Chaplaincy research is dominated by self-report data collected directly from research subjects or participants. Self-report response bias is the research measurement inaccuracy that originates with the respondent. This article focuses on seven categories of this bias and offers recommendations for acknowledging and addressing this problem.

**Keywords:** methods, research, survey

**Dealing with the Growing Complexity of Resident Chaplain Orientation**

The increasingly complex role of chaplain has necessitated more extensive orientations for clinical pastoral education (CPE) residents and students. This article describes an overlap period between graduating and incoming residents and highlights strengths and weaknesses of this model of orientation.

**Keywords:** CPE, shadowing, transition

**Living as a Burn Survivor: Implications for Pastoral Care**

As chaplain serving a burn unit and trauma ICU, the author discusses common issues faced by burn survivors and their families. Writing from his personal experience, he also explains how recognition of his Shadow Gifts and incorporation of them into his ministry enable him to “pay it forward” to others who walk the path of healing from burn injuries.

**Keywords:** shadow, grief, PTSD

**The Collegiate Sports Chaplain: Kindred or Alien?**

This paper examines the role and function of collegiate sport chaplains, including core elements of their work. Data from one study are included along with a discussion of credentialing and training initiatives.

**Keywords:** competency, profession, FCA

**Consoling Rachel: A Bereavement Program for Perinatal Loss**

Maternal grief associated with perinatal loss often is not acknowledged or addressed in the hospital setting, leaving patients to lament silently or in isolation. This article presents a program for specific bereavement intervention in which chaplaincy care is an integral part of the overall care provided to the woman who experiences loss as a result of infant death, stillbirth, early-term miscarriage or therapeutic medical termination of pregnancy.

**Keywords:** lament, neonatal, RTS
Peggy A. Miller

**Essay - The Galapagos Islands and the Now**
Personal reflection arising from work with patients diagnosed with Alzheimer’s Disease.
*keywords: Alzheimer's, memory, aging*

Martha R. Jacobs

**On Holy Ground - A Not So "Silent" Retreat**
Personal reflection on the call to chaplaincy.
*keywords: spirituality, chaplaincy, connection*

Judith Lethin

**Poetry - The Sound Has Gone Out**
Personal reflection.

Joe Baroody

**Poetry - Holy Water**
Personal reflection.

W. Noel Brown

**In the Literature**
A survey of current literature related to chaplaincy care culled from an international selection of professional journals and other media.

Mark LaRocca-Pitts

**Expression of Faith - The Tao of Dying**
Personal reflection on the manner of dying.
*keywords: self, body/mind/spirit/wisdom*

**Media Review**

![Image of book cover](image_url)
I WRITE THIS FROM A NEW VANTAGE POINT ... literally. After thirty years in the Chicago suburb of Barrington, Illinois, my husband George and I moved to New Jersey last December. My new view (from the twenty-fourth floor of a New Brunswick high rise) includes the Rutgers University campus, the Raritan river, the New Jersey Rail Station, the headquarters of Johnson and Johnson and the Robert Wood Johnson Medical Center. Between the sirens, train whistles and the occasional helicopter, it’s a lot noisier than my former home in what author Bob Greene called “the land beyond O’Hare.” It’s also energizing, invigorating and expansive. On clear days, I can even glimpse the Manhattan skyline.

It goes without saying that one needn’t move a thousand miles in order to look at life in a new way or from a new angle. In fact, the content of this issue does that without any geographical change. Diane Dodd-McCue and Lex Tartaglia look at chaplaincy research and point out the potential danger of using self-report data. Paul Derrickson and Angelina Van Hise look at new ways to orient their CPE residents. Douglas Phillips explains how revisiting his experience as a burn survivor has informed his delivery of chaplaincy care to trauma patients and their families. Steven Waller and his colleagues at the University of Tennessee examine the sports chaplain from a new angle. Sandra Londa writes how her ministry to women experiencing perinatal death evolved from her perception of Rachel weeping for her children.

Reflective pieces by Peggy Miller, Martha Jacobs and Mark LaRocca-Pitts bring their new insights to ministry with Alzheimer’s Disease patients, silent retreats and the process of dying.

As a result of the APC task force conversations facilitated by Martha Jacobs, chair of the Communications and Publications Council, Chaplaincy Today is expanding its editorial view as well. The goal is multifaceted: encourage chaplains to engage in various forms of research, provide mentoring during the writing process and increase opportunities to publish the results.

At the risk of delivering what George calls “old news,” I venture to say that the practice of re-viewing and re-visioning is something each of us needs to do with some regularity. How easy it is to parrot what a colleague terms the seven last words employed by so many congregations: “We have always done it this way,” or conversely, “We have never done it that way,” or even the definitive, “We tried that once; it didn’t work!”

In the hope that you too are looking for new perspectives, I invite you into this issue of Chaplaincy Today.
Self-report Response Bias: Learning How to Live with Its Diagnosis in Chaplaincy Research

Diane Dodd-McCue • Alexander Tartaglia BCC

Chaplaincy research is dominated by self-report data collected directly from research subjects or participants. Self-report response bias is the research measurement inaccuracy that originates with the respondent. A review of research published in The Journal of Pastoral Care & Counseling (1998-2008) found that all but one of thirty-eight research articles used self-report data. Of this total, less than half acknowledged methodological limitations, and only two acknowledged the potential impact of self-report response bias.

This article focuses on seven categories of self-report response bias that may impact chaplaincy research: social desirability, acquiescence, leniency or harshness, critical event or recency, halo effect, extreme response style and midpoint response style. Although these biases have the potential to impact self-report data, the data themselves are not inherently flawed. This discussion offers recommendations for addressing self-report response bias during the research process. It also suggests that acknowledging and understanding the impact of self-report response bias may result in more rigorous research as well as more creative and informed interpretation of results.

All hospital employees—including hospital chaplains—are asked to complete a survey about their institution’s organizational culture. The survey instrument is piloted and its methodological strengths, validity and reliability, are established. A plan for distribution and administration of the surveys is clearly developed and communicated to employees. Additional break time is allotted so employees can complete the forms that day. Break rooms are organized and user-friendly to facilitate a more conducive environment for survey completion. Surveys are provided to employees on a Monday morning. They are asked to complete them that day and return them to Human Resources. Monday morning, before work, a hospital chaplain opens up the local paper to this headline:

Local Hospital to Cut Workforce by 15%
Details of Cuts to Be Announced Later this Week

Assume for a moment that this is not a fictitious event, but a real situation. The chaplain walks into the break room where this headline is the main topic of conversation. What would be the impact of this news on hospital employees’ assessment of organization culture? In essence, nothing has changed except one most critical element: will respondents, who are being asked to report perceptions of the hospital’s organizational culture, be biased by the headlines and the anxiety that was absent a short twelve hours before? If so, how?

What are self-report data?

Self-report data are data collected directly from the research subjects or participants. The emphasis is on those from whom the data are collected, as well as the direct means by which the
Self-report data are secured. Self-report data takes multiple and varied forms. It may include data collected from face-to-face interviews with chaplain interns about their CPE experience or data collected from patients using established, validated survey instruments to measure satisfaction with pastoral care services. With self-report data the individuals providing the information are the study participants providing their perceptions about a topic of interest. Regardless of the collection method, e.g., survey, interview, observational narratives, cases, the expectation is that the data represent an accurate, unbiased reflection of what is being measured. Self-report data are frequently used in social behavioral research, the broad research umbrella that includes chaplaincy.

This article addresses self-report data using a three-pronged approach. First, it looks at how extensively self-report data are used by chaplaincy research through a review of ten years of research published in The Journal of Pastoral Care & Counseling (JPCC). This overview also highlights the acknowledgement of the strengths and limitations of self-report data within the context of chaplaincy research. Second, it focuses on several response biases commonly associated with self-report data that may impact chaplaincy research. Finally, it concludes with some recommendations for both researchers and consumers of research in the area of chaplaincy.

**Literature review on self-report data and chaplaincy research**

Chaplaincy research is dominated by self-report data. A review of the most recent ten-year period (1999-2008) found that JPCC published thirty-eight research articles. All but one presented data collected using one or more self-report methods.

A closer look provides more details on the prominence of self-report data in chaplaincy research. Three major categories of self-report data served as the basis for the studies in these publications.

- Two-thirds (25 articles) described data gathering as exclusively self-reported. These articles used a single self-report method in data collection, e.g., survey, questionnaire, interview, focus group.
- Five of the articles described the use of readily available, previously developed scales being completed by subjects. It is unclear whether this suggests that the instruments used had not previously been evaluated for their measurement quality (most frequently conveyed by descriptions of measurement validity and reliability) or whether the omission of this information was a result of journal space restrictions.
- A third group (7 articles) described use of some two or more self-report methods. The most frequently used combination coupled interviews with self-report measurement scales.

Approximately half (18) of the articles acknowledged limitations to the research rigor. The most frequently identified research limitations included small sample size and use of convenient samples, which in turn limit generalizability of results. Only two of the articles acknowledged limitations related to the use of self-report data.

During this same time period, several articles addressed the status of research in chaplaincy but with limited acknowledgement of self-report response bias. Three articles offered support for the promotion of chaplaincy research and provided suggestions for conducting chaplaincy research. Both O'Connor et al. and Flannelly et al. emphasized specific deficiencies in research design. O'Connor et al. also noted the lack of acknowledgement of researcher bias. Flannelly et al. suggested that chaplaincy research did not reflect a sophisticated knowledge of statistical sampling or statistical analysis. Without detracting from the merits of these this article seeks to fill the void by focusing solely on self-report response bias within chaplaincy research.
Self-report data strengths and limitations

As previously mentioned, chaplaincy research is dominated by self-report data for good reason. Data gathered through self-report methods are strengthened by direct rather than third-party observed responses to study questions. Additionally, some research constructs, such as attitudes and beliefs, cannot be observed. Self-report data also provide a richness that personalizes data and facilitates elaboration of responses. Finally, self-report data are relatively easy to collect, which is a significant strength when access to study participants is limited.

Even though a major strength of self-report data is that it comes directly from the study participant, this does not rule out the potential impact of the respondent as one source of measurement error. Such error surfaces from three sources: the respondent; the method or instrument of data collection, e.g., interview, survey; and contextual factors, e.g., setting, time pressures. Although all three warrant the attention of both researchers and consumers of research, this discussion is limited to measurement error that originates with the respondent. This is response bias.

Self-report response bias

Historically, research methodology describes a quality measurement as unbiased, valid and reliable. Response bias, which originates with the respondent, affects measurement quality by introducing inaccuracy or lack of precision into the research. Respondents may be unwilling or unable to respond accurately for countless reasons. They may be informed but reluctant. They may be tired or feel time pressure. They may strive for consistency in their responses rather than consider individual questions. They may have concerns about how their response will affect others’ opinions of them. This discussion focuses on seven types of self-report response bias. While this list is not exhaustive, it does highlight several that may impact research in the area of chaplaincy.

Social desirability

Social desirability is “the tendency for people to present themselves (or their attitudes) favorably according to the current cultural norms.” Thus, individuals’ responses are influenced by their perception of situational norms and expectations.

A hospital chaplain interviews patients and their families about how frequently they pray. Even though some may not see prayer as an important part of their lives, they may overstate the amount they pray because they think the chaplain sees this as very important. Similarly, patients and their families may skew their responses to what they see as controversial “hot button” issues based on their projections of the norms of those with whom they are interacting.

Acquiescence

Acquiescence, also referred to as yea-saying, is “the tendency to agree with items regardless of their content.” Although there is no research consensus on when acquiescence occurs, several explanations have been proposed. One explanation interprets acquiescence as a personality trait and sees it as an outgrowth of “impulsive acceptance.” Another view sees acquiescence as related to “uncritical agreement” that is associated with the respondent’s logical consistency of attitudes, social taste and verbal ability. Narayan and Krosnick support the latter, noting a negative correlation between education and acquiescence. A third view, dominant in sociology and survey research literature, interprets acquiescence as a reflection of the relatively lower social status of respondents compared to the higher social status of interviewers or researchers posing the questions.

Research also finds acquiescence related to the content of the question posed as well as to situational factors in the data collection process. Individuals may be more inclined to respond as yea-sayers if the items or questions posed are ambiguous, neutral in desirability or vague.
Respondents also may be more prone to acquiescence if situational factors, such as time pressures and other distractions increase the cognitive demands placed on them. A patient is asked on a patient satisfaction survey to evaluate the hospital’s chaplaincy services (along with other hospital services that are provided). The patient really has not given this service much thought and only briefly interacted with a chaplain but feels the need to complete the survey before discharge. The patient, who just wants to go home, assigns the pastoral care service a positive rating presuming that others (the hospital staff that introduced this patient to the chaplain) think it is probably satisfactory.

**Leniency or harshness**

Individuals systematically may respond more negatively or positively, regardless of the question posed. This response tendency is specific and consistent with the respondent.

Two professional chaplains, with the same job description and job responsibilities, are asked to assess their overall job satisfaction. One chaplain actually is quite pleased with current job responsibilities but consistently rates job satisfaction, as well as other work attitudes, as only moderately favorable. The second chaplain’s rating of job satisfaction is consistently favorable, even though the chaplain’s general enthusiasm for the position reflects dissatisfaction.

**Critical event and recency**

Both critical event and recency response biases are related to respondents’ recall. Critical event response bias occurs when a dramatic event is given a greater weight in the evaluation than routinely occurring events. Recency response bias occurs when events or information presented more recently are weighed more heavily by the respondent than events or information presented in the more distant past. The example at the introduction of this article is an example of critical event or recency. The uncertainty created by the news article likely would override employees’ previously positive perceptions of the organizational culture.

**Halo effect**

Halo effect occurs when a participant’s response to a previous question serves as a trigger for determining responses to subsequent questions. Although halo effect generally is thought to suggest a positive bias in responses, it may be either positive or negative. The central issue is that an individual’s previously made assessment determines the pattern of later responses.

A hospital chaplain is asked to provide perceptions of the hospital’s electronic medical record system. In the past, the chaplain responded favorably to a question about the convenience of the central location of computers used for charting. Even though the chaplain has had difficulties with this new system and thinks that overall it is sometimes difficult to use, the chaplain will respond favorably to other questions because of the previous assessment of computer location convenience.

**Extreme response style**

Extreme response style is the “tendency to endorse the most extreme response categories regardless of the item content.” When provided a survey with a 5-point (Likert) scale, a particular patient will always respond using one of the two end points, either a “1” or a “5,” even though the patient’s view of some items is not in the extreme.

**Midpoint response style**

Unlike an extreme response style, a midpoint response style reflects the “tendency to use the middle scale category (or most moderate response alternative) regardless of the content.” When provided with the same 5-point (Likert) scale, a particular patient repeatedly responds with the neutral midpoint alternative, “3,” even though the patient’s view of many items is not neutral.
Recognition, mitigation and avoidance

Perhaps one signal of the maturity of research in a discipline area is recognition of its limitations accompanied by concerted efforts to improve its methodological rigor. Within chaplaincy research, attention has previously focused on the methodological limits in sampling strategies, sample sizes, research design and statistical analysis. This discussion has added another methodological issue, self-report response bias. While each of these concerns offers opportunities for research methodological improvements, improvements are constrained by the context and constructs in chaplaincy research. In many cases, changes that could result in a greater methodological rigor, e.g., a larger sample size, more elegant statistical analysis, must be weighed against factors that may inadvertently weaken other design dimensions and complicate interpretation.

Even with the limitations highlighted in this article, self-report data are not inherently flawed. In chaplaincy research, self-report data often are the most effective—and thus the most appropriate—way to glean respondents’ assessments of substantive issues.\(^{19}\) Self-report response bias does introduce variation into this research but its magnitude is not known. While it is unrealistic to think that response bias may be avoided completely, researchers may begin to address this problem by addressing it prior to, during, and after data collection. Increased sensitivity to the potential impact of response bias by consumers of chaplaincy research leads to increased caution in interpretation of study results. For both groups, thoughtful consideration of the potential impact of self-report bias compliments consideration of other research methodological dimensions, e.g., design, sampling strategy, sample size and response rate, statistical analysis.

The first step is acknowledgement of the potential for self-report biases even before collecting data. Researchers and consumers of research might begin by asking a few simple questions about their study.

- Who are the respondents? Are there characteristics associated with them that may make them prone to response bias? A significant perceived status difference between an interviewer and an interviewee, e.g., CPE supervisors interviewing CPE interns, could result in responses colored by yea saying or social desirability. Consider to what extent these status differences do or do not relate to the research question.

- What methods are being used to collect data? Face-to-face interviews may introduce the potential for social desirability. Vaguely worded questions and limited response alternatives may lead to patterned responses, e.g., extreme, midpoint, or consistency biases, halo effect. Assuming face-to-face interviews are the most feasible option, to what extent can the interview be tightly scripted, the interviewer rigorously trained? Would basic demographic information on the interview dyads, including the ages, genders and ethnicity of interviewer and interviewee, improve interpretation? Are alternatives to face-to-face interviews, e.g., mail, online, feasible and/or potentially effective? Should scaling be adjusted to add a midpoint (if a neutral position is seen as a realistic option) or removed (if definitive responses are seen as realistic options)?

- What is the context in which data are being collected? Situations where there is little control over extraneous variables, e.g., scheduling and time pressures associated with data collection, distractions due to noise/lighting/temperature, may result in a greater tendency for response biases to influence the results. Are differences in patient satisfaction surveys accurate reflections of changes in patient satisfaction if they are administered at different times—immediate predischarge compared to one week or one month postdischarge?

Prevention is not a realistic option but recognition is warranted and mitigation possible. For chaplaincy researchers at the planning stage, simple efforts such as providing a uniform and controlled time and environment for data collection reduces potential biases. Serious consideration of who is conducting the interview or focus group, or who is distributing surveys may help. Revising instrument instructions measurement scales and wording to eliminate ambiguity reduces the
potential for response biases. If concern about specific response biases still exists, items may be included in the survey or interview to offset these tendencies.

Sensitivity to the potential interactions between interviewer and interviewee, researcher and respondent, leads to subtle changes in data collection activities. Consistent interviewer/researcher training and monitoring addresses potential sources of bias before they surface. The use of neutral parties to conduct interviews or introduce surveys may reduce the magnitude of self-report response bias, but even with neutral parties, respondents still may want to cast themselves in a favorable light, second guess the desired outcome or be affected by a dramatic recent event.

Even before data collection, researchers can acknowledge the potential for self-report response bias. Items may be included in a survey or interview in an attempt to capture some of these biases. For example, the Marlowe-Crowne Social Desirability Scale (or versions of this scale validated for specific audiences) may be included in a survey to “tease out” respondents’ tendency toward social desirability bias. A recent study of chaplaincy interns included the measurement of social desirability to detect its influence on study results.

Mixed methods research, sometimes referred to as data triangulation, may be applicable within the context of chaplaincy research. Data are collected using several methods, yielding results that differ on key dimensions, e.g., qualitative/quantitative, primary/secondary. These data may be used to strengthen analysis and confirm confidence in the self-report data. For example, an employee satisfaction survey may reflect positively on the organization but the hospital’s personnel records may reflect lower retention, increased recruitment and higher absenteeism. This lack of congruency may reflect any number of potential sources of bias before they surface. The use of neutral parties to conduct interviews or introduce surveys may reduce the magnitude of self-report response bias, but even with neutral parties, respondents still may want to cast themselves in a favorable light, second guess the desired outcome or be affected by a dramatic recent event.

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Although surveys, interviews and focus groups are qualitative research methodologies, the results from these techniques may be quantified to reflect response distribution, range and frequencies. After data collection, statistical procedures are used to adjust for response bias. An in-depth discussion of these techniques, which vary in complexity from partial correlation techniques to sophisticated procedures, is beyond the scope of this article. However, a number of review articles and software products provide options for addressing response biases.

For consumers of chaplaincy research, recognition of potential self-report bias in research results promotes more astute understanding, interpretation and generalization of findings. All studies suggesting that patient satisfaction is promoted by a particular action by a hospital chaplain are not the same. A uniform pattern of favorable responses may signal overall favorability. Conversely, it may signal patients who are eager to be discharged, patients who are concerned about how providers perceive them or patients who think that they should provide the “right” answer. Untangling which of these explanations accurately describes a particular patient group may be even more important than recognizing their level of satisfaction.

Opportunities in chaplaincy research
The intent of this discussion is twofold: to provide chaplaincy researchers and consumers of chaplaincy research with greater understanding of self-report response bias and to promote research and research interpretation that acknowledges its potential impact on study findings. Self-report response bias is of critical importance, specifically because of the predominance and appropriateness of self-report data in chaplaincy research. Although this is one of several sources of methodological weakness, it is not a fatal flaw.Acknowledging the potential for self-report bias in coloring chaplaincy research results and giving thoughtful consideration to its impact on interpretation are wise and prudent steps that will improve the development and use of research in chaplaincy.


4 Chan, "So why ask me?" 303-36.


7 David A. Aaker, Vijay Kumar and George S. Day, Marketing Research (New York: Wiley and Sons, 2007).


9 Ibid.

10 Baumgartner and Steenkamp, Response Bias.


13 Baumgartner and Steenkamp, Response Bias.

14 Aaker, et al., Marketing Research.


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19 Chan, "So why ask me?" 303-36.


22 Baumgartner and Steenkamp, Response Bias.

Dealing with the Growing Complexity of Resident Chaplain Orientation

Paul E. Derrickson BCC • Angelina Van Hise BCC

The increasingly complex role of chaplain has necessitated more extensive orientations for clinical pastoral education (CPE) residents and students. This article describes an overlap period between graduating and incoming residents and highlights strengths and weaknesses of this model of orientation.

The role of chaplain has become much more complex

in the past three decades. This has required more extensive orientations for clinical pastoral education (CPE) residents and students. Various solutions have been proposed for coping with these increasing role complexities.1

The chaplain resident program at the Hershey Medical Center traditionally ran from September 1 to August 31. When the Human Resources Department changed to a biweekly orientation for new employees, the Department of Pastoral Services took the opportunity to begin the program in mid-August. This change provided an overlap between graduating and incoming residents.

The new pattern began with two days of orientation to the institution followed by an introduction to the department. Exposure to clinical areas was interspersed with orientation to department policies, procedures and protocols plus Association for Clinical Pastoral Education (ACPE) requirements. It also included sessions with other departments with which chaplains closely work.

Orientation structure

The typical structure of orientation to clinical areas occurred in three phases.

General conversation among all the residents and chaplain staff

Current residents spoke about each of their clinical areas, including the types of patients, spiritual issues likely to arise with different patient populations, current status of relationships with staff and typical interactions with families and their concerns.

Shadowing

New residents shadowed their experienced colleagues either individually or as a group. Following staff introductions and a few pastoral visits, the new residents selected their clinical areas. The database, which lists patients in the clinical area for each new resident was recalibrated to accommodate changes in clinical assignments. Graduating and incoming residents spent a few days together doing more in-depth orientations, including attending interdisciplinary medical staff rounds and/or other meetings pertinent to the chaplain’s work.

New residents also partnered with their counterparts in carrying the on-call pager. This enabled them to experience the chaplain’s role in traumas, codes, deaths, brain attacks, heart alerts and end-of-life ministries.

Ceremony of installation for the incoming residents and thanks/send off for the graduates

During the service, a CPE supervisor gave each new resident a pin with the department insignia, and graduating residents handed over their pagers as a symbol of their ministry. Afterward, incoming residents moved into the office space of the graduates.
Evaluating the changes

Feedback from residents indicated both groups benefited from the new process. Allowing the graduating resident chaplains to assist in the orientation of their successors encouraged them to pass on much institutional and specific knowledge about their clinical areas. In addition, they appreciated knowing “their areas” were in good hands. They also found themselves reflecting on the year through the eyes of the new residents.

Some, who did not like saying goodbye, complained that the time was too long. Others found that allowing them to share what they knew and to appreciate what they had learned by sharing it was helpful to their grieving process. The hand-off also gave a structure and expectations to the graduating residents’ final month and helped to prevent “premature emotional leaving.”

The incoming residents felt much more grounded by the time they assumed on-call and clinical responsibility. Supervisors sensed that they had a deeper appreciation for the medical center, its mission and the role they were being asked to play.

Specific issues

Overall, the feedback was very positive; however, some incoming residents commented that this process did not fit their learning style, namely by not providing enough obvious structure. In the same vein, some graduating residents wanted much clearer instructions as to what they should be telling the new residents.

Vacation time also posed some challenges. Previously, the CPE supervisor scheduled vacation during the week between final evaluations and the beginning of the new resident year. This problem was solved by moving the final evaluations for the graduating residents last unit back a week to the end of July. Typically graduating residents often saved vacation time to use in August, which complicated the scheduling and structuring of the overlap time. In previous years, residents had been required to take one week’s vacation during the December and April practicum periods. They were now asked to also use the rest of their vacation time before August, unless they needed to save a day or two for job interviews.

A previous issue that the new process actually alleviated centered on the fact that students who had taken an introductory unit at Hershey Medical Center frequently returned for the residency program. This made orientation needs very diverse across an incoming group. Prior to initiating the overlap orientation, some of these returning students had felt pressure to orient their new peers. Having graduating residents on hand relieved incoming residents who had previously trained at Hershey of the responsibility to orient newcomers.

Conclusion

Ultimately, all participants—supervisors, staff chaplains and residents—found this orientation process to be helpful with most recommendations focused on tweaking rather than totally revamping it. The transition time helped graduating residents to focus on a task during their final weeks and gave incoming residents an extended period of guidance to help them acclimatize to their new setting. Supervisors found that it strengthened the orientation part of the residency program without adding the burden of additional time or effort.

1 A. Tartaglia, D. Dodd-McCue, B. Horrocks and K. Faulkner, “Enhancing students engagement and critical thinking during hospital orientation for level 1 CPE students,” Chaplaincy Today 25, no. 1 (Spring/Summer 2009), http://www.professionalchaplains.org/uploadedFiles/Publications/CT_free_access/25_1tartaglia.pdf

Living as a Burn Survivor: Implications for Pastoral Care

Douglas S. Phillips BCC

As chaplain serving a burn unit and trauma ICU, the author discusses common issues faced by burn survivors and their families. Writing from his personal experience, he also explains how recognition of his Shadow Gifts and incorporation of them into his ministry enable him to "pay it forward" to others who walk the path of healing from burn injuries. A reflection based on his experience as a burn survivor was published earlier this year. See “Called through Grace,” PlainViews 9, no. 23 [January 6, 2010]: Spiritual Development.

A COLLEAGUE LED ME TO THE BURN CENTER, opened the door and literally shoved me inside. My legs shook, my mouth felt dry and my stomach churned. Suddenly, I was eleven again.

On a cold morning back then, I’d leaned too close to the stove and my flannel shirt had caught fire. I panicked and ran before I finally remembered to stop, drop and roll. By then, I’d been burned over 40 percent of my body. I nearly died in the hospital from a subsequent blood infection.

In the immediate aftermath, I felt ashamed for having brought this injury on myself and for encumbering my family with concern, but during my hospitalization, I met a compassionate chaplain. He helped me to heal from more than the physical injury by teaching me to forgive myself. His accepting me made me feel like God had forgiven me. It was a simple and profound lesson in grace that served as a foundation for my later entry into ministry.

Following my ordination, I spent eighteen years in the parish before transitioning into hospital chaplaincy. During clinical pastoral education (CPE), I had no trouble visiting any other part of the hospital—not even the morgue. The one place I consistently avoided was the Burn Center, which ironically was next to the chapel and pastoral care offices. God has a strange sense of humor.

Discovering **Shadow Gifts**

I was introduced to the Jungian concept of the **Shadow Gift** during CPE. The Reverend Susan Lunning, my supervisor, encouraged us to discover our individual Shadow Gifts, referencing Dr. Patrick B. McGinness:

> [The shadow is] the unconscious repository of an individual’s unacceptable impulses and characteristics (and painful experiences). Disowned and unacceptable parts of ourselves are shoved out of our awareness into the shadow. We used the shadow to hold those parts of ourselves that we learned were bad or unacceptable.¹

McGinnis says the Shadow Gift is not always a negative experience; it also contains portions of beauty and goodness that one cannot own—the lost self.

Discovering my Shadow Gift meant revisiting my walled off shame and horror from the burn experience and reintegrating it into the rest of my psyche. It meant facing an old demon and transforming a weakness into a strength. Even though I knew there was healing and new life to be
found in reopening this old wound, I desperately wanted to avoid reentering memories of the sights, sounds, smells and ultimately, the horrific pain of being a burn patient.

Though it was a shock when my colleague shoved me through the Burn Center door, once I got my bearings, I noticed a weight falling away. Easing into it gently, I first visited patients with minor burns who were about to be discharged. Over time, I worked into more serious situations. Although I’ve now learned to effectively separate the patient’s pain from my own, occasionally I encounter tactile reminders that bring me back to my own pain. When flashbacks occur, I’ve found the best way to work through the experience is to acknowledge them and deal with them directly in supervision. I have found that journaling is cathartic and helps immeasurably in coping with the daily horrors of this ministry.

Every bit as much as the chapel, the Burn Center is my spiritual home. I serve other trauma units, but nowhere else do I identify more with the patients, their families and the staff. Burn injuries have been described as the worst injury that the human body can endure and survive. Part of me did die when I was burned, but, like the Phoenix rising from the ashes, I also was reborn. I carry my scars, but now claim them as my badge of healing, rather than shame. It’s been a sacred privilege to shepherd others through their own transformations.

Common issues for burn survivors and their families

Having said a lot of hellos and goodbyes to burn patients and their families through the years, I’ve noticed some common burn-related issues and emotions relevant to their spiritual and emotional care.

Guilt and shame
Burn patients feel these emotions most frequently when the accident occurred because of inappropriate risk taking, such as using gasoline to light a campfire. Friends and family may feel that they have failed to protect burn patients. Whether or not these feelings are appropriate, they are powerful. Sometimes burns happen because of abuse and/or neglect, e.g., inappropriate anger directed at a child for soiling a diaper, leaving an elderly relative unattended to fall asleep with a lit cigarette. Some guilt and shame is deserved, but other times it is inappropriate and undeserved. Only when these feelings are acknowledged and explored will healing begin. The chaplain’s accepting presence may facilitate the process of forgiveness.

Anger
Because of cultural prohibitions, it’s often difficult to acknowledge anger directed at people who are sick or injured. Frequently, such feelings simmer beneath the surface and leak out in poisonous ways. Deservedly or undeservedly, anger often is directed at other family members out of a need to place blame or responsibility for the accident. Large burns require long hospitalizations. Families find their lives disrupted; they feel frustrated and helpless, so the hospital staff becomes a convenient target for their anger. Typically, this last originates from perceptions of quality of care and/or perceived miscommunication/lack of communication. Chaplains may be instrumental in averting problems by leading patient/family meetings with the hospital staff so that questions may be answered and concerns addressed in a calm manner. Similarly, in caring for staff, chaplains are invaluable in alleviating or preventing compassion fatigue and burnout.

Posttraumatic shock
In his 1996 book, The Inner World of Trauma: Archetypal Defenses of the Personal Spirit, Donald Kalsched writes about posttraumatic stress disorder (PTSD) and our human attempts to adapt to trauma. We do adapt, he says, and our defenses—shock, dissociation, disorders of memory and focus—are survival mechanisms. When traumatic events are repeated familial or environmental forms of abuse, our defenses kick in and block, in various ways, the acute aspect.
In other instances, e.g., military trauma, sudden violence, accidents, burns, our defenses are overwhelmed and unable to cope. Visual reenactments, sounds, smells and colors may trigger recurrent, unpredictable and vivid memories of the trauma. These nonverbal but somatic and psychological memories remain lodged in our brains long after the physical injury has healed. For example, burn patients often experience recurring nightmares. Decades after my own injury, the smell of burned meat makes me queasy, and I want to run from the room.

Physical pain, hospitalization and, later, the searing sense of shame, anger and accruing worry cannot be shaken from either body or mind. When the immediate shock of a trauma lessens, the personal horror deepens. To be caught off guard is a state of defenselessness, like an infant’s speechless cry. Kalsched asserts the only way out of this kind of trauma is through it. Needless to say, this is a perilous journey.

Grief and loss
Loss always accompanies a burn injury though it may come in varied forms:

- Loss of appearance, whether by scarring or amputation.
- Loss of the former self.
- Loss of loved people and/or pets.
- Loss of home and possessions.
- Loss of employment because of time spent away recuperating, being no longer able to do the job and/or loss of the worksite.
- Loss of time and sometimes loss of relationships. Burn injuries often require long-term hospitalization and rehabilitation in faraway places. Following house fires, families may be geographically separated as well. This may shift relationship dynamics, and marriages may not survive. The patient’s changed appearance also may be a factor.
- Loss of control over one’s life and future.

All these losses must be grieved because part of the past died with the fire. Chaplains may be helpful in exploring individual losses, aiding the healing process and helping to forge a new image and reality.

Pain
The skin has billions of nerve cells. Unless these were destroyed, there are few things more excruciatingly painful than a burn. As pain colors how we see the world and affects our ability to heal and to find hope, pain management is a critical part of burn care. Great strides have been made in making burn pain more tolerable, thus aiding in healing and restoring a sense of well-being; however, it cannot be completely eradicated. Sometimes burns cause permanent damage to nerve cells leaving patients to endure a measure of chronic pain for the rest of their lives.

Burn patients may downplay their level of discomfort out of fear of becoming addicted to pain medication and suffer unnecessarily as a result. Chaplains may be advocates for patients, encouraging them to speak up for their needs with regard to pain management.

Fear of disfigurement
Life is forever changed by a burn accident. Not only are there physical scars, there also are psychological scars. Whether or not it actually shows in their appearance, burn patients feel differently about themselves and are more self-conscious because of their injuries. The care of scar tissue becomes a lifelong responsibility. Healing from a large burn requires them to grieve the loss of their former lives and to make peace, not only with changes in their appearance but changes in...
their very selves. Scar tissue is tougher than normal skin; recovering burn patients also need tough psychological scar tissue to protect their spirits from the stares of people who see their changed appearances. Chaplains may help burn patients claim their scars as badges of strength and survival.

**Sexual dysfunction**

Because of the scarring nature of large burns, patients’ self-perception often changes. Similarly, spouses/partners may see them differently. Beyond visual appearances, nerve damage may result in chronic pain or numbness that affects sexual response. Often severely burned patients withdraw socially. An important part of burn treatment is offering spiritual and psychiatric intervention for patients and their partners in order to help them cope with this new reality.

**Substance abuse and mental illness**

While some burn patients are simply victims of circumstance, the majority carry predisposing factors. Dr. Charles A. Welch states that there is a high incidence of burns occurring to people in altered states.³ Citing a study of 155 adults who had sustained burns, MacArthur and Moore found that 59 percent of women and 38 percent of men had such predisposition. Drug and alcohol abuse was the most prevalent factor, affecting 36 percent of the predisposed group; 21 percent suffered from senile degeneration; and 20 percent had been diagnosed with chronic mental illnesses, e.g., schizophrenia, bipolar disorder. Of the predisposed persons, 76 percent suffered their burns at home, typically in a fire involving a bed or mattress.⁴

This high-risk profile was confirmed by Rockwell et al., who found that the majority of adult burn victims in their study were unemployed, depressed and acting carelessly at the time of the burn. Similarly, children from disturbed or disadvantaged families are at increased risk for burns.⁵

**Infection**

The skin is the body’s largest organ and serves as a barrier to infection. When it is compromised, the body is left wide open to opportunistic bacteria. Controlling infection is a critical part of burn care as this is the most common complication and the major cause of death. Despite the fact that new antibiotics have done wonders in containing or eliminating once fatal infections, there is continued mutation into drug-resistant strains.

It is crucial that anyone who visits a burn patient honor all infection control protocols to the letter as the patient’s life literally is at stake. The necessary gowned, gloved and masking required to enter a burn patient’s room is a poignant reminder of isolation and alienation from the mainstream of life. Burn patients are often lonely as people are less inclined to visit out of fear as well as the inconvenience of infection control procedures. Chaplains who are willing to go the extra mile to bridge the gap may be invaluable reminders of God’s shepherding presence through this difficult journey.

**Community and support**

Ministry to family is critical throughout the hospital stay. Meeting separately with patients and family member may provide an opportunity for each to say things that they would not feel at liberty to disclose in the other’s presence. An additional way in which chaplains may be valuable to recovering burn patients and families is to create a network of former patients/families who are willing to serve as guides and resources to those new to the journey.

**A personal note**

Although other people’s burn stories often are quite different than mine, we do share a measure of commonality. However, unless it feels extremely relevant and appropriate, I don’t share my own story with them. When I do, it is just before they are discharged.
In sharing my own burn story through this article, I realize how much my future ministry has been shaped by this event. From my own scars and suffering, I am linked to others who bear their own pain and woundedness. I see God’s hand at work both in the pain and in the healing while discovering my Shadow Gift. Finally, I am grateful for the angels God put in my path and dedicate my life to “paying it forward” to others who venture down this same road.


The Collegiate Sports Chaplain: Kindred or Alien?

Steven N. Waller • Lars Dzikus • Robin Hardin

This paper examines the role and function of collegiate sport chaplains. Very little research has been done on this subject. To date there have been only two scholarly papers written on the subject.

The core elements of the collegiate sport chaplains’ work centers around encouraging; praying for spiritual guidance; responding to emergencies; being a liaison with hospitals, clinics or other institutions; and counseling. These key tasks are comparable to those of traditional chaplains. There are a minimal number of training and certification initiatives in place. Sport chaplains tend to affiliate with organizations such as the Fellowship of Christian Athletes (FCA) and Athletes in Action (AIA) and are less inclined to affiliate with traditional organizations such as the Association of Professional Chaplains (APC) or the American Association of Pastoral Counselors (AAPC).

This paper presents data from one study on collegiate sport chaplains and explores opportunities to improve the quality of sport chaplaincy through affiliation with chaplaincy organizations such as APC, AAPC, embracing credentialing and collaborative training initiatives. Material presented also appeared in “Sport chaplaincy: Problems and promise,” Journal of Issues in Intercollegiate Athletics and is reprinted with the consent of JIIA. http://csri–jilia.org/documents/publications/research_articles/2008/JIIA_2008_5_Waller_Publish.pdf

SPORT CHAPLAINCY AS A PROFESSIONAL and volunteer endeavor has evolved over the past half century in the United States. In light of the similar work that the sport chaplain does this type of chaplaincy is kindred to more traditional types of chaplaincy, e.g., hospital, military, corporate. The term “kindred” connotes something that is related, having similar ancestry or origin.

In contrast, some argue that sport chaplaincy and its practitioners are more “alien” or emanating from a very different family, people, or place, or the state of being an outsider. Very little is known about sport chaplaincy as a facet of ministry. Courses in sport ministry or pastoral care for athletes are not mainstays in pastoral care and counseling curricula. More commonly, sport chaplains operate in isolation from other credentialed chaplains reinforcing the stigma of “alien.”

An increasing number of collegiate athletic departments at public, private and religious colleges and universities utilize the services of team chaplains across sport areas. For example, in the most prominent National Collegiate Athletic Association (NCAA) conferences, such as the Southeastern Athletic, Big Ten, Big East, Atlantic Coast, Pacific Ten and the Big 12, sport chaplains are affiliated with most athletic departments. Sport areas such as football, basketball, track and field, baseball, softball and swimming typically have one or more sport chaplains assigned to them. These usually are unpaid, appointed positions that allow individuals to remain religiously neutral while serving administrators, coaches, and players.1 Generally, in collegiate athletic departments, the individual responsible for the spiritual care of a team is referred to as the chaplain or “sport chaplain.” Lipe notes that “a sport chaplain provides pastoral care for the sports person and the broader sports community including coaches, administrators and their families.”2
The primary purpose of this paper is to introduce the specialized and emerging field of sport chaplaincy to practitioners of professional chaplaincy and to provide an overview of the role and functions of this specialty. It also includes a descriptive profile of the collegiate sport chaplain and presents key findings from a pilot study on collegiate sport chaplaincy in the United States.

**Sport chaplains defined**

In the modern era, the term sport chaplain commonly is utilized to define the role and function of a lay or ordained member of the clergy who provides spiritual care for athletes. Lipe (2006, 5) argued this term is losing its usefulness in light of the many different approaches used to serving athletes. He offers a more definitive series of titles for the sport chaplain along with their associated responsibilities.

*Evangelistic chaplains*

Their goal is conversion to Christ and the proclamation of the Gospel. They typically work with a team or club and also serve at major sporting events. They hold chapel services, and their ministry is primarily program, event and message driven.

*Pastoral chaplains*

Their goal is to inspire personal piety (Christ-like behavior) and spiritual growth. Their approach is more relational, and they employ methods such as Bible study and personal discipleship to emphasize the spiritual dimension of life with those whom they serve.

*Sport mentors*

Their goal is more comprehensive and seeks both a wholehearted, “Christ-honoring” life within sport, e.g., relationships with the sport, teammates, coaches, support staff and officials, and outside of sport, e.g., relationships with spouse, family, friends, and church. This approach is evangelism and discipleship based on the individual’s journey with biblical application in the sport experience for faith and life. They approach spiritual matters with a long-term focus, committed to the whole-life development process of each person. While evangelist chaplains and pastoral chaplains may simply tolerate sport as a way to minister to people involved in it, the sport mentor fully engages the sport, its culture and all those who participate in it.

Additionally, the National Institute of Sports (NIS) and the International Sports Professionals Association (ISPA), two organizations that advocate for sports counseling, utilize the term “sports pastoral counselor” to describe individuals who counsel and provide spiritual care for athletes. Athletes in Action (AIA) and the Fellowship of Christian Athletes (FCA), both broad-based, parachurch organizations, label those who serve players and coaches in a spiritual capacity as “character coaches/chaplains.” Despite this plethora of names, sport chaplain is the most commonly used.

**Work of the sport chaplain**

In the collegiate ranks, the duties and responsibilities of sport chaplains are diverse and often influenced by the role and function of the office or unit of the university within which the position is located. Three common offices in which sport chaplains may dispatch their duties are the Office of Student Life, Athletics Department or the campus-based office of a parachurch organization such as AIA or FCA. According to FCA, the sport chaplain performs an assortment of duties, including the following:

- Leads and coordinates chapel services.
- Provides personal care to players, coaches and support staff.
- Alerts coaches to critical issues that could affect the program.
- Is available and equipped at all times to help in crisis situations.
- Provides training and resources for character development and life management skills.
- Prays for, encourages and exhorts players, coaches, coaches’ families and support staff.

For more than a half century sport chaplains have been at the forefront of triumph and tragedy in collegiate sports. With a growing degree of frequency, the collegiate sport chaplain solely, or in collaboration with other campus chaplains, steps in to manage the best and worst of events including player eligibility, balancing academic loads, family crises, injury, death of teammates, coaching changes, weekly performance, media commentary and spiritual concerns.

**Training of sport chaplains**

While the core motivator for some Christian sports chaplains may be proclamation of the Gospel, the foremost competency is pastoral care. The chaplain’s role sometimes is construed as a “spiritual and pastoral safety net.” Chaplains may be used in informal situations—as a listening ear, friend or counselor—because of their underlying spiritual dimension along with the promise of confidentiality, trustworthiness, and neutrality. They also may be called on for other religious reasons, such as officiating at weddings or funerals. Training and credentialing are necessary to facilitate professionalism in the performance of such duties and to provide an acceptable standard of care.

Commenting on the need for meaningful training in sport ministry chaplaincy, Connor states that “the quality of training will have a direct bearing on the quality of ministry.” Currently, no single organization serves as a clearinghouse for credentialing sport chaplains although several academic institutions and faith-based organizations offer training programs. Neumann College and Baylor University train chaplains in-house to serve athletes on their own campuses. FCA is a major provider of collegiate sport chaplains, particularly in the southern states, and Auburn University has functioned as a home for FCA’s chaplain training program. The following describes these programs in greater detail.

**Neumann College**

A Catholic institution located in Aston, PA, Neumann sponsors a one-day training program for individuals interested in working as volunteer sport chaplains. The training initiative is jointly sponsored by the Center for Sport, Spirituality and Character Development and the Department of Pastoral Care and Counseling. The key elements of the training include prayer, listening skills, sport and spirituality, boundary issues and personal reflection. On completion of the program, individuals are eligible to serve one of the college-affiliated sport teams.

**Baylor University**

The world’s largest Baptist university, Baylor is located in Waco, TX. Its program is unique as control of the sports chaplaincy program, an outgrowth of the vision plan Baylor 2012, was returned to the athletic department. The primary aim is to provide players an opportunity to grow spiritually and individually.

Volunteer chaplains generally are selected by coaches and serve baseball, men’s basketball, golf, softball, track and field, football and volleyball teams. They represent a range of experience, including associate pastor, minister of education, FAC area director, Baylor employee and several individuals associated with university ministries. Baylor chaplains encourage athletes to participate in weekly Bible studies, locate guest speakers for their Night of Champions, collaborate with head coaches to coordinate chapel services and develop opportunities for student athletes to serve the university community.
The sports chaplaincy program, titled the “6-10 Sports Ministry Initiative,” fulfills Imperatives VI and X of Baylor 2012. Imperative VI emphasizes understanding life as a stewardship and work as a vocation, and imperative X encourages coaches, student-athletes and staff to “compete with excellence, as designed by God.”

In recent months, the Baylor Athletics Department, in collaboration with George W. Truett Theological Seminary, began deliberations toward developing a new concentration in sport ministry as a part of its current master of theological studies (MTS) degree. This concentration, which will provide training in theology, pastoral care and sport ministry, represents an important first step in formalizing training for sport chaplains.

**Fellowship of Christian Athletes (FCA)**
This nonprofit, interdenominational ministry was founded in 1954. In 2007, FCA reportedly reached more than 340,000 participants on 6,803 junior high, high school and college campuses through clubs, Bible studies and special events (Fellowship of Christian Athletes 2008). Its training program for “Sport Character Coach/Chaplains” is outlined on the Web site (http://www.teamchaplains.org/training/). Requirements that candidates must meet include the following:

1. Completion of the online FCA Character Coaches/Chaplains Training that includes an application process called the Ministry Leader Application.
2. Communication with the FCA staff prior to the season for planning, prayer and resources.
3. Communication at the end of the season for evaluation and reporting of results.
4. Connection with the FCA Character Coaches/Chaplains Network for ongoing training, encouragement, resources, information on regional training opportunities and other information from those who are actively engaged as sport chaplains.

The training program is segmented into the following units or sessions: Relationships, Attitudes, Presence and Strategies, and Methods and Tools.

In 2007, FCA published a Chaplain Training Manual, which comprehensively outlines the duties and responsibilities of FCA chaplains. It outlines the structure of FCA and elaborates on the reporting relationship between chaplains and athletic departments. Following are some of the subjects covered:

- Strategic methods for fostering relationships on campuses.
- "How to" items, which address applied methods for interacting with teams.
- Role and function of prayer in the work of the sport chaplain.
- Administrative work of the chaplain, including steps to avoid violation of NCAA rules and regulations (FCA Training Manual 2007).

The FCA intends to use the new training manual to establish a standard for training sport chaplains affiliated with the organization.

**Auburn University**
Under the direction of Wes Yeary, FCA director of chaplaincy training and development and former Auburn head chaplain, Auburn has coordinated a chaplain training and internship program, one of the first in the nation. Since 2007, this public institution located in Alabama, has trained and dispatched more than two dozen sport chaplains. The nine-month program, which utilizes a structured training guide also developed at Auburn, includes familiarity with the Christian Bible,
observation of campus ministries, applied ministry experience working with student athletes and a final sport chaplain internship; however, no certification is offered on completion.

**Credentials**
Currently, there are no standardized or commonly accepted criteria and competencies for certification as a collegiate sport chaplain in the United States. The majority of persons practicing sport chaplaincy may be ordained within a religious denomination, may have some level of theological training, perhaps even a seminary degree. However, they perform their duties without the benefit of an official credential.

The National Institute of Sports Professionals/International (NISP), an advocate of the credentialing of professionals working with collegiate athletes does issue a “Certified Sports Professional” certificate. The Sports Professional Certificate addresses the need for a national standard of training and education for this area of specialization, including those certified as “Sport Pastoral Counselors.”

NISP notes that “Certification requires a state license or employment by an accredited institution and experience in a related field. Certification is renewable every two years. A diplomate, the certification issued based on the highest level of demonstrated professional competency, requires advance training and experience in working with athletes. Diplomate status is renewable every two years. Six continuing education units are required for re-certification.”

**Profile of the collegiate sport chaplain**
A recent pilot study conducted by the authors of this article provided a descriptive profile of collegiate sport chaplains. The purpose of this research project was to explore the state of collegiate sport chaplaincy. The study addressed three key questions:

1. What training do collegiate sport chaplains have?
2. What affiliations do collegiate sport chaplains have?
3. What role do collegiate sport chaplains see themselves having?

**Methodology**

**Sample**
This study targeted chaplains who work with student athletes and sport teams at collegiate institutions in the United States. They were identified using the FCA directory, a list of contacts from the Institute for Sport, Spirituality and Character Development at Neumann College and the researchers’ personal contacts. The result was contact information for 149 chaplains, yielding a convenience sample that was readily accessible (Warner 2008).

**Data collection**
Institutional Review Board (IRB) approval at the department and university levels was obtained, and a questionnaire was then placed online. An introductory e-mail was sent to identified chaplains with a follow-up after ten days. A final reminder was sent seven days later, and data collection ceased seven days after that. The survey was open for respondents for twenty-four days.

Fifty-five chaplains completed some portion of the questionnaire. All questionnaires were used even if respondents answered only one question, which led to varying numbers of responses for individual questions. An overall response rate of 37 percent was established.
Survey questions

The first part of the survey consisted of twenty-four questions focused on descriptive data related to demographics, education/training, professional affiliation and roles/responsibilities. The second part asked participants to indicate their level of agreement with ten statements regarding their duties and responsibilities as collegiate sport chaplains using a Likert-scale where 1=Strongly Disagree and 7=Strongly Agree. A copy of the survey instrument is available on request (swaller2@utk.edu).

Results

Demographic profile and religious affiliation

The mean age of the respondents was 46 years with a range of 24 to 73 years. A significant majority identified as male (80.0%, n=40) and white (78.7%, n=37).

Over one-third (37 percent n=20) listed Protestant as their religious preference with 75 percent (n=15) of those indicating a Baptist affiliation. (See Table 1.)

In terms of employment/ministry setting, respondents were almost evenly divided between private and public institutions. Of the respondents affiliated with private schools almost 60% (n=15) were Catholic. Most (76 percent n=41) chose the title of chaplain, in preference to pastoral counselor, sport mentor or “other” as that which best describes their position. The seven who chose other listed titles such as administrator, AIA staff, character coach, life skills coach, teacher or women’s campus director.

Of those who responded to the question on professional affiliation most (83% n=25) listed FCA. Only 32.0% (n=16) hold full-time, paid positions. Of these, eleven are affiliated with FCA and two with AIA. Regardless of type of position, most (74%, n=37) work within NCAA Division I institutions.

Religious/theological training

With respect to religious/theological training, MDiv and MA were the degrees most often cited. Four respondents have doctoral degrees (PhD or DMin). The most common specialization listed was pastoral care and counseling although a quarter of the respondents indicated that they had no specialization.

Approximately two-thirds of the respondents (64.8%, n=35) were ordained by a religious organization to practice ministry. More than three-quarters (81.5%, n=44) indicated that they provided counseling services for players and coaches, but only two of 53 (3.8%) responded affirmatively when asked if they were licensed professional counselors.

Agreement on key functional tasks

Table 2 presents the results pertaining to agreement on key functions of collegiate sport chaplains listed in descending order. Offering encouragement, emphasizing spiritual development and prayer received the highest levels of agreement.

Chaplaincy affiliation and credentialing

To gauge the respondent’s involvement with professional chaplaincy organizations that go beyond the narrow focus on collegiate sports, participants were provided with a list of five national chaplaincy organizations—American Association of Pastoral Counselors (AAPC), Association for Clinical Pastoral Education, Inc. (ACPE), Association of Professional Chaplains (APC), National Association of Catholic Chaplains (NACC), National Association of Jewish Chaplains (NAJC)—and a “none of these” option and asked to indicate their affiliations. Of the respondents, AAPC and the National Institute of Sports Professionals (NIS) each had one member, possibly the same person.
Although the majority of respondents in the sample (60 percent, n=30) supported a standardized credentialing program, they disagreed as to the best source. Sport specific organizations received the most support: FCA 70.0% (n=30), AIA 43% (n=13), NIS 27% (n=8). Only four respondents (13%) named APC, and 2 (6.7%) selected AAPC.

**Discussion**

The central aim of this article was to highlight the ministry of sport chaplains working within college athletic programs in the United States. As an emerging sector of chaplaincy, titles, standards of practice and training still are in foundational stages.

Clearly, sport chaplain is the more commonly used title. Over the past five years, training programs have been developed; however, they are not standardized. Content and rigor vary widely as does availability. In short, none compares to opportunities offered through AAPC, APC, NACC or NAJC. Further, existing credentialing is not competency based. The NISP certification is based on the evaluation of credentials, specifically, resume, transcripts, continuing education courses, ordination credentials and any pertinent licenses.

This pilot study provided a portrait of college sports chaplains and how they function. While 24 percent (n=38) indicated that they use organizations for chaplaincy training and continuing education other than those listed in the questionnaire—including the institutions in which they serve—33% (n=17) indicated that they do not pursue any additional chaplaincy training and/or continuing education.

An important issue collegiate sport chaplains must consider is demonstration of competencies for ministry. Organizations such as FCA offer online training units where some level of competency with respect to sport ministry may be demonstrated. The training programs at Auburn, Baylor and Neumann offer the opportunities for reflection on the theology behind the work of the sport chaplain, but as yet, there are few outcomes-based measures in place to demonstrate competency in this area. Grossoehme posits that demonstration of competencies not only is an important step toward certification but also serves as a “quality assurance” measure. Compared to chaplains who are credentialed through organizations such as APC, NACC or NAJC, sport chaplains may have a distance to travel to gain parity.

Noticeably absent from the training regimen of sport chaplains is the clinical pastoral education (CPE) requirement. Despite the fact that both Auburn and Neumann have supervised practicum elements in their programs, neither is comparable to CPE. As Delong and Turner note,

> Chaplaincy uses clinical pastoral education (CPE) as the primary training method to equip those seeking to become chaplains. And, like other professional groups chaplaincy uses a certification process to ensure a standard level of professional competence for those in the field.  

CPE may be an invaluable experience for the collegiate sport chaplain as this is where theology and practice are linked. Given the range of duties and responsibilities and the volume of traumatic events that occur, CPE should be given strong consideration as a part of the sport chaplain’s training regimen. Understandably the different nature of the work of the sport chaplain may present unique challenges because of the nontraditional setting and the potential lack of supervisory personnel with expertise in sport chaplaincy.

As a significant number of collegiate sport chaplains engage in pastoral counseling without appropriate credentials and/or a license, this is an area that should be addressed expediently for both ethical and legal reasons. There is a line between encouraging players, families and coaches and providing counseling services. Despite the fact that many of the respondents in the 2009 study are degreed in theology, pastoral care and/or counseling, the critical issue is clinical training. This
may explain the large percentage of sport chaplains who support credentialing but not as administered by AAPC, ACPE, APC, NACC or NAJC.

**Limitations**

There still is much to learn about the role and function of the collegiate sport chaplain. This paper is grounded in a very small amount of literature available about this specialized group. Sport chaplaincy is an emerging vocation. This paper and the studies cited are descriptive in nature; therefore, no statistical analysis has been conducted to test suppositions about this population.

Anecdotal evidence supports the fact that there are perhaps double or triple the 149 sport chaplains who were surveyed via this questionnaire. Many are unaffiliated with any sports organization, so their names do not appear in directories or databases. In addition, separation of church and state, especially within public institutions, means that the chaplain’s salary may be paid by an independent source, such as a private donor, FCA and/or AIA. Such chaplains may not be listed as a part of the team support staff even though they serve within the athletic department.

Respondents in this sample were primarily Christian and do not reflect the interfaith tradition of chaplaincy as a vocation. Both public and private universities increasingly recruit non-Christian athletes who need spiritual care and therefore these institutions also are seeking rabbis and imams to work alongside their Protestant and Catholic colleagues. As the sample was homogenous, some of the respondents may have reported what they perceived to be the “right” responses based on their familiarity with the subject matter and for the sake of social desirability. Warner terms this bias as “yea-saying.” Despite the fact that e-mail addresses of chaplains participating in the survey were concealed, there was no way to control for conversations between respondents about the survey.

Additionally, the study did not solicit information about the importance of named responsibilities, which may have yielded a more accurate assessment of duties by priority. Finally, a mixed methods approach to studying this population of chaplains might have yielded additional insights into their role and function as well as their desires to interact with traditional chaplains and their affiliate organizations.

**Conclusion: kindred or alien?**

The available literature and data generated from studies suggest that there is value to the work that collegiate sport chaplains do. The critical question is what qualifications should the collegiate sport chaplain possess? Should a person who provides some level of spiritual care for collegiate athletes be called chaplain? Is character coach or sport mentor a more appropriate title? In light of the argument that one may operate effectively as a lay minister in the capacity of chaplain, should the sport chaplain be concerned with a seminary education, CPE and affiliation with the broader community of professional chaplains?

One of the major assertions of some collegiate sport chaplains is that they do not feel they fit in with professional chaplains because of the distinct difference in the nature of their work, theological training and the absence of a CPE requirement. Although these differences do not diminish the importance of the work or the sports chaplain, theological training, CPE and professional continuing education all increase professional competence. One chaplain working at an SEC university noted that he did not want to feel like “the other” or an outsider if he joined organizations like AAPC or APC. He further noted that he was more comfortable within the ranks of fellow chaplains associated with FCA or AIA.

How do we bridge the gulf between collegiate sport chaplains and professional chaplains? Perhaps an appropriate beginning is to dialogue about professional chaplaincy and where sport chaplaincy fits within the larger structure. The success of this dialogue mandates inclusion of organizations
from both groups, including APC, AAPP, NACC, NAJC, FCA, AIA and NISP, as all play some role in training and credentialing chaplains.

Taking deliberate, constructive actions toward identifying training and credentialing aspirations is another important step. Further examination of the existing training programs for collegiate sport chaplains offered by the FCA, AIA, NISP, Auburn, Baylor and Neumann Universities will be valuable. Examination of continuing education programs that highlight the work (theology and methodology) of collegiate and professional sport chaplains also should be part of this process.

The development of a CPE program in the area of collegiate sport chaplaincy, in collaboration with the ACPE, would benefit collegiate and professional sport chaplains greatly. The profession of chaplaincy is becoming increasingly diverse with new subspecialties emerging periodically. Chaplains must be willing to conduct and to participate in related research.

In the final analysis, in the eyes of professional chaplains, are collegiate sport chaplains who lack the trappings of education, training and credentialing kindred or aliens? That question can only be answered with more scholarly inquiry and an open dialogue.

Author note
Material presented in this manuscript also appeared in “Sport chaplaincy: Problems and promise,” Journal of Issues in Intercollegiate Athletics and is reprinted with the consent of JIIA.


3 Ibid., 5.
4 Ibid., 6.
8 Ibid.
9 FCA, Chaplain Training Manual.
11 FCA, Chaplain Training Manual.
17 Grossoehme, “Patterns of unmet competencies,” 13-16.
Table 1 – Demographic profile of collegiate sport chaplains

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Table 2 – Key responsibilities of collegiate sport chaplains

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<td>It is important to hold chapel services</td>
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<td>I minister to student-athletes immediately following competition</td>
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<td>I network with chaplains within my school</td>
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<td>I minister to student-athletes during competition</td>
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<td>I network with other chaplains at other schools</td>
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N=number of responses
M=mean level of agreement (1=strongly disagree and 7=strongly agree)
Consoling Rachel:
A Bereavement Program for Perinatal Loss

Sandra Londa BCC

Maternal grief associated with perinatal loss often is not acknowledged or addressed in the hospital setting, leaving patients to lament silently or in isolation. This article presents a program for specific bereavement intervention in which chaplaincy care is an integral part of the overall care provided to the woman who experiences loss as a result of infant death, stillbirth, early-term miscarriage or therapeutic medical termination of pregnancy.

I FIRST MINISTERED IN A SITUATION OF PERINATAL DEATH as a chaplain intern, during an extended unit of clinical pastoral education (CPE) at The Methodist Hospital in Houston, Texas. The mother was twenty-one weeks into her pregnancy. The image that comes to my mind now is that of Rachel, “refusing to be consoled.”

In the Judeo-Christian tradition, Rachel is remembered as Jacob’s second wife and the mother of Joseph and Benjamin. (Gen 30:22, 35:17-18) Some one thousand years later, the prophet Jeremiah invokes her name to articulate the inconsolable grief and humiliation of the Babylonian exile: “A voice is heard in Ramah, lamentation and bitter weeping. Rachel is weeping for her children; she refuses to be comforted for her children, for they are no more.” (Jer 31:15 NRSV)

As the exiles departed after the fall of Jerusalem at the hand of the Assyrians in 587 BCE, “Jeremiah heard Rachel’s lament. She wept bitterly, refusing all consolation. Rachel had lost her own life in giving life to Benjamin … Now she watched again as life and a future slipped away. She accepted no comfort.”

Rachel’s lament is reprinted in Matthew’s gospel. After the birth of Jesus, King Herod ordered all the children in and around Bethlehem who were two years old and under killed. “A voice was heard in Ramah, wailing and loud lamentation, Rachel weeping for her children, she refuses to be consoled because they are no more.” (Matt 2:18)

This is often the figure I encounter when I enter the hospital room of a mother who has just experienced an infant death, a stillbirth, an early-term miscarriage or a therapeutic medical termination of her pregnancy. For me, Rachel is the icon of the woman who is inconsolable following such a loss. Thus, my ministry in these situations has a biblical, theological and spiritual basis.

Prior to April 2006, the nurse attending to a woman who experienced a perinatal death asked her if she wanted to see a chaplain. If the answer was no, the woman underwent the appropriate obstetrical procedure and was discharged, perhaps lamenting silently, without her grief being properly acknowledged. When we were notified, I brought a memory box filled with the baby’s armband, footprints, t-shirt and cap and provided emotional and spiritual support for the mother and father. If they wished, I also provided a service of blessing. As a rule, we were not notified in situations of miscarriage, except in the case of extreme grief or if the patient requested to see a chaplain.
In 2006, Texas state law was changed to require that any fetus weighing 350 grams or more be issued a fetal death certificate.\textsuperscript{5} Spiritual care interventions became much more extensive and comprehensive, using the Recovery Through Sharing (RTS) materials offered by Gundersen-Lutheran Medical Center.\textsuperscript{6} Care focused on the grief experienced by both the mother and father; bereavement interventions were expanded to include the following:

- The nurse notifies the chaplain of perinatal death, e.g., miscarriage, fetal demise, stillbirth or neonatal death.

- In the case of medical termination of pregnancy, the physician notifies the chaplain upon admission of the patient.

- On determination of weight and gender of the fetus, the chaplain brings the appropriate materials to the mother and father. These include memory box with disposable camera, teddy bear and bereavement folder containing the following: a condolence note from the director of spiritual care and education, the chaplain’s business card, RTS bereavement information and brochures from the support groups Houston’s Aid in Neonatal Death (HAND) and Mommies Enduring Neonatal Death (MEND). Volunteers provide the memory boxes, and HAND donates the teddy bears.

- When appropriate, the chaplain offers to take a photograph of the baby or notifies a volunteer photographer.

- The chaplain offers a service of blessing and remembrance (alternative ritual to baptism). If this service is provided, a certificate is mailed to the parents. (See Attachment A.) If parents profess a faith other than Christianity, the chaplain offers to contact clergy from their faith community, e.g. rabbi, imam, and also offers her prayers and presence.

- In the case of miscarriage, the chaplain brings only the bereavement folder. A teddy bear is given when appropriate.

- A condolence letter signed by the director of the Department of Spiritual Care and Education is sent following discharge from the hospital. (See Attachment B)

- The chaplain calls the mother within a week of her discharge to address any spiritual issues that might have arisen.

- The mother receives a card from the Department of Spiritual Care and Education 120 days after her hospitalization.

- The parents receive an invitation to the annual “A Life to Remember” ceremony.

Prior to the implementation of these specific bereavement interventions for perinatal death, the chaplain and the bereavement coordinator conducted a series of nursing in-services to educate the staff. In March 2007, The Methodist Hospital collaborated with St. Luke’s Episcopal Hospital, Texas Children’s Hospital and Woman’s Hospital of Texas to hold the first annual “Life to Remember” ceremony in Hermann Park. Some 200 people came to celebrate and to remember those who had died. Parents were invited to call their children’s names aloud and to participate in planting a tree in their memory.

Quality pastoral care in the case of perinatal death allows for and is present to the “wailing and loud lamentation” of present day Rachels. At The Methodist Hospital, our efforts are not meant to smother the grief, to silence the lament or to discount the loss. Walter Brueggemann says that, “Mother Rachel cannot cease her trembling, shattering, sobbing, ever because the children are never forgotten and never given up. It is the hard work of mothering always to remember.”\textsuperscript{7}
It is our belief that in allowing mothers—and fathers—to grieve and in providing education about the bereavement process, healing may begin. Although our chaplaincy interventions have become more extensive and intentional, we realize that they continue to evolve and that ultimately, they only approximate the healing that God affords.

1 Frederick A. Niedner, “Rachel’s lament,” *Word and World* 22, no. 4 (Fall 2002): 408.


3 Memory boxes are donated by volunteers, who paint and decorate the boxes.

4 Smith, “Pastoral and ritual response,” 26-35.


6 RTS Bereavement Training In Early Pregnancy Loss, Stillbirth and Newborn Death, Gundersen Lutheran Medical Center, LaCrosse, WI.

7 Walter Brueggemann, “Texts that linger, words that explode,” *Theology Today* 54, no. 2 (July 1997) 185.
Attachment A – Certificate of blessing and remembrance

Certificate of Remembrance

Let the children come unto me, for of such is the kingdom of heaven.

Matthew 19:14

On __________________, prayers and a blessing were offered in
remembrance of ________________________________
child of ________________________________

Gracious God, your Son took children into his arms and blessed them.
Grant us now the assurance that ________________________________
is nestled in God’s loving arms. In the midst of our grief, strengthen
our faith and hope in your Son, Jesus Christ our Lord. AMEN.

Department of Spiritual Care and Education

Methodist  The Methodist
Hospital
Attachment B – Condolence letter

Dear

We at The Methodist Hospital wish to express our love and sympathy to you, your immediate, and extended family in the loss of your baby, who recently died within our hospital. Even though death ended our efforts to help, it did not put an end to our caring. Leaving the hospital without your baby was very painful and we join with you in your grief.

A common initial response is shock and disbelief. Whether death was sudden and unexpected or anticipated makes little difference. For many parents it is only later that the reality of what has happened begins to sink in. This delay in accepting reality is perfectly normal. As one’s inner strength increases, death will be more realistically faced.

You may also experience feelings of anger. It may take the form of mild agitation or verge on the point of rage. As an emotion that is felt, anger should be accepted as normal and healthy. Hopefully your family will offer understanding and encourage you to share those feelings.

Guilt is often felt among many family members. Many people try to identify something they did or failed to do as the possible cause of their baby’s death. We encourage you to consult with your physician who can help you understand the medical events that led to your baby’s death. Of course, feelings of guilt can persist even with the reassurance that you acted in the best interest of your baby. These troublesome feelings will ease with time.

Couples often consider the death of their infant as a failure at parenthood. Feeling a loss of one’s femininity or masculinity is not unusual. In response, couples frequently want to quickly plan for another baby. We urge you to resist this alternative and give yourself sufficient time to work through the loss you have experienced. Courageously facing this loss will help you feel better about yourself and will enable you to deal more effectively with the future.

As time passes, your grief will lessen in intensity. God’s love for you will reveal itself in the inner strength you will gain and in the care and concern of the people around you. To assist you, we offer two sources of help. First, we provide a Grief Support Group, which meets monthly. Secondly, our Bereavement staff offers individual support and a listening ear. For information about the Group or individual emotional support, please call our toll free number at 1-866-519-6111 or e-mail hope@tmhs.org.

We consider it a high privilege to have had the opportunity of caring for you and your baby here. We will continue to ask God to minister to you in your grief and in your new life ahead.

Sincerely,

Theodore M. Smith, Director
Department of Spiritual Care and Education

The Reverend Sandra Londa
Chaplain

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The Galapagos Islands and the Now

Peggy A. Miller

**AS CHAPLAIN AT A RETIREMENT COMMUNITY** which had a special program for patients with Alzheimer’s Disease, I prided myself on detaching from the issues of memory loss and the people I served. It was okay that Mrs. A could not remember that we had already said the Lord’s Prayer and that Mr. B asked my name daily even after two years of seeing me four or five times a week.

Counseling the families of those diagnosed with Alzheimer’s was my strong suit, I thought. I seemed to be able to relate to those who could not understand: when a mother screamed that she had not been fed minutes after finishing her breakfast; why a scientist father no longer remembered how to get his pants off in time to avoid defecating on himself; why a school teacher insisted that she was late for work when she had been retired for eighteen years; when a former office worker continued to prepare for her move back home “as soon as my husband comes,” when her husband has been dead for some twenty years and her home sold long ago.

It was so easy to gently remind families, their friends and others that the person they knew was gone, and that they would have to make a relationship with this new person, based on where s/he is on a given day, at a given time. How simple the advice seemed, and how well it worked for me. No longer did I try to help the sufferer remember; we recalled what we could, and that was that. My sermons and Bible study lessons were prepared for the moment.

Then one day, I forgot the “Now.” When I went to the dayroom to do a worship service, the wide screen TV was on, and there was a nature special about the Galapagos Islands. Five ladies were watching it, and we began to talk about how beautiful the scenery was. We laughed at some of the strange looking creatures on the island, and we talked about how green the foliage, how blue the water and the sky.

The program ended, and eventually, I left for the day. The next morning my fellow TV viewers again were assembled in the dayroom. I greeted them with, “Good morning ladies, wasn’t that a terrific show about the Galapagos Islands?” Their response was a resounding chorus: “We didn’t see a show about the Galapagos Islands.” Oh, the pain, as I realized that we shared no memories of yesterday. My mind shifted quickly to confirm that they were right because any other answer would have led to their agitation. They already were annoyed at my suggestion that they had seen the program.

Now is a word meaning at the present time and moment. It is existence. I had the viewing and the fun of talking about the Galapagos Islands with these five women at that very minute and no more. Beyond the Now, there was no existence of that experience to share. This is the abandonment experienced by family members.

Alzheimer’s Disease causes those who interact with the sufferer to be jumpy and at odds with all of their natural sensibilities. One has to remember that there is absolutely no assurance of any
connection with the Now beyond that very moment. The loneliness experienced by those whose loved ones have this disease encompasses places others can’t see, anticipate or even conceive. All one has is the enjoyment of the current moment, never its continuation. It’s enjoying the moment *Now*, and Now means only while it’s transpiring, not the reflection or the recall.

“You were there,” they want to tell their loved ones, but no they were not, at least not in the Alzheimer’s world they inhabit. In the world of family and friends, the Now has a future placement in recall of a past event perhaps preserved in an album, a journal, a quilt, a recording or a tribute. Those who suffer from Alzheimer’s have lost the capacity to store the Now for later.

In the real world, my five ladies enjoyed the Galapagos Islands show along with me. Does it matter that I still remember it, and they can’t? Their Now winds down to less and less sharing until the disease progresses, and the sufferer’s body no longer can remember even to live. Perhaps that is reason enough to seek the best Now possible in each of our encounters. 

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A Not So “Silent” Retreat

Martha R. Jacobs BCC

This year, as I have done for the past three years, I went on a seven day silent retreat. This is a gift that I give to myself and to God.

In the past, these retreats have been verbally very quiet, but internally quite noisy as I “talk” with God, wrestle over issues and concerns and try to be open to hear what God would have me hear without the hustle and bustle of “real” world distractions.

This year’s retreat was equally noisy externally because all around me, others were whispering, talking and interrupting my internal conversation. I contemplated that and wondered why it bothered me so much. I found myself judging others for their seeming lack of ability to be silent.

On the Sunday of my retreat, I was asked to participate in the worship service and was formally introduced to a fellow retreatant, whom I will call Tom. I was surprised because it was the first time that formal introductions had been offered. Clearly, as it turned out, there was a reason for this introduction.

As I walked into the dining room the next morning, there was Tom, in conversation with one of the staff of the retreat center. I tried to avoid them but overheard him say that he was in a lot of pain. I sat down with my breakfast and again found others having conversations and again, thought to myself, why is this bothering me so much? I should be able to ignore it. Then I noticed that Tom had sat down to my right. After a few minutes I heard my name and looked up to see him trying to get my attention. He told me that he was leaving to go home because of physical pain from a back problem. We continued to talk about what was happening in his life and the difficulties he was having. We talked for quite a while, and when I looked around, the dining room was empty. I realized that we had be doing what I had been judging others for doing—talking while on a silent retreat—and had done so for almost an hour! I wondered what the others thought about us! Hopefully, they granted me more grace than I had given them.

As I pondered what happened and my own inability to ignore the distractions, I realized that there are all kinds of silent retreats, just as there are all kinds of silence. Our not-so-quiet conversation was a gift from God to both of us. As my spiritual director pointed out to me later when I told her about this, “You are a chaplain at heart, and you were there to remind him that he is not alone. You were bringing him God’s Spirit when he felt bereft of it. You were reminding him that God is present even in the difficulties of his life. That is what chaplains do.”

It is sometimes hard to remember that just because one is on retreat, it does not mean that one is separated from one’s work, from society or from the day-to-day lives of people. I guess I could have been annoyed that Tom was interrupting my silent time, but it is at times like this when I remember that God’s timing is perfect, that God is always working through us, even when we try to be silent.
The Sound Has Gone Out

Judith W. Lethin BCC

Although they have no words or language
And their voices are not heard,
Their sound has gone out into all lands,
And their message to the ends of the world.

Psalm 19:3-4

The sound that goes out into all lands,
The sound of grief,
Fills the desert.

Assassins take aim
And erase the Other
As though they had
No voice;
As though they had no mothers
To mourn their loss;
As though they had no grandsons
Who strain against the silent sorrow, waiting.

Who, who will hear this silent grief?
Is there no one to listen
to this howl of agony
That slips out at midnight?

El Lobo, caught in a steel trap,
With his tortured voice,
Haunts the landscape.

Vapors lift off the Rio Grande,
Slip and glide into
All the low places
All the empty places
All the void places until
The low-down-ness
The emptiness is
Lost to us, again,
In the silence.

There are no words for this kind of grief.
Language cannot cipher loss.

We sniff the tangled marrow,
At last purged;
El Lobo
Relieved by green grasses.

Tempted,
We feed on the vomit
As thought we had nothing else
To eat.

Poverty does that to us.

Poverty robs us of our dignity
And silences our voice,
But even though the ancient kindled fires
Silenced the voices of holy prophets and their bones
Scattered on the wind at dawn,
Their sound has gone out into all lands
And their message to the ends of the world.

We listen, now.
Holy innocent mothers
Finger their beads and weep
At the foot of empty beds in Chihuahua,
And we weep
In the silence.

We listen, now.
Holy innocent children
Boot the burnt earth and bare stones
At the foot of the drive way and wait
For their fathers and grandfathers
To come home,
And we, too, wait
In the silence.

In the silence,
Our Lady gathers the children of the Desert
Under her flowing robes;
The canyon wren begins her song.

We, too, gather the holy innocent ones
Into ourselves,
Join voices, and listen, now,
To the sound of one song.

Holy innocent fools wait
At the foot of the cross in Nuevo Mexico.
Heads snap up at the first crack of thunder and the
sound of the curtain being torn in two.

Awake now, we pray.
And as we pray,
We prepare the holy food and drink of
New and unending life

And our sound has gone out into all lands,
And our message to the ends of the world.
Poetry

Holy Water

Joe Baroody

FOR CARSON ARTHUR

Blessings are spoken, prayers are said,
The priest’s voice calls my name,
His large hands cradle my small frame,
Holy water gently falls upon my head.

My wet skin feels cold,
My voice cries loud,
While all heads are bowed,
Holy Water cleanses my soul.

Look into my eyes,
See my tears,
Hear my cries,
Feel my fears.

Holy Water and tears,
Tingling my cheeks,
Their mingling proclaims,
What the words do not speak.

God’s choice turned,
Your two hearts into three,
The Spirit’s voice yearned,
We became a family.

What God’s breath,
So mysteriously intwined,
Neither life, nor death,
Has the power to unbind.

Joe Baroody DMin is director of Baroody Pastoral Counseling, Florence, SC. A fellow in the American Association of Pastoral Counselors (AAPC), he is endorsed by the Southern Baptist Convention. He is pictured with his granddaughter Carson Arthur.

joe.baroody@yahoo.com
Anne Aldridge, Derek J. Fraser, Keith Morrison. “What do people talk to chaplains about?,” Scottish Journal of Healthcare Chaplaincy 12, no. 2 (2009): 3-10. ● Chaplains in UK hospitals continue to heed the urgings of Mowatt, Swinton, as well as administrators of the National Health Service to conduct evidence-based research, which will demonstrate the efficacy of the roles they play in health care. This paper reports one such effort that collects basic, but nevertheless important, information about a hospital chaplain’s work: what do people talk to chaplains about? With verbatim writing a standard practice in one hospital, the authors took the forty-three verbatim written by chaplains during a three-month period of 2007 and, with permission, gave them to two independent chaplains to review. The verbatim had not been written for the project. The chaplains, independent of each other, read and identified the main themes from each verbatim, compared their findings and then did an additional check of the themes using the computer program NVivo. The fifty-seven categories identified fell into four major groups: spiritual themes/exploration, hospital experiences, life stories and emotional language. They give examples and discuss each of the groups in turn. The authors assert that the value of their research is, first of all, to show that the “contents” of a chaplain’s visit may be the subject of research and that the focus of the visit may be on the person of the patient. They also acknowledge that this project does not answer the question of whether the pastoral visits were beneficial to the patients.

Rodney Baxendale. “24 hours in the chaplaincy,” Scottish Journal of Healthcare Chaplaincy 12, no. 1 (2009): 28-31. ● This is the report of a straightforward study, undertaken by the head chaplain in a hospital in Plymouth, England. His aim was to find out about the usage of “chaplaincy real estate” in his hospital, a large, acute treatment center. To do so, an anonymous observer completed a 24-hour observation of the chapel and then the administrative/prayer room areas. The author provides a schematic plan of both areas so the reader may visualize them. He describes the process of the survey, reports the events observed, their frequency and the numbers of persons involved. He lists the limitations of the method, followed by the survey’s conclusions. A number of practical ideas have occurred to him based on the data collected. Best of all, it seems to have started Baxendale and his colleagues thinking about issues they might address to increase the effectiveness of their overall chaplaincy services. He also thinks that a second survey, growing out of what they now know that a chaplain doesn’t know, would produce even more valuable findings. This is a good example of a research project that was quite straightforward in design and which has provided helpful information for the department involved.

Mary Q. Browne. “A significance of sacramental ministry among individuals with severe and persistent mental illness,” Journal of Religion, Disability & Health 13, no. 3/4 (Jul-Dec 2009): 260-73. ● Research has shown that people with serious mental illness are aided in their recovery by their spirituality. However, little is known about the role of sacramental ministry in such recovery. Using a structured interview method, Browne reports ways in which sacramental ministry functions in the lives of persons with severe and persisting mental illness. The narratives show how the concrete elements of bread, water and oil may contribute to recovery. Browne thinks of recovery in terms of an ongoing and highly personalized experience, rather than in terms of a
biomedical disease. She says that this is a new and somewhat radical concept in the mental health field. The sample size in this study was small, and the author hopes that it will be repeated with a larger sample. However, she also observes that with the shift in mental health care from inpatient to outpatient settings, it is increasingly the responsibility of local churches to understand and to provide for the spiritual and religious needs of this population. The article includes the interview questionnaire Browne used.

Donald Capps. “Relaxed bodies, emancipated minds and dominant calm,” Journal of Religion and Health 48, no. 4 (Dec 2009): 368-80. • In May 2009, Donald Capps retired after an illustrious 40-year history as a pastoral theologian, teacher and mentor for countless ministers both in the United States and overseas. During this period, he published or coedited approximately forty books and hundreds of papers. This is perhaps the last piece he wrote before he retired. William James presented “The Gospel of Relaxation” to the 1896 graduating class of the Boston Normal School of Gymnastics and ten years later he delivered his presidential address, “The Energies of Men,” to the American Philosophical Association. In both lectures, James looks at the body’s influence on emotions and the liberating effects of live ideas on the human body’s natural energies. As Capps shows, James makes use of the popular spiritual hygiene thinking of his time to support his arguments. In his first, he draws on the ideas of Hannah Whitall Smith’s views on disregarding “negative” emotions and on Annie Playson Call’s writings, specifically her ideas about relaxation. In the second, he draws on ideas by a Horace Fletcher, especially with respect to anger and worry. Capps discusses the key ideas in the two lectures: the role of imitation in changing unhealthy physiological habits and the energy-releasing role of suggestive ideas. Though the title may strike you as being of naught but historical significance, you may find that this article has strangely important lessons for pastoral care and for one’s own life today.

Carl Elliott. “The drug pushers,” The Atlantic Monthly (Apr 2006): 2-13. • In 2004, Elliott, who teaches at the Center for Bioethics at the University of Minnesota, published a paper on the efforts of the pharmaceutical industry to influence the medical world concerning the use and effectiveness of specific drugs. He documented in The Hastings Center Report the use of ghostwriters, the placement of journal articles over the names of prominent physicians (for a fee) and the general use of inducements to influence the prescribing patterns of physicians. In this article, he presents more evidence showing how the pharmaceutical drug industry supports the spiraling drug costs in American society. Although this article is now a little dated, the information it contains is still relevant as recent discussions with fourth-year medical students made very clear. If you wish to talk to someone from the pharmaceutical industry in your hospital or facility, look for someone who is young and immaculately dressed. However, you will need to look quickly because the new drug reps are becoming the doctors themselves. This is a disturbing paper.

George Fitchett, Kenneth Rasinski, Wendy Cadge, Farr A. Curlin. “Physicians’ experience and satisfaction with chaplains: a national survey,” Archives of Internal Medicine 169, no. 19 (26 Oct 2009): 1808-10. • Chaplains have just received a clear nod of approval from doctors in the United States. This comes from a study that uses data collected in 2004 from over 1,100 medical doctors representing all specialties. How the initial data were gathered is described in a paper cited in this article. While the doctors responding were mostly male (74 percent), they practiced across a variety of settings. The authors chose to concentrate their study on the relationship between the physicians’ practice location, their religious/spiritual (R/S) views and their experiences with chaplains. Concerning their interactions with chaplains, 89 percent of the physicians reported experience with chaplains, and 90 percent of these said they were satisfied or very satisfied. On the other hand, physicians from the northeast, and those who noted more negative effects of R/S on patients, were less likely to be satisfied with chaplains.

Tom Gordon. “Reflections on aspects of health, wholeness, suffering and healing,” Scottish Journal of Health Care Chaplaincy 12, no. 2 (2009): 60-62. • In 2008, the Church of Scotland established a working group to examine issues of health and healing within the context of that Church’s ministry and mission. This paper, written by a recently retired hospice chaplain in
Scotland and a leading figure in chaplaincy in that country, is his contribution to that discussion. Writing from a hospice context, he makes ten declarative statements that individually may be understood as "strands" in his thinking. Together they form the basis for wise discussion on subjects about which there is still polarization among people of religious faith, such as the following: illness, suffering, pain and death are not a consequence of sin; God wills us to be whole—he does not will us to be cured; expectations of physical healing may cause more harm than good; there is an arbitrariness to God’s love and intervention.

Donald E. Healy Jr. “Rediscovering the mysteria: sacramental stories from persons with disabilities, their families and their faith communities,” Journal of Religion, Disability and Health 13, no. 3/4 (Jul-Dec 2009): 194-235. When Healy requested stories about the communion experience from the disability community, he received an outpouring of letters and stories about all of the seven sacraments of his church. One common theme was an appreciation of the experience: the presence of persons with disabilities receiving or administering them, which resulted in transcendent insights and emotions that “passed all understanding.” Healy is not interested in simply retelling moving stories. He wishes to explore the possible activating mechanisms that underlie the levels of insight shared by the storytellers. He begins with his own literature review concerning sacraments and disability, which is not limited to theological writings. Then he uses a synthesis of Corbon’s construct of the synergy of worship as well as David and Rebecca Nye’s relational consciousness theory to prepare the reader to attend to some of the stories he has received. In the final section of his essay, Healy reproduces some of the stories he has been sent, using them as exemplar stories across each of the seven sacraments.

David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler. “Medical bankruptcy in the United States, 2007: Results of a national study,” American Journal of Medicine 122, no. 8 (Aug 2009): 741-46. This study examines the impact of health care costs on personal bankruptcies. The authors surveyed 2,314 persons who declared bankruptcy in 2007, interviewing just over 1,000. The findings: In 2007, just over 62 percent of personal bankruptcies in the United States were caused by health care expenses, and this figure continues to climb. In contrast, in 1981, it was 8 percent. In an accompanying editorial, James Dalen asks, “Why is the United States, one of the richest countries in the world, the only major industrial nation that is unable to provide access to health care for all its citizens?”

Julie M. Jones. “How one system defines quality,” Health Progress 90, no. 3 (May/Jun 2009): 39-43. Since 2006, the chaplains in the Sisters of Mercy Health System have been tracking how they spend their time and discussing the implications. The results led to questions and decisions about priorities and patient care and, subsequently, to more questions about patterns of practice and to the measurement of quality of care. Jones, who is director of mission and spirituality for the system, lists the primary questions that have been discussed, following a natural process of inquiry as chaplains talked about activities in their individual institutions and then across the system. The questioning began with the following: What is the measure of quality for pastoral services departments? Pastoral care directors discovered that a variety of different methods had been used to try and find an answer. This led to question two: What services do chaplains provide? They started with the work of Dean Marek and the chaplains at the Mayo Clinic. (See Vision, July 2005.) This eventually led to question three: How long does it take to deliver these services? This involved the tedious, but necessary, work of tracking each chaplain’s activities over an extended period, which raised some concerns on their part. However, there proved to be three benefits from this phase: chaplains had a common language to describe what they did; they became aware of how they were using their time; and a foundation was set for great system-wide collaboration. This information prompted the fourth question: What do the differences between departments tell us? Jones describes a variety of valuable knowledge gained here, not the least of which was having the information needed to obtain funding for a new chaplaincy service when one hospital opened a new service. Finally, they asked the following: What are the current priorities? What should be the current priorities? From the start, some of the chaplains had feared that this process was simply a way for their institutions’ administrations to force them to do what they, the administrators,
wanted the chaplains to do. The chaplain directors had been firm is assuring their staff that the process was being driven from within chaplaincy, and that they would be the decision makers with respect to change. As Jones indicates, new goals emerged from discussions of priorities. As each department—and each institution—was different, each had to establish unique goals—and they did. This is a brief paper that has insights for chaplains who have not made thinking about standards of care a priority and reflects the type of accountability questions administrators are asking.

Neziha Karabulut, Behice Erci. “Sexual desire and satisfaction in sexual life affecting factors in breast cancer survivors after mastectomy,” Journal of Psychosocial Oncology 27, no. 3 (Jul-Sept 2009): 332-43. • This study reports the impact of treatment, personality characteristics and support needs around femininity and body image issues in women with breast cancer. The group of women studied (n=123, married) had undergone mastectomies and were being followed in the oncology clinics of a university hospital. Results showed that the sexual desire of the women was low and that they were only “slightly satisfied” with their sexual lives. As a result, they needed support around femininity and body image issues. The authors state that their findings are important because most of the staff working with this population seem to find it easier to focus on management of treatment side effects rather than to address issues related to sexual behavior. This study and other research show that issues of survival are not more important than issues of sexuality.

Jen Lumsdaine, Anne Mulligan. “Live donor kidney transplantation and the place of chaplaincy in the donor advocacy team,” Scottish Journal of Healthcare Chaplaincy 12, no. 2 (2009): 11-15. • This article is essentially two essays about live donor kidney transplantation. Lumsdaine writes from the perspective of the transplant coordinator. She outlines a process of assessing the physical aspects of a live donor, e.g., immuno-compatability, general health, renal function, and some of the ethical issues that also need to be considered. Mulligan, a chaplain, has been appointed one of four persons who together comprise the donor advocacy team (DAT) for the Scottish Liver Transplant Unit. She describes her role on this team as being responsible for evaluating a person’s medical, psychosocial and social stability as well as general suitability to be a donor. DAT follows a model created in the United States after the suicide of a live donor in New York in 2002. This team works independently of the transplant team and all four members must agree before a person is accepted for organ donation.

Robert Mundle. “Religious pluralism and the hospital chaplain,” Scottish Journal of Healthcare Chaplaincy 12, no. 2 (2009): 16-20. • How can a chaplain possibly serve and be spiritually available to persons of other religious traditions while remaining grounded in and faithful to his/her own religious tradition? This is the central question of Mundle’s essay. A chaplain in the Toronto Rehabilitation Institute in Canada and himself a married Roman Catholic priest, he grows his thinking out of the work of Raimon Panikkar, a contemporary Catholic theologian who is the son of a Catholic Catalan mother and a Hindu Indian father. Mundle describes how Pannikar’s dialogical approach to religious pluralism provides a useful methodology for chaplains to use in thinking about their own ministries. To illustrate, he describes sacramental ministry from the perspective of a Roman Catholic chaplain toward a Hindu patient. With respect to the offering of prayers to persons of other-than-one’s-own tradition, Mundle, after Pannikar, emphasizes “embodied alterity,” i.e. embodied otherness, pointing out that chaplains already know the experience of alterity/otherness. This is because of their peculiar position in the modern health care team: they are at once members of the team and yet not members of the team. Mundle writes: “By training and temperament, hospital chaplains embodied as “intimate strangers” in the strange land of health care are indeed able to tolerate and sustain the live creative tension of incommensurable religious beliefs in both interpersonal and intrapersonal relationships. Thus they offer a vibrant model of Panikkar’s dialogical approach in action. From their direct experiences of ‘spiritual availability’ and ‘communion’ with a great variety of ‘others,’ including even themselves, chaplains stand to broaden understandings of sacramental ministry and prayer that no longer can be contained or explained within isolated traditions.” (p. 19)
The Organization for Economic Cooperation and Development. “OECD at a glance 2009: Key findings for the US” http://www.oecd.org (Accessed 4 Jan 2009) 2p • This site provides highlights from a larger report released at the end of last year by the Organization for Economic Cooperation and Development (OECD), with data from 2007. It contains the following facts: People in the United States may expect to live a shorter life than people in half of the thirty countries in the OECD. On average, they will live just slightly longer than people in Poland, the Czech Republic and Mexico. In 2007, persons in the US spent an average of $7,290 on health care, almost 2 ½ times the OECD average of $2,984, to reach an average of 79.1 years. The US far outspent Norway and Switzerland but life expectancies there were two and four years longer respectively. At 6.7 deaths/1,000 births, the US infant mortality rate was worse than the OECD average of 3.9/1,000. Only Mexico and Turkey had higher infant mortality rates, and Luxembourg had the lowest (1.8/1,000). The report notes that factors beyond the quality of the system and the amount of money for the system affect these figures; income inequality, individual lifestyles and attitudes all affect infant mortality. In addition, the US spent an average of $878 per person per year on prescribed medications, while the OECD average was $461. The public sector is the main source of health funding in all OECD countries, with the exception of the US and Mexico. In 2007, 45 percent of US health spending was funded by public sources, significantly lower than the OECD average of 73 percent.

Katherine M. Piderman, Mary E. Johnson. “Hospital chaplains’ involvement in a randomized controlled multidisciplinary trial: Implications for spiritual care and research,” Journal of Pastoral Care & Counseling 63, no. 3/4 (2009): 6p. Piderman is a psychologist and the coordinator of research for the Department of Chaplain Services at the Mayo Clinic College of Medicine and Johnson serves as chaplain and the coordinator of education in the same department. Based on their own experiences, they describe how a chaplain’s involvement in spirituality and health research may bring vital and unique contributions and also may result in valuable professional growth and increased effectiveness. They focus on a particular project that involved patients with a life expectancy of less than five years who were receiving radiation therapy for their cancer. They describe what they learned through this research that has been important in providing pastoral care to such patients.

Claire Tuck. “Assessment and documentation of religion and spirituality in the Liverpool Care Pathway for the dying patient—how well is it done?,” Scottish Journal of Healthcare Chaplaincy 12, no. 1 (2009): 52-59. • The Liverpool Care Pathway for the Dying (LCP) was created in the late 1990s by the palliative care teams in two hospitals and a hospice, located in the general Liverpool area of England. LCP lists the specific interventions that are to be made with all patients and their families, and which are to be documented in ways that will allow subsequent retrieval of the data to confirm whether the standard of care has been met. This paper reports on a study to learn whether or not Goal 6 of LCP, which deals with religion and spirituality, was being met. Results clearly demonstrate that compliance with an 80 percent standard of care, set before the data were gathered, was not met. Although 50 percent of patients and 74 percent of their relatives had their tradition/spiritual needs identified, it is unclear what happened with that information as only 42 percent were offered chaplaincy support. The author reports that hospice staff were “not necessarily comfortable discussing religion/spirituality, especially at the first patient meeting,” something the survey results make abundantly clear. The results were the basis for Tuck’s nine specific suggestions for improvement to this system, which is the point of having a pathway in the first place.

Laraine Winter, Marie P. Dennis, Barbara Parker. “Preferences for life-prolonging medical treatments and deference to the will of God,” Journal of Religion and Health 48, no. 4 (Dec 2009): 418-30. • How does personal belief in the “will of God” play a part in the thinking of persons who must decide whether to continue life-prolonging medical treatment? Contradictory relationships between preferences for treatment and commitment to such a belief are conceivable. If life-prolonging interventions are perceived as artificial and unnatural, acceptance of them may be seen as opposition to God’s will. Highly religious persons also may be less willing to accept a
treatment because of a stronger belief in the power of direct divine intervention or because of a diminished fear of death. On the other hand, refusal of life-treatments may be seen as a decision to end life, which some regard as God’s prerogative. In the latter situation, greater religiosity would indicate a stronger preference for life-prolonging medical intervention. In this study, the authors defined and measured a dimension of religiosity that chaplains hear families speak about in end-of-life situations—deference to God’s will (GW)—and examined its relationship to preferences for life-prolonging treatments. This involved 35-minute phone interviews with 304 older men and women, who were given the 5-item GW scale the authors had created. In addition to some personal data, participants were queried on three attitude items concerning length of life followed by measures of two health indices, depression and life-prolonging treatment preferences. The overall results showed that deference to GW was associated with stronger preferences for life-prolonging treatments in poor-prognosis scenarios. The situation in which the decision was being made is important as the results did not hold up when there was a chance for the person’s recovery. This is a paper that increases understanding about the use of religious faith. Rather than merely inquiring as to whether the person was religious—or to what extent—this work specifically defined “religious” in the context of GW.
Expression of Faith

The Tao of Dying

Mark LaRocca-Potts BCC

It is a fairly accepted notion that the human being is composed of at least three parts: body, mind and spirit. Faith traditions throughout the world frequently refer to this as the “great chain of being.” In the west, the mind is called psyche, which often includes the soul. This tripartite being is recognized by western science in what are called holistic understandings.

At the time of death, the whole person—body/mind/spirit—passes through the death stage of life. From our studies of the dying process, especially as part of the palliative care/hospice movement, we have seen that the body “knows” how to die. As death approaches the body begins to shut down, which is seen in the lessening of the appetite as well as in its ability to move fluids. One might say that there is a body-wisdom (gnosis) that knows the way (tao) of dying.

Other studies, such as Singh’s The Grace in Dying, suggest that at the time of death, the spirit also knows the tao of dying. As death approaches, the human spirit returns to Spirit, the Ground and Source of Being. The spirit is able to surrender to and trust the dying process. As Singh notes regarding how many people die, “They die into their True and Essential nature. They appear, often knowingly, to melt into Spirit, as naturally as a snowflake melts on the hand.”

This leaves us the mind (psyche/soul). Though the body and spirit have knowledge (gnosis) of the tao of dying, the mind has either forgotten this knowledge or buried it. Instead of embracing or melting into death, the mind fears death, which, according to existentialists, is the condition of our existence. It is the mind’s fear of dying that generally obstructs the dying process and causes such a ruckus.

Charles Taylor in his Sources of the Self argued that the “self” is primarily a psychological, social, and cultural construct: the self is shaped more than it shapes. If it is agreed that this constructed self resides more in the mind than in the body or spirit, then the only way to teach the mind the tao of dying is to teach the self how to die. In other words, since the locus of our fear of dying is more in the self than in the body or spirit, the mind must practice killing or dying to this self until it no longer fears death thereby escaping our existential condition. This is the purpose of most genuine spiritual paths: to kill, as it were, the socially constructed and constricted self so that the true Self, which is our Original Face, Christ-consciousness, or Buddha-nature, may surface, which has the gnosis of the tao of dying.

I think we learn the tao of dying by taking up a time-tested spiritual practice that has meditation/centering/emptying (Via Negativa) or devotion/identification (Via Positiva) at its core and then practicing it for life. Too many people use religion and/or faith as a shortcut, thinking that belief alone without practice will lead them to this tao. However, belief alone does not overcome the existential fear of dying that inhabits the self. Instead, belief just masks or palliates the fear behind a more solidified self.
The body and the spirit, by their very essence, know the tao of dying—that is the nature of tao. The mind does as well, but it cannot see it or remember it until the old self dies and the True Self emerges. Most people, ready or not, experience this tao of dying only once—at their physical death when body, mind, and spirit all merge together and pass into what is next. I believe that at the time of dying there is a way/wisdom/tao that the human being (mind/body/spirit) knows by right of essence and which it follows naturally. I further believe that it is only after this death that true or “eternal” life begins. Spiritual paths enable us to experience this death earlier in life so that we may earlier enter this eternal life. As Jesus, the founder of my faith proclaimed, “I came that you might have life and have it abundantly.”

The telos or purpose of life is to learn the tao of dying—body/mind/spirit. Only then does one truly live. 🌿

2 Ibid., 12.
**A Clergy Guide to End-of-Life Issues**  
**Martha R. Jacobs** (Cleveland: Pilgrim Press, 2010, 164 pages, softcover)

The purpose of this wonderful, timely and well-written book is summarized in the following two statements, both found in the first chapter titled provocatively, but wisely, “Why are we afraid to die?”

> Clergy trained in dealing with end-of-life issues can ... begin conversations with their congregants about their health care wishes. Congregants would then be better prepared with advanced directives, or at least know to discuss their wishes with family members and, perhaps with ... their clergyperson. (p. 3)

> Death is not the enemy, and yet we treat it as though it is .... When clergy address, teach, and model ... [the] realities of our living and our dying, death can once again become a natural and much less frightening part of life. (p. 4)

Sharing her vast experiences as a hospital chaplain and as an educator as well, Jacobs sets out a handbook that is eminently practical and well researched. The book is arranged in three major sections, followed by an array of appendices. The first section considers end-of-life issues, both legal and medical. The second section, theological issues, also divides into two parts: miracles and cures followed by our own demons. Pastoral issues, the final major set of chapters, focuses on clergy working with congregants: preparing for the end of life, working with congregations, knowing the options and focusing on transformation.

The seven appendices are filled with valuable information and links to various relevant Web sites that address many of the issues found in the book:

- State-specific Web sites for information about advance directives.
- Denominational links to end-of-life issues and other denominational resources.
- Advance directives and end-of-life Web resources.
- Prayerful discernment process for congregational use.
- Materials and resources for use with congregations.
- Book suggestions on grieving and rituals.
- Sample sermon: “A Chaplain’s Prayer.”

A helpful bibliography concludes the volume.

Jacobs explains in clear language many of the technical terms that are part of the jargon of end-of-life decision making, e.g., advance directives, living wills, do-not-resuscitate (DNR) orders, do-not-intubate (DNI) orders, capacity versus competence.

In the chapter on medical issues she offers advice in helping clergy (and families) navigate their way through the hospital. She has a segment on “the ethos of intensive care units” and explains the symptomology of what it means to be actively dying. Then she considers such issues as pain control, artificial nutrition and hydration (ANH), brain death and terminal sedation. In the section on ANH, she explains that “Artificial nutrition is not ‘food.’ It is a chemically balanced mix of nutrients and fluids. It is ‘being forced into the body to keep a body functioning (not necessarily alive).’” Jacobs then explains that some studies show that continuing ANH creates a “bad death.” She is well aware of, and comments on, the fact that “Eating is the central focus of many cultures” and that this presents its own set of conflicting problems for the family who want to do what is best for their loved one. (p. 43)
The theological issues portion contains a section on racial, cultural, social and economic issues, matters which often impact end-of-life decision making (pp. 55-60).

Jacobs has found that while many clergy are adept and experienced at conducting funerals and offering comfort to the bereaved, they are far less likely to have asked themselves the hard questions about how they feel about dying and death. Therefore, she has added a section for clergy titled “The Prayerful Discernment Process,” where she invites readers to consider not only their mortality, but also decisions about their own end-of-life care. The way she has this set up, it takes about an hour to go through the relevant rubrics. As she explains, there is a variation of this for congregational use in Appendix 4 as well as a PowerPoint presentation on the associated Web site she has developed, (www.deathisnottheenemy.com), which also offers additional resources.

As the title of the book explains, this is intended for clergypersons. Certainly it has a particular focus within that category. Jacobs primarily addresses Christian clergy, and specifically it appears to me, Protestant clergy. The denominational links to end-of-life issues and other denominational resources range from the American Baptist Church through the Unitarian Universalist, but make no reference to the Roman Catholic Church. Jacobs does quote from the Christian Scriptures, specifically the Gospels and Romans. Though this work has relevance for clergy of other faiths, periodically her language is specific: “As Christians, while we may not know exactly what is on the other side of death, we do believe that God is there.” (p. 6) “Jesus bid us to visit the sick (Matt. 25:36) to remind people that they are not alone, that they are part of a community ... Jesus demonstrated through his ministry the importance of community when we are most in need.” (p. 104)

The focus of the book on Christian clergy notwithstanding, there is much that can be learned irrespective of one’s religious affiliation. The material on legal and medical issues, the aforementioned subsection on racial, cultural, social and economic issues, as well as the subsection on sexual orientation, plus many of the appendices have broad application. The whole third part of the book dealing with pastoral issues may be translated from her Protestant model to other religious systems with little effort.

This volume, which is attractively bound and printed, is an excellent and valuable contribution to the relevant and needed dialogue dealing with end-of-life issues. It also is an excellent resource for professional chaplains to suggest to their local clergy. Jacobs points out several times that the best way for a local clergyperson to navigate the hospital system is by getting to know and utilizing the hospital’s chaplain.

The Reverend Dr. Martha Jacobs probably is well known to readers of Chaplaincy Today. She has served in numerous voluntary positions for the Association of Professional Chaplains (APC). She serves as the managing editor of PlainViews, the electronic chaplaincy journal. An APC board certified chaplain, she holds a DMin in pastoral care and is an ordained United Church of Christ minister.

Reviewed by David J. Zucker PhD BCC, Rabbi/Chaplain, Director of Spirituality, Shalom Park, Aurora, CO.

**Faith-Based Caregiving in a Secular World: Four Defining Issues**  
**James J. Londis** (Privately published, 2009, 172 pages, softcover)

The title of this small volume seems too general as it is written entirely from an evangelical Christian perspective and for Christian readers. The author writes from many years of experience in three areas: health care administrator and ethics resource, pastor, religion and ethics professor. He offers this book as his personal reflections on the “universal issues” of Christian health care.

It is difficult to determine the target audience. At various times Londis addresses himself to health care administrators, to caregivers—both professional and private—and to a congregation. He considers the four “defining issues” of healing: Christian spirituality, caregiver burnout, suffering
and prayer. Anyone preaching on healing and faith, on the imperative of compassionate care for all of God’s children—certainly timely topics—will find worthwhile resources and sermon starters.

While this volume is of limited use to professional chaplains who generally minister in more diverse settings, there are points to highlight. The short chapter on caregiver burnout is one for all Christian caregivers and their administrators to read. It recalls the basis for a Sabbath rest, not only in the Creation account but also in the commandment—not suggestion—in Deuteronomy to rest out of gratitude for liberation from bondage. A regular time of rest also restores caregivers’ perspective on the human and the divine role in the work of healing.

Londis suggests concrete ways in which Christian health care institutions might embody the principles of love and justice for their patients as well as for their staff. Referring to the accounts of Jesus’ ministry, he makes the case for a holistic view of healing that is more than curing. Quoting Rachel Naomi Rumen, he contrasts one-directional “cure” with “healing,” which he views as a two-way gift that may profoundly affect and change both parties.

Healing must take into account more than physical needs. Poverty, depression, addictions—whatever cuts people off from a life-giving community, anything that isolates and diminishes them—must be addressed for healing to occur. Londis illustrates this broader view of healing with the story of a medical doctor and a Native American medicine man both caring for a boy with a broken ankle. The former focuses only on the how of the break: the boy fell off his bike. The latter calls attention to the why: the boy had argued with his mother, jumped on his bike and raced away furiously. Bones can be set, the medicine man noted, but the stress at home must be addressed in order to effect full healing.

There are points on which chaplains may differ with the author. His definition of Christian spirituality as “the ability to understand another’s roundedness and feel as God feels about someone else” seems needlessly narrow. Londis notes that an appeal to divine inscrutability is not sufficient for someone in pain, but he does not seem comfortable with allowing the “why” questions to stand. As he reports on his pastoral encounters, voices that speak in anger or doubt are notably absent. For many patients and families who struggle with the why questions and/or who do not feel free to voice their anger, doubt or fear healing can be a slow process indeed. The author’s examples seem to suggest immediate healing.

In the final chapter, Londis addresses with insight and compassion traditional views of God’s sovereignty and providence that lead some patients to conclude that “God sent this to me for a reason.” His discussion invites greater empathy for a worldview that the chaplain may not share and keener sensitivity to the underlying human needs. Finally, the author takes readers along as he “walks in a nurse’s shoes,” a practice periodically expected of nonclinical staff at his health care facility. What if more administrators, trustees and perhaps even policy makers or insurance executives periodically immersed themselves in the gritty and spiritual realities of day-to-day care and healing, of frailty and compassion? Imagine the possibilities.

Reviewed by Astuti Bijlefeld BCC, Staff Chaplain, St. James Mercy Hospital, Hornell, NY.

**The Heart Transformed: Prayer of Desire**

**Celia Wolf-Devine** (Staten Island, NY: St Pauls/Alba House, 2009, 225 pages, softcover)

In the painting by Claire Brown used for this book’s cover, there is an image of Jesus standing facing humanity with pierced feet and a pierced left hand, which is raised symbolically. The left shoulder is covered while the right shoulder exposes the under garment and the pierced heart of Jesus. In an e-mail inquiry to Celia Wolf-Devine into the reason Brown’s painting was selected, she indicated that she loved the painting. She wrote, “The eyes seem to look at you. It is serious—almost haunting looking—but looking inviting and loving.”
This work is a loving invitation to become engaged in private prayer. Wolf-Devine writes that “the focus in this book is on the sort of conversion that occurs in prayer, which is why I entitled it The Heart Transformed: Prayer of Desire. The “heart,” however, should not be understood as merely our feelings or emotions.” (p. XV) Both positive and negative experiences may happen at the core of our being. Wolf-Devine writes, “If some word or action is “heartfelt” it is deeper or richer than just the words of the lips. Something is “heartening” if it is encouraging and inspires us with courage and hope. Negatively, we speak of people as “hardhearted,” “coldhearted,” or “heartless.” Weak or cowardly people are described as “fainthearted.” (p. XV) When a person is sad we speak of them as “downhearted,” or “disheartened.” We all know these experiences in our lives.

There are five chapters that provide the structure for this book, and each offers insights into aspects of prayer. In chapter one, Wolf-Devine notes that many people have problems with the language of prayer and shows how God may be experienced as transcending gender without changing the language. She writes: “[I]t is not the case that we should never change religious language, it is important to keep in mind that Christianity is an extremely deep and complex religion that operates on a number of interconnected levels (intellectual, affective, imaginative, symbolic, etc.), and small changes in one area may have large unexpected effects elsewhere, perhaps compromising the truth, power and coherence of the whole.” (P. 21) Readers may appreciate this acknowledgement.

The use of images in private prayer is enlightening. She writes that “different images may be helpful at different times. Some days you may feel particularly like an enemy occupied city—beset by temptations and powerless to do anything to help yourself. Another day you may feel like dry, hard, brambly ground longing for the softening dew or rain of the spirit. Another day you may feel a sense of delight as though you are drinking from a spring of living water.” Wolf-Devine shares her prayer routine, including long and short prayers and how they might be integrated into one’s prayer life.

Chapter three provides many insights into how one’s prayer life is affected by temptations, scruples, discouragement and doubts. Consider the practical suggestion regarding desires. The distinction is made between "first order desires" and "second order desires." A person may feel a strong desire to wound another, but on second thought realizes that this is not the kind of person she wants to be. "The desire to be this better sort of person, then, is a second order desire ....” (p. 70) Chapter four suggests different types of praying. "Certain things like penitence, thanksgiving and praise are standard aspects of Christian prayer generally, but other things like the Jesus prayer or praying in tongues may be right for you or they may not." (p. 109) Some practical ways that our lives may continue to be transformed are shared in chapter five. Here Wolf-Devine reveals the significance of caring for one’s imagination, following guidelines for seeking help, caring for relationships through forgiveness and cultivating a nonjudgmental attitude both toward others and oneself.

These five chapters are inviting suggestions and sharing of experiences that seek to show “the way in which prayer might facilitate God’s transforming work” of keeping our lives centered on the Holy. (p. 179) The appendix provides reflections on prayers provided in chapter two and includes The Apostles’ Creed, Nicene Creed, as well as some additional prayers. Chaplains, pastors and other supportive persons may recognize in this book the spirit of love gently calling and inviting them into a life that is continually being transformed by God. This resource may be used for the chaplain’s self-care and offers a range of wisdom that may be useful in helping others to pray.

Reviewed by Michael G. Davis DMin BCC (retired), Hernando, MS.
The following two reviews offer viewpoints of the same book.

**Disaster Spiritual Care: Practical Clergy Responses to Community, Regional and National Tragedy**


Rabbi Stephen B. Roberts is the Associate Executive Vice President of the New York Board of Rabbis overseeing the Jack D. Weiler Chaplaincy Program and also founder of a partner organization within the American Red Cross, which is now called, Disaster Chaplaincy Services, New York. The Reverend Willard W.C. Ashley, Sr. is a psychotherapist and founder/senior pastor of the Abundant Joy Community Church in Jersey City, NJ. He implemented The Care for the Caregivers Interfaith Program, a ministry of the Council of Churches of the City of New York. Individual chapter authors in *Disaster Spiritual Care* include many APC board certified chaplains: Kevin Masey, Naomi Paget, Greg Bodin, Arthur Schmidt, Yusaf Hasan, George Handzo, Earl Johnson, Zahara Davidowitz and Timothy Serban as well as numerous other spiritual care professionals. Together they provide expertise in the field of disaster spiritual care as collaborators with a diverse group of faith backgrounds. A point made by several authors included the centrality of becoming prepared and informed about appropriate disaster spiritual care etiquette and procedures for providing disaster spiritual care. Above all, they clearly voice a theme of wisdom, knowledge and preparation so as to “do no harm.”

Roberts and Ashley have organized *Disaster Spiritual Care* into two parts: the life cycle of a disaster and special needs. Both contribute to the introduction and author or coauthor several of the twenty chapters. Many have extensive experience in writing for academia; nevertheless, they clearly have followed the editors’ advice to be concrete and provide useful information as well as resources. Although the clergy professional certainly will want to read this book before disaster strikes, it is a valuable reference in any case.

The authors have achieved a goal in providing valuable disaster care information for persons in a variety of ministry settings, including chaplains. Topics covered include the following: defining disaster and its impact on the community; life cycle of a disaster; congregational and community work in small, regional and national disasters; recognize coping mechanisms, both healthy and unhealthy, within a congregation and community; preparing congregants and congregations prior to disaster; cultural and religious considerations in disaster response; compassion fatigue; working with children and adolescents; responses to anniversaries and other reminders; and lasting adjustment issues. While on the whole, the editors are writing to the larger clergy community, the information shared has universal application.

Each chapter is full of information that helps the reader to become better informed and more competent in providing competent disaster spiritual care. “The Life Cycle of Disasters” gives the reader a detailed overview of phases that community congregations and persons go through. In Chapter 9, the authors cover issues such as triage in disaster care, when to make referrals to other disaster care agencies, identification of symptoms, and understanding the difference between spiritual emergence and spiritual emergency. The volume is full of illustrations for handouts that may be used in training others in disaster spiritual care. Permission is given to copy these with appropriate citation. This text easily could be required or strongly suggested reading for basic pastoral care or pastoral counseling courses in seminary.

Chaplains in all settings would be wise to secure a copy of this volume for use in continuing educational programs, volunteer trainings or for sharing with local clergy groups. The authors strongly suggest linking with the various disaster care groups, such as American Red Cross, and becoming informed about their disaster spiritual care training programs. The book includes a list of these organizations.
Disasters are a given, and let us not be so presumptive that our prior chaplaincy training has provided us with the necessary breadth of knowledge, tools and skills to assess the spiritual needs of persons affected by a disaster in today's environment. Since 9/11 APC frequently has included disaster spiritual care trainings at annual conferences. If you have not attended one of these, this volume will fill in the information gap. Further, it goes a long way toward increasing the chaplain's competency, skills and comfort level with ministry in disaster situations and preparing individuals to provide in spiritual care during such times.

Reviewed first by Beverly C. Jessup DMin BCC; CPSP Diplomate, Pastoral Education; Clinical Director, Pastoral Care, FirstHealth Moore Regional Hospital, Pinehurst, NC.

Second Review of Disaster Spiritual Care

Faith group clergy and personnel are really the intended audience of this work; however, as most chaplains have connections with local faith communities, this is a worthwhile read for us as well. The purpose of the book is to prepare leaders of faith communities for the “expected unexpected.” The authors point out that while individual disasters are unexpected, “disasters and trauma in general are expected.” (p. xi) It is a vital arena in which clergy need to be involved. A 2001 Red Cross study learned that it is to a spiritual counselor that the majority of people turn in times of crisis. (p. 106)

The approach of the book is very practical. Various contributors chronicle the life cycle of a disaster from initial threat through impact, immediate rescue, honeymoon phase, disillusionment phase and reconstruction phase. Probably the most important part of the book addresses the pre-disaster phase, which includes instructions for preparing congregations with details about “go bags” and “ice buddy systems.” A very helpful suggestion is for “every congregation to have a partner congregation that is located at least one hundred miles away. If you need to evacuate, your partner congregation will welcome you as your ‘ready receiving center.’” (p. 50)

One chapter’s author recommends that each congregation focus on identifying a particular target need, e.g., space for sheltering, kitchen for mass feeding, parking lot for emergency vehicles, and preparing resources to meet that need if/when disaster strikes. (pp. 72-73) Another common sense suggestion: “If your program is not going to provide food or water during the relief stage, make up your mind early on not to accept offers of food or water. Get the name of the program that is providing food and water and have it available to those who wish to give food and water.” (p. 175)

A repeated emphasis throughout the book is that a disaster is no time for proselytizing. “Religious diversity is a given in a disaster.” (p. 89)

A significant portion of this volume addresses lessons learned from hurricane Katrina. Responders to that disaster heard the heartache of people who not only lost their homes but their doctors, post offices and everything that was familiar to them. A study two years after Katrina determined that 14 percent of Katrina victims showed symptoms of severe mental illness while another 20 percent experienced mild to moderate mental illness. (p. 130)

This book includes helpful chapters on special needs, e.g., compassion fatigue, cultural and religious considerations, attending to the dead, working with particular age groups. My only criticism is that in the chapter on working with college students after a disaster, there was no mention of the importance of the students connecting with their parents as quickly as possible. When our eldest son was a brand new university student on 911, I think that connection was important to him—I know it was to us!

Reviewed by Mark A. Bonnema MDiv BCC, Staff Chaplain, Swedish Health Services, Seattle, WA.
Journeys of Heartache and Grace:  
Conversations and Life Lessons from Young People with Serious Illness  
Melody Chatelle (Austin, TX: Langmarc Publishing, 2008, 220 pages, softcover)

As part of her dissertation for the PhD in communication studies, the author interviewed thirteen seriously ill children and their families. The primary audience for the book includes patients, their families and the people who love them. However this poignant book also is a good resource for chaplains and pastoral caregivers, particularly those beginning to work with seriously ill children. The multidimensional stories at the edge of pain and suffering invite the reader to understand, to know and visit in deeper ways the foreign land of serious and life threatening illness for children, young adults and their families. Out of this deeper knowing through story, the reader is challenged to revise trite and common phrases that often offend, isolate and unintentionally harm fragile people when they most need sensitivity and compassion.

Chatelle states that she was motivated to engage in this journey partly by her unanswered questions in the aftermath of the deaths of her mother and grandmother. Each compelling story is followed by “An Interview's Perspective” page with sections labeled: “A Lesson Learned,” “Suggested Response Strategies/Discussion Questions/Commentary” and a short space for “Your Personal Notes/Action Steps.”

The summary conclusions offered in “Their Stories; Our Lessons” may help people to become more sensitive in working with people who are seriously ill. These five “hand-holding hints for use during end-of-life times” are summarized by ”Show Up and Stay Connected.” The author includes an excellent table with “specific suggestions for talking with people who are dying and/or dealing with chronic serious illness.” The table alone is worth the price of the book since it offers ”language phrases found to be offensive when said by healthy individuals” along with ”preferred language phrases/behavioral strategies.” The short and helpful bibliography includes references about children, pain, death and qualitative research.

The writing style is accessible and her compassion for the people involved shines through their stories. Chatelle connects with them in ways that evoke honest self-reflection. She serves as an evocative witness to the stories of hope, despair, confusion, faith and doubt. Seeing into the lives and reflections of the children and their caregivers in the extreme circumstances of life threatening illness is a precious gift, and through this book, she opens it to a wider audience.

Obviously, Chatelle is a talented interviewer and writer. She develops, deepens and honors the stories by including numerous verbatim quotes—sometimes with raw language—and offers carefully chosen interpretations and evocative images. There are stories of hope, faith and grace. There are stories laced with chaos, anger, bitterness and confusion. Five of the stories end in death. Throughout, I consistently sensed the respect and admiration that she holds for these people.

In one narrative, Chatelle reports the patient’s perceptions of interventions by the chaplain, which, from my perspective, did not demonstrate competent pastoral care. The chaplain in the story (p. 106) explains the death of a beloved five-year-old friend to twenty-year old Harry by saying, “How do you know that God’s not actually saving him from something bad that was going to happen?” This and other explanations from the chaplain seem counter to the suggestions that Chatelle offers. The chaplain, from the patient’s perhaps distorted report, defined God, rather than opening the conversation to diverse interpretations or helping the patient to deepen or broaden an understanding of God.

I appreciated Chatelle’s attention to detail and her inclusion of diverse, sometimes challenging and chaotic perceptions of death and God. She admitted that listening to some conversations, and perhaps seeing dysfunctional family dynamics, was challenging. Her sacrifice of personal comfort
and the work of summary and synthesis to produce these compelling stores was a sacrifice on behalf of us all.

Reviewed by M. Catherine Hasty BCC, Director, Health Ministry and Pastoral Education, Chaplaincy Department, Presbyterian Hospital, Charlotte, NC.

**All Your Waves Swept Over Me: Looking for God in Natural Disasters**


Nancy de Flon and James A. Wallace have edited and created a gem of a book that address the theological dialogue between people, God’s people and the larger society around the topic of God’s work and re-creation amidst disasters. The book has ten short, yet detailed essays on various topics addressing creation/chaos motifs, the Psalms as laments and how they help give worshippers a place to begin worship (again) following disasters. Other topics include the ever present theme of beauty amidst disaster, disease in epidemic proportions and unexpected horrors from nature.

Throughout the book, the individual writers hold in tension the theological themes of free will versus providence, human sin versus divine retribution and the Church’s response to ravaging diseases and epidemics such as yellow fever and plague. I was surprised that the worldwide AIDS epidemic was not addressed.

Each chapter ends with several thought-provoking questions that help the reader find his or her place among varying viewpoints. The editors and authors write from a Roman Catholic theological perspective that could give any Christian a handle on dealing with theology of pastoral care and worship following disasters.

As I write this review, the world just marked the fifth anniversary of the tsunami catastrophe of 2004. Several writers comment and use sermons and materials as fodder for discussing the age-old belief that God is angry and that nature is the arm of God to bring justice to a sinful world. This opinion is disputed several times in the book with the writers favoring the idea that God is present, albeit “from a distance” (p.4) and cares for (loves) the entire created order. (p. x)

The strengths of the book are the emphases that the writers place on possible responses following disaster and the theological reflection on disaster and the response of God’s people. No doubt the development of appropriate worship is tricky following events like Hurricane Katrina, the Tsunami of 2004, and even lost hikers who perish at nature’s feet. Nonetheless, the book contains Bruggemann’s four biblical theologies around natural disasters (pp. 77-79) as well the useful ideas of preaching that use remembrance, presence, and promise to give hope and faith to those suffering. (p. 82, 84)

The theological idea that “nature is free” just like humanity resonated with my own soul and gave me a new understanding of its randomness. (p. 51) Nature has its own DNA so to speak that causes water to rise, earth to rumble and winds to howl at 200 mph! The reader will be prompted and encouraged to rightfully respect nature. The person of faith is called to be a co-creator with the Creator even in the middle of terror, disease and death. The writers call the reader to locate God and to hear and see God each day with a forceful reminder that “common suffering leads to the common good.” (p. 97)

I highly recommend this book to pastors, ministers, chaplains and counselors who are seeking to hone their theology of pastoral care and worship following natural disasters. This book will probably deepen the reader’s theology of Creation as well as give him/her resources for guiding God’s people and interpreting nature’s fury following such events.

Reviewed by Chaplain George M. Rossi MA MDiv BCC
Peace at Last: Stories of Hope and Healing for Veterans and Their Families
Deborah L. Grassman (St. Petersburg, FL, Vandamere Press, 249 pages, softcover)

The HBO movie, Taking Chance, is based on true events, and chronicles the details of a Marine’s combat death. The author is the Marine who escorts the remains to the family. The movie takes you behind the scene showing in detail how a combat causality is handled with dignity, personal care and honor. One line in the movie resonates. “Without a witness, they will disappear.” In Peace at Last, author Deborah Grassman is your escort and the veterans witness, detailing the stories of those veterans who come home, not in a body bag, but in a mentally and emotionally altered condition as a result of their military service. This book is very powerful and should be required reading for all chaplains, counselors, nurses and volunteers who work with returning veterans.

Grassman quickly captures the reader as she describes the challenges faced by veterans, especially those who enter hospice with deep-seated emotional baggage they have carried for years. Her central focus is to help veterans face and acknowledge the past. She shares her twenty-five years of experience by explaining when and how to ask the hard questions in the veterans’ language and on their turf. This creates a safe environment for them should they choose to open their cans of worms. They are invited to do so with the expectation of learning how to release emotional pain, receive and embrace forgiveness and redemption as well as embrace a peaceful resolution instead of continuing to struggle with their demon-driven memories.

The author clearly articulates her belief that it is the caregiver’s responsibility to serve those who first served us by helping them to pick up the pieces of their fragmented lives: “We have the opportunity and responsibility to learn how to better understand the science of violence and how to integrate prevention and new evidence-based treatments with the human experience of serious trauma.”

Grassman paints a clear picture of the emotional pain posttraumatic stress disorder (PTSD) cements within the minds of many veterans and shares clinical success stories that have brought them true peace at last. She understands the warrior freeze instinct, which purposely avoids confronting feelings and memories by burying them deeply within. Later these memories explode from the recesses of their subconscious minds and may result in violent, tormented days or even bring them to death’s door.

Peace at Last gives caregivers an easy-to-read blueprint for understanding veterans’ emotional behaviors. It clearly details why many veterans suffer and then provides proven successful clinical techniques for helping them to find personal redemption and peace.

The author points out that although only 15 percent of all veterans have some form of PTSD, most do not find their way to a VA hospital. Rather they can be found in local hospitals throughout the United States, often being labeled as the town drunk, the abusing spouse or the drug user.

Peace at Last is instructional, inspirational and healing. Not only does it describe clearly how to understand and help veterans, these same clinically proven techniques are most valuable for identifying and helping the non-veteran who has experienced an emotionally and/or physically violent event.

Reviewed by Gus Martschink BS, Adjunct Chaplain, Moses Cone Hospital, Greensboro, NC.