Volume 20 Number 1 • Spring/Summer 2004

1 Editor's Voice - Rozann Allyn Shackleton

3 Gary L. Patton • Karen Simmons
   A New Model:
   Locating the Employee Assistance Program (EAP)
   Within Pastoral Care

8 Gretchen Thompson
   Personality Disorders and the Dying Experience:
   Reflections on Pastoral Care

16 Robert L. Hendricks
   One Out of a Hundred:
   Providing Chaplaincy in State Schools to
   People with Mental Retardation

23 David E. Tucker
   Rewriting the Story-Myth: A Rehab Experience

27 MarieAnne Ekedahl
   The Coping Processes of Swedish Hospital
   Chaplains: How Can You Bear the Challenge of
   Working at the Edges of Life and Death?

35 On Holy Ground - Florence Galo
   Margaret's Room

37 Poetry - Robert W. Duvall • W. H. Shirk •
   B. Wayne Morris • Gwen Becka • Beverly
   K. Hartz • Julie Sara Kramer

43 In the Literature - W. Noel Brown

49 Book Reviews - Al Voorhis • Linda
   Francisco Bets • Kenneth L. Nolen •
   David J. Zucker • M. Catherine Hasty •
   M. Sue Reid

56 Expression of Faith - James F. Brandis
Life rarely remains static for any length of time. In fact, sometimes it seems as though change is the order of the day. As poignantly described by this issue’s poets, each patient/family dynamic becomes the stuff of the chaplain’s “ordinary” day.

Surrounded by this sacred ordinariness, we journey with those whom we meet, sometimes for little more than minutes, sometimes for days or months or even years. We come in the hope that our shared faith will indeed move the mountains of despair, of doubt, of loneliness. This issue tells stories of those encounters: with those who suffer from personality disorders, with residents in a state school for mental retardation, with individuals undergoing rehab, with the dying, with staff members in crisis.

Even as we are invited to share others’ most intimate moments, within these pages we share who we are—the ordinariness of our daily lives. As I completed the final editing of this issue, I was reminded anew of the tradition of caring that is represented here.

This is our twentieth year of publication, first as The Caregiver Journal and, since 1998, as Chaplaincy Today. The autumn/winter issue will include a focus on this history, and I invite you to share your reflections on how this journal has influenced your service as a professional chaplain. Please e-mail me (rozallyn@earthlink.net) by August 15.

As mentioned above, change is ongoing. Vic Trogdon, who has shared the duties of book review editor, has assumed new duties at St. Mary’s which preclude his continuing in this capacity. I am grateful for his service to CT as well as that of Paul Buche, who has accepted an expansion of his book review responsibilities.
A New Model: Locating the Employee Assistance Program (EAP) Within Pastoral Care

Gary L. Patton • Karen Simmons

The concepts of chaplaincy and Employee Assistance Programs (EAP) are not commonly linked. This became evident through a word search using “chaplain” and “EAP” which gave the response “no records found.” Despite this fact, combining the two at St. Mary’s Medical Center did not seem to be a novel idea at first. Yet, the interest of both employees and other organizations has indicated that this arrangement is both noteworthy and unusual. Today, in addition to being a unique organizational structure that created special interest, it has proven to be a meaningful and compatible partnership between pastoral care and counseling.

At St. Mary’s, EAP is located within the Department of Pastoral Care and the EAP coordinator reports directly to the director of pastoral care. This was not a cost saving measure or a merger of job descriptions. Both programs are still distinct. However, administration wanted the employees to understand that this new structure was intentional. In order to accomplish this, the preparation required careful thought and implementation. This article addresses the reasons and methods by which St. Mary’s chose to make this organizational change.

Glossary of terms

In order to enhance the understanding of the structure of both Pastoral Care and EAP at St. Mary’s, it is important to offer both definitions and the context in which these terms are used.

Chaplain: A person who is ordained by an ecclesiastical group and certified to provide spiritual and emotional care to people.

This article explains how St. Mary’s Medical Center in Huntington, West Virginia, enhanced and expanded its Employee Assistance Program (EAP) by bringing it under the management of the Department of Pastoral Care. The outcome of this paradigm shift not only resulted in benefits for EAP, but the chaplaincy program has grown and realized an increased visibility in the organization as well. While employee assistance and pastoral care are quite different, the experience of St. Mary’s demonstrates the compatibility of these two programs when aligned in a creative manner. This article shares the practical steps that have produced a comprehensive program of spiritual care and counseling.

Gary L. Patton, PhD, BCC, is the director of the Department of Spiritual Care, Counseling, and Mission at St. Mary’s Medical Center, Huntington, WV. A licensed professional counselor and national board certified counselor, he is endorsed by the Church of God, Anderson, IN. Karen Simmons, LICSW, CEAP, serves as coordinator of the Employee Assistance Program at St. Mary’s. She holds a master’s degree in social work and is certified by the ACSW. Correspondence may be directed to Gary.Patton@st-marys.org
EAP: In general, an EAP can be described as a counseling and referral program that is, "focused on employees' mental and physical health and deals with personal problems that might, even indirectly, affect job performance."

Counseling: Both historic and contemporary definitions help to explain the context of counseling in St. Mary's EAP. "The term 'counseling' also has been applied to a wide range of activities designed to aid individuals in solving their problems. Most simply defined, counseling is a learning process in which individuals learn about themselves, their interpersonal relationships, and behaviors that advance their personal development." Counseling in St. Mary's EAP also is consistent with the following explanation given by the American Counseling Association and the National Board of Certified Counselors: "the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral, or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology."

Pastoral Counseling: "Pastoral counseling is the utilization, by a minister, of a one-to-one or small group relationship to help people handle their problems of living more adequately and grow toward fulfilling their potentialities."

Spirituality: "It has been said that spirituality is the courage to look within and to trust. What is seen and trusted appears to be a deep sense of belonging, of wholeness, of connectedness, and of openness to the infinite."

Pastoral care at St. Mary's Medical Center

St. Mary's is located in Huntington, West Virginia. It is a not-for-profit Roman Catholic hospital founded by the Pallotine Missionary Sisters eighty years ago. The medical center is licensed for 440 beds and offers a full range of services. St. Mary's is also a Level II Trauma Center and is affiliated with the Joan C. Edwards School of Medicine at Marshall University for purposes of research and medical education. The faculty of the medical school has privileges at the medical center. St. Mary's has 2,175 employees. Additionally, the medical center has a School of Nursing and a School of Radiologic Technology. These two schools have a combined enrollment of 130 students.

St. Mary's has had an organized Department of Pastoral Care for twenty-eight years. The department employs 7.55 full time equivalents (FTE). The actual work force of the department consists of a director, an office manager, three full-time chaplains, two part-time chaplains, a part-time eucharistic minister, and three per diem chaplains. All of the chaplains employed on regular status are board certified.

The department also has twenty-four area clergypersons who serve on a stipend arrangement of fifty dollars per night to provide in residence continual coverage from 10 p.m. until 7 a.m. Pastoral care is available twenty-four hours every day of the year.

In the organizational structure of the medical center, pastoral care reports directly to the vice president of mission integration. In autumn 2003, the medical center underwent a survey by the Commission for Accreditation of Pastoral Services and was fully accredited. The survey team took note of the close link between the spiritual and counseling aspects of the organization.

Pastoral care has an affiliation with the Counseling Program in the College of Education and Human Services at Marshall University as a site for undergraduate and graduate students to do internships for the completion of their degree programs. The intent of the internships is not necessarily to train interns in classical pastoral counseling as such. However, acceptance into the internship is contingent on one of two intentions of prospective interns. First, students may have some experience in addressing spirituality as a part of their counseling model and wish to further explore or expand this knowledge base. Second, students may not have any prior knowledge or experience related to spiritual issues in their counseling work or training but desire to learn about this dimension of humanity.

While the students may or may not be interested in pursuing a career in terms of chaplaincy or pastoral counseling, the internship is designed to complement the traditional counseling training of Marshall University while providing a context to explore and better understand spiritual issues with clients and patients. This is consistent with the awareness in many dimensions of mental health care that spirituality has an important role in the holistic care of people. From a psychological perspective, Abraham Maslow refers to the critical dimension of some type of spiritual care: "the human being needs a framework of values, a philosophy of life, a religion or religion surrogate to live by and understand by in about the same sense that he needs sunlight, calcium or love."
As the pastoral care department is guided by its spiritual care of patients and staff, it is compatible to include both the work of EAP and interns learning to do counseling. Eugene W. Kelly comments that, “the prevalence of spiritual and religious beliefs among the general population, the preference of so many individuals for counselors who value spirituality, and the connection of spirituality and religion to many critical life issues certainly suggest that the spirituality / religious dimension is pertinent to counseling in secular settings.” Members of the department also serve on the medical center’s ethics committee, palliative care team, and the institutional review board (IRB).

**Employee assistance programs**

EAPs vary widely in terms of their scope of work, credentialing of staff, organizational reporting, and whether they are fee based, benefit based, or both. The following list provides the examples of how EAP services can be organized and structured:

1. Program may be assessment and referral based or therapy based.
2. Services are charged to insurance providers, provided free for a specific number of sessions before fees are charged, or provided as a complete benefit of employment.
3. Providers include professionals who are registered nurses, social workers, psychologists, counselors.
4. Services usually report to human resources, senior administration, psychiatry/behavioral health, risk management, wellness departments.

Certification is now required or highly recommended by some agencies for referrals. This requires a graduate degree in a mental health field, two thousand hours of employee assistance work, continuing education, supervision, and successful completion of a national exam. Provision is made for individuals who do not hold a mental health degree through increased hours of work experience and continuing education.

**EAP at St. Mary’s**

The EAP of St. Mary’s was established in 1991. For several years the program was in the Department of Psychiatry and the coordinator of the program reported to the manager of psychiatry. The program was successful and grew to include not only employees and students of St. Mary’s, but also nine additional agencies and organizations. These external organizations pay an annual rate per capita for enrollment in the EAP of St. Mary’s. For this fee, they are entitled to access the services of the EAP as often as needed.

Presently, the EAP is staffed by a full-time coordinator and one counselor, who works on a per diem basis. (Check this with author) The director of pastoral care is a licensed professional counselor and also assists in seeing clients. For continuity of care, the following provisions give access to EAP. Messages may be left on the EAP coordinator’s voice mail, which is regularly checked. The outgoing message includes a pager number that is staffed 24/7. During week days, the office coordinator of the Department of Pastoral Care also accepts phone messages for the EAP coordinator.

Employees of St. Mary’s have access to EAP as an employee benefit. Care is free of charge regardless of the number of sessions needed. The program also is available to immediate family members, defined as spouse, children, parents, and grandchildren. This generous definition is appreciated by St. Mary’s staff.

At St. Mary’s, the EAP is therapy based with referrals to other professionals as specific needs arise. Counselors have the authority to determine the number of sessions needed for each particular case. In addition, the EAP coordinator, the director of pastoral care, and some of the chaplains are trained to provide critical incident stress management (CISM) services both for employees of St. Mary’s and the contracted agencies. The debriefing and de-fusing events held during times of traumatic events, accidents, and sudden death have been used frequently. These services provide a nonthreatening way for EAP services to be introduced to employees who also might need individual care whether related to the critical incident or other personal issues.

St. Mary’s implemented new procedures to comply with the Health Insurance Portability and Accountability Act (HIPAA) in early 2003. The Department of Pastoral Care and the EAP both wrote and instituted policies to meet HIPAA requirements. These policies, while not identical, are consistent in the roles of both chaplains and counselors and include the reporting structure of the EAP coordinator to the director of pastoral care. Clients seen through the counseling program are provided with a privacy statement and a consent for.
treatment form. Files on each client are secured in a locked file cabinet in a locked office. Referrals to the EAP either may be mandated by hospital managers or received as employee self-referral. Mandatory referrals are usually made for concerns about use of substances where such use is compromising or impairing job performance, attitude on the job, or where there are issues of tardiness/absences related to work.

If an employee is seen for counseling by mandatory referral, then the manager is notified of the compliance or lack of compliance on the part of the employee. Clients are informed that information about their attendance at the counseling sessions and general level of compliance will be provided to their managers. Specific concerns and issues in the context of the counseling sessions are considered confidential and are not released to anyone.

Often a manager will suggest to an employee that they voluntarily be seen in the counseling program due to concerns related to their work or personal life. Ongoing education within the organization relative to pastoral care and EAP stress the availability to staff and encourage contact. Within the culture of the medical center, a suggestion by managers to employees to contact pastoral care/EAP is understood to be an act of compassion rather than a directive.

Pastoral care and EAP personnel participate in the monthly orientation program for new employees and also produce articles for organizational publications. Due to the recognition of spiritual care and counseling services within the medical center, employees know of these programs and services and often refer. Primary care is given for marriage and family concerns, grief and bereavement, mood disorders, substance abuse, suicidal ideation, crisis intervention, or combinations of these.

Referral relationships with area psychologists and psychiatrists have been established to serve patient needs that are outside St. Mary’s scope of care. While EAP no longer reports to the Department of Behavioral Health (formerly Department of Psychiatry), a working relationship continues, e.g., EAP uses behavioral health’s intake and assessment staff in times of psychiatric emergencies with clients who may need hospitalization.

As the chaplains have a collegial working relationship with the EAP coordinator, they understand the program well. As they make rounds throughout the hospital, they often have conversations with employees who are troubled. While they are fully empowered to attend to the spiritual and emotional needs of the medical center staff, they also have the resource of recommending the EAP program to those whom they encounter. Through their day-to-day contact with EAP, they are able to provide a first-hand perspective to employees about the program and the care they can expect to receive. Likewise, the EAP coordinator often refers clients with spiritual concerns to chaplains for more specific care in this area.

Combining pastoral care and EAP

Though EAP was successful while under the auspices of psychiatry, the idea began to emerge that there might be a better arrangement for both. There were several considerations that prompted the affiliation of pastoral care and EAP. First, the EAP office was physically located about forty feet from the door of the locked psychiatry unit. Thus, it would not be unusual for EAP clients to wonder if that might be the next step if they did not respond well to outpatient counseling.

Second, the primary focus of psychiatry was on a population of patients with high acuity requiring inpatient admission. While the staff was supportive of and interested in the program of employee counseling, it was not their specialty.

Third, at one point the EAP at St. Mary’s essentially was a referral practice. Employees in need were assessed by the EAP coordinator and then referred to the most appropriate source for the type of treatment needed. Obviously, this resulted in people having to pay for care if it was not included in the range of services offered at St. Mary’s. As some of the pastoral care staff had expertise in counseling, many employees were referred there. When a new EAP coordinator was hired who was licensed to provide counseling, employees were more often cared for within the scope of the EAP office.

Several realizations prompted the organizational change. EAP needed to be sited to provide for greater client privacy. It needed to be located within a department that could encourage and facilitate the growth that EAP had the potential to experience and where services could be provided directly, without referral. An initial suggestion was to make EAP a free-standing entity reporting directly to senior management as so many critical employee issues came within the focus of the newly emerging EAP style. Some viewed EAP as a part of human resources since it is an employee benefit and the work of counseling employees
often is related to organizational policies. After careful consideration, senior management decided that the EAP, in its most basic form, is a statement of the corporate mission of St. Mary's. In order to convey the aspect of mission—the belief that such care was essential in this organization—it was decided that the EAP should be institutionally related to pastoral care.

The EAP office was physically relocated to the wing which housed the Department of Pastoral Care, and the director of pastoral care officially was given oversight of the program. An announcement was made to the hospital at large to inform every employee of this new structure.

These actions expressed the intention of the medical center with respect to deeply held beliefs about EAP. First, the medical center is committed to providing counseling services to the employees as a benefit of their employment. Second, the role of EAP is clearly identified with the mission of St. Mary's. Third, while EAP is not synonymous with spiritual care, the association between pastoral care and EAP embodies the conviction that spirituality is honored and upheld as an indispensable aspect of all mental health care in this organization.

The administration of St. Mary's is convinced that EAP, while not a truly revenue producing activity, is a financially prudent one. By assisting employees as they work through personal problems, St. Mary's believes that they will remain more focused on their work and have improved attitudes. A 1986 study of five thousand employees who were parents of children under the age of eighteen revealed that 77 percent of the women and 73 percent of the men dealt with family problems during their work day. The results would likely be higher today, given the stress that modern workers face in the delicate balance between their work and home lives. Thus, St. Mary's views the cost of EAP as an investment in the staff and medical center rather than merely an expense.

The administration of St. Mary's understands that the cost of caring for employees who might be terminated unless problems can be corrected is far less than the cost of recruiting and replacement. EAP is a way of providing care that is consistent with St Mary's mission, financially helpful to its employees, and financially beneficial to the institution.

The employees of the medical center received the announcement of the move of EAP from psychiatry to pastoral care extremely well. Both Referrals by managers and self-referrals have continued to increase since this new arrangement was established.

Another new design

St. Mary's recently decided to place the patient advocate program under the direction of the Department of Pastoral Care. The recent accreditation process also provided insight into the possibility of this department becoming involved in the development of other innovative programs related to education in the community and preventative health care programs with churches. With the growth of services provided through pastoral care, it is time to consider a new organizational structure that preserves the identity of its primary emphasis of spiritual care yet allows room for other programs that are compatible with our work and focus. In addition, the Department of Pastoral Care is being renamed the Department of Spiritual Care, Counseling, & Mission. The department will continue to report to the vice president of mission integration. The inclusion of the EAP under the management of the Department of Pastoral Care was the first step in the process of growth that has led to this new structure and strategy for future growth.

While pastoral care and the EAP are not the same, there is sufficient similarity in focus and goals that the two programs can function extremely well together. At St Mary's each has actually enhanced the success of the other.

References

Personality Disorders and the Dying Experience: Reflections on Pastoral Care

Gretchen Thompson

Dying is huge. Whether the process begins in an ICU, ER, a hospital room, a nursing facility, a hospice, or the familiarity of one's home; whether it approaches rapidly, slowly, violently, peacefully, predictably, or quite unexpectedly; it is a sacred and often demanding journey, perhaps the most monumental of all human experiences.

Dying can be a time when spiritual transformation already has so much natural momentum that chaplains face a somewhat distinctive task. Often, it is too late to help individuals to reframe theological frameworks, belief systems, habits, behavior patterns. The dying process itself may reframe—sometimes dramatically—any or all of these. The chaplain's role may be simply to provide a comforting presence.

Spiritual comfort at the time of dying often springs from two human capacities: hope and trust. Across cultural and religious variations, despite age or gender, these two capacities can serve the dying process tremendously. They help to fend off terror and panic, or at least to place these painful emotions in a larger and more redeeming context. They can generate the courage needed for reconciliation, forgiveness, and closure, leading the individual to an invaluable calmness and peace of mind. They provide great sustenance as the individual is forced to endure longer and longer periods without physical expression. And perhaps most important, from a spiritual standpoint, they provide connection to both holiness and future. Trust helps us as humans connect to that which is greater than we are, and to be sustained by it. Hope helps us to believe that this connection will be there for us in the future, even if we cannot, from our present vantage point, comprehend or imagine how that will occur.

The Reverend Gretchen Thompson, MDiv, serves as chaplain at Health Partners Hospice of the Lakes, Minneapolis, MN. Correspondence may be directed to gretchen_thompson@hotmail.com.

The Journal of the Association of Professional Chaplains
If we as spiritual caregivers can evoke any degree of trust and hope in the dying patient, we are doing well. Typically, we do this in many ways, utilizing various techniques: active listening, prayer and ritualization, naming and honoring, creation of time and space for life review and/or reconciliation, music, touch, expression of compassion, witness, scripture, support for loved ones and family, reconnection with sources of strength. Each of us has our own list, and each list is the result of years of training, experience, and honed intuition.

This article focuses on pastoral care to the dying in terms of evoking trust and hope. It deals specifically with patients whose unique needs regarding hope and trust are frequently misunderstood or overlooked: those people with personality disorders.

It addresses two basic questions: How can we best serve those who enter into the dying process with personality disorders? How can we help them find hope and trust as they set out on this often overwhelming journey? Though it is written from the perspective of a hospice chaplain, the concepts are applicable to other settings in which the chaplain encounters people suffering from personality disorders and seeks to establish an environment of comfort, hope, and trust.

What is a personality disorder

M. Scott Peck provides the following global explanation of personality or character disorder—the terms are used interchangeably—in his recent book Denial of the Soul:

It can be helpful to look at both neuroses and character disorders as disorders of responsibility. As such, they are opposite styles of relating to the world. Whenever she is in conflict with the world, the neurotic tends automatically to think it is her fault. Whenever he is in conflict with the world, the character disordered person tends to assume it is the world's fault.

A significant portion of our lot of existential pain throughout life is the anguish of continually and accurately discerning what we are and are not responsible for. It can be seen that both neurotics and those with character disorders avoid this existential anguish.\(^1\)

He goes on to say that while neuroses often cause acute internal suffering for their bearers, personality disorders—also painful for their bearers—may cause profound pain in the world around them because accusation and blame are predictably aimed outwards, no matter what the circumstances.

If you feel as though everything is your fault i.e., neurosis, you may seek help from a therapist or other care provider. This leads to diagnosis. On the other hand, if you think everything is the world's fault, i.e., personality disorder, you simply try to endure a world that you perceive as indifferent at best, cruelly hostile at worst, and are less apt to seek therapy. Thus, people with personality disorders often remain undiagnosed.

Though statistically representative of up to 19 percent of the general population, such people often are unidentified.\(^2\) Even when they are diagnosed, they rarely self-describe by naming their specific disorders.

It is not uncommon for patients to say, “I've struggled with schizophrenia since I was a young adult,” or “They say I'm bipolar,” or “I'm an alcoholic in recovery for five years now.” They are very unlikely to say, “I have a histrionic personality disorder,” or “I think I may be borderline,” or “Call me a narcissist.”

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, personality disorders (Axis II) are distinct from, and yet can coexist with, Axis I disorders such as depression, psychosis, schizophrenia, bipolar disorder, and post traumatic stress syndrome.\(^3\) In fact, they can hide behind or look like these other conditions, making them even harder to recognize.

Research suggests that these disorders have both genetic and environmental origins. For instance, though some studies indicate a very strong correlation with childhood trauma, neglect, and sexual or emotional abuse, recent studies of twins and other research point to biological and neurochemical correlations as well.\(^4\)

Although the DSM identifies ten different forms of personality disorder, grouping them into three broader categories or clusters, all tend to manifest in the following two ways.

Inflexibility

People with personality disorders are often rigid or inflexible, lacking the ability to adapt or self-correct. This is not their fault per se; it is simply the way their personalities, for reasons both environmental and genetic, have become formulated over several years. With reference to
Scott Peck's explanation, because of their more outward focus, they have a decreased capacity for self-reflection that can seem very unusual to those who are adept at discerning a given context and responding to it in kind.

Psychologist Gregory Lester, who has done some excellent work translating personality disorders into practical terms specifically for health clinicians, gets at this quality through the metaphor of piano playing. He posits that for most of us the developmental process of growing up involves learning to adapt and adjust to the world around us. Like piano performers, we learn a wide repertoire of pieces, become adept at many, and, in our maturity, play the right piece in the right context with little effort. At a wedding, for example, the skilled pianist will play joyous music; at the funeral, dirges; at the ball park, a national anthem.

Likewise, when things go well for us, we feel happy and celebrate. When we experience loss, we grieve and offer condolences to others. Injustice angers us, and we act to correct what is wrong. In other words, we respond to our world in ways that show we are basically in sync with it, that we discern its changes and variations with some accuracy.

According to Lester, someone with a personality disorder functions more like a player piano. This individual has only one or two tunes and plays them again and again, starting up the same roller over and over, no matter what the context. It is as though the capacity to interpret and adapt is largely missing. Thus, those with a paranoid personality disorder have a distrustful piano style, which is played out at work, at home, at the wedding or the funeral or the ballpark, in the store.

On the other hand, those with a narcissistic disorder will play the tune of their own superiority wherever they go. It does not matter whether they are CEOs in board rooms, librarians in the stacks, or cabbies in rush hour traffic. They understand themselves as the center and the best, and no amount of feedback from the environment is likely to change their tune. Indeed, this is the only tune they know, and often the only one they can learn.

Unlike depression or other diagnoses more responsive to medication and therapy, personality disorders are, by their very nature, fairly intractable. Recent insights in psychiatry and cognitive therapy are beginning to offer new hope, but at this point, the treatments are lengthy, intense, and, sadly, often unsuccessful. As a result, such therapies would rarely be appropriate to enlist in relation to the dying process because of time limitations.

For detailed information about current modes of diagnosis and treatment, see Jeffrey E. Young, Cognitive Therapy for Personality Disorders: A Schema-Focused Approach, 3rd Edition. It is clear, yet comprehensive, and includes a diagnostic questionnaire as well as a whole section for clients.

**Difficulty in relationships**

A person who can play only one or two tunes will do fine in a few specific contexts, but poorly in many others. Sustained relationships can prove the most challenging of all, for they often require the widest range of adaptability over time.

People with personality disorders may struggle profoundly with deep or intimate connections, leaving, in their wake, a tragic array of broken, painful, and unresolved relationships. They are often identified by others as difficult or bad rather than impaired though the latter is a more accurate description. Although their struggle with relationships causes pain among family and loved ones, it also can be very painful for them. Imagine, for a moment, what it would be like to play a Bach concerto at a rock concert and then have no idea why you're booed off the stage.

Because these disorders do wreak havoc with relationships, professional staff working with such individuals can find themselves feeling inexplicably drained, angry, frustrated, or unsuccessful. Caring for persons with personality disorders may result in polarization or triangulation within even the most tightly knit teams.

Returning to the narcissist example, patients who assume they are the center and the best may do quite well during hospital intake as everyone asks them questions and attempts to make them comfortable. Later, when they ring the call button every few minutes and expect immediate attention, they'll be quick to categorize staff as good or bad based on quickness of response. If staff members buy into this, they eventually will direct their frustration toward one another to the detriment of all concerned.

Likewise, patients with dependent personality disorders will be very content with staff more inclined towards excessive nurture, and averse or passive aggressive toward others. Those with
avoidant disorders may react in an opposite fashion to these caregiver styles. All these are patterns that will not change; they need to be understood and worked with.

**Personality disorders and their characteristics**

Chart 1 (p. 12) gives thumbnail sketches of the ten DSM personality disorders, based on Lester’s material. While useful in providing an overview, these are obviously gross simplifications, and should not be given diagnostic authority. In reality, they often seem to overlap or fall into far less discrete formations. This chart includes Lester’s descriptions of how each disorder typically is experienced by others, such as neighbors, family, acquaintances, or fellow workers in language chaplaincies may well hear as they listen to loved ones or facility staff talk about these patients.

Chaplains frequently observe these traits in patients, only to watch them dissipate later on. After all, being stingy, wishy-washy, melodramatic, or forgetful is all part of what it means to be human, and none of us is immune. The term personality disorder becomes a legitimate categorization only if these traits persist with predictability over long periods of time and in a wide variety of contexts, remaining intact even when they obviously generate problems instead of solutions. Further, it is never a useful categorization if it is used to dismiss, discount, or otherwise diminish patients, and it is never to be used as an excuse to give up on them, though that may be very tempting at times.

To name the challenge, however, is worthwhile as it is best to know as much as possible about what we chaplains may be dealing with.

- These are often the patients that drive a staff to fury, virulent disagreement, or stony indifference: the ones we are called in to “handle” in hopes that we will somehow muster the patience and tolerance others have long since spent.

- These can be the patients that we try hardest to connect with, but who remain oddly immune to connection: the ones we wake up thinking about in the night, wondering why we couldn’t have done better.

- These are sometimes the patients whose rooms we secretly dread walking into: the ones in last place on our visit list, situated there in the unspoken hope that we won’t have time to get there.

- These can be the patients whom families complain about—even in the waiting room during surgery—patients who few people come to see or who seem completely friendless, whose connections to the broader community seem tenuous, superficial, or non-existent.

- These can be the patients who express an excruciating pain they cannot break out of, who describe over and over a world that is unjust, unfair, untrustworthy.

- These are the patients who are prone to extremes: wildly impulsive at times, then distant or even dissociated, then vehement when we wouldn’t expect it, then impulsive again.

- These are the patients who seem to travel with a cloud of chaos around them, wherever they may go. They may already have passed through several other facilities, moving from place to place because of chronic dissatisfaction or because they’ve repeatedly been asked to leave.

Living with a personality disorder can be hard, not only for the patient, but also for involved family and staff.

Dying with a personality disorder can be hard too. Add to chronic rigidity and disturbed relationships, the elevated importance of both trust and hope in the dying process, and what may emerge is a high risk, chaotic, painful situation.

**What does this mean for spiritual care?**

Following are suggestions for chaplains who provide spiritual care to these special patients, their loved ones, and their caregiving staff. It is by no means a systematized or finished collection.

**Establishing trust**

Understand that you may not be trusted, and avoid self-critique if your normal abilities to connect and establish trust seem diminished. Perhaps you cannot offer a perfect harmony to the piano tone your patient is so persistently playing. In fact, count on it, but also assume that some degree of trust still is possible.

Consistency is very important here. Even if you can't do exactly
<table>
<thead>
<tr>
<th>Disorder (DSM)</th>
<th>Disorder as commonly described by laypeople</th>
<th>View of others</th>
<th>Individual's View of self</th>
<th>Coping method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 1 – Mature Type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid: suspicious, distrustful, manipulative</td>
<td>Takes everything personally, questions every motive or intention, gets angry or obsessed over small things gone wrong, blows everything out of proportion, seems thin skinned, “chip on shoulder,” seems vindictive, is spoiled for a fight.</td>
<td>Dangerous</td>
<td>Mistreated</td>
<td>Secretiveness</td>
</tr>
<tr>
<td>Schizoid: socially distant, detached</td>
<td>Seems cold, aloof, blank or zombie-like, easily forgettable, impossible to talk to.</td>
<td>Uninteresting</td>
<td>Self-sufficient</td>
<td>Solitude or one strong interest</td>
</tr>
<tr>
<td>Schizotypal: odd, eccentric</td>
<td>Seems weird, strange, eccentric, oddly anxious, inside own head, different, crazy, genius, full of odd non-sequiturs, confusing.</td>
<td>Boring, plain</td>
<td>Gifted</td>
<td>Eccentricity, grandiosity</td>
</tr>
<tr>
<td>Cluster 2 – Immature Type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antisocial: impulsive, aggressive, manipulative</td>
<td>Charming at first, untrustworthy later; sincere at first, duplicitous later; immature, self-centered, manipulative, dangerous, cognitively inflexible, rationalizing, haughty, contemptuous.</td>
<td>Suckers</td>
<td>Superior</td>
<td>Opportunism</td>
</tr>
<tr>
<td>Borderline: impulsive, self-destructive, unstable</td>
<td>Unreasonable, dependent, in chronic emotional pain, overly intense, vaguely threatening, dramatic, manipulative, runs hot and cold, inconsistent, frequently depressed or agitated.</td>
<td>Angels/Devils</td>
<td>Vulnerable</td>
<td>Emotional justification</td>
</tr>
<tr>
<td>Histrionic: emotional, dramatic, theatrical</td>
<td>Always seems needy, showy, superficial, melodramatic, seductive, shallow, childlike, overly body oriented.</td>
<td>Admirers</td>
<td>Fetching</td>
<td>Performing</td>
</tr>
<tr>
<td>Narcissistic: boastful, egotistical, “superiority complex”</td>
<td>Always focused on self, selfish, presumptuous, demanding, uncaring, manipulative, demeaning, rageful, self-righteous, power mad, arrogant.</td>
<td>Servant</td>
<td>Special</td>
<td>Image management</td>
</tr>
<tr>
<td>Cluster 3 – Anxious Type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent: submissive, clinging</td>
<td>Clingy, wishy-washy, fearful, manipulative, passive-aggressive, inviting exploitation, naïve, desperate for caretaking.</td>
<td>Competent</td>
<td>Confused</td>
<td>Following instructions</td>
</tr>
<tr>
<td>Obsessive-Compulsive: perfectionistic, rigid, controlling</td>
<td>Stingy, perfectionistic, indecisive, cold or unemotional, hoarding, anxious, controlling, demanding, workaholic.</td>
<td>Contaminated</td>
<td>Righteous</td>
<td>Control</td>
</tr>
</tbody>
</table>
what someone else wants or needs you to, you can still be meticulous about what you say you're going to do. This does, over time, affect a dependable pattern of caring that a patient can comprehend as trustworthy. These patients usually don't tolerate well a casual phone call informing them that you have to cancel a visit. They may seem angry or highly distressed or brokenhearted, but at the root of it, they're probably scared. Death is scary, change is scary, and at some point the fear becomes hostility or frustration or panic. This is true for all of us, but often somewhat exaggerated for those with personality disorders.

If you do the unpredictable with these patients a time or two, forgive yourself quickly, and move on. Do your best to be as dependable as possible, and let go of the rest. Don't waste time attempting to persuade patients that you are trustworthy with words when your actions don't communicate an identical message. They typically pay acute attention to both and often expect you to fail. If you are baited to engage in volatile exchanges about trust or failure, desescalate as compassionately and as calmly as you can.

I have failed to establish trust with personality disordered patients in one of two ways: by avoiding them, usually because I couldn't be what they wanted me to be and felt drained by that, or by losing calm in the face of their own distress drama, inadvertently demonstrating that I am emotionally unpredictable after all.

If you have established trust, know that you may have provided something profoundly important. The life history of many personality disordered people is chapter upon chapter about trust broken, relationships torn or mutilated. To offer someone with such a history something even semitrustworthy to hold on to as life's end approaches is not trivial and can matter a great deal.

**Evoking hope**

A patient's personality disorder in and of itself has often provided a primary—if somewhat limited and limiting—source of hope for them over many years, e.g., "If I can just play my tune and everyone listens, I will be all right." Translation: "If people just pay attention, if they just respond to how ... [important, dependent, fearful, untouchable, afraid] I am, I will be all right."

To put this in theological terms, the disorder, functionally, has become a god. Like some old, inflexible, and relatively loveless deity, it has told them what to do for years. It probably has no name, so it can't be talked about easily, and that only increases its power. Those with personality disorders who are members of a faith community may speak about their faith in very plain and conventional terms, but what they are truly bound to—and bound by—is the disorder itself.

Whether one's personality is disordered or not, to lose one's God, the deepest source of focus and strength and internal organization, is to lose hope altogether. This is terrifying for anyone. Some personality disordered patients describe unbelievable transformations regarding hope from inside the crucible of the dying process, breaking free and then regenerating spiritually with the lightening speed of conversion. Others seem to die as they have lived, playing the same tunes that have been their only themes for years.

As chaplains, we have an ethical obligation never to deconstruct or even significantly reframe self view or world view at this point in a patient's life, even with the plan of bringing forth a perspective we deem more hopeful or healing. As the patient's remaining time on earth is limited, there may not even be time for reconstruction, especially for someone who has limited spiritual resources in the first place.

Many personality disorder patterns are so strong that we couldn't deconstruct them if we wanted to, even in the face of death. Yet we may experience pressure, perhaps from our own internal agendas, more likely from family members who desperately need something from our patient and see that time is running out: "Dad hurt me for so many years. Can't he apologize just once before he dies?" "My wife has left me and come back again so many times I've lost count. It's killing me that she can't tell me how she really feels before she dies." Such needs are hard to ignore. Even so, we best honor our personality disordered patients at this point by leaving whatever they cling to fully intact. However, this does not mean that hope is out of reach, either for patients or for their families.

**Utilizing life review**

Life review, the panoramic retelling of one's own story with opportunity for focus on selected details and events, can be very potent in generating hope for personality disordered patients at end of life. These are people whose limited
capacity for self reflection has led them to focus far more on the exterior world and its flaws than on their own inner workings. Often, others get tired of listening to them and find some excuse to get away.

It can be very helpful, and also soothing, for them to be well heard. As we provide an encouraging and supportive presence, ask questions about or highlight the more hopeful segments, point out patterns of resilience or redemption—no matter how fragmented—we help them to remember that life does have larger meaning. This implies that death does too.

 Tradition, ritual and prayer

Patterned repetitions that feel familiar and safe also can soothe and comfort. For example, the obsessive-compulsive patient, suffering greatly from loss of control as the dying process progresses, may find deep relief in the repetitive reading of a single scripture passage. It is a touchstone, a sign that at least one thing is not in upheaval.

A patient with antisocial disorder told me he'd been raised in a mainline Protestant tradition, adding that this meant little to him, that he hadn't been to church in years. When he mentioned that he was one-quarter Cherokee, I asked if he would like to explore that tradition a little more, and he said he would.

In our very first round of learning, he came upon an illustrated description of a warrior and recognized immediately the positive manifestation of his own disorder. Like a warrior, he too was fearless in battle, willing to take on any enemy. Like a warrior, he too was proud, and possessed superior strength and agility. Like a warrior, he too loved to win but also was capable of surrendering with great dignity.

He used this image from his own lost heritage to guide himself through the dying process. It provided him with an ideal, a way of picturing how to proceed, how to deal with physical suffering, how to let go when the time came. My only task was to bring him more information and to listen as he worked his way through it.

He never apologized to the wife he'd hurt very badly and never received visits from the children who'd come to hate him, but at least he knew he'd die like a warrior, and this brought him considerable peace of mind.

Supporting loved ones and facility staff

Chaplains whose pastoral care includes families, loved ones, and even facility staff may come upon significant chaos and pain surrounding personality disordered patients. It is not uncommon for much to be left undone. The final gifts often cited in hospice—I love you, I forgive you, I ask for your forgiveness, and I release you—simply remain ungiven. They are gifts that many people with personality disorders can't pass out. They often see no need for reconciliation or wish to avoid it at all costs. They may be unable to provide the kind of self-reflection that others feel strong need for at such times.

This means that spouses, children, friends, and loved ones may end up with a lot of unfinished business. Not at all uncommon are unexpressed anger and resentment, a strong sense of disconnection, or tremendous guilt for having failed, despite Herculean effort, in what they consider a primary relationship.

Earlier struggles, which quite likely have occurred with their personality disordered relative, may have resulted in spiritual and emotional growth, and inspired them to seek out new supports. If this is not the case, we chaplains can at least give them a useful framework from which to process their loss. For example, we can normalize and affirm their struggles and point them toward means of support, e.g., individuals, groups.

Staff may reveal to you that they have given up, made some big mistakes through loss of perspective, or become frustrated with one another. Again, we as chaplains can provide helpful affirmation and normalization. These patients can be very difficult to work with. If we enter into their drama by blaming ourselves or one another, we lose effectiveness.

Staff can spell one another at points of exhaustion, habitually interact with the patient in pairs, draw up a clear list of expectations and consequences, communicate clearly about attempts at polarization, and practice cheering one another on. We can offer encouragement, non-judgmental listening, and affirmation. Last, but far from least, a bit of humor often provides much needed release.

Conclusion

Most human beings, when told that their condition is terminal, experience profound spiritual vertigo. A monumental shift in perspective is called for as their whole lives undergo a sea change. Fear, anger, numbness, denial, bargaining—all the phases Kubler-Ross so elo-
quently described for us—are part of a challenging journey to final acceptance, a journey that involves massive adaptation to a new reality.

For patients with personality disorders, who struggle greatly with both self-reflection and adaptation, this journey may seem impossible. They may lock on to the phases most aligned with their disorders, denying that they are dying at all or expressing so much fear that loved ones become enslaved in attempting to reassure them at all costs. Alternately, they may proceed with full dignity and grace, depending upon how well their individual player piano tunes suit their particular circumstances. In any case, we need to honor who they are, rather than focusing on who they can, or cannot, become.

Perhaps most helpful of all is simple acceptance of how insurmountable this process of radical adaptation can seem to them. Just as we don’t expect patients with chronic obstructive pulmonary disease (COPD) to engage in activities that leave them desperate for breath, we should not expect large amounts of flexibility from patients with personality disorders. We encourage them to do their best toward achieving that delicate balance of self-empowerment and surrender that lends them the greatest possible spiritual comfort. We invite them to seek out, to name and to be supported by all sources of hope and trust, and to rest in these.

As their dying progresses and mobility, consciousness, and communication diminish, their loved ones may experience more acutely than before the painful realities of unresolved negative emotions. We can assist them, in turn, by offering simple comfort and affirmation, helping them to be realistic, and to normalize their own feelings as much as possible. To the extent that these same difficulties plague our colleagues and fellow staff, we can offer extra support to them as well.

References


One out of a hundred: Providing Chaplaincy in State Schools to People with Mental Retardation

Robert L. Hendricks

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), calculates the prevalence of mental retardation (MR) in the general population at about 1 percent. DSM-IV indicates that the degree of MR can be observed on four descending levels: mild, moderate, severe, and profound. In the world of the remaining 99 percent, verbal wars are fought, relationships are built, deals are made, prayers are offered, spiritual healing is made available, financial strategy is implemented, songs are sung, love and anger are exchanged, and grief is expressed. It is no different in the world of the 1 percent.

When I came to San Antonio (Texas) State School seven years ago, I had almost no experience working or living with people who are mentally retarded. I began my research at the city public library with the DSM-IV. Diagnostic criteria for MR include the following: a functioning IQ level of approximately seventy or below; deficits or impairments in two areas of daily life—communication, self-care, home-living, social/interpersonal skills, self-direction, functional academic skills, work, leisure, health, safety and use of community resources; onset before age eighteen. MR is an Axis II entry in the DSM-IV.

Books devoted to understanding MR were surprisingly few in number and reflected the legal aspects of guardianship for those needing special services or the benefits of placement into a community home. The public library offered no real studies on the spiritual aspects of living with MR or how those aspects could be addressed in an institutional state school. One author, a sociologist who seemed to be writing for shock value, wrote that there were no biblical references to mental disabilities. To the contrary, from the Pentateuch to the Revelation, God is present for the weakest among us as well as the smartest and wealthiest.

The Reverend Robert L. Hendricks, MDiv, BCC, serves as director, Chaplaincy Services at San Antonio State School. He is endorsed by the Baptist General Convention of Texas. The section of this article profiling Ronnie is featured as "Ronnie’s Walk" on the institution’s Web site. Correspondence may be directed to bobbyhen_99@yahoo.com
In contrast to a biography written several years ago by a popular celebrity, people with MR are not angels. To name them as such is to take away from their God-given humanness as well as to ignore a variety of behaviors. It is the equivalent of revising John Newton's "Amazing Grace," to say "how sweet the sound that saved a swell person like me." It is far better to demythologize MR rather than to disguise it with platitudes. Most recently, the descriptive term used by some groups changed from mental retardation to mental disabilities. This is an unfortunate trend because it dilutes issues experienced exclusively with MR.

The philosophical and clinical debate among those who treat MR has been polarized through the years, moving from the practice of warehousing severely retarded people with no effort to habilitate them, to the theory that all institutions are bad and should be closed. It is from the former that we hear horror stories; however, over the last fifty years, many institutions have created and refined progressive developmental techniques—either voluntarily or because of litigation. It is also true that at any given time, there are people who are so severely retarded that they cannot function in a community home or a private center without institutional preparation.

Ronnie, a middle-aged African American with poor socialization skills, was admitted to the state school less than two years ago. Almost nonverbal at the time of admission, his affect was nearly cata
tonic. Much of his life had been spent in seclusion, and his psycho-
logical assessment suggested he was agoraphobic. However, with his newfound freedom, he began to walk trance-like at the end of each day from his dormitory to the opposite side of the campus where he sat at a picnic table and watched the cars and people in the parking lot. As he gained vocational training skills in the school's developmental center, he began to communicate in short sentences and to walk to the picnic table with a friend. He eventually enjoyed liberal freedom of movement as well as participation with friends in numerous on- and off-campus activities.

After about eighteen months, Ronnie began appearing at Sunday worship in the chapel, partly in anticipation of the cookies served at the end of service. Satisfied just to look and listen, he would worship by sitting in the middle of the sanctuary. Within a few weeks, he became one of the first people to arrive at the chapel; his chosen role was to acknowledge the arrival of others. He learned to serve as an acolyte, pass out bulletins, to sing songs, and to join in responsive reading and prayer—and he began to smile. He now assists with the distribution of the elements during Holy Communion. His future is promising.

The causes of MR include, but are not limited to, Down Syndrome, brain damage due to physical trauma, Fetal Alcohol Syndrome, and Fragile X Syndrome. In fact, more than two hundred causes have been documented. Despite this statistic, the cause often is unknown. Slow motor skill development in infancy frequently is a first sign. If MR is mild, the body may develop normally through adulthood. If MR is more severe, the body still may develop normally but with stark behavioral consequences. As the body matures biologically, the mannerisms and social skills can remain infantile. A fully-grown adult male may prefer to crawl or sit in the middle of a busy hallway. A woman may giggle loudly or squeal to make a point in what should be a quiet situation. Inappropriate public sexual behavior may become a problem for either gender. Everything from personal hygiene and meals to education and transportation must be addressed exhaustively on a daily basis.

It is important to note that MR is a condition, not a disease; people with MR do not have a sickness that can be cured with surgery or a drug. As previously noted, MR is an Axis II entry in the DSM-IV. Some persons with MR also are diagnosed with Axis I mental health issues, e.g., schizophrenia, self-injurious behaviors (SIBs). Understandably, communication problems make Axis I diagnoses difficult. Assault or maladaptive sexual behavior by persons with dual diagnoses often bring them before a judge in the public court.

David is a forty-five-year-old Hispanic male, who was admitted after a series of unsuccessful group home placements. His mother reportedly received prenatal care with no problems noted. However, she was treated with antibiotics for a severe ovarian infection during the pregnancy. David was a "blue baby," who required oxygen at birth, and she attending physician advised her that he had suffered brain damage. His developmental milestones were delayed: he walked between ages three and four, did not talk
until he was four, and was not toilet trained until past age five. He was diagnosed with MR at age twelve.

David demonstrates anxiety and nervousness. His speech pattern is rapid; he often must repeat himself to be understood and continues to receive speech therapy. Despite these handicaps, he has completed the general equivalency diploma course (GED) and is able to manage small amounts of money and to make minor purchases. In addition, he has had varying degrees of success with employment at janitorial services and grocery stores. David enjoys movies, dancing, music, and basketball. He dislikes being redirected by females, playing soccer, and eating spaghetti.

David was a charter member of the chapel services, which were begun at the school seven years ago. His desire to wear multiple layers of clothing was satisfied with the opportunity to wear a choir robe. He frequently arrives at the chapel with a long, noisy key chain dangling from his jean vest pocket. David’s motor skills are such that he can use a candle lighter for altar candles without much prompting. He enjoys congregational singing and is a joy to the choir director because he follows direction. Though speech does not easily come to David, he can be heard reciting the Lord’s Prayer. David is proof positive that spiritual growth is not exclusive to the 99 percent world.

Once their child is diagnosed with MR, parents most likely will receive a referral from the school district to a local mental retardation authority (MRA), which will provide a menu of options and services depending on funding from the state or commonwealth and the severity of the MR. The MRA ensures that a “permanency plan” is developed for each child and reviewed every six months. If the condition is mild, the child may stay in the home well into adulthood. The individual’s independence may be encouraged through placement in a group home or even in an apartment. If the condition is more severe, the legally authorized representative (LAR) must make difficult decisions. Caring for people with MR in their home of origin can be exhausting to parents. At some point, they often must make the heart-wrenching decision to place their child in a group home or a state school.

Texas has eleven state schools with populations ranging from 295 to over 600. These state schools receive federal funding as intermediate care facilities for mental retardation (ICF-MR). The word school is something of a misnomer. In the past, these facilities enjoyed independent school district status, but today, most residents are well above school age, and those who are enrolled in special education classes are bused to the nearest high school. Because they receive ICF-MR funding, state schools must undergo an annual survey similar to Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) inspections.

When individuals arrive at the school, whether by placement or court order, they first attend an admissions meeting that includes the interdisciplinary team which will monitor and supervise their care throughout the length of their placements. Every aspect of their lives becomes an object of treatment and concern. A caseworker will already have been assigned along with a psychologist who will develop a behavior modification plan (BMP). A social history is documented with input from family members. Vocational potential is determined. Health and medical concerns are addressed by doctors and nurses employed by the school. Physical, occupational, and speech therapists are available. Pastoral care addresses religious needs. Other issues considered include the person’s vision, hearing, mealtime habits, diet modifications, communication methods, reinforcers, need for bathroom assistance, likes/dislikes, required level of supervision and mobility, e.g., ambulatory, non-ambulatory. Once the admission is formalized, individuals meet with a smaller interdisciplinary team within the dormitory. This team includes the home supervisor, case worker, psychologist, and specialists called active treatment providers. These titles differ from school to school and state to state. An annual review assesses the individual’s progress toward personal goals, which may be as simple as daily teeth brushing or as detailed as vocational objectives.

Vital to the life of a person in a state school is the promotion and protection of basic human rights. These rights include the right to make decisions regarding medical treatment and finances; to vote; to send and receive unopened mail; to make and receive confidential phone calls; to receive visitors; to wear, keep and use clothing as well as other personal possessions and personal hygiene items; to have access to, keep, and spend money; to freely move about the home and neighborhood. Residents have the right to a voice in program development and placement decisions, and above all, they have a right to
privacy, and the right to participate in religious services of their choice.

Rix is a tall, fifty-eight-year-old Caucasian male, who has lived in state schools since 1960. His father was an attorney, his mother an administrative assistant for his father’s firm. He has a younger brother. After a normal delivery at term, Rix developed as expected up to thirty months of age. At that time, he had a serious reaction to a vaccination which resulted in severe disability. Testing ultimately revealed a very low IQ and low socialization skills. His parents initially cared for him at home. He was admitted to a child development center in San Antonio and later to state schools in Austin and Travis before coming to San Antonio State School in 1980.

Rix became a recognizable fixture on campus. Staff learned his self-help skills were his strength: he could eat and drink neatly, wash and dry himself, use toothpaste, and perform other helping tasks. His periodic self-injurious behavior (SIB) required medication, which unfortunately produced severe side effects. Eventually, a behavioral modification program helped to refine his self-help skills and to improve his impulse control and inter-personal skills.

His vision was impaired in his left eye due to cataract development, and a few years ago, Rix lost sight in both eyes. Tasks that were difficult before now became impossible without constant attention and care. Rix’s father has died, but his devoted mother continues to visit him every week. On Sunday morning, Rix will walk with other residents from his dormitory to the pavilion where chapel services are conducted. One, sometimes two, active treatment providers guide him across a street and up a sidewalk to the entrance of the building. If staff members are not available, Rix’s mother makes the 75-yard walk to and from the dormitory to make sure that he has an opportunity to worship.

Once seated in the chapel, Rix responds to the people around him and the activities of the worship service. He enjoys the “clapping songs” and tries to become a part of the festivities. Sometimes without warning he will stand and exclaim, “Chocolate!” in anticipation of the chocolate candy his mom gives him after the service. At Communion time, the bread and cup are taken to Rix. His mother whispers into his ear why the chaplain is there and receives the bread and the cup with him.

In the Genesis story we read that creation came out of chaos. Caring for people with extreme mental and physical disabilities twenty-four hours a day is an attempt to control chaos. At San Antonio State School, it takes approximately six hundred employees to provide necessary services for three hundred residents. Chaplaincy services is a part of the interdisciplinary approach to treatment, and each of the eleven state schools in Texas has one chaplain. With ever-declining budgets, only five schools provide full- or part-time assistants. Though state schools must conform to ICF-MR facility and state regulations, they are fairly autonomous in the manner in which they carry out the mission. Likewise, each pastoral care director adapts to the needs of the individual institution.

Chaplains at state schools love the works of the Roman Catholic scholar Henri J. M. Nouwen, in part because his final ministry, to the shock of many, was to be chaplain of the L’Arche-Daybreak Community for people with MR in Toronto, Canada. In Reaching Out: The Three Movements of the Spiritual Life, Nouwen reminds all in the healing business that they do not own the people for whom they care: “The great danger of the increasing professionalism of the different forms of healing is that they become ways of exercising power instead of offering service . . . many people who suffer—view those who are helping them with fear and apprehension. Doctors, psychiatrists, psychologists, priests, ministers, nurses, and social workers often are looked up to by those in need as if they are endowed with a mysterious power.” During the first few years of my ministry to people with MR, I often underestimated their abilities. Now I often hope for more than can be expected.

Chaplains ministering in state facilities work within a political where employees sometimes raise the red flag of “separation of church and state” and resist religious programming or even interdisciplinary involvement. However, I have never seen a parent, family member, or guardian of a client with MR do this. If chaplains retain integrity and professionalism, their ministry will at least be endured, if not accepted.

In addition to the standard orientation, the best way for a chaplain to begin an assignment in a state facility is to wear out the shoe leather. Rounds at a state school are unlike rounds at a hospital because residents are not acutely sick and may reside at the institution for decades. The most important aspect is face time, or what chaplains call “ministry of presence.” This assures both residents and staff that the chaplain does not appear only on Sunday. Opportunities for work in the interdisciplinary setting
abound and usually increase over time. As a department head, the chaplain is included in institutional management and participates in the admissions process, not only because this is the first “hello” to the resident, but also because it alerts staff that pastoral care is an essential part of the treatment process.

As with health care institutions, chaplains may be members of or chair the ethics committee. State schools utilize a human rights committee which monitors, approves, or disapproves changes in a resident’s behavioral management program. I serve on a volunteer state “surrogate decision making” committee which convenes in special circumstances for an individual whose LAR cannot exclusively make a decision for the individual, often for a medication change or a medical procedure. Committee members usually will include a physician, attorney, and an MR worker closely familiar with the individual. Chaplains also may act in liaison with area churches, clergy, and volunteer organizations. Many state schools utilize their chaplains in either a critical incident stress management (CISM) team or some other grief counseling model. As these responsibilities multiply, care must be taken not to blur the boundaries between administrator and pastor.

The “family association” of each state school is crucial to its well-being. This group not only generates projects to benefit residents of the school, it also networks with other family associations, which as a single organization can then lobby legislators. As employees of state schools and therefore employees of the state, chaplains would not normally join family associations and by law cannot lobby legislators on state time. However, for family members, the pastoral care director symbolizes the spirituality of the facility. Thus, family associations and chaplains are mutually supportive.

Larger state schools may have medical clinics to treat residents. Smaller schools have physicians and a nursing staff to dispense drugs; however, emergencies, surgeries, and acute medical concerns are directed to area hospitals. A state school chaplain soon realizes that an assessment of a school resident often will not be similar to an assessment in a medical center. Many times the resident will be nonverbal and nonambulatory. Unless a family member or school employee is in the patient’s room, communication becomes the nurse’s responsibility.

In my first six months at the school, I visited a resident with a dual diagnosis who had been hospitalized for about two weeks and was fairly verbal. He expressed loneliness during his two weeks in the hospital. I noticed there were no get well cards or flowers displayed in the room, an occurrence not uncommon for school residents. As a result of that encounter, I began a simple system of providing cards for residents when doing rounds. Though the patient may not even realize a card is in the room, the tacit message to hospital staff is that the mentally retarded person in the bed is important to others.

Most state school chaplains compare their work to parish ministry. The tenure for most residents of a MR facility is much longer than that of patients at a medical center or even a mental health hospital. The chaplain’s role is highly relational because of the trust factor with facility staff. For each of us, the positive indicators are likely to be personal. For instance, I knew I had arrived as my school’s chaplain when staff of various faiths and ethnic backgrounds, or with no particular religious background, began calling me their pastor.

The worship service at a MR facility is the most visible spiritual outlet experienced on a regular basis. In this safe place, people with MR can express their faith and hope without fear of rejection. The chapels at most state schools in Texas were built with private funding. Some are quite elaborate with stained glass and large choir lofts. One chapel building was donated and moved to the campus from another location.

When possible, residents are encouraged to attend churches or temples in their communities. Some state schools work closely with Jewish representatives to make this a reality. However, few churches have the knowledge or the patience to accommodate people with severe MR. I know of one church outreach program that seated people with MR in the cry room where there was no opportunity for them to experience congregational worship or for the congregation to experience them. I once wrote a brief article for a church association newsletter asking for volunteer help. Though the newsletter went to about fourteen hundred addresses, there was not one inquiry.

At San Antonio State School, the first Sunday worship service commences in a general purpose pavilion. The assembly hall converts into a worship center in an hour. A communion table with casters for easy movement doubles
as an altar. Brass altar ware, paraments and artificial flowers decorate the table. An attractive oak podium stands to the right of the altar. Plastic chairs are arranged in curved rows with a large middle aisle to accommodate wheelchairs. Colorful felt banners hang at the front of the stage area.

The stage is used only for special programs. All chapel furniture is at floor level. The space to the left of the altar is the designated choir area with one microphone covered by some of the choir members. For congregational singing, many state schools use an overhead projector to project words onto a large screen. Because of the time factor in converting a large room into a worship space, San Antonio prints a soft-sided "hymnal" that has a shelf life of about six months. Since the songbooks must be replaced so often due to wear and tear, new songs and liturgy can be added easily thanks to Microsoft Word. Currently, the hymnal contains thirty-eight songs and four pages of an easy-to-follow liturgy. Hymns range from the oldest favorites to praise songs and "El Shaddai," an often requested song.

The Order of Worship reflects the vocational training philosophy of repetition, one goal of which is to prepare residents to participate in congregational worship should they be able to move into the community. Many residents take on duties, reminiscent of conventional church congregants, e.g., one man has assumed the role of the deacon who thinks he should control every aspect of the service; a woman has become the matriarch who expresses approval or disapproval of chapel social activities.

Bulletins are distributed with the weekly Order of Worship, which begins with a prelude, welcome announcements—including birthdays. The service incorporates at least six songs sung by the congregation as well as special music provided by the choir. Prayer requests are invited and followed by a pastoral prayer and the Lord's Prayer. A responsive reading, Scripture and either message or Holy Communion round out the service.

The birthday recognition is extremely important to people living in a state institution as it is the special day that separates them from everyone else. Half the worship may be devoted to music as people with MR love to sing. They also are wonderful audiences, projecting confidence to performers who are not really too sure of themselves. Songs are selected from the hymnal in numerical order, i.e., 1, 2, 3, or 5, 6, 7, because this makes it easier for residents to locate them. Scripture is followed by a "message" that is really more of a single object lesson. I struggled for six months over whether or not to institute the Holy Communion as probably 95 percent of the resident have no intellectual understanding of what constitutes consubstantiation or transubstantiation. Finally, I decided to let the Holy Spirit take care of the theology.

Many people with MR are capable of memorizing the Lord's Prayer, and they practice every Sunday. In fact, the two most important elements of our worship are the times for prayer requests and special music. Residents follow our models of vertical to horizontal, that is, God to human and human to human. They almost always pray for their parents first, followed by other family members.

They ensure staff members attending services hear their names in prayer requests, and they often express awareness of war as they pray for military service members. The special music time gives a resident the opportunity to sing a solo with the coveted microphone and to dedicate the song to a staff member or a romantic interest. Over the years, it has been gratifying to see the improvement in individuals who focus on music.

Memorial services for residents at state schools not only assist people through the grieving process, they also support weekday staff who normally would not be present for Sunday worship. In larger state schools, memorial services may be scheduled on a quarterly basis to honor more than one deceased resident. At our smaller campus, services are held at the home in which the resident lived. Those with a higher level of MR may experience great anxiety at a friend's death and may self-activate this anxiety through end-of-life questions. Direct-care staff who may have worked with the deceased individual for years often have emotional and spiritual ties. Though this sometimes requires pastoral counseling, many memorial services celebrate not only the life of the resident but the vocations of caring to which staff members are called.

Debbie's parents moved from Brooklyn, New York to San Antonio to be closer to their other daughter. Debbie had lived in a nursing home specializing in cerebral palsy, and her sister recommended the state school to their mother with the assurance Debbie would receive good therapy here. Debbie, who is now thirty-three years of age, was delivered at full term by
cesarian section due to placenta previa. Pronounced developmental delays were noted after only a few months, and she was diagnosed with profound MR. Her adaptive behavior composite age equivalent is assessed at seven months. Her best modes of expression are facial/gestural, and she is known to occasionally cry or scream for no apparent reason although she calms with music. She also was diagnosed with spastic quadriplegia, athetosis and thoracic kyphosis with severe lordosis of lumbar spine. Debbie receives physical management and positioning, and communication therapy. Her mom visits frequently.

Debbie lives in a home on campus where all forty residents are nonambulatory. Some are more expressive than others and can self-navigate their wheelchairs. Debbie is completely dependent upon others and has a feeding tube. Yet, those who work with her daily know her likes and dislikes and are well aware of her unique personality and soul.

Worship services conducted at this home have the same musical emphasis as the other services. A few residents can sing or mouth the words, and a few can express prayer requests either verbally or through gestures. Debbie can do neither. Her soft gaze reveals nothing, yet we know music is beneficial for her. So much of conventional ministry depends upon transference from those ministered to, but in this environment, love cannot be expressed in conventional terms.

The future of chaplaincy in state schools pivots on future models of ICF-MR programs. Some states have already closed all of their state schools in favor of group homes or private institutions. The philosophical battle lines drawn for treatment methodologies tradi-

Be present, Lord, among us and bring us to believe
We are ourselves accepted and meant to love and live.

Teach us O Lord, your lessons, as in our daily life
We struggle to be human
And search for hope and faith.
Teach us to care for people, for all, not for just some,
To love them as we find them, or as they may become.5

References

1 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, (Washington D.C., American Psychiatric Association, 1994), 40-44.

2 Ibid., 39-40.


Rewriting the Story-Myth: A Rehab Experience

David E. Tucker

Patients in a rehabilitation hospital enter into a world that tends to focus on their limitations as this is the primary reason for the admission. Therapists focus on weaknesses and how they can be overcome. This effort can produce a secondary effect of making other attributes of the person less visible as patients sometimes focus so much on what they have lost that they fail to notice what they still have. A key element, therefore, in assisting persons through the rehab experience is for the spiritual caregiver to help them view their circumstances through a different, less limiting, prism. This alternative view also has the potential to open up a line of sight that incorporates more of their life pictures.

The need for a new story-myth

Each of us lives with certain beliefs, certain understandings about life, or as I choose to identify them, myths. In this sense, myth does not refer to children's bedtime stories, or even to the classics of ancient Greece. It refers to a comprehensive internally guided understanding of life that undergirds one's sense of meaning and direction. We all possess, to one extent or another, an internal understanding, or "world view." What I propose involves the proactive creation of a new myth, or a revising of one's existing, but suddenly inadequate, myth that takes into account the new life events, e.g., accident, disease, which have resulted in the rehab event. This can be accomplished through an assessment of what has been lost against what remains, followed by the creation of a new story that makes the best use of both. Patients in rehab hospitals are certainly persons with weaknesses, but they also have strengths. This seemingly simplistic dualism is one that quite likely will become a primary aspect of the new myth.

This article presents a rehabilitation chaplain's approach to caring for patients in rehab hospitals. It focuses on patients' strengths as a way of helping them to begin the process of rewriting their life stories. This approach—creation of new "story-myths"—assists them as they learn to cope with, and adjust to, a lifetime of disability. These new myths also serve as landmarks to measure their progress as they journey through and beyond the rehab event.

David E. Tucker, DMin, BCC, serves as rehabilitation chaplain at Orlando Regional Rehabilitation Institute, Orlando, FL. He is an ordained elder in the United Methodist Church. Correspondence may be directed to d Tucker@orhs.org
A foundational principle in the development of new story-myths is the understanding that health and disability are not opposite conditions. People are neither completely disabled nor completely healthy. A significant aspect of providing spiritual care in this arena is adoption of a caring posture that primarily focuses upon the person, not the disability. A former patient and wheelchair user illustrated this when he said concerning his own life with disabilities, “I’m not sick, so don’t treat me like I am.”

A person with a disability is first of all a person. Using a relational approach serves to bridge the dualisms present in a particular situation and also to eliminate “either-or” type thinking, which focuses on one of the polarities in the dualism at the cost of the other. This approach moves closer to “both-and” type thinking, which produces statements such as, “The patient is neither fully weak nor fully strong but somewhere in between.”

Honoring strengths

Not to recognize, utilize, and encourage a person’s strengths is to some extent to devalue them. A person who has been devalued may adopt a position of low self-esteem or even a victim mentality, neither of which is conducive to the rehab process. In addition, either of these can compromise the rehab process, which requires full participation on the part of the patient. Those who do not fully participate in the rehab program because of low self-esteem, a victim mentality, or any other internally unhealthy story line, often do not receive its benefits.

Through “both-and” type thinking, patients’ strengths as well as their weaknesses are recognized as equally crucial to the rehab success. Thus, the whole person is honored, and true healing involves the whole person. Whatever the caring role, each member of the treatment team can help to bring about greater healing by honoring this truth. When patients who have unhealthy attitudes are encouraged to explore their own inner worlds, they can begin to lay the groundwork for their new myths.

Developing a new story-myth

How does this look in practice? As chaplains, we can be proactive about helping patients find adjusted ways of living that draw from both their strengths and weaknesses. Though the ways in which we accomplish this may be as varied as the situations themselves, they all need to begin with the fundamentals of spiritual care, e.g., meeting people right where we find them, addressing their immediate needs through reflective listening, and, as much as possible, maintaining a nonanxious presence.

This approach is of primary importance. As we sometimes enter into the relationship with bits and pieces of prior information about the patient’s history or way of living, we need to remember that the way one viewed life before rehab often undergoes significant change—with or without help—during the actual course of rehabilitation.

What is initially presented also can be intense. Some patients still are very angry and hurt, blaming everyone who makes a good target, including God whom the chaplain to some degree represents. Others come to rehab with more than adequate understandings of the events and people involved. What is important is finding out where individual patients are, e.g., how they are coping with the rehab process at that point. This starting place is important because if we misinterpret this aspect of the process, it colors all that follows and may result in a misguided direction. If a caregiver enters this arena having presupposed what direction patients need to go in their journeys, that caregiver has violated the caregiving process. It is the patient who must lead us.

The “Tree of Me”

If patients have completed “The Tree of Me,” the helping tool that we use at Orlando Regional Rehabilitation Institute (ORRI), we start there. (See facing page.) Members of the rehab team share their own trees with patients. This allows patients and caregivers to know each other on a far richer relational level than is usually present in rehab hospitals. The dynamic purpose behind this aspect of care is the desire to be transparent, which conveys a sense of availability and helps to form meaningful relationships between the patients, staff, and families.

The transparent posture of the caregiver works best when it is presented with unconditional positive regard. Persons who are becoming aware of the need to rewrite their stories often are aware also of where to start. If we listen accurately, we will be able to meet them right where they are physically, emotionally, socially, and spiritually. However, they have to write their own stories, and sometimes this writing continues throughout the remainder of their lives.
The “Tree of Me” was created by Martha McConnell, director, Organizational Development, Orlando Regional Healthcare. It was introduced to the ORRI staff by Christina McGuirk, assistant nurse manager, and is used extensively by the treatment teams. Its roots reflect that which gives the person life, foundation, and stability. The trunk bears the name s/he wishes to be called, and the branches hold the fruits that have grown out of his/her life: careers, skills, talents. Children also are often placed here. The completed tree is posted on the wall beside the patient’s bed.
At ORRI, we pair new patients with those who have been in the rehab process longer, former patients, or others who have lived with disability for a number of years. These persons can provide assistance on a totally different level than those who have no such experience.

As one who has lived with disability for twenty-three years, I share my story only when asked to do so and always within a context of valuing the resources within the patient to whom I am speaking on a higher level than my own. This is no about us; it is about the person for whom we are caring. Sometimes, we may share some of the changes to our own story-myths that have proven to be the most effective when adjusting to disability, as a way of giving express permission for patients to begin to do the same.

**Living into the new story-myth**

Principally, the new story-myth provides congruency between the individual’s being and behavior, between direction and driving purpose. Common areas of adjustment can include how one sees oneself, God, the world’s treatment of persons with disabilities, others in one’s world. The new story-myth may incorporate an individual’s purpose, hope, theology, and/or philosophy. In essence, just about anything that is meaningful to the person may need to be rewritten.  

Caregiving, provided in this fashion, seeks ways to promote survival and well-being, no matter what mythological framework was previously in place. In the end, just as no two persons are alike, no two reworked story-myths turn out exactly the same, even though they may serve similar adjustment needs.

Growth in this nature tends to move toward understandings that serve as landmarks to guide patients through the remainder of their lives. Although rehab is a uniquely challenging event, patients seem in some unknown way to be prepared for, and open to, change. Sometimes nothing of the former story-myth seems worthy of defending; this leaves a vacuum in which a new story-myth can be born. Inherent in this openness is the challenge to patients to draw upon both courage and strength in order to create an understanding that adequately incorporates the events that brought them to rehab.

**Conclusion**

This process provides a revitalized sense of meaning and direction through the formation of story-myths that bring personal meaning and direction to the life journeys as shaped by the unique level of crisis-induced disharmony experienced by each individual. As caregivers, we engage patients within their evolving ontologies, being certain not to align them with some preexisting story line, either theirs or our own, and supporting them in the midst of some of the most potentially creative moments of their lives. This place, where they choose to reshape or not to reshape their lives story-myths, is an awesome place indeed!

**References**

3. Jerry Wald, personal testimony from a person who has lived with quadriplegia for thirty-nine years.
5. Quoted in *Good Emotional Care*, “Seventeen items that go into providing it for patients and families in the hospital,” http://www.groups.yahoo.com/groups/pastoralcare.html.
Swedish hospital chaplains are a group of professionals working with patients, relatives, and hospital caregivers in various stressful life situations. This group, which numbers approximately 350 full- or part-time chaplains, ministers in a cultural context characterized by secularization, privatization, and pluralism.

This study, the first of its kind in Sweden, focused specifically on stress and coping. It originated from a perceived empirical vacuum relating to pastoral care, the author's personal interest, and a general concern for investigating existential questions. Specifically, the objective was to examine a well-defined group of hospital chaplains and their handling of existential confrontation occurring in their daily work. The analyzed material was based on a life story approach and interviews carried out with nine Swedish hospital chaplains.

The research question of the study was as follows: What are the coping processes used by hospital chaplains in their work with existential confrontation? Analytical questions were formulated in close connection with the central concept of Pargament's coping theory.

1. How does the orienting system appear over time? Being a part of the orienting system, what is the build up, maintenance, or transformation of the belief system? What are the resources and burdens of the orienting system? What is the nature of a secular/profane orientation, and how does it interact with a religious orientation?

This study focused on how hospital chaplains handle the stress of existential confrontation in their daily work. A qualitative study, the first of its kind in Sweden, it consisted of interviews based on a life story approach. A life orientation incorporating both the religious and the profane proved to be effective in the way that hospital chaplains dealt with direct and indirect multiphased stress with an existential dimension. The chaplains used a number of coping methods including boundary marking. This article is excerpted from the author's dissertation on this subject.

MarieAnne Ekedahl, DTheol (psychology of religion), is senior lecturer in Practical Theology, Pastoral Counseling, and Psychology of Religion at the School of Theology, The University of Uppsala, Stockholm, Sweden. Correspondence may be directed to marianne.ekedahl@ths.se
2. Is it possible to identify various forms of stress during the coping process?

3. What kind of appraisals are made?

4. What coping methods are applied in different stressful situations?

These questions focused on the individual hospital chaplain and his/her approach in dealing with work related to existential confrontation. The study also examined coping processes on the following levels: a group level, such as the work team of the hospital chaplaincy; an institutional level; and finally, a societal level. The study notes the interaction taking place between the individual level and the other levels.

Theory

The study used the main components of Pargament's coping theory up to 1997. These components constitute assumptions about the coping process as follows:

1. People seek significance, which is defined as "a phenomenological construct involving feelings and beliefs associated with worth, importance, and value. It embodies the experience of caring, attraction, or attachment." Significance, however, is more than that. It is object-oriented; "we care for, we are attracted to something. We might call these somethings, whatever they are, objects of significance or even 'significants'" (92). People make primary appraisals when they identify stress that goes to the core of their significance.

2. Events are constructed in terms of their significance to people. They become stressful when they shake the things that people care about, when they go straight to the core of personal values. The coping process also involves another perception with appraisals of the resources and burdens the individual brings to the coping process. Components in these secondary appraisals could be the ability to handle the problem, the individual's responsibility to solve the problem, and external social, financial and material resources. These two appraisals interact with each other to determine the stressors in each situation. Pargament also suggests the concept of tertiary appraisals. "Through a tertiary appraisal process we select the most compelling option, the strategy expected to bring the greatest gain and the least loss of significance through the use of the fewest resources and the accumulation of the least burden" (114).

3. People bring an orienting system to the coping process. "The orienting system is a general way of viewing and dealing with the world. It consists of habits, values, relationships, generalized beliefs, and personality. The orienting system is a frame of reference, a blueprint of oneself and the world that is used to anticipate and come to terms with life's events" (99). Our orienting system consists of resources and burdens which are involved in how we handle difficult situations.

4. People translate the orienting system into specific methods of coping.

5. People seek significance in coping through the mechanisms of conservation and transformation. Mechanisms of conservation attempt to protect significance. Transformational forms of coping attempt to change it. Preservation and transformation of means and ends can be combined into a four-square matrix. Preservation as a coping method conserves both means and ends. Reconstruction transforms means, but conserves ends. Revaluation conserves means but transforms ends and recreation transforms both means and ends.

6. People cope in ways that are compelling to them.

7. Coping is embedded in culture.

8. The keys to good coping lie in the process and its outcomes.

Pargament's coping theory of psychology of religion, which constituted the study's main theory, is a follow-up of Lazarus and Folkman's research on stress and coping. Other Scandinavian research in psychology of religion emphasizes the existential perspective, which has been absent in Pargament's theory.

Method and material

Methodologically the study is grounded on three structural levels of human reality suggested by...
These levels move from the lowest mechanistic to the organicistic and conclude on the personalistic level.

The mechanistic level recognizes that human beings are affected by external influences, causal relations, and natural powers. On the organicistic level the individual is regarded as an organism, i.e., a dynamic and coherent entity that develops and changes in constant interaction with its surroundings. On the personalistic level, the individual is seen as being equipped with intentionality and consciousness. Thereby, the individual is able to give his/her life meaning and explanation. The individual is an active agent in a sociocultural context. The method chosen by the scientist to study human reality depends on which structural level the scientist is interested in and hence adopts as the primary focus.

Zock advocates a hermeneutic (interpretive) psychology when studying religion. She argues that the lower levels are being investigated by the natural scientific approaches; however, at the highest personalistic level, hermeneutic approaches are required. Zock's observations are important for this study as they focus on coping processes in hospital chaplains who work with existential confrontation. This focus assigns the personalistic level a central position through which the individual's search for meaning and explanation is undertaken. The life story approach directs attention toward the personalistic level, focusing on existential confrontation. This approach also encompasses the organicistic level.

The material comprising the foundation of the analysis consisted of nine interviews, varying in length between one and three hours. The interview content included information about informants' lives prior to entering hospital chaplaincy, their journeys into and work within chaplaincy, and their lives away from the hospital.

The group consisted of six women and three men with different confessional backgrounds: three priests, two deacons, and a psychologist from the Swedish Lutheran Church, two ministers from The Mission Covenant Church of Sweden, and one minister from the Pentecostal Church. Their service as chaplains ranged from five to twenty-two years.

The analysis of the material was carried out in two steps according to Kvale's model of analysis. The first step is carried out inductively, in which categories and themes were sought. The second step was an abductive process, moving between empirical and theoretical perspectives. This process included the execution of a hermeneutical, meaning-making analysis.

Results

The orienting system of the hospital chaplain was analyzed using the following concepts: resources, burdens, religious and profane orientations. Resources identified included the following:

1. Religious and profane orientation.
2. Analyzed experiences of stressors with an existential dimension.
3. The ability to use a supportive social network.
4. Being aware of resources and limitations.
5. The ability to maintain significant values.
6. Flexibility/being able to face different cultural activities.
7. Participation in intellectual challenges through a variety of educational courses.

Burdens also were identified:

1. Dysfunctional self-belief.
2. Being and thinking according to stereotypical sexual roles.
3. Lack of working experience.
4. Reduced containing ability combined with a tendency to escape.
5. Insufficient basic knowledge of the working field.
6. A static view of the diaconate.
7. A limited social network.
8. Private and/or work related tragedy.

Further, the burdens imposed by the employer included a narrow ecclesiastical orienting system, lack of presence and insufficient financial resources.

The results indicated that both religious and profane orientations are important resources. The hospital chaplains translated them into coping strategies in order to handle multiphased stress with an existential dimension. In this process, the orienting system was both maintained and changed through the use of these conserving and transforming coping mechanisms. For example, religious orientation changed when conceptions of God, in relation to the belief system, were affected in order to more adequately meet the demands of work related tasks.

The study explored the different types of stress chaplains experience,
e.g., physiological, social, psychological, ethical, material. Hospital chaplains related direct stress to themselves and indirect stress to patients, colleagues, and relatives. They noted that they sometimes put themselves into stressful situations in order to reinforce their orienting systems with new coping resources.

The aforementioned stressors either coexist or occur independently of each other. Furthermore, an existential dimension of stress has been identified that interacts with the various other forms of stress. In situations where various forms of stress occur simultaneously and when the existential dimension is activated, the term used was **multiphased stress with an existential dimension**.

Working in hospital chaplaincy is characterized by multiphased stress as opposed to life situations in general. This particular form of stress occurs in a direct or an indirect form or in average doses. **Direct stress** develops in confrontation with direct stressors. **Indirect stress** occurs when one encounters others whose well-being is threatened because their resources are insufficient for dealing with the current situation. Direct stress may develop from indirect stress, depending on various factors:

1. The complexity and intensity of the stressor.
2. Resources and shortcomings of the orienting system with regard to pressure.
3. The orienting system of the surroundings relating to the group, the institution and the society as well as its ability to support and interact with the different levels.

4. The appraisals and their ability to identify threats, resources and the fastest way towards significance.

5. Level of religious and profane coping methods available.

During working hours appraisals relating to stress are made on different levels i.e. individual, group, institutional and societal. Among them there is an ongoing interaction. Appraisals of stress made by the staff lead to tangible tasks for the hospital chaplain.

The hospital chaplain makes primary appraisals in connection with multiphased stress with an existential dimension at the request of the patient and relatives. He or she makes secondary appraisals concerning resources in collaboration with other staff members. The chaplain makes tertiary appraisals in connection with urgent tasks at work and in connection with preserving what is considered significant.

Thus, hospital chaplains often find themselves in an interaction between subjective appraisals and other people's appraisals made on individual, group and institutional levels. These appraisals result in tasks which may be connected to stressors.

An overall finding was that hospital chaplains adopt coping methods that involve preservative, reconstructive, reevaluative and/or reconstructive activities in order to handle existential confrontations. The following is a specification of these findings. Preservative coping methods refer to support and marking boundaries and thus daily routines in the line of duty of the hospital chaplain. Switch constitutes a reconstructive coping method which makes it possible for the hospital chaplain to hold on to their values when dealing with ethical, psychological and multiphased stress with an existential dimension. Reconstructive methods, which include religious reframing of the event, the person and the sacred, have a prominent place in the work of the hospital chaplain with an existential confrontation. The re-evaluating coping method called "rites of passage" is used by the hospital chaplain in the line of duty. The powerful recreative coping method called universal conversion can relate to coping with multi-phased stress with an existential dimension.

An orienting system which is spacious and full of resources can be translated into both religious and profane coping methods. Hospital chaplains switched between these two to achieve a suitable strategy for handling work-related stress. On occasion, double coping methods were applied in connection with multidimensional stress.

The interviews indicated that hospital chaplains used a large number of coping methods in order to handle various types of stress. Support was prevalent, and so was marking boundaries as a daily routine. Switch was a reconstructive coping method used in connection with work that included multiphased stress with an existential dimension.

The findings pointed to an interaction between orienting system and culture, representing vital parts of the coping processes, i.e., between processes of secularization and privatization on the one hand and the tasks of hospital chaplains on the other. In this context the chaplains supported people seeking meaningful guidance in times of crisis. In spite of the ongoing pattern of increasing secularization in...
Scandanavian society, people still turn to the church for support in critical situations. Excerpts from interviews with chaplains Frida and Eric illustrate several of these points.

Frida: the hospital chaplain’s significance

Frida gave voice to the significance of the hospital chaplain’s work. To be where the people are is significant for her as well as for the other informants. As she said,

“The characteristic feature of hospital chaplaincy is to be where people are...not to believe they will come to us. “Therefore go...”, Jesus said in the great commission. ... It is brilliant to be where people are.

Frida’s work significance is motivated by, and rooted in, the Christian tradition, which she has built into her orienting system. In the informants’ private arena, one finds significance connected to relationships and health. This private significance may differ from individual to individual.

Eric: examples of stress

What does the stress look like that Eric appraises in his work? Is it possible to distinguish different types of stress? Three aspects of Eric’s work-related stress were observed: his psychological stress, indirect stress which can develop into direct stress and also his inclusion of a stress-creating perspective in his work.

Eric appraised psychological stress in his work with, for example, aggressive patients and patients that will not let go. These patients refuse to separate from their helper. Eric said that

Some patients are easy to handle emotionally and some are really difficult to handle. They are aggressive and it can be hard. Some refuse to separate... they cling on to me. It’s important to be clear with them and tell them what you can do for them and what you can’t do.

This is an example of psychological stress without the existential dimension.

Eric also ministered to a man of his own age with a cerebral tumor. This patient’s children were exactly the same age as Eric’s children. In speaking of this encounter, Eric said,

I get very involved, and it’s very easy to identify with this father. I can’t do a good job in this situation. It comes too close to me, and I can’t cope. I usually leave these cases to my colleagues. It’s important to see your limits and not to turn off your feelings.

This patient exhibited multi-phased stress, which threatened his family and his social system. At the psychological level it claimed a cognitive response and at an existential level the patient had to cope with the ultimate questions of life. The patient’s direct stress caused indirect stress to the hospital chaplain, which then developed into direct stress. Eric made a primary appraisal and identified that he felt multi-phased stress with an existential dimension that threatened the core of his significance. He used the concept of identification through the father and the children being of the same age groups.

It is possible to find both psychological stress and multi-phased stress with an existential dimension in this story about Eric’s work and life. In his coping process, he used secondary appraisals when he asked for the resources in the work team and let a colleague continue the contact with this patient.

When Eric reflected on his work at an oncology clinic, he said, “Maybe I am attracted by what I am most afraid of. ... We all feel death anxiety somewhere.” Perhaps, through his work, Eric lets that part of himself that experiences fear and death anxiety confront situations that consist of multi-phased stress with an existential dimension. In this way, he constructs, anticipates, and plans for this stress so that he can cope with his own fear.

Eric’s coping strategies

Eric uses a number of coping strategies, e.g., boundary marking, support, reframing, reconstruction, revaluing. His work at the oncology clinic consists of “a lot of death.” One way he copes with this, both at an individual and at an institutional level, is to mark the boundary between the work on the ward and the outside world. The destructive aspects of death are only allowed inside the institution. Eric uses another type of boundary marking to cope with the many funerals, ceding this responsibility to parish priests.

Away from the hospital, Eric’s coping strategy relies heavily on his well-developed social network which includes friends, relatives, a jogging partner, neighbours, parent cooperation, and a group of people that gathers for dinner once a month. He uses family as a base to build this network to create stress-free zones. Eric also uses preserving strategies to a great extent;
however, when a close friend was diagnosed with cancer, this strategy was no longer adequate. He required more of the transforming mechanisms of reconstructive and re-valuing coping to take care of his own vulnerability. Eric described this situation:

When things happen in private life, people are much more vulnerable. Now we have a friend who is suffering from cancer. This affects me and my whole family. It feels like a great burden.

Eric believes that it is not possible to maintain theological understandings that do not go together with his work. Things must make sense. He integrates experiences from his work with his own meaning-making into a process which changes his representation of God. In coping terms, he uses reconstructive coping with re-framing where traumatic experiences are redefined in relation to his orienting system, or the reverse, in which the orienting system is redefined in relation to what happens in his work. This practice indicates that the coping strategies of reframing the event and reframing the sacred can be combined. The latter alternative implies a revaluation of the concept “almighty God” in which a suffering God becomes evident. In Eric’s words,

I don’t believe in an almighty God right here...but in eternity. My opinion is that God’s omnipotence belongs to hope and the future. Talking about an almighty God and at the same time witnessing all the suffering... the dying young woman with cancer and her two little children. If he was all-mighty I can’t understand it intellectually. I can only perceive a suffering God...to go together with my intellect. So it’s very difficult for me to talk about God as an almighty God.

Vacation is another coping strategy for Eric. During his vacations he doesn’t need boundary marking. He is open and receptive, and this widens his orienting system: “The vacations take away the filter and I’m open for all impressions.” He lowers his defenses. When he returns to work, he needs some time to build up the filter again, time to switch back to his coping strategy of boundary marking.

Hospital chaplains often work in the twilight zone between life and death where rites of passage may function as a revaluing coping method in situations with multiphased stress with an existential dimension. They not only may be offered to patients and their relatives, but, as Eric’s story demonstrated chaplains also may use the rites of passage strategy for themselves at the same time.

Eric described his ministry to a seriously ill woman with a cancer diagnosis. Initially supported medically in her home, she was moved to Eric’s hospital in order to be cared for during the last period of her life. The woman’s father had been a sailor. Being a patient at this hospital, which was situated by a lake, brought back memories of her father and the sea. In this last period of her life, she began formulating a wish to go out on the water in a boat. The nurses made it possible for her to row a boat on the lake on a sunny day accompanied by Eric and one of the nurses. The woman enjoyed being on the water for two hours, but then she became very tired. Back at the hospital she went to bed and she died the following day.

Eric related his perception of the whole event and about the water as a symbol for her childhood with her father. But even more, it was beyond the boundary, much more than just the patient’s experience. For Eric it was a powerful experience to perceive this woman’s trust and confidence. “That was God for me,” Eric said.

This incident of a seriously ill woman who finds herself in this borderland contains a rite of passage where she is allowed to be in a boat. The chaplains’s significance is to be where the people are and the patient has a wish to be in a boat out on the water. A primary appraisal of her stress is made by the doctor, who says she can die any day now and Eric agrees with this appraisal. Secondary appraisals are made by the ward staff, including Eric. They have resources to take her out on the lake. Eric and a nurse go with her.

This rite of passage is not in the church handbooks, but it is created by the chaplain, the patient and the nurse, who are present when the rite of passage is carried out. The woman uses this rite in her revaluing coping and so does Eric. Within the rite of passage a transformation of his basic trust occurs. A perception process in which he interprets the woman’s basic trust is added to his lack of trust in his own orienting system. This could mean that the chaplain and the patient at the same time use the same coping method and strategy. The woman uses it to cope with her death and the chaplain uses it in order to continue his work. This example points to the fact that rites of passage offered by chaplains in their service
to patients can be used by them as well to cope with existential confrontation in their work.

Limitations

There were limitations to this study. Some concepts of the coping process could have been elaborated upon, e.g., significance, the cultural context and personality aspects. At the time of the interview, coping theory was not yet known to me; hence, I was not able to put more specific questions to the informants about how this theory operated in their lives. The interviews were carried out from May 1996 to January 1998. My first contact with Pargament’s coping theory was in the summer of 1998, when his book from 1997 was introduced to me by a Norwegian colleague.

Another limitation is that the material containing two of the informants’ stories about their breaking up from hospital chaplaincy is too thin. The value of having more information cannot be stressed enough.

The material comprising the foundation for the analysis consists of nine interviews, varying in length between one and three hours. Nine interviews may be considered limited, especially from a quantitative perspective. However, in this type of qualitative research, with a life story approach, five to twenty-five interviews is considered enough. It is also possible to compare this study with similar studies by Schwarz (1988) who carried out ten interviews, and Barrow’s study (1993) containing twelve interviews.

Implications for hospital chaplaincy

Study results indicated a discrepancy between the position description and the work actually carried out by hospital chaplains in a clinical environment. The material indicated a lack of sufficient introductory preparation for new chaplains. The present study suggests that mentors should be appointed at least during the first year of employment within the hospital chaplaincy system.

Hospital chaplains with a history of disconnecting from their social networks are particularly vulnerable. This should be taken into account when new hospital chaplains are recruited since the job can at times be very demanding. The study shows the importance of ongoing accessibility in the face of constant occupation with catastrophic duties. It is therefore necessary to have access to preservative coping methods. Otherwise the resources of the hospital chaplains risk being drained completely.

Marking boundaries is one important method in this regard. The material points to unresolved conflicts inside work teams. These constitute stressors that contribute to work-related stress. Working and training focused on conflict attitudes and conflict management need to be included during periods of extra training. Conflicts could be related to coping theory and in particular to resources and burdens in the orienting system.

This study points to the possibility of reinforcing the resources of the orienting system by means of leisure activities. On the whole, however, it will be up to the individual hospital chaplain to be active in this respect. When a hospital chaplain leaves his/her position, there should be a requirement to work through the experience as a measure of mental cleansing. This should be done in order to prevent “black remnants in the soul” which otherwise may occur in the wake of regular encounters with multi-phased stress with an existential dimension.

An urgent research task is to further explore the relationship of religion, spirituality and existential questions in order to clarify the interaction of various components in the orienting system. Another area of concern for future research relates to what occurs when coping processes go wrong. Examples of this include dysfunctional stress-reducing behavior such as drug abuse and at-risk sexual behavior.

This study touches upon processes of stress developing into a burn-out state, which requires in-depth exploration. The coping processes of the nursing staff in relation to work-related stress is of equal importance. Focusing on the orienting system of the nursing staff is required in order to separate profane from religious orientations. The question that remains to be investigated is the function of these orientations for coping processes.

Conclusion

Despite the limitations noted, this study makes several important contributions to the question of how hospital chaplains cope with multi-phased stress with an existential dimension. Through this study the focus of hospital chaplains’ daily work has been expressed verbally, which may contribute to a deeper understanding, both theoretically and clinically, of this area. To understand what your feelings are, how you contain them and how you cope with these feelings as a hospital chaplain makes your work easier in many ways. At the same time, this understanding
is a new resource in daily work. It is possible to view the results from this study as a refilling of resources in the coping processes of hospital chaplains.

“How are you able to stand it?” is a question commonly put to hospital chaplains when they are describing their work. This question is a challenge for every individual chaplain. He or she has a responsibility to analyze the coping activities that he or she uses. The conclusion is that there may be different answers to that particular question about the individual’s own coping activities.

There is also a possibility that many chaplains actually cannot manage their work. This study brings to light the fact that hospital chaplains have burdens in their orienting system and it is of importance to investigate where potential fields of development may be found. Increasing the hospital chaplain’s restricted social network is, for example, one way of moving away from the burdens towards new resources.

References

1 For more information about the Swedish hospital chaplaincy see http://www.svenskalkyrkan.se/samariterhemmet/Hoschap.html


3 Ibid.


Additional Bibliography


Margaret's Room

Florence Gelo

Margaret's room faced west. The sun was setting as I entered her room to find her quietly sitting up in bed, her head turned slightly toward the window. The room was lit only by a small lamp on her night table. She turned to greet me and to invite me to sit in the easy chair at her bedside, then returned to the setting sun and remarked on its beauty. She was quiet and pensive, and we sat together in silence as we often did.

Margaret had lived alone and well. A woman of independent spirit, she enjoyed her volunteer commitments to the historical houses where she dressed in colonial costume and was recognized as one of the most engaging and talented tour guides. At seventy-three years of age, she was passionate about living, and filled the days of her life with beauty—art, music, literature and nature itself.

Margaret had been widowed for twenty-eight years, did not have a life companion, and never had children. Her most intimate relationships included a nephew whom she adored, and his wife and son, who lived fifteen hundred miles away. She had many close friends and was a founding member of her church. Although she was no longer able to attend or contribute to the daily life of the community, her tithing was generous and consistent.

After a three-year battle with cancer, Dr. Stone, Margaret’s physician for over thirty-years, had informed her that there was nothing more that he could do. He recommended hospice. Reluctantly, Margaret acknowledged that her medical condition had worsened and decided to comply with his recommendation. She was having great difficulty breathing, no longer had the strength to prepare meals, and was often too tired to get out of bed and dress.

My first visit as the hospice chaplain came only days after her admission. Margaret was receiving regular visits from her pastor, who was also a close friend, but she asked if I would visit once a week as well.

Margaret enthusiastically shared stories about her life but was reserved in speaking about her illness. She refrained from any reference to the suffering caused by her rapidly deteriorating health. She claimed instead to be coping well. She acknowledged that her time left was very limited and was forthright in stating she did not want any extraordinary care. Her only wish was to see her nephew and grandnephew before her death.

During one visit, as Margaret looked toward the setting sun, her first words were spoken in a whisper. I told Margaret I could not hear her. Without turning, she again spoke softly, saying that she was afraid of death. “I’ve been thinking about heaven and hell and afterlife. I’m not afraid of dying, and I have no fear of hell, but I am afraid of death.” When I asked what it was that she feared, she exclaimed, “Even though I don’t believe in it, I’m afraid of reincarnation, I might be born again in a country where people are very poor, tortured, imprisoned and oppressed. I have spent my life protesting the inequalities in this world—the poverty, suffering and death in third world countries.

Florence Gelo, DMin, BCC, is assistant professor in the Division of Medical Humanities, Drexel University College of Medicine, Philadelphia, PA. A Fellow in the American Association of Pastoral Counselors, she is endorsed by the Unitarian Universalist Association (UUA) and serves Thomas Paine UU Fellowship, Collegeville, PA. Correspondence may be directed to florence.gelo@drexel.edu
But what if I come back again and am born into that kind of life?”

Surprised by the unexpected nature of Margaret's question, many thoughts flashed through my mind. I asked myself, why would a Christian be thinking about reincarnation? Yet, isn't reincarnation linked with karma? Was Margaret verbalizing only half her concern? Was she struggling with feelings of guilt, real or imagined? Facing the unknown and the uncertainty of the afterlife, was Margaret pondering the ultimate life mystery of the roll of the dice, puzzling about life's characteristic randomness? Was Margaret telling me that the pain in her life was so great that she could not conceive of a life more difficult than the one she had lived? Or was this an experience of the transcendent, the existential tragedy, when one realizes that one's life work towards a paradise on earth has come to an end and will never be fulfilled?

The quality of pastoral care at the end of life is dependent on many variables; the health of the patient upon admission is a critical one. The illness may be too far along for patients to begin new relationships. At best, chaplains have a brief time with patients, which affects the ability to establish trust and intimacy. Additionally, patients often do not have the strength and clarity of mind to engage in conversations, to review life, and to meet the challenges of life closure.

What is the role of the chaplain with respect to the many questions that may arise with severely ill or dying patients, conundrums which we have neither the talent nor the time to address? When questions and concerns are profound, how should a chaplain respond?

Prompted by personal need, time constraints, or patient expectation, the chaplain's first impulse may be to "do" or "say" something. My first impulse was to console Margaret and to offer her reassurance. I did not do this because reassurance is most powerful when expressed in the context of an established and trusting relationship. An impulsive response might have heightened her fear or have had a negative impact on the emerging pastoral relationship. I also am aware that existential questions of this magnitude are complex and elusive. Superficial or inauthentic answers to Margaret's question most likely would have been incomplete and unsatisfactory.

Instead, I encouraged Margaret to talk, trusting that in doing so, she might construct and reconstruct a more meaningful and potent answer to her own life questions. Rather than attempting to solve a mystery, together we, as chaplain and patient, entered into the futility, sorrow, pain, loss, anger—the myriad thoughts and emotions that can be a part of life's ending. This is a thoughtful and more reverent posture towards ultimate questions.

Margaret and I met weekly for nearly two months. Though I encouraged her to talk, I did not probe. I did not direct our conversations to her fear of reincarnation, however curious I was about its origins. My intention was to communicate acceptance through a willingness to allow her to prioritize what was important for her to discuss. Margaret decided what we would talk about and once she believed that I had no other purpose than to visit and to listen without judgment, she continued her own exploration of her fear. Together, we celebrated her collection of life's joys, mourned life's losses and challenges, while acknowledging the complexity, uniqueness, and sometimes the "strangeness" of our faith journeys.

During the weeks of our visits together, Margaret raised the question of reincarnation occasionally and only briefly. As a constant and reliable presence, I mainly listened. When I spoke, my words were meant to encourage further conversation. In the end, it was not my words, but our relationship, that proved to be healing—a relationship affirming the holiness of those questions that arise as we reflect upon our life journeys.

Though Margaret did not find absolute comfort, consolation or peace of mind, drawing upon the power of the most radical aspects of her faith, she found solace in the promise of forgiveness and in the assurance of neverending love.


**Traumata**

Sudden impact with sounding  
to chill the collective spine of the workplace.  
A sound heard in the dusty corner,  
at the high grated window,  
shaking the coffee sitting on the break room table.  
A sound that marshaled some to run  
to run like they were ten  
with a new pair of All-Stars.

Sound carried one to kneel beside the wounded.  
With no thought,  
no breath taken  
he moved the crushing tonnage off and away.  
Moments later this near ton  
was full bird colonel weight,  
like some unseen hand had slipped  
on a few added bells to the bar.

Now time moved slow and surreal  
in the thick slurry of trauma.  
His bod lay limp  
and loose across the rough pallet.  
One soul gentled his head in lap  
with the intimacy of mother and child.

Firefighters and paramedics moved to and fro  
the workers froze in place,  
 psyches locked in trance  
of helplessness and shock.  
The traumata was lifted up and whisked away.  
For moments that hung  
as though generations were passing,  
as though forty years were wandered in wilderness,  
they all remained in place.

Then another sound  
a phone ringing in a distant office,  
the movement of the hands on the courthouse clock.  
A door slammed.  
And they all moved  
back in place  
back in place.  

Robert W. Duvall
The Great Physician, Board Certified

those who once whispered God’s name
with eyes reverent closed in prayer
the Good Book clutched to tender breast
now espouse psychoneuroimmunology
pounding thick tomes of clinical trials
by golly, it’s proved true at last: religion is good for you!
o to find frocked as God, the serpent science!
faith in things unseen now replaced by cold hard fact:
all the rules, regs and disciplines yield not just stuffy
righteousness, but better yet—improved medical outcomes!

Four poems by W. H. Shirk

under the care of physicians

the doctors come out and tell the family
that their already extensive tests reveal
that they don’t quite know what is wrong
but that they are going to “conduct further testing”
(this, no doubt, because they are experts, and
it angers them that an obviously very ill patient
should beat them at their own game and leave them
looking as ignorant and helpless as the family)
it is hoped by all that the patient will not die
before it is decided what is wrong, that further testing
will somehow be therapeutic, at least for the family
(sometimes a diagnosis is as good as a cure:
Oh, well if it was that, he had no chance...) and will
somewhat justify the whopping bill the dead man will receive
for the mistake of dying under the care of physicians.
in the elevator

at each stop we readjust our positions
shifting instinctively unconsciously
creating equal maximum distance on all sides
2nd floor six people shuffling this is not hard
at the 3rd two more reduce margins to inches
at the 5th floor there is this threatening influx
of newcomers, immigrants, intruders, invaders
actually it's only four more people but they're big and
the situation has become critical people are almost touching
bumping rubbing, my own nose itches but if
I move my hand I will scratch someone else's butt
on 6 five people step off, at 7 three more, the air freshens I can
scratch my nose and stand in the center of a comfortable
column of clear space, at 9 there are just two of us
separated by the full breadth of the car
she is one of those beautiful young nurses
we share eye contact and a smile
I want to hold her but I stand my ground.

Bebadobba-doo badobba
-To Loren and Ethan

“What’s the Secret Word?
The angry king demands of the
meek supplicants who had come
seeking his favor: a small girl
dressed in an old lace curtain,
supposed to be a princess, and
a little boy wearing bear foot slippers,
pretending to be her puppy-
no excuse me, her pet lion.
“Well, what is it?” the king shouts.
“Bebadob, um beeba oh I forget!”
“Say it or I will eat your dog!”
She smiles and stamps her foot, “I can’t!”
“I’m a lion!” says the lion.
With a scowl, I scoop up the puppy
onto my lap and pretend to bite his neck,
he squeals flailing and she attacks in his defense...
We tumble to the floor, arms and legs
 tangled in laughter and dusty lace.

They’re teenagers now and have
other kings to see, but I remember
two kids on the road to bright tomorrow
who couldn’t remember the secret word.
But I do: it’s Bebadobba-doo badobba...
I think it meant play with us now
because we can’t stay here much longer.
Karley's Cry
On a hillside neatly dressed with cold, stark stone,
A lonely gray warrior keeps vigil row upon row.
The people gather.
They wear a stiff upper lip.

The strange, quiet box is set down to rest,
Its contents draped in the colors of a nation served.
The breath of kindred hearts is sucked from aching lungs.

Then the silence is broken,
Not with the word of prophet or priest,
But in the tender, anguished cry of a child,
Raised unashamed, unceasing.

She gives voice to hearts that bleed behind shaded glass.

B. Wayne Morris

The Cup Was BitterSweet
This poem reflects two communion services for a long-term patient: in the first, the dry white wine available through the hospital was used; the second, on the day of his death with his estranged wife present, was celebrated with sweet grape juice.

The cup was bitter
Sharp and dry and unyielding
His light was dimming
Obscured by clouds of death.
Whispered prayers, hushed petitions
Endless hours that all too soon end.

Did he know I was there or how much I cared?
Was the bitter cup fruitful with love?

The cup was sweet
Syrupy and dripping ... with regret.
The labor of his death's birth
The pain of her life's death.
Quivering hands, convulsions of despair
Endless hours that never end.

Did he know she was there or how much she cared?
Was the sweet cup fruitful with love?

Gwen Beeka

The Journal of the Association of Professional Chaplains
The Chaplain's Day

It is just an ordinary day.
Monday morning, rushing about, making breakfast, packing lunch.
The woman drives her daughter to school.
When she comes back,
The man
Her husband
The father of the child climbing on the monkey bars
Is hanging by a rope from the second floor staircase.
In the hospital, she touches his already cold cheek.
"He looks like he is sleeping," she says to the chaplain.
Such courage,
She pulls the blanket back and the angry red mark on his neck
Screams at her.

It is just an ordinary day.
Sun dazzling, children's laughter,
Pool toys bobbing on churning water.
All eyes blink.
And he slips unnoticed under the surface.
At the hospital, the words blur:
"Sorry. Brain dead."
The silence of their child is deafening,
The stillness of his small body jolts them.
But they hear the words.
One boy dies and five other children will live.
The numbers are right.
But they don't add up.

It is just an ordinary day.
Quiet room, light dim, footsteps and laughter in the hall outside.
Three men sit around the body
Guarding,
Protecting.
When they ask the chaplain to pray,
She makes a terrible mistake.
She closes her eyes a split second too late.
And sees three grown men bow their heads over the woman they love.
The mother, the wife.
A sacred moment of such terrible intimacy,
No one should see it.
The deathbed, a burning bush, holy ground.

It is just an ordinary day.
They are all ordinary days.

Beverly K. Hartz
Chaplaincy
God, divine giver of life
You, the final reconciliator,
The one who decides
when a life is over.
Stay with me.

Help me be with
the grandson, who
grieves on his knees
at his grandmother’s deathbed;
with the Jewish man, who
prays for the first time;
with the atheist who
believes in charity
and tells his life story
as he waits for
a pacemaker;
with the premature baby
I baptize before surgery;
with the 37-year-old
double lung transplant, who
hasn’t slept in four days;
with the 74-year-old, who
doesn’t know if
he wants to live or die
and begs me to decide;
with the grandmother, who
dies just after we arrive.

Help me hold the space
for the drama of
this life and that death,
bring bravado to
the people
so they can see
through your eyes
the hugeness,
the meaning,
the royal largesse
in the love stories
of it all.
This heart-way
comes up accidentally,
leads by listening,
crawls under sorrow,
leans into pain.
This heart-way
takes big cowboy breaths,
misses nothing of reason,
and knows much more
than I do.

Julie Sara Kramer

Robert W. Duvall, MDiv, BCC, serves as chaplain at Gwinnett Hospital, Lawrenceville, GA. He is endorsed by the Cooperative Baptist Fellowship (bdvall@gsnet.org). W. H. Shirk, MDiv, BCC, serves as staff chaplain at Allegheny General Hospital, Pittsburgh, PA. He is endorsed by the American Baptist Churches, USA (wshirk@wpahs.org). The Reverend B. Wayne Morris, DMin, serves as staff chaplain at Comanche County Memorial Hospital, Lawton, OK. He is endorsed by the Cooperative Baptist Fellowship (MorrisW@memorialhealthsource.com). The Reverend Gwen Becka serves as chaplain at Nurses On Wheels Home Health and Hospice, Corpus Christi, TX. She is endorsed by the Baptist General Convention of Texas (preacherlady@grandecom.net). Beverly K. Hartz, MA (pastoral care and counseling), BCC, serves as education coordinator, Spiritual Care Department, Mission Hospital, Mission Viejo, CA. She also is an ACPE associate supervisor (beverlyhartz@hotmail.com). Julie Sara Kramer, MA, MPH, serves as chaplain at Eden Medical Center, Castro Valley, CA. She is certified as a spiritual director (jkramer@roadspring.com).
Deborah Antai-Otong. “Anxiety disorders: helping your patient conquer her fears.” Nursing 2003; 33, no. 12 (Dec 2003): 36-41. • In the course of your ministry, you encounter a man who tells you that he feels that he has to pray for reassurance numerous times every day. In fact, he says his life is being disrupted by his need to pray so much. What would you think, and what would be your response to this man? This is one of a number of common situations described by Antai-Otong in her article about anxiety, the variety of its forms, and what can be done to help people who suffer from its ravages. Using examples, she describes six common ways that anxieties can appear. Though some of her suggestions will not apply to chaplains, e.g., use of medications, her suggestions regarding the care of these patients will inform the clinical chaplain.

Joe Baroody. “Should clinical pastoral education and professional chaplaincy become more scientific? It’s a matter of salt.” Journal of Health Care Chaplaincy 12, no. 1/2 (2002): 1-10. • In considering whether or in what ways science should relate to professional chaplaincy and clinical pastoral education (CPE), Baroody turns to the past for guidance, describing the work of Anton Boisen and Elwood Worcester. A Congregational minister, Boisen is perhaps the better known of the two. He relied on both psychology and medical science to illuminate and expand his vision of ministry, combining his evangelical faith with Freudian theory to create a new method of healing. Worcester, an Episcopal priest who organized the Emmanuel Movement, reacted to the impersonal nature of the Social Gospel as well as the healing claims of Christian Science and sought to “recover Christ’s healing ministry.” His response was the development of “scientific psychotherapy.” In the work of both men, Baroody finds permission to utilize science as a means for “continuing the priestly, healing ministry of Jesus ....” However, he warns against the uncritical use of some of the recent scientific studies which claim that faith leads to better health. “Accepting the so-called scientific faith claims of medical researchers like Dr. [Harold] Koenig may help professional chaplains survive health care reform, but in so doing, they will have traded the evangelical, liberal faith proclaimed by Elwood Worcester and Anton Boisen for an identity based on the pseudofaith created by science” (pp. 9-10). Baroody’s essay is the first of twenty-four which address the question stated in the title from a variety of perspectives.

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. Chaplain Brown is a chaplain at Northwestern Memorial Hospital, Chicago, IL. Correspondence may be directed to oreresource@rocketmail.com or PO Box 362, Harbert MI 49115; fax 312.832.9739.
William J. Baugh. “Spirituality and data: the need for a new paradigm,” *Journal of Health Care Chaplaincy* 12, no. 1/2 (2002): 11-17. • “How I have resisted this day! I have wished that it would never come.” This is Baugh’s reaction to the suggestion that chaplains may need to make use of science to assess their ministry in some manner. “I have yearned for the good old days when holding a hand was an expression of my desire to care, my commitment to ministry and not a means to reduce the length of stay” (p. 12). He is full of caution for the chaplaincy profession as he remembers some of the missteps of the recent past when science was not as helpful as had been hoped or when its fruits were ignored by administrators. In the end, though, he suggests that chaplains will have to learn how the “blending of sensitive spiritual care, individualized to maximize each person’s coping skills” can be done alongside state of the art medicine. He believes that this could be the most significant breakthrough of the twenty-first century.

Howard J. Bennett. “Humor in medicine,” *Southern Medical Journal* 96, no. 12 (Dec 2003): 1257-1261. • Permeating this article is the line, “this has not been studied adequately,” through which Bennett notes that the health benefits of humor, while the subject of many claims, have never been validated by acceptable research. This is not to say that it does not have value, rather that its value has not been measured in an acceptable way. Bennett provides the reader with an overview of the field of humor in medicine under the following: humor and health, humor and patient-physician communication, humor and patient care, humor and the health professional, humor in medical education, humor in medical literature. He covers the waterfront and finds the waters are not very deep. To date the most promising research is in the area of humor’s ability to lessen pain.

A. Mark Clarfield, Michael Gordon, Hazel Markwell, Shabbir M. Alibhai. “Ethical issues in end-of-life geriatric care: the approach of three monotheistic religions - Judaism, Catholicism, and Islam,” *Journal of the American Geriatrics Society* 51, no. 8 (Aug 2003): 1149-1154. • Ethical dilemmas are common in the care of the elderly, and an important consideration in many cases is the patient’s religion. The three Abrahamic monotheistic religions—Judaism, Christianity (in its Catholic variant), and Islam—have well considered positions on medical ethical issues. Although they hold much in common, there remain significant differences. This paper presents three relatively common clinical cases, each of which involves ethical dilemmas found in geriatrics care, especially near the end of life. Starting from those scenarios, the normative ethical position of each faith group is compared and contrasted. This is one of the scenarios: “An eighty-four-year-old woman with mild dementia and compensated congestive heart failure is admitted to a nursing home. Her husband, the surrogate decision-maker, presents the attending physician with a signed and witnessed advance directive that states that under no circumstances does she want resuscitation, antibiotic therapy for life-threatening infection, or transfer to an acute care hospital.” There are several focus questions followed by a brief introduction to the medical ethic arising out of each of the three religions. This article presents useful teaching material.

George F. Flannelly, Andrew J. Weaver, George F. Handzo. “A three-year study of chaplains’ professional activities at Memorial Sloan-Kettering Cancer Center in New York City,” *Psycho-Oncology* 12, no. 8 (Dec 2003): 760-768. • There have been few published reports of the number and kind of interventions that chaplains perform over a period, nor have there been reports on the number and kind of referrals made to chaplains by other health care professionals. The purpose of this study was to find the answers to these questions. What are the relative numbers of referred to non-referred visits to patients? What are the patterns of referrals to and from chaplains, families, and staff? What are the reasons for the referrals? What type of pastoral activities do chaplains engage in? Do the lengths of chaplain visits vary under different circumstances? Are there patterns which develop over the course of a person’s hospitalization? Data was gathered during a two-week period in each of three consecutive years. The participants were three full-time certified chaplains, a Roman Catholic sister, a Lutheran minister, and a rabbi; a part-time certified imam; and chaplain residents, five in 1995, four in 1996, six in 1997. Among the findings: almost 20 percent of chaplain visits originated from referrals; most staff referrals came from nurses, very few from doctors; the percentage
of referrals from nurses increased significantly during the study; more than one-third of chaplain contacts were with family/friends of the patients; pastoral visits were much shorter when the patient was not present; interventions provided by the chaplain varied according to the patient's religious faith; pre-op visits usually were much shorter than post-op visits. The most frequent intervention provided by the chaplain, even more than Bible reading or prayer, was described as "emotional enabling," defined as facilitation of the expression of feelings.

Linda Ganzini, Elizabeth R. Goy, Lois L. Miller, Theresa A. Harvath, Ann Jackson, Molly A. Delorit. "Nurses' experiences with hospice patients who refuse food and fluids to hasten death," New England Journal of Medicine 349, no. 4 (24 Jul 2003): 359-365. • There are well-known barriers preventing patients from being assisted in ending their lives. However, the choice to stop eating and drinking is an option for competent patients and does not necessarily require the participation of a physician. The authors are residents of Oregon where physician-assisted suicide is an option. They asked nurses in hospice programs whether they knew of persons who had chosen to end their lives by ceasing to eat and drink or who had asked for physician-assisted suicide, so that they could compare and contrast the two groups. One hundred and two nurses, 33 percent of those contacted, reported that they had cared for at least one patient who had hastened death by stopping all food and liquid intake. The nurses reported that persons had done so because they were ready to die, saw their continuing existence as pointless, and/or considered their quality of life poor. The nurses reported that 85 percent of the patients died within fifteen days, and on a 0 – 10 (very bad – very good) scale, the median rating for the quality of these deaths was eight. While there are ethical issues that need to be considered, the authors suggest that there should be further discussions about the choice to hasten death by refusing food/fluids and about standards for evaluating and caring for patients who make this choice.

Ellen Gutter, Mary Marinaro. "Words ... the most powerful drug," The Satisfaction Monitor (Jan/Feb 2002): 1-3. • This article is the report from the emergency department of a 241-bed acute care facility in New Jersey, which wanted to increase the level of satisfaction reported by persons who had used their services to the ninetieth percentile. To do so, they began by creating "scripts," i.e., the exact words the doctors agreed they would all use in order to fully and appropriately respond to patient concerns, from having to wait too long in the waiting room, listening to what patients had to say, to discharge planning. They also set the following standard of service: if a nurse doesn't talk to a patient within fifteen minutes of entering the ER, the bill is cut by 50 percent. If a doctor does not see the patient within thirty minutes, treatment is free. There were considerable benefits from this approach. Some were hoped for, e.g., an increase in the level of patient satisfaction, and some were unexpected. An unexpected benefit was that when doctors used the words of the scripts, they began to do the caring actions that they were expressing in the words. This publication can be read online; do a Google search for "The Satisfaction Monitor."

Dena Hassounah-Phillips. "Strength and vulnerability: spirituality in abused American Muslim women's lives," Issues in Mental Health Nursing 24, no. 6/7 (Sept-Nov 2003): 681-694. • How does intimate partner violence affect the spiritual life of a woman survivor? This paper examines that question in American Muslim women. The study included a literature search and interviews with two groups of women (n=17), mostly Sunni. Hassounah-Phillips found that spirituality provided an important means of coping with the ongoing violence the women experienced but that in many instances it also created barriers to their safety. For example, their faith suggested to them that their lives do not matter and that the acceptance of abuse will lead to greater reward from Allah. Secondly, the abusers' use of religious texts to maintain power and control made it difficult for the women to react to the violence directed against them. Hassounah-Phillips also describes the spiritual journeys taken by the women after their abusive relationships ended. She has identified a continuum of change on which she locates these women. She names and describes three positions on the continuum: the retainers, the interpreters, and the rejecters.

Beth Homicki, Eileen K. Joyce. "Art illuminates patients' experience at the Massachusetts General
Hospital Cancer Center,” The Oncologist 9, no. 1 (Feb 2004): 111-114. • Even though there is no hard data to date, it is widely accepted that the arts have healing power. There are studies which have shown that patients exposed to views of nature, either via a painting or a window outlook, were less anxious, requested less pain medication, and made their postoperative recovery more quickly. While the search for more data continues, many hospitals are finding opportunities to use art in a variety of ways. For the past several years, the Cancer Center has worked to create a healing environment using a three-pronged approach: sight, sound, and expression. Each approach is described in this article and is accompanied by photos. The central piece is a rotating art exhibit called Illuminations, which has been developed to create “a visually healing environment.” The authors have included steps that can be taken to start an exhibit in an institution or hospital. More information is available at http://www.massgeneral.org/cancer/illuminations.

Daniel C. Javitt, Joseph T. Coyle. “Decoding schizophrenia,” Scientific American 290, no. 1 (Jan 2004): 48-55. • Schizophrenia is a mental illness that is widely misunderstood by the general public and only partially understood by scientists. Javitt and Coyle, two of the leading minds in the field of mental health research, describe its multiple symptoms, current understanding regarding its causes, new drugs which more effectively control symptoms, and current research regarding new treatment possibilities. Schizophrenia takes an enormous toll on US. society, affecting about two million persons. Because the disease often starts in young adulthood, it takes a long-term toll in lives, social disruption and economic status. About 10 percent of those with the illness commit suicide. About half abuse alcohol, marijuana, or cocaine. Fewer than one-third are capable of holding a job, and half of those can do so only with extensive social support. This is a review article for mental health chaplains and is of educational value for anyone concerned about the field of mental health.

Thomas Johnson-Medland. “The privacy of pain: identifying barriers to pain management,” Healing Ministry 10, no. 2 (Spring 2003): 89-92. • People who are sick frequently refuse pain medication and resist efforts to encourage them to change their minds. This article will help chaplains recognize the barriers people erect when they must deal with pain: choose to see pain as being insignificant compared to the pain in the wider world; do not wish to appear weak or childish, i.e., if I don’t acknowledge pain, it is either not present, or it isn’t serious; do not wish to trouble others with the pain, i.e., a self-esteem issue; have a high pain threshold; believe suffering is payment for a karmic debt or to undo a wrong; pain is overwhelming, leading to belief that nothing can alleviate it; denial of emotional pain, only concentrating on the physical manifestation. Johnson-Medland includes a case study in which he demonstrates that through the chaplain’s working to understand an individual patient’s pain, she was able to change her mind about taking medication. He concludes that “Pain is a private issue. It can make people do things that seem ridiculous in the light of reason. This is to be accepted. It also makes people want to isolate themselves. This is another given. The reasons that drive people not to treat pain in themselves or others are their own. As caregivers, we can educate, provide therapeutic support and interventions, and enlist other caring professionals; but, in the end, the patient makes the choice to treat pain or not treat pain.” Above all, he maintains that patients’ rights to make such choices must be respected and supported (p. 92).

Stephen Kiesling. “A simple prayer, a profound freedom,” Spirituality & Health 6, no. 4 (Oct 2003): 39-41. • An interview with the Trappist monk, Thomas Keating, in which he talks about contemplative prayer and its power to help people. There is a sidebar with guidelines for centering prayer which could be used by a chaplain to teach this style of praying in one pastoral visit.

Alan Kolp. “Hospice: The via dolorosa ad pacem (The way of sorrow to peace),” Healing Ministry 10, no. 2 (Spring 2003): 77-82. • Kolp, who grew up a Quaker, describes the life of his father—from discovery of terminal illness to his deathbed—within the perspective of the Stations of the Cross.

Simon J. C. Lee. “In a secular spirit: strategies of clinical pastoral education,” Health Care Analysis 10, no. 4 (2002): 339-356. • Lee is an anthropologist who has been studying the pastoral work of people in two unidentified hospitals in California. The hospitals
differ in that one is a faith-based institution (Roman Catholic), and the other is a secular, community-based nonprofit hospital which in 1994 was forced for economic reasons to become part of a large religiously-sponsored health care system. Lee has been studying the philosophy and methods of chaplaincy in the two hospitals in order to compare them. Based on his interviews and observations, he concludes that the clinical pastoral education (CPE) model for the provision of spiritual care represents the emergence of what he describes as “a secularized professional practice from a religiously-based theological practice of ministry.” He sees the word spiritual as a label that is being “strategically displayed” in order to extend the chaplains’ sphere of interest from the more narrow world of “religion,” thus allowing them to move from being religious functionaries to a limited group of patients, to being health care professionals with the potential to contribute to all patients. “Such a secularized professional practice is necessary to demonstrate the relevance and utility of spiritual care for all hospital patients in an era of cost-containment priorities and managed care economies.” Such a transformation is the result of clinical pastoral education, which Lee sees as “the means to establishing chaplaincy as a codified method of patient care that, rather than being purely revelatory or intuitional, is a routinized and systematic process that can be taught, evaluated and its providers tested and certified. CPE represents a secularized model of one aspect of religiously-motivated healthcare.” While the flow of this paper is a little choppy—perhaps edited from a larger document—Lee’s perspectives may trigger useful debate concerning the future relationship of chaplains to the religious bodies in which they were ordained or commissioned.

Ruth Macklin. “Dignity is a useless concept – editorial,” British Medical Journal 327, no. 7429 (20 Dec 2003): 1419. • Macklin claims that dignity, a word widely used in medical ethics, is not a useful concept. She argues that appeals to dignity are either vague restatements of other, more precise concepts or mere slogans that “add nothing to an understanding of the topic.” She suggests that its extensive use might be because it appears so often in religious writings. However, she admits that this does not explain why the notion of dignity has “crept into the medical literature.” Macklin’s provocative suggestion received over thirty responses to BMJ’s Web site in the ten days after this issue of the journal appeared.

Wilfred McSherry, Keith Cash. “The language of spirituality: an emerging taxonomy,” International Journal of Nursing Studies 41, no. 2 (Feb 2004): 151-161. • The word spirituality is in danger of becoming meaningless. These authors argue that the definition of this word differs with an individual’s interpretation or worldview. Thus, they are concerned that this word will lose any real significance in discussions about the health care of patients. To counteract this possibility, they developed what they call a “spiritual taxonomy” that clarifies the different meanings they identified, and how these meanings exist alongside each other. At one end of the taxonomy is a spirituality based on religious and theist ideals, while at the other end is a spirituality based in secular, humanistic, existential elements. A middle ground contains elements from each, though these are not as fundamental or radical as the extremes. However, having completed their taxonomy and examined its implications for both practice and education, they conclude that a universal definition of spirituality does not exist. Further, the theoretical probability creating one is essentially nil. They propose that one way to proceed would be to shift the focus from “the restrictive arguments of definition.” Through qualitative research, conceptual discussion, and examination of “the reciprocal interactions of persons and patients, practitioners, and diverse cultures,” they hope to move the discussion from the cognitive and academic to a place that embraces social practice.

Michael H. Monroe, Deborah Bynum, Beth Susi, Nancy Pfifer, Linda Schultz, Mark Franco, Charles D. MacLean, Sam Cykert, Joanne Garrett. “Primary care physician preferences regarding spiritual behavior in medical practice,” Archives of Internal Medicine 163 (8/22 Dec 2003): 2751-2756. • This article presents the results of a research project by a group of doctors to determine the willingness of interns and family physicians to be involved in spiritual and/or religious behaviors in various clinical settings. The data were gathered from six teaching hospitals in North Carolina, Vermont, and Florida with responses from 476 physicians for a rate of 62 percent. The results indicate that 84.5 percent of the
doctors thought they should be aware of their patients' spirituality, but most would not ask about spiritual matters unless their patient was dying. Less than onethird would pray with their patients even if the patient was dying; though 77 percent would pray if the patient asked. Family practitioners were more likely to take a spiritual history than general internists. Regardless of the intervention—spiritual history taking, silent prayer, vocal prayer—physicians were more likely to agree to participate as the severity of the patient's illness increased. Interestingly, physicians were not asked if they would refer a patient with a prayer request to a chaplain or religious leader if they were unwilling to offer prayer themselves.

Jill Neimark. “New life for near-death,” Spirituality & Health 6, no. 4 (Oct 2003): 42-45,73. • When Moody wrote his book about near-death experiences (NDE) over thirty years ago, many people were intrigued and many were highly skeptical about what he reported. Chaplains were somewhat less skeptical, especially if they had heard stories from patients who had experienced NDE. Today, there is a desire to better understand these experiences. Neimark recounts the growing interest in these stories, including the work of Pim van Lommel in the Netherlands, whose paper in The Lancet (January 2001) sparked the first serious public discussions by doctors. A major observation in this paper was the fact that people reported experiences after all their brain activity should have ceased. Neimark also describes research which may add to the understanding of this phenomenon, but adds, “There is a mystery at the heart of these experiences that no electrode or PET scan has yet explained.”

Ellen M. Redinburgh, Amy M. Sullivan, Susan D. Block, Nina M. Gadmer, Matthew Lakoma, Ann M. Mitchell, Deborah Seltzer, Jennifer Wolford, Robert M. Arnold. “Doctors' emotional reactions to recent death of a patient: cross sectional study of hospital doctors,” British Medical Journal 327, no. 7408 (26 Jul 2003): 185-191. • What are the emotional reactions of doctors to the death of patients in their care? Are the reactions different if the doctor is a man or a woman, or has practiced medicine for a long versus short period of time? Do senior doctors help junior doctors cope with deaths? The results of this study, conducted in two teaching hospitals in the US, found that 74 percent of the doctors surveyed had satisfying experiences caring for the dying. They reported moderate levels of emotional impact: mean 4.7 on a 0-10 low- high scale. Women doctors and male doctors who had cared for a person for a longer time experienced stronger emotional reactions. Fifty-five percent of the doctors reported that a patient’s death disturbed them very little, while 23 percent reported they were very disturbed by a death. On average, doctors reported experiencing two out of a possible fourteen symptoms of grief after a death, e.g., 47 percent reported feeling upset when thinking about the patient. Though interns reported that they needed significantly more emotional support than did attending physicians, chaplains who wish to pro-

provide pastoral support to doctors should not assume automatically that interns are more in need of pastoral care.

Susan A. Salladay. “Medical futility - When is enough, enough?,” Journal of Christian Nursing 20, no. 4 (Fall 2003): 25-28. • In the last year, there have been reports in the media that medical futility is not Christian. Some speakers and educators have linked futility with euthanasia, even confusing them. A nurse educator, Salladay unravels the confusion as she differentiates between the two and explains how Christian nurses can and should support hospital policies on medical futility.

Robert W. Stuford. “The spiritual journey of an organ transplant patient,” Journal of Pastoral Care & Counseling 57, no. 2 (Summer 2003): 191-196. • This article is a hospital chaplain's detailed description of the psychological, emotional, and spiritual dynamics of an organ transplant patient who was the recipient of a new liver. The patient, a former fireman in his early sixties, had been at death's door a number of times before he received his transplant. We are told how his life and the lives of his two daughters have been affected by his illness and how these effects have continued long after the surgery, as a result of posttransplant routines.
When Violence Is No Stranger
Kristen J. Leslie
Minneapolis: Fortress Press, 2003 • 186 pages • $18.00 softcover

When a woman talks about being assaulted, what do you hear? There are those who will take her statement as pure truth and those who do not want to believe her. The allegations (versus reality) of sexual misconduct associated with government and sports figures has led to a deepening mistrust of such accusations.

Kristen Leslie addresses acquaintance rape from the position of those who were violated and offers hope for both victims and pastoral caregivers that recovery is possible. Leslie addresses myths versus facts associated with this trauma and offers sound direction for pastoral support of victims. This book captures the depths of emotions associated with assault by a trusted individual through the voices of four survivors of acquaintance rape and presents a theology which seeks to equip the pastoral caregiver who chooses to journey with victims of acquaintance rape.

As a male chaplain who has been with those in the midst of trauma, I found that this book bore into the depths of my being. I struggled with my identity as a man, and I grieved for those who had been assaulted. When Leslie noted that most women who have been raped by male acquaintances have difficulty relating to male pastors, I was able to hear this and became interested as to how I may become more sensitive to the subtle cues and outright statements voiced by women who have been raped at some time in their lives.

When Violence Is No Stranger records the words of four of the women who came seeking to regain the strength stolen from them by rape. Leslie makes it clear that the process of reading this book may be difficult for some and notes that she struggled while writing it. Her initial call to this subject came while she was serving as a college chaplain, and a woman walked into her office to talk about being raped by a “friend.” Leslie’s work with this individual led to many more who found their way to her.

Though the author offers no easy answers, a significant part is the theology presented, which seems to come out of the depths of the maelstrom associated with the psychological and spiritual trauma. Anecdotal excerpts from survivors voice both the struggle and the hope that new life is possible.

Within the structure of this work there is a strong feminist presence, not surprising in light of the subject material. Those who would avoid such a rendering are encouraged to come with an open mind, to hear the passion within, and to hear the cry for support by those who have been assaulted and struggle with their psychospiritual identities.

In the opening portion, Leslie records statistics that are hard to hear. One out of four or five women on college campuses are victims of rape, and 84 percent of those are raped by people they previously had trusted.

“Even my close friend whom I trusted, he who shared meals with me, has turned against me” (Psalm 41:9).

Al Voorhis, MDiv, BCC
Director of Pastoral Care
Salem Community Hospital
Salem, OH

Paul Buche (Pfbhr3649@aol.com) serves as liaison to Augsburg/Fortress and Haworth Press; Bob Cullum (bobcullum@yahoo.com) handles reviews of university press and self-published books. If you have authored a book that you wish to have reviewed in CT, please contact the appropriate individual. If you wish to suggest books for review from other publishers, or if you are interested in writing reviews, e-mail Paul Buche.
if I get to five: What Children Can Teach Us about Courage and Character
Fred Epstein, MD, and Joshua Horwitz
New York: Henry Holt and Company, 2003 • 208 pages • $20.00

Dr. Fred Epstein recounts the story of his own life and the stories of some of his patients. Perhaps most interesting to chaplains, he tells the story of the creation of a hospital that had spiritual care built into it from the beginning and how that spiritual care strengthens and comforts patients, families, and staff.

The book's title comes from a four-year-old girl named Naomi, who had a complex brain tumor requiring an innovative two-part surgery at a time when pediatric neurosurgery was in its infancy. After the first operation, Naomi stood up on her bed and informed Dr. Epstein, "If I get to five, I'm going to learn to ride a two-wheeler!"

Each day's progress brought a new goal for Naomi—if she got to five. She was a formative influence upon this surgeon at a teachable time in his career. She did get to five, and beyond, and still keeps in touch with Dr. Epstein. Her living legacy to him was opening his eyes to the resilience, courage, and hope within children. This led him to look at the child first and the disease second. When he suffered a brain injury himself, his recovery and rehabilitation were inspired by his experiences with children.

Though the anecdotes about many of the children he has treated over twenty-five years are remarkable, it is the Institute for Neurology and Neurosurgery (INN) under the auspices of Beth Israel Medical Center in New York City that stands out as a model of holistic care for children and their families.

Dr. Epstein dreamed of "a top-flight medical facility where patients, their families, their doctors, and their nurses could work together as a team, where cutting-edge care didn't start and end in the operating room, where no families would be turned away because their cases were too hopeless or their finances too limited." His dream turned out to include a chapel and chaplain, doctors who will pray with a family before surgery, and a weekly prayer circle that includes everyone. The prayer circle became a place "where everybody could replenish their hope—patients, their families, doctors, nurses, non-medical staff—regardless of their religious background.... We all needed to renew ourselves, and praying alongside our patients and their families reminded everyone that we were all in this together."

This simply written book would make a good gift for a pediatrician, or better yet, a medical student or pediatric resident. It would also find a place in a hospital family resource library. Dr. Epstein would be an excellent resource for those involved in building or reorganizing any sort of health care facility who want to discuss the value, rather than the cost, of spiritual care.

Linda Francisco Bets, MRel, BCC
Staff Chaplain
Iowa Health-Des Moines
Des Moines, IA

Chronic Pain: Biomedical and Spiritual Approaches
Harold G. Koenig, MD
The Haworth Pastoral Press, Binghamton, NY, 2003 • 328 pages • $49.95 hardcover • $24.95 softcover

In recent years there has been increased rhetoric on the issue of treatment and care of individuals who live with chronic pain. This is due to a new awareness of persons who live with chronic pain. With this increased awareness have come new regulations for health care providers regarding their responses to pain. Chronic Pain: Biomedical and Spiritual Approaches provides the insight and medical acumen of Harold G. Koenig as a man who experiences chronic and debilitating pain himself and provides support to others who live with such pain. His book provides "a view from the trenches" regarding chronic pain, coupled with a detailed discussion of pain as a diagnosis. Koenig's approach to the treatment of pain considers medical treatment, e.g., pharmacological and surgical interventions, complimentary care, e.g., herbal treatments, physical manipulation, and psychosocial/behavioral support, and spiritual care directions for addressing the unique experience of chronic pain and those who live with it.

Koenig provides a brief description of each modality. For instance, a separate section is devoted to herbal and complementary medicine techniques. Verbatim and case study material are used effectively to help the reader better appreciate the experience of the victim of chronic pain and to develop appropriate responses to these individuals, who often ex-
experience failure, confusion, and abandonment.

Chronic Pain: Biomedical and Spiritual Approaches has one weakness, which perhaps only a professional chaplain would notice. As Koenig refers to spiritual caregivers, he writes of the work of the local pastor and the pastoral psychotherapist but makes no mention of chaplains. With great concern this reviewer must ask, does this lack of awareness reflect an absence of professional chaplains in his personal journey of pain?

This book may be seen as a manual on the support of persons who experience chronic pain. The material is presented in a clear manner that can be utilized equally well by one who lives with such pain and by one who journeys with those who live with, or support others, in the midst of the valley of chronic pain.

Al Voorhis, M.Div, BCC
Director of Pastoral Care
Salem Community Hospital
Salem, OH

Faithful Conversation: Christian Perspectives on Homosexuality
James M. Childs, Jr., Editor
Minneapolis: Fortress Press, 2003 • 132 pages • $9.00 softcover

The relationship between homosexuals—gay, lesbian, and transgendered persons—and the Church is a potentially divisive issue generating impassioned debates. Many denominations exclude all known homosexuals from participation in the life of the church. Others accept homosexuals into fellowship and membership but exclude them from ordained or commissioned clergy.

A few denominations accept homosexuals into all aspects of church life, including ordained leadership.

In his introduction to Faithful Conversation: Christian Perspectives on Homosexuality, James Childs writes, “Conversations about such an emotionally charged and potentially divisive subject needs to be faithful … faithful to the mission of the church … [faithful] to the Scripture … and faithful [in] conversation with Christian tradition” (p. 1). The question confronting the Evangelical Lutheran Church in America (ELCA) is whether the welcome of practicing homosexuals into membership should be extended to embracing and affirming them, not only into fellowship, but also into the ranks of ordained clergy.

Six contributing professors from different Lutheran seminaries have made an honest attempt to present their material in a thoughtful and scholarly way while heeding Childs’ call to be faithful. However, the authors have slanted their articles toward affirming, in some form or another, homosexual behavior. Only James Nestingen’s article, “The Lutheran Reformation and Homosexual Practice,” expresses doubt that the Church can remain faithful to its mission, to Scripture, and to traditional Christian conversation while blessing same-sex unions or ordaining practicing homosexuals.

Although written by Lutherans and addressed to Lutherans, Faithful Conversation lives up to its title of “Christian perspectives,” rather than “Lutheran perspectives.” Christians of other denominations who struggle with these issues will find the book worthwhile because of the call to the Church and its members to remain faithful and to engage and remain in dialogue with each other while preserving the integrity of Scripture and Church. It is not a balanced dissertation on the relationship of homosexuals to the Church, nor does it provide definitive conclusions. However, it does provide valuable information, which may help to inform an individual’s position.

One of the book’s most helpful sections for chaplains is Daniel Olson’s article, “Talking about Sexual Orientation: Experience, Science, and the Mission of the Church.” Although Olson leans in the direction of accepting homosexual behavior, his writing is more neutral than most of the others. In the first part of his article (pp. 97–111), Olson discusses pastoral care elements, specifically the dynamics of listening and anger avoidance, which are necessary for faithful discussions. In the second portion (pp. 111–117), Olson holds to the middle ground as he discusses scientific evidence and how it does not prove or disprove what causes homosexual orientation and whether sexual orientation can be changed.

While Faithful Conversation is easy to read, it also is a thought provoking, and informative work. Regardless of one’s viewpoint, it is a must read for all who wish to enhance their understanding of homosexuality and Christianity while remaining grounded in the unity of faith. It is not for the faint of heart or those who are unwilling to listen to differing viewpoints. On a scale of one to five—one being “skip this book” and five being “run out and buy it”—I
would rate it a four, a book that should be in every chaplain’s personal library.

Chap. Kenneth L. Nolen, MDiv, BCC
Supervisor/Educator
Spiritual Care Department
Orlando Regional Healthcare
Orlando, FL

Pastoral Counseling: A Gestalt Approach.
Ward A. Knights, Jr.
Binghamton, NY: Haworth Pastoral Press, 2002 • 125 pages • softcover

In this book, Ward A. Knights, Jr. introduces the reader to Gestalt theory and offers some ideas for integrating those concepts with “pastoral care and counseling.” This is a slim volume, with the longest of the eight chapters less than thirty pages. Knights is both a Unitarian Universalist minister and a qualified Gestalt therapist, so he writes with an insider’s knowledge.

Early on and throughout the book, the author explains that the Gestalt approach was developed by his teacher, Frederick S. Perls (d. 1970). Like Freud, Perls “put great emphasis on dreams.” Indeed, Perls wrote, “I believe that it is really the royal road to integration.” (italics in original, 71). An entire section is devoted to dreams (chapter 6).

The initial three chapters outline Gestalt theory: Gestaltists tend to shy away from diagnoses; the Gestalt stance is that it is the person who interprets his or her own behavior, not the counselor; the Gestaltist is not much concerned with explanations of unconscious processes, but rather is pragmatic in outlook. According to Gestalt theory, people block themselves from the fullness of their own experience through projection, introjection, retrojection, and confluence. Knights defines these terms.

Often, Knights’ explanations begin with a simple definition and then become very convoluted. For example, “Confluence basically refers to a lack of awareness or definition of self …. Confluence is one of the four ways we block ourselves from fullness of our own experiences. Confluence differs from the three others mentioned in that it can operate as a complete system to block awareness …. Confluence, in its purest, primitive form, can survive without projection, introjection, or retrojection. This, however, rarely occurs except in severely psychotic children. Projection, introjection, retrojection, and confluence do not operate in isolation from one another in the average person seen in pastoral counseling. They are, in life experience, both interlocking and functionally interrelated. Projected identification, for example, is a combination of confluence, projection, and introjection between two persons where each (in a confluent manner, and through projection and introjection) trades parts of themselves that the other member of the pair does not mind adopting” (pp. 19, 21).

In a chapter entitled “Peeling the Onion,” Knights writes of “rules” used by Gestalt theorists, including The Principle of the Now and “It” and “I” Language. He explains that these rules are used in Gestalt groups or individual sessions through the use of “games.” Among these games are I Take Responsibility and I Have a Secret. Other resources Gestalt uses are Fantasy Journeys, Dream Integration, The Hot Seat, and Pillow Talk (pp. 35-41).

Knights writes that he purposely intended to “put experience first and theory second … [for] from the Gestalt perspective, our experience is far more important than mere statements made about that experience” (p. xi). Nonetheless, Knights remarks at the beginning of chapter 4 that he was “feeling somewhat exhausted from writing the first three chapters. They seem to contain too much head-stuff” (p. 49).

Throughout the book, Knights refers to the Bible, primarily the Christian Scriptures and often the Gospel of Matthew. Reading this as a rabbi, I found these references jarring and felt that they did not add to the clarity of the text. I wondered, given these particular references, if readers in other religious traditions, such as Buddhists, Hindus, and Muslims, would question the applicability of these theories to individuals in their own faith traditions? (For a discussion about this dilemma, see the recent article authored by my colleague Rabbi Bonita E. Taylor and I: “Nearly Everything We Wish Our Non-Jewish Supervisors Had Known About Us as Jewish Supervises,” The Journal of Pastoral Care & Counseling, Spring 2003.)

The volume features endnotes, an index, and an appendix devoted to a biographical sketch of Gestalt’s founder, Frederick S. (Fritz) Perls.

David J. Zucker, PhD
NAJC board certified chaplain
Director of Pastoral/Spiritual Care and Recreation,
Shalom Park
Aurora, CO
The Rabbi As Symbolic Exemplar:
By the Power Vested in Me
Jack H. Bloom
New York: Haworth Press, 2002 • 338 pages • softcover

Clergy of all denominations—female and male alike—whether they serve as chaplains, pastoral counselors, or are congregationally based, share the experience of being regarded as “outsiders.” This is because all clergy are symbolic exemplars, symbols of something other than themselves.

This book analyzes what it means to be a symbolic exemplar. Bloom explains that when we understand this phenomenon and integrate the knowledge into our lives, we can utilize it to be more effective in our work. The book has a clear application to all who do pastoral care, pastoral counseling, or chaplaincy. Its potential audience is much wider than the rabbinate, or even congregational clergy. In terms of this book, the word rabbi is synonymous with chaplain, or clergy in general. Likewise, congregants may be defined as residents of nursing homes, patients in acute care settings/hospices or coworkers in a variety of settings.

Bloom makes the case that the clergyperson is a symbolic leader who is set apart to function within the community as a symbol of that community and as an exemplar of its collective desire for moral perfection. Clergy are thus walking, talking, living symbols. They stand for something other than themselves. In order to function successfully, they must be perceived as such and must not act in a way that would destroy the symbol. He suggests that it is crucial for the clergy to fill the symbolic aspects of that role.

Perhaps the major expectation of the clergy is that in some crucial way, they are considered a different kind of human being. They are the embodiment of what people ought to do, but have no intention of doing. For Bloom, clergy must truly care and must fully believe, or at least be perceived and experienced as fully believing, in what they are doing. Indeed, who the clergy are, is more important than what they do.

Symbolic exemplarhood carries great power. It authorizes clergy to bless people; to name and by naming, create new entities; to help people heal; to pray for others; to confer significance by symbolic presence and acts; and to absolve guilt on behalf of a higher power.

Particularly relevant to chaplaincy and pastoral care is the section on curing and healing. Bloom, who is a clinical psychologist in Fairfield, Connecticut, offers ideas about how clergy can use their symbolic exemplarhood as a “major source of efficacy, influence, potency, and power.” He explains that clergy “can make a positive difference in people’s physical health and well-being by what they do in contact with the ill, in hospital, synagogue [church, mosque, temple, congregation], and home.” He points out that when people are ill, the clergy’s symbolic exemplarhood grows, and what one says and does is vitally important.

How we frame our words is important, e.g., offering hope without being sugary or insincere. Indeed, Bloom maintains one should avoid being a cheerleader and offering pep talks. Though well meant, he says the net effect of this approach is to shut off feelings. However, he recommends use of methods such as presupposition, e.g., telling the patient who is going into surgery, “I will see you when you get back to your room.”

Think broadly, think widely, he urges the reader. Think in terms of both and, not in terms of either/or. Either/or thinking is self-limiting; it leads to a kind of fundamentalism. “We are not solely one or the other aspect of ourselves. We are at all times [both and]. No part, aspect, or characteristic stands alone. Each may serve as context for the other.”

Readers need to be able to translate and transcend Bloom’s specific imagery of rabbis and synagogues, and understand that these are but specific examples of a wider phenomenon. A number of the chapters are reprints of his previous articles and speeches joined together with some new observations. Bloom might have considered using gender inclusive language at all points, adding bracketed words like [she/hers] to previously printed material, and likewise, where appropriate, adding the words [chaplains/clergy] where that was applicable.

This book abounds in theoretical and practical wisdom. Chaplains and other clergy, as well as laity who care about them and their sacred work, will benefit from reading this volume.

David J. Zucker, PhD,
NAJC board certified chaplain
Director of Pastoral/Spiritual Care
and Recreation
Shalom Park
Aurora, CO
Strategies for Brief Pastoral Counseling
Howard W. Stone, Editor
Minneapolis, MN: Fortress Press, 2001 • 242 pages •

The overarching thesis of this book is that the strategies of brief counseling are important to the pastor who provides short-term counseling. The illustrations are from parish work. This book presents thirteen chapters: three written by Stone, one co-authored by Stone, and several others that are obviously heavily influenced by him. The intended audience includes Christian pastors, priests, and pastoral caregivers in the parish setting with a secondary audience of chaplains.

The strengths of the book are related to pastoral care and chaplaincy in the descriptions of several brief therapy strategies, such as looking for exceptions, focusing on strengths and solutions, setting time limits, and articulating a positive future story. These strategies also are helpful in the practice of pastoral care in institutional settings. The illustrations and examples of the strategies connect religious themes to concrete experiences in practical and creative ways. The book is clearly grounded in theology and pastoral care.

Two chapters are particularly helpful: chapter 9, “Collaborating with the Spirit: Brief Spiritual Direction in Congregational Ministry” and Chapter 8, “Staying Solution-Focused in Brief Pastoral Counseling.” Karin Bruce, an LPC candidate who reviewed the latter, writes that it presents a structured model for using solution-focused brief pastoral counseling in sessions with parishioners. A clear and easy-to-use diagram is introduced that enables pastoral caregivers to walk through the process with counselees in a solution rather than a problem-oriented approach. Each section of the diagram is augmented by analogies and examples of clarifying questions one may use within counseling sessions.

The goal of the questions is to help the parishioner discover potential exceptions to the presenting problem. The questions are meant to flow naturally from the discussion and to be effective, timely, and appropriate to the individual’s given situation.

This model is helpful for chaplains in that it shows how Scripture may be used within sessions. Moreover, the approach encourages the pastoral caregiver and counselee to work together to construct solutions for the parishioner with the goal of instilling hope—hope that an alternative solution exists and that God is active in the process, as well as in the life of the counselee. When people are able to view their presenting problems from different and new perspectives, this change often will lead to a change in personal meaning for the counselee.

The two main limitations of the book were the extensive repetitions by authors of individual chapters and the blatant bias against long-term counseling. For example, the strategy of looking for, highlighting, and reinforcing exceptions was explained at length at least five different times. The book reflects a strong and over-stated thesis that brief therapy is always superior to long-term pastoral counseling, and Stone goes so far as to say that long-term therapy is unethical. Though extensive, his arguments were not convincing. Buried in one footnote in chapter 5, authored by Katherine Godby, is a paragraph stating when Stone would recommend referral. The criteria given were surprisingly broad and wide ranging, clearly applicable to many people who present to a local pastor, and thus confusing, given Stone’s obvious bias against referral to long-term therapy stated elsewhere in this text. The reader may want to balance Stone’s view by reading from sources that offer research supporting the efficacy of long-term therapy. See the following Web sites:

http://www.apa.org/journals/seligman.html

http://www.mmpi-info.com/mmpi outcome.html

http://apsa.org/pubinfo/fonagy.htm

Overall, chaplains will benefit mainly from the strategies for brief therapy and the examples of creative and interesting integrations between the presenting problems of the parishioners and religious and/or scriptural themes.

M. Catherine Hastry, MDiv, BCC
ACPE Supervisor, AACIPE Diplomate Assistant Director – ICL
Department of Pastoral Care
Carolina’s HealthCare System
Charlotte, NC

Healing Bodies and Souls: A Practical Guide for Congregations
W. Daniel Hale and Harold G. Koenig, MD
Minneapolis: Fortress Press. 2003 • 125 pages • $15.00 softcover

The authors write for leaders of congregations of any faith tradition to encourage the development of health ministry programming.
within a variety of religious institutions. After a brief introduction, Hale and Koenig spend one chapter each on the emergence of a health ministry program within nine congregations, all Christian. The tenth chapter summarizes the lessons learned and an appendix lists further information and funding resources.

I found myself pulled easily into the story of each congregation. There was usually a person or an event that triggered the idea of exploring health ministry. One parishioner, a competent office manager, suffered from severe depression. After attending a conference on congregational health ministries at a nearby church, she responded to a call from her own pastor to help form this new ministry for their church. In another congregation, a parishioner experienced a major medical emergency on the pastor’s first Sunday in the pulpit. Medical professionals in the congregation gave immediate aid until the ambulance arrived. This experience set the new pastor on a trajectory toward health ministry.

Other chapters focus on the breadth and diversity of congregational health ministries. In one, a woman who had developed excruciating back pain while caring for a severely ill adult child was assisted by her congregation’s health ministry. A nurse took the time to teach her new caregiving methods and addressed her mental and spiritual needs as well as her physical pain. In another, simply opening the church doors to the Life Line screening program began the process of diagnosing a parishioner’s serious blockage in a carotid artery as well as an abdominal aneurysm. A health care ministry does not have to emerge fully formed. It may begin by permitting outside groups to use the physical space to present informational programs.

Knowing something of the early stages in the development of a health care ministry within a congregation in the Episcopal Diocese of Indianapolis, I was pleased to see the number of denominations and organizations that now encourage such work on the local level. My own congregation already is trying some of the options mentioned in these case studies with strong approval by our members, particularly the elderly.

As Hale and Koenig state in the introduction, there are three important characteristics that enable religious institutions to play an important role in health care: religious institutions are generally established and governed in large measure by residents of the community, most have well-established communications networks, and they have strong traditions of volunteerism and civic engagement.

This is an excellent introduction to what health care ministry can be on the congregational level. Each example is unique, though several caregivers received training through a Lay Health Education program based at Stetson University, DeLand, Florida, where Daniel Hale taught. In addition, most chapters end with a section by Harold Koenig which focuses on particular medical conditions or issues, e.g., Alzheimer’s disease, Parkinson’s disease, strokes, advance directives.

How can hospitals and other branches of the health care system aid religious institutions in such ministries? A number of suggestions were offered. Approach reli-

M. Sue Reid, MDiv
Rector
St. Alban Episcopal Church
Indianapolis, IN
Going to “Church”

They call it “Church.”
worship service or Bible study,
Protestant or Catholic,
weekend or weekday.
It's all the same to them.

They're all God's children with
crippled bodies, failing vision,
some awake, some asleep, and
others hardly aware of their surroundings.
Not the typical Sunday morning congregation.

Yet something mysterious happens
as the hymns are sung,
the lessons read,
the prayers prayed,
and God's children offer their praise and worship.

God comes and makes God's Self known in this humble setting.
The Spirit of God moves among these frail and aging children
to stir their holy memories of worship in Christian community
imprinted by loving parents and faithful pastors,
now in the company of saints gathered round the throne of God.

Beloved old hymns retrieved from failing memories
Join the choir of heaven, praising God as Father, Son, and Holy Spirit:
bread broken, wine shed,
God's kingdom revealed.
Christ is truly present: "Taste and see that the Lord is good."

The curtain pulled back for a brief moment
to give God's children a glimpse of eternity,
strength for the day,
hope for the future.
“Happy are those who take refuge in Him.”

James F. Brandis

The Reverend James F. Brandis, STM (Master of Sacred Theology), BCC, serves as corporate at Shepherd of the Valley Lutheran Retirement Services, Inc. He is endorsed by the ELCA (Evangelical Lutheran Church in America). Correspondence may be directed to jbrandis@shepherdofthevalley.com.