysis need to be made more transparent. There needs to be a better description of the institutional and environmental context that mediates moral action. Data need to be provided to stimulate individual and institutional moral accountability. Consequentialist claims need to be tested. There needs to be validation, refutation or modification of principals in the light of their relevance to moral agents. We need to recognize the relevance of otherwise neglected ethical principles and to generate new normative concerns.

There needs to be an identification and documentation of new moral problems. There needs to be more clear specification and acknowledgment of problems. There needs to be greater clarification of causal mechanisms within the process of ethical analysis. Solomon concludes that bioethicists need what empirical researchers can offer: a variety of powerful means for helping get "from here to there."

Mark Sutherland. "Spiritual focus at the interface," *bjr Newsletter* 18 (Apr 2007): 8-11. • Sutherland's article is a reflection on Mark 5:1-34, healing from a madness which was the result of being possessed. Sutherland addresses aspects of the human cost of mental disturbance, most specifically problematic societal attitudes toward mental disturbance. He discusses the fear and terror that may accompany an individual's experience, especially psychosis, and the different forms and actions in which such an experience may be expressed and released. Finally, he focuses on the "spiritual domain" and how the experience of psychosis may herald "a sudden and unexpected open-

ing to the energies of the spiritual ground" which may be the start of new spiritual development.

Jessica Tartaro, Jonathan Roberts, Chaira Nosarti, Tim Crayford, Linda Luecken, Anthony David. "Who benefits? Distress, adjustment and benefit finding among breast cancer survivors," *Journal of Psychosocial Oncology* 23 no. 2/3 (2005): 45-64. • This study examined levels of distress and adjustment over time in women who are surviving breast cancer as well as their ability to find benefit in their experiences. Over seven hundred women were assessed, and thirty-nine then participated in four study assessments over a two and a half year period following diagnosis. Women who reported finding benefits in breast cancer had experienced high levels of distress prediagnostically, which then significantly declined over time. The results of this study suggest that a woman's distress prior to receiving a breast cancer diagnosis may be related to her ability to find benefit during later stages of the illness. This is an interesting contribution to the meaning-making, or sense-making literature.

Crossing the Desert: Learning to Let Go, See Clearly and Live Simply

Robert J. Wicks

Notre Dame, IN • Ave Maria/Sorin Books • 2007 • 186 pages • hardcover

"There are four questions and three steps that must be encountered by anyone seriously interested in taking a spiritual journey toward true inner freedom." (p. 11) Thus begins the invitation to enter into the desert for a journey into self-discovery. For us chaplains, it is a wonderful reminder of what we began when we entered our first clinical pastoral education (CPE) unit. It is also a helpful instructional manual for those of us involved in spiritual direction or counseling.

Using the sayings of the Desert Fathers and Mothers, Wicks weaves a journey that becomes one's own life journey through one's own particular deserts. Wicks regards the wisdom of these Christian Parents as a treasure trove of insights for those who are experiencing stress, depression, grief or loss. Becoming disciples of these third and fourth century Fathers and Mothers, we are called to sit quietly and listen.

Wicks first encountered desert wisdom through Thomas Merton's book, *The Wisdom of the Desert*. He quotes Merton, "These monks insisted on remaining human and 'ordinary.' … they had come into the desert to be themselves, their ordinary selves, and to forget a world that divided them from themselves." (p. 12) From his background in psychology, Wicks realized that this was the present milieu; our attachment to "things" is pulling us away from ourselves.

Henri Nouwen also touched Wicks's life deeply through personal encounters and through his writing in *Desert Wisdom*. Through reflection on these writings, Wicks developed his thesis for this work. He writes, "Why had I forgotten my deep love for (in Nouwen's words) 'the spirit of discipleship' of the Desert Fathers and Mothers? How could I now use them more completely to help guide me in my own life as well as to assist others who sought my help? And finally, could I now glean the essential elements of a 'desert spiritual apprenticeship' from a number of religious traditions …." (p. 15)

Wicks states that his goal "is to provide a sense of how obscure women and men of the fourth century, along with some of the other most beloved spiritual writers of our time, offer us the wisdom of the desert to free us from the chains of our modern insecurities and attachments." (p. 28) He has organized this book into a journey within the desert, guided by three gates, four voices, four questions and three steps.

To begin, we must flee to the desert, which Wicks describes as unfriendly and harsh, a place of extremes where one has to consider that survival depends on one's choices. More importantly, in the desert "an opportunity to gain a new perspective and a unique appreciation for what is truly important is joined by a radically different sense of what relationship, hospitality, and compassion should mean in our lives." (p. 22) To survive in this desert, one must experience a true conversion, a letting go of everything nonessential. Only by being free can one experience a true and radical relationship with God.

book reviews

Everyone who commits to this journey must enter through three narrow gates to attain a complete and full life. The first gate is passion, which Wicks defines as "a sense of commitment, faithfulness, and appreciation of the gift of life." (p. 43) Gate two is knowledge, which "helps one differentiate between unnecessary suffering on the one hand, and the kind of pain that must be faced rather than defended against or avoided on the other." The final gate is humility, which is "the ability to fully appreciate our innate gifts and our current 'growing edges' in ways that enable us to learn, act, and flow with our lives as never before." (p. 45)

The desert permits us the space to enter each gate and to consider our unexamined memories and perceptions. Although the desert may he harsh and unforgiving, our encounter with our self is one of love, understanding and acceptance. The desert is a place of growing up where we take those perceptions we formed as children and reexamine them in the light of maturity. We once again open our ears and listen to those stories for the truth of our lives.

Next Wicks presents four voices to which we must listen. These are the voices of our friends. The first voice is the prophet, who challenges us to continually examine ourselves. Next we hear the cheerleader, who supports us through those difficult moments of our lives. Third is the harasser, who forces us to keep a perspective about ourselves. Finally, we hear the wise companion or soul friend, who encourages us to be all that we can and supports us without ridicule or shame.

Four questions confront us. What am I filled with now? (examination of where are we attached, caught,

addicted or blind). What prevents me from letting go? (acknowledgment of the fears and habits that imprison us). How do I empty myself? (effective use of our spiritual tools—prayer, meditation and silence—from which comes the grace to open up). What will satisfy me yet leave me open to more? (refurnishment of the self).

Finally, there are three steps: find your true name, find a second word, take a leap of faith. Ultimately, these steps are a call to let go, to gain purity of heart. They evolve into a grace-filled transcendence that allows us to embrace and act on our own divine gifts.

This small book is packed with wisdom, so much so that the reader may feel that the text tackles too much. Perhaps, Wicks is calling us to slow down and chew on each morsel rather than grabbing a "quick-fix" fast food. This is a different book every time I pick it up. Behind the simplicity, it is dense with Desert Wisdom that flashes like lightning as one reads, rereads and matures.

This book would appeal most to those who are comfortable with change and have been engaged by the theologies and philosophies of other faith traditions. For those who are ready for the pilgrimage of life, this is a highly recommended guidebook.

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Let in the Light: Facing the Hard Stuff with Hope
Patricia H. Livingston
Notre Dame, IN: Ave Maria Press •
2006 • 156 pages • softcover

Patricia Livingston is so at home in her own skin that she invites her readers to join her in her spiritual journey and to share their own experiences. She is perfectly at ease in revealing how she received illuminating insight and hope from experiences with friends and family. Her transparency can encourage readers to an openness that permits the light to shine through.

Her grandson, George, running into the bedroom wall, at age four, symbolizes her reason for sharing this collection of stories. George was trying to get to the bathroom early one morning and ran into the bedroom wall. "I'm okay, Grandma," he replied slowly, in response to her concern. "It's just—I guess—I have too much dark in my eyes." (p.9) Livingston says she wrote this book "because there is too much dark in our eyes. We are badly bruised from running into the walls of our existence, trying to find a doorway." (p.10)

Her variety of supporting evidence and illustrations combined with the range of her resources makes this an interesting book. For example, in Chapter 1, "Light and Life," she explores these questions: Why do we have such a fear of the dark? Why is light such a significant source of imagery for our sense of life? (p. 11) Insights from the Bible, science, the Nicene Creed, watching a movie with a priest and another with her two sons are employed to reveal the significance of learning the skill of "letting in the light." (p.14).

Recalling her grandson, Daniel's birth, Livingston writes: "There were no labor rooms, no delivery rooms, no separate maternity ward rooms, just one corridor for it all. Unless a woman had a C-section, it was all in the same place. There were women in labor up and down the corridor." (p. 19) Her experience affected her physically. "I could feel adrenaline pouring through my body. I just could not believe this place! I had heard about the crisis in medical care in hospitals. I had heard about the severe strain on overworked nurses. But how could a medical system do this to these women? How could they advertise this maternity design as if it were some kind of a beneficial upgrade?" (p. 21) However, her perspective changed when she heard her daughter's voice: "Look at him, Mom! Just look at him. Isn't he a miracle?" Livingston writes: "I will never forget the impact of that moment. It was a stopped-in-my tracks challenge to where I chose to put my focus." (p. 21)

She enhances the chapter on the power of reframing by using what meteorologist Edward Lorenz described it as the "butterfly effect." "Even the smallest of actions can make a big change" (p, 24).

The transitions that link each of the sixteen chapters show the connectedness with the central theme. Livingston's personal style of storytelling is to let the insight into light emerge naturally from retelling the story. She lets her readers see how she responded to her experiences with honest emotions. Accordingly, she shows us how to translate our experiences of darkness—even our darkest nights of suffering, anxiety and hopelessness—into positive light.

Livingston acknowledges that her book "may be familiar territory." (p.29) Pastoral caregivers will recognize many of the methods and concepts she uses, and some may deem this as a limitation. On the contrary, the fact that old methods are infused with new insights for application is a primary strength of this work. This book will prove useful as a resource for self-care, improving chaplains' supportive skills and in assisting them in finding sources of light in new and unexpected places.

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Pastoral Care of Depression: Helping Clients Heal Their Relationship with God
Glendon Moriarty
Binghamton, NY: The Haworth Pastoral Press • 2006 • 239 pages • softcover

Helping depressed people heal their relationship with God sounds great, but of course there is no "quick fix" to make that happen, and this book makes no claim to be such. The author states a twofold purpose: to provide the reader with a strong understanding of depression and the God image and to furnish the reader with the therapeutic ability to change the God image. (p. xvi)

Throughout this book, Moriarty discusses the development and characteristics of a person's God image, which he defines as "the personal, emotional, and subjective experience of God" as derived from the person's early experiences with his or her parents. (p. 42) If the person experienced his or her

parents as loving and trustworthy, the person's image of God will be the same. On the other hand, if parents were experienced as harsh, impatient or unpredictable, the person's God image will have those characteristics. The author's premise is that depressed persons are stuck in a negative feedback loop: feeling guilty before God, feeling they have to be perfect to please God and fearing abandonment by God and others.

Included in the book are exercises designed to help discover one's God image by evaluating relationships with father, mother and God. The reader is encouraged to complete each in order to thoroughly understand the concept of the God image. (I completed them and found them thought-provoking and helpful.)

Moriarty uses case examples of Bob and Lilith, pastor and deacon respectively, to illustrate the God image. Throughout the book he returns to them, discussing how the concepts he identifies apply to each. After he identifies how to assess a client's God image, he discusses how to affect/change the God image, first from the standpoint of psychodynamic therapy, then by way of cognitive techniques. An interesting array of interventions are offered for the latter.

Therapists, especially pastoral counselors or others who work with clients whose beliefs about God are important to them, will find this book most useful. I think chaplains will find it of limited value unless they are in a setting where they have opportunities for multiple, deep contacts with clients.

Finally, the book's perspective is Christian. While I think the concepts could apply to any monotheistic belief system, readers should

be aware of the Christian assumptions made by the author.

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The Unwanted Gift of Grief: A Ministry Approach
Tim P. VanDuivendyk
New York: The Haworth Pastoral Press • 2006 • 183 pages • softcover

The author's practical approach to grief, along with his straightforward dialogue, his recounting of personal grieving events, as well as his decades of hands-on experiences as a hospital chaplain validates the emotional and spiritual challenges of grief work, and opens the reader's eyes on almost every page, where deep down within one can hear a voice shouting, "Yes!"

The author maintains that grief work, hard as it may be, is truly a God-given gift. The result is a renewed person who can grow on many emotional and spiritual levels and move forward living life to its fullest while still honoring the loss of a loved one.

Each of the four distinct sections contains a major building block of understanding grief as gift. The easy-to-read text provides a clearly laid out map of structured learning, a healing guideline, both for the individual and the group, e.g., family, friends. It also is a teaching tool and resource for healthcare professionals, chaplains and other pastoral caregivers, grief counselors, social workers, CPE and seminary students.

Throughout the book where clinical or technical words are used, the next sentence defines the word in a way that does not insult the professionally educated or the layperson. The index is especially helpful for reference to key words and the location within the text for further study or review.

The Unwanted Gift of Grief is a practical guide through the wilderness of the grieving process. It outlines the differences in male and female grieving, and the marriage and intimacy issues that may arise. The author also describes the different ways introverts and extroverts grieve and touches on numerous aspects of grief, e.g., praying for a miracle, anger toward God, recognizing when sadness/depression become pathology, the need for sojourners on the journey through grief's wilderness. He notes turning points as healing begins to manifest itself: early euphoria and its potential pitfalls, peek-a-boo experiences of grief's' return and what the healing transformation looks like.

VanDuivendyk presents a healing pathway for all who grieve to navigate as well as a teaching and learning resource for professionals that I believe will stand the test of time. This book deserves space on the shelf next to Elizabeth Kubler-Ross's groundbreaking book *On Death and Dying.*

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Under Orders: A Spiritual Handbook for Military Personnel
William McCoy
Ozark, AL: ACW Press • 2005 • softcover

Chaplain McCoy offers a handbook to the current generation of military personnel, most of whom are young adults living outside of their growing up environment for the first time. It is, he says, "a handbook to think through one's faith about, to reflect about one's choices with, and to guide those people as they create the new world ahead." (p. 15) His intention is to translate the essential gospel message of unconditional love and forgiveness into the language of the current generation, and for this to be a place for them to begin, "their intellectual and spiritual quest." (p. 17)

The book is comprised of ten "orders" for such growth, each of which concludes with several questions for individual or group reflection. It is intended to be used either individually or as part of a formal or informal group discussion.

From the perspective of a healthcare chaplain, the book's greatest value may be that it is a new resource to offer to our staff—or to their young adult children—impacted by deployments and increased military service. To the extent that they are searching, this book may be an aid to "sorting things out" during the long periods of waiting that is a part of military service.

The orders McCoy gives include understanding yourself, accepting this generation as inherently "good," believing in God, understanding faith through asking the right questions, finding good friends, understanding death and its influence on your life now, fighting sin, understanding one's vocation, looking at how one "knows" what is real and experiencing love as the fundamental law of the universe.

McCoy sets out to explain abstract concepts such as postmodernism, hermeneutics and other theological

constructs in simple, everyday language. He assumes very little formal religious background on the reader's part, an assumption that is both a strength and weakness. Though the text is likely to be helpful to those who are searching, it may be too much "milk" and not enough "solid food" for those who have a strong church background. Even they, however, will benefit from the questions at the end of each chapter. It is unabashedly a cognitive approach that seeks to encourage the reader to identify and then to correct theological distortions absorbed from family or society.

Under Orders is written in a breezy, conversational tone that makes it accessible and an easy read. One can almost hear McCoy's voice; however, what works in direct conversation does not necessarily work well as prose. The book's primary difficulty is the apparent lack of editorial attention. The punctuation, grammatical and word choice mistakes are distracting.

Though healthcare chaplains may have to stretch to find creative ways to use this book, its limitations should not prevent its use. People throughout the institutions we serve, and the congregations in which we worship, are at various stages in their quest for answers. This book offers a way to reach out to those who, by the virtue of their deployments, often are invisible to the church and offers them some signposts on their spiritual journeys.

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The Year of Magical Thinking
Joan Didion
New York: Knopf • 2005 • 231 pages • hardcover

In the final analysis, the book is less than the sum of its parts. Didion writes this work as a mixture of memoir and mourning. It is her way of attempting to come to terms intellectually and perhaps emotionally with the terrible and sudden loss she sustained when her husband of many years, suddenly died from a massive coronary in their front room. To complicate matters, their only child, a grown daughter, lay seriously ill in the hospital.

Chaplains who deal daily with crisis and catharsis will recognize and applaud the honest reporting of many of Didion's comments as she makes her way through this year of magical thinking (… this is not really happening/I did not abruptly become a widow/my child is not deathly ill/this terrible nightmare is happening to someone else/I cannot give away his shoes; he will need them …) There are some wonderful insights tucked away in the book. "Grief, when it comes, is nothing we expect it to be …. Grief is different. Grief has no distance. Grief comes in waves, paroxysms, sudden apprehensions that weaken the knees and blind the eyes and obliterate the dailiness of life." (p. 26-27) "People who recently have lost someone have a certain look, recognizable maybe only to those who have seen that look on their own faces …. The look is one of extreme vulnerability, nakedness, openness …. These people who have lost someone look naked because they think themselves invis-

ible … incorporeal." (p. 74-75)

Joan Didion—novelist, screenwriter, descriptive reporter—depicts well the sense of surprise that anguish brings in its wake. She ably conveys the emptiness and the unreality that the mourner feels within. "Grief turns out to be a place none of us know until we reach it …. We might expect if the death is sudden to feel shock. We do not expect this shock to be obliterative, dislocating to body and mind. We might expect that we will be prostrate, inconsolable, crazy with loss. We do not expect to be literally crazy, cool customers who believe that their husband is about to return and need his shoes." (p. 188)

So with all these gems, what is missing? Perhaps it is that in describing their life together as successful writers with upscale homes at various times on both coasts of the United States, or their travels to Hawaii, or other marks of their accomplishments and achievements, it feels as though Didion is showing off, bragging about her triumphs. Though never stated, it feels as if she is thinking, "this should not happen to people like me."

Overall this is a good book, and there are many well described insights into this initial year of mourning. She engages, returns to and moves through many of the stages of grieving, including anger, disappointment, bargaining and denial. The Year of Magical Thinking affirms the human face and common experience of these stages of grief.

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Obsessive-Compulsive Disorder: A Guide for Family, Friends, and Pastors
Robert Collie
New York: The Haworth Pastoral Press • 2005 • 118 pages • soft cover

A young woman moved slowly and methodically down the hallway, rubbing raised hands on the wall. Even in a psychiatric facility, this behavior seemed odd. While pondering whether to intervene directly, a dim light came on. Could she be a part of our new treatment program for anxiety and obsessive-compulsive disorders? She was. She was carrying out a behavioral therapy assignment known as exposure or response blocking.

Robert Collie has written an excellent little book, packed with information for both chaplain and parish pastor. A diplomate in the American Association of Pastoral Counselors (AAPC) and licensed social worker, his primary expertise grows out of being a consultant to an obsessive-compulsive disorder (OCD) support group. He weaves their stories into the tapestry of a clinical presentation of the etiology, symptoms and a primarily Christian pastoral response to OCD and related disorders.

Five chapters address neurological and biological origins, including a predisposition to be overly anxious, responsible, hypervigilant and conscientious with frequent religious manifestations. The sufferer experiences unwelcome automatic intrusive thoughts that quickly become obsessions and compulsions leading to rituals. Superstitions and magical thinking often follow. Collie carefully explains the brain dysfunction process underlying these disorders.

Three chapters differentiate between pastoral and unpastoral caregiving. We afflict the afflicted with even more anxiety when we overemphasize themes of guilt and punishment for sin and leave persons of faith no room for doubt. Offering faith certainties forcefully or sound theological logic does not appease a mind that constantly fires a doubting challenge. The more magical and vague the religion, the more the imagination is engaged and superstitions fed. Collie urges caution in offering forgiveness of sin for these thoughts and behaviors. "The pastoral task is to establish that the thoughts and behaviors are morally and ethically neutral" so that the sufferer can emerge from secrecy and shame to receive treatment.

Pastoral caring helps sufferers to manage religious doubt, to work with unwanted intrusive thoughts as temptations; to move away from an image of God as the Grand Inquisitor; to rebalance law and grace, legalism and kindness; to address the fear that magical superstitious thinking has given in to evil witchcraft; to move from endless perfection seeking to good enough and normal; to accept the normalcy of the fear of death and thereby reduce its power; to regain new perspectives on what is to be valued in life; and to utilize Catholicism's historic understanding of OCD as scrupulosity.

Collie concludes with more practical advice for the pastoral caregiver and three appendices, including one on resources.

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Addiction: Pastoral Reponses
Bucky Dann
Daniel G. Bagby, editor
Nashville, TN: Abingdon Press • 2002 • softcover

This book emerged from the author's service both as a United Methodist pastor and clinical director/certified alcohol and substance abuse counselor. He rightly notes that substance abuse and addiction are both complex and difficult to treat.

This book fills a deep void in pastoral care literature. Many pastoral care specialists have relied too much on secular resources for thoughtful reflection about treating persons with addiction. Although Dann writes primarily for the pastor who has ongoing and significant contact with congregants who fit the addictive pattern, this book has a place in any pastoral care library, especially as few volumes have been written from the pastoral care perspective.

He notes that the local church is a natural place to locate assistance for the addicted person. Many congregations already offer their physical facilities for such organizations as AA and NA. He encourages them to move beyond this and to develop a more comprehensive approach for treating persons with addictions. Clergy are in a unique place to empower individuals to seek the help they need, and they often assist in the individual's transition back into the faith community following treatment.

Dann notes several misconceptions concerning the nature of addiction: there is a clear definition of the problem; people can be identified as addicts merely by looking at them; there is a clear reason for the addiction; using an illegal

substance does not automatically mean addiction. He provides a list of symptoms any three of which indicate substance dependency: tolerance—the ability to consume more of the substance over time; withdrawal—aftereffects such as hangover, chills, sweats, cramps, diarrhea, insomnia or seizures; exceeding intentions—lacking control over the use; failed attempts to quit; poor use of time—the amount of time needed to maintain the habit increases; interference with important roles and activities—drops out of social events, recreational activities, and the occupation is jeopardized; makes problems worse—medical or psychiatric problems become worse.

He differentiates between abuse and addiction, defining the latter as the point where negative consequences interfere with several aspects of life. The word "interference" becomes key in making a pastoral diagnosis.

Dann outlines four essential pastoral care stances or therapeutic positions for helping persons with addiction: patience, honesty, withholding judgment and maintaining personal boundaries. He notes that associated problems, such as medical issues, illegal behaviors, sexual issues and family problems, also may need to be addressed.

The final portion of the book is devoted to developing a positive and comprehensive morality/theology concerning addiction. The author sets the western cultural context of the drug environment and the immense ambiguity that surrounds the use of drugs in general. He points to four suggestions that enlarge a morality for the addicted person. While I understand the layout of the author's material, as a theologian, I would have benefited from reading this chapter first. This book would be a useful resource for a beginning CPE student assigned to the substance abuse unit.

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Reflections from a Resident

In her recently published memoir of faith, Barbara Brown Taylor claims "that the call to serve God is first and last the call to be fully human." Sitting here with a pager on each hip, seven months of residency behind me and six more ahead, I am struck by the truth of her words.

Even before I signed on, I knew that I was in for a year of emotional intensity, personal growth, theological reflection and challenge. I knew that in listening to the stories of others I would encounter precious truth and profound pain. I knew that seeking grace and peace in the face of crisis and trauma would result in exhilaration and exhaustion. And I knew that learning to offer myself as vulnerable learner alongside colleagues and patients would bring both insight and frustration. With all of this in mind, I entered the world of the hospital with equally matched tentativeness and expectation. At this halfway point, I easily admit that my adventures as a pediatric chaplain have surpassed any thing I thought I knew—or didn't know for that matter.

The most desperate and devastating moments have not been tidal waves. They have not come crashing down, leaving me discombobulated or stunned. Neither have the most life-giving moments been grand revelations, announcing themselves with bright light shining down or trumpets blasting. Rather, these moments have tiptoed up—often several days after an event—sometimes moving me to a place of confusion or unsteadiness and other times to a place of serenity or renewed hope. They have come to remind me that this year—this life—is not only about serving God, but also about realizing that no matter how faithful, how connected with the Divine, how spirit-filled, I am still human. Fully. Human.

To recognize the burden—and ultimately the blessing—of serving God is to recognize that I am most faithful when I am most human. I am most authentic, not when I am reaching higher and higher for a theologically significant insight, but when I am humbly grounded in the realities of truth in those around me and the God who dwells among us. This opens a space to take more risks, make more mistakes, ask more questions and confess more doubts. It also carves out a place where, in the midst of it all, grace can slip in and fill me. Perhaps for the first time in my life–and not without surprise—I dare myself to celebrate all the many parts of me that are far from perfect. In so doing, I become more attuned to the uniqueness of my human self and can more deeply connect with the humanness of those around me. In turn, our shared humanity is more beautifully illuminated by God's divine presence among us. This, I have learned, is what it means to serve.

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Hadley Horne Kifner, MDiv, is an APC student affiliate. This reflection, which was written during his pediatric chaplain residency at the UNC Hospitals, Chapel Hill, North Carolina, originally appeared in *PlainViews* 4, no 6 (April 18, 2007).

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expression of faith