BEST PRACTICES: THE CHALLENGE TO PROMOTE SHARED LEARNING IN PASTORAL CARE

By

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Introduction: Chaplains learn from each other and those they serve. Shared learning is a part of human discourse that can facilitate professional growth and aid spiritual enlightenment. A premise of this paper is that shared learning can also move pastoral care initiatives forward through applied research by putting useful pastoral care strategies to the test. Think for a moment about how you might answer the following questions. Many of you have been trained in Clinical Pastoral Education (CPE) to use your listening and discernment skills to aid others. As you hone and perfect your skills, have you developed strategies that seem to work well with certain patients to aid their recovery and to help them relate to their understanding of God? There also may be possible research implications. Are you able to validate that what you do aids spiritual healing and contributes to patient recovery? This can be a particularly daunting task for chaplains in hospitals given the nature of spiritual healing, and the time constraints influencing medical and spiritual interventions. Lastly, if you have strategies that seem to work well, would you be willing to share your findings and ways of doing things with other chaplains to permit possible replication and testing by them on a broader scale? The goal would be to see whether what you do can serve to advance pastoral care through broader-based applications.

Purpose: The purpose of this paper is to encourage pastoral care providers to identify and share strategies (best practices) which seem to aid spiritual healing. The two small steps described below are based on strategies that have been found useful for aiding spiritual growth. The applied research value is derived by building on what has worked in the past and by determining whether modifications in content and application can benefit a specific patient population, in this case, individuals suffering from post traumatic stress disorder (PTSD). All too often, positive outcomes occurring in a pastoral care setting can be treated as personal or private moments or “signs of God’s grace,” and therefore be under-valued for their research potential, and lost or hidden as might be a “lighted lamp under a bushel basket.” (Matthew 5:15) The basic theme of this paper is that personal pastoral care strategies that work for you may have value for other pastoral care providers as well, and should be brought out into the light.

Shared Experience and Learning: Before becoming a chaplain about seven years ago, I worked for most of my professional life as an evaluator and managed a research group responsible for assessing and improving pilot and demonstration programs funded by the
federal government. The programs focused primarily on improving the training and employment prospects for at-risk youth, older workers, prison inmates, and veterans. This experience carries over into my work as a chaplain where I find that certain applications seem to work better than others depending on the patient populations. An early example of this occurred in CPE training when I was struggling with trying to improve my relationship with a patient who was blind and hard-of-hearing. I presented the problem to my peers and supervisor in the form of a written reflection (verbatim) to gain added perspective from the group on how I might improve my effectiveness. The learning moment for me came when my supervisor got up, came over to where I was sitting, stood behind me, leaned over and started to talk into my ear. He asked if it were any easier for me to hear what he was saying and suggested that I try the same thing with the patient. Such a simple strategy is something that I probably would have avoided at the time for fear of being overly intrusive. In actuality, once I gained approval from the patient, the strategy became an accepted and comfortable part of our relationship. Besides improving communication, it also greatly reduced the noise level on the unit and enabled us to hold relatively private conversations. I have subsequently modified the strategy with other hard-of-hearing patients to accommodate their preferences and find that moving closer to a patient, sitting directly in front of a patient, or talking directly into a patient’s “good ear” also help improve communication.

My experience as a chaplain has been mainly with individuals suffering from mental illness, addictive behaviors and acute depression. The two strategies cited below focus primarily on patients diagnosed with PTSD. Just as in the case of the patient who was blind and hard-of-hearing, their unique needs forced me to reconsider how I might help them reconnect with God in ways which could give them “spiritual” options to draw upon in their hour of need. Among this population, there are some PTSD patients who barely have strength enough to connect to a “higher power” because of their mental anguish and pain. Others question whether anyone can help them, even God, because of their heightened state of vulnerability, horrific life experiences, and total devaluation of self-worth. Some have attempted suicide. Many experience what might be called a “spiritual dryness” that resembles what St. John of the Cross refers to as the “dark night of the soul”. PTSD patients experience flashbacks, nightmares, recurrent dreams, disturbances from noises and other events, any one of which can trigger fear and depression. Over a period of three years of working with these patients, I find that many of the same problems surface in discussions. Two stand out in particular: (a) problems in dealing with recurrent pain from hurtful thoughts that cause depression and sap patients of emotional strength, and (b) confronting the problem of forgiveness and learning to “let go” as part of recovery.

The strategies described below are small steps to address these problems through pastoral care. The first strategy borrows from the practice of monks in the early Orthodox Christian church. They used what has become known through the ages as the Jesus Prayer, a mantra said over and over to promote closeness to God: “Jesus, Son of God, have mercy on me, a sinner.” For PTSD patients, the words have been changed to meet their needs and preferences. The strategy of a mantra is flexible and can be used at any time. It can be anticipatory when a patient may feel threatened or uncomfortable, or, used in direct response to an event to help patients overcome undesirable and persecutory thoughts and to establish an intentional alliance with God as a source of strength and inner motivation.
The second strategy draws upon the example of Jesus in the Christian Bible when he shows us the way of forgiveness by asking God to forgive his persecutors.

**Strategy 1:** This strategy can be a life-long option for PTSD patients to help them overcome invasive, debilitating thoughts and to bring a transcendent power into their lives on a regular basis. Prior to discussing the mantra, I make an assessment of whether a patient could benefit from such a strategy. Once a determination is made, I explain its purpose, and ask the patient to read and react to its content.

Handout #1:

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We are human. Frequently thoughts come which trouble us. Those thoughts can lead to negativity, depression and despair. In some cases, they may urge us to do things which we know are not good for us. Negative thoughts can be easy to spot but difficult to dispel especially when they feel very strong. Join with me in using a “mantra” as a means by which to confront negative thoughts. A mantra is an expression said over and over again as frequently as necessary to interrupt negative thoughts and connect with a source of strength beyond ourselves, a “higher power.” It can be a double blessing by enabling you to join with God as an ally in the process of recovery. Use the mantra if you think it will help you recognize and deal with thoughts which are hurtful to you. Sometimes the simplest approaches are the best. See how this works for you.

**OH GOD, PLEASE SAVE ME FROM NEGATIVE THOUGHTS. I BEG OF THEE. I BEG OF THEE.**

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Generally, patients find value in having recourse to a spiritual option that they can use to gain control over their afflictions. When a mantra helps them gain control over their thoughts, they start to gain confidence. Each time they are able to overcome a negative thought is a small victory. Continued progress in reducing the impact and pervasiveness of such thoughts through the use of a mantra can diminish negativity, lead some patients to gain some sense of empowerment, of control over what happens to them in life, and can nurture a habit of turning to God for support. The same mantra does not appeal to all patients. Some suggest changing the content to fit their particular concerns and needs such as: “Oh God, forgive me my sins and help me to heal.” or, “Dear God, bring your love, peace and goodness into my life.”

One of the unanticipated outcomes in working with patients who expressed lack of faith and skepticism about God’s presence was their recognition and appreciation for the visible sign of support (a handout) in their struggle with pain. Many in this group might express doubt that God could or would help them, but most seemed to respond positively to pastoral care which included as part of the action offering them something tangible. Such
a gesture often appeared to open doors for discussions that otherwise might have remained closed. Regardless of whether or not the strategy was used by a patient, another common residual effect was the positive response of patients to what they saw as proactive pastoral care on their behalf, the effort to invite God into their lives in ways which they could understand even though they might not be ready to take advantage of such an opportunity.

From a research perspective, results are tied to a one-on-one, case study methodology and personal, idiosyncratic experience. Time constraints affecting number and duration of visits as well as lack of follow-up of patients greatly limit assessment of results. My personal experience with patients and reactions from many of them lead me to believe that mantras can be useful for some patients and deserve consideration as strategies for pastoral care. Mantras ground pastoral care in something that requires patients’ efforts, but also brings rewards. Mantras are forms of prayer which can enable patients to experience the effects of spiritual healing sooner than they might expect otherwise.

**Strategy 2.** The second strategy centers on what can be a lifetime struggle for many PTSD patients and one of their most painful challenges, the problem of forgiveness. Strategy 2 moves patients away from the source of their pain and follows the example set by Jesus in his hour of need. It is a strategy that minimizes patient confrontation with offenders and relies on God to serve as both advocate and intermediary. Many chaplains may already be using this approach or variations to help patients. The following is a prologue in support of the intervention.

When Jesus experienced his most intense human suffering, he cried out, “Forgive them Father for they know not what they do.” His expression of forgiveness was spontaneous, heartfelt and came in response to callous and brutal treatment from others. At a time of total vulnerability and need, he turned to his “higher power” as the source of healing and forgiveness. The earthly Jesus lifted his persecutors to God. He did not say to God, “I forgive them for what they have done”. Rather, he did what came naturally to him. Jesus asked God to do something for him that he was not ready to do for himself, deal with forgiveness and offer forgiveness to his persecutors in God’s own way and in God’s own time. In the murkiness of their pain, depression and possible aversion to forgiveness, PTSD patients are asked to consider doing the same thing, relying solely on God, until they are ready to forgive on their own.

Discussions with patients can lead to strategizing about possible ways to include forgiveness as a viable option for healing. Below is an example which illustrates one approach to forgiveness. The strategy is intended to help patients get started by reducing fear of direct confrontation and by according God a position of prominence. Just as for Strategy 1, this type of pastoral care does not lend itself to evaluation without continuing contact and follow-up of patients to monitor progress. Given the indecisiveness and reluctance on part of many PTSD patients to forgive because of their deep seated grievances, the main short-term outcome measures may center on factors such as: Does the strategy help patients to include forgiveness as part of their healing? Are they able to ask God to help them in this process? Does the strategy help them to overcome specific barriers to forgiveness?
Handout # 2:

- **The key to your success in dealing with problems of forgiveness centers on asking God to join you in bearing your pain. Be straightforward with God in acknowledging that you may not be ready to forgive but that you are ready to ask God to forgive. Leave in God’s hands the responsibility for dealing with the hurt that you experience and work with God to include “forgiveness” as part of your healing. The idea of forgiveness may sadden you, but partnering with God can ease your suffering and gladden your heart. “Come to me, all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from me, for I am gentle and humble in heart and you will find rest for your souls.” (Matthew 11:28). It takes courage and humility to turn to God for help. Both are signs of God’s love operating in your life if you are willing to give forgiveness a try.**

- **There are useful guides and resources dealing with forgiveness. (Care Notes, for example, from Abby Press offer reflective materials.) Try to decide on how you want God to help you. For example, you may want to pray to God to provide grace and insight to your offenders to enable them to come to an awareness of the harm they have done and the pain they have caused. You may want to ask God to give them the grace and insight to be able to feel sorrowful and contrite for their actions. With an openness that recognizes God’s love as being effusive and embracing all, you may want to include as part of your prayer that God gives them the grace and insight needed to repent and make a new beginning. Also, don’t forget about yourself.**

- **Part of this process includes working with God to forgive yourself for what you may have done that is upsetting to you. Forgiveness plays out differently in each person. Reflect on whether there are things which you have done that contribute to your pain and try to reconcile these through discourse with God. Be persistent in asking God for help, realizing that the courage, insight and compassion you may experience in the process are those easy-to-miss signs of God’s presence.**

**Next Steps**

Within the chaplain community, there is a wealth of experience in many different areas that remains relatively untapped, underutilized and untested. Hopefully, some of you will be motivated to take note of what you do that seems to work well, document to the extent you are able, and “save” so as not to lose a shared-learning opportunity. How the vast array of experience and valuable strategic resources for spiritual healing can come together in ways that are meaningful for providers of pastoral care and for those they serve is the fundamental challenge presented in this paper. By sharing a couple of strategies that I have found useful in working with patients who suffer from severe and debilitating depression, I offer examples of two approaches to shared-learning that seem to have merit but remain inconclusive without further testing and refinement. From a research standpoint, I would value being able to interact with chaplains interested in exploring one or more strategy to discern relevance, share results and assess outcome.
There is a web site on the internet that my wife enjoys using when searching for recipes for particular meals or food items. The site includes comments from viewers who have tried recipes of interest to her. She combs through recipes and judiciously takes note of others experiences and reactions. Some critique the recipes and add their own suggested changes to improve upon them, sometimes as simple as using less salt or substituting chicken for turkey. She has an array of suggestions and options to consider before deciding on her choice of ingredients for a particular recipe. In the broader arena of pastoral care, there may be advantages to having an interactive web site for chaplains interested in sharing recipes for a different type of food, healing strategies by which to promote spiritual health and advance pastoral care.

Right now, there are very few ways for pastoral care providers to contribute to shared learning through an interactive process. The Association for Clinical Pastoral Education (ACPE) Research Network identifies the “Spiritual Care Initiative for Professional Excellence” as a useful resource. The section on Knowledge Base of Spiritual Care Samples documents and organizes over 350 “best practices” that include the experiences of professional chaplains. This is a valuable approach to broader-based sharing of information. The National Association of Catholic Chaplains (NACC) has a website which encourages shared learning through several venues. One in particular, “Vision,” features informative articles by chaplains providing helpful insights on wide-ranging topics. Organizations outside of pastoral care provide an added dimension to consider by stressing interactive, web-based technologies as a means by which to encourage and expand information exchanges between members. The American Psychiatric Nurses Association (APNA), for example, has a secure interactive website to enable nurses to stay current, dialogue with each other, and problem-solve to aid medical practices. Nurses can share and access information from diverse sources including medical journals, research studies and work-related experiences. The website encourages professional growth and development through ease of access, targeting of information, and by valuing user discourse. As a proven web-based strategy, the APNA model may have relevance and potential for strengthening information sharing among pastoral care providers.

Strategies for spiritual healing are put to the test every day in the quiet of God’s vineyard. The results often remain relatively hidden and unknown except to the laborers in the field and those they serve. The nature of pastoral care does not lend itself readily to recognition of its ministers for their accomplishments but entrusts to God the power of healing and attributes to God any positive outcomes. As noted earlier, documenting and storing information about specific types of pastoral interventions that seem to work can be easy to overlook or undervalue. A secure, user-friendly, interactive website for pastoral care providers may help bring what is hidden into the light and lead to a number of possibilities including development of a broadly based reservoir of data containing precious seeds for growth, insight, and applied research.

Such an undertaking is beyond the scope of this immediate paper. But, down the road a bit, some of you may have ideas about how best to do this within the framework of a possible sponsor or provider-organization. The next steps include inviting you to think about what is needed to move shared-learning initiatives forward, and how you might contribute to this process of discovery.
Post Script

This paper was written to encourage chaplains to value, assess and share what they do that seems to work well (best practices) in ministering to others. It was written for a broad audience of pastoral care providers with a variety of skills, interests and backgrounds. There were a few scriptural references, some parenthetical comments, but mostly observations based on personal experience. The descriptive narrative in the paper and the proposed strategies helped to flesh out and support a relatively simple, individualized and easy-to-implement case study methodology based mainly on participant observation and pastoral counseling. I used personal experience and strategies I found useful in working with PTSD patients to serve as examples of shared learning (my own best practices) and welcomed reader feedback to build on and critique my observations. An early hypothesis in development of the paper was that reader comments would fill in some of the unknowns and help confirm whether “mantras” were useful to other pastoral care providers as well. My hope was that reader comments would expand and possibly broaden the relevance and usefulness of the proposed interventions for pastoral care and research purposes.

Both the ACPE and NACC made the paper available to members through their respective websites. The response rate from both sites was much lower than anticipated. I thought there would be at least thirty responses. Instead, there were less than ten. None of the respondents offered critiques of the proposed strategies. But, two readers provided substantive leads and insights in support of mantras as valid strategies for patient recovery and spiritual healing. One respondent cited a publication focused specifically on PTSD and traumatic brain injury (TBI) patients entitled the “Spiritual Care Handbook on PTSD/TBI” by Rev. Brian Hughes, BCC and Rev. George Handzo, BCC.

A section of the handbook highlights Spiritual Mantram Repitition and some of the beneficial medical effects associated with the use of a mantra such as calming associated with lower heart rate, blood pressure, breathing rate and oxygen consumption. There are also specific references to hospitals (mainly military) offering formal training in the use of Spiritual Mantram Repitition. The core training which can last up to six weeks centers on developing meditation techniques to reduce stress, anxiety and pain. In monitoring patient progress, some sites are also able to follow up on patients to assess longer-range outcomes. By including Spiritual Mantram Repitition as a valued resource for the treatment of PTSD, the handbook helps to confirm the connection between the use of mantras and spiritual healing.

A second respondent sought to strengthen the evidence-based value of mantra intervention by noting the collaborative works of a neuroscientist, Andrew Newberg, M.D. and a therapist specializing in spirituality, Mark R. Waldman. Their book on How God Changes Your Brain provides scientific evidence of the benefits gained from active and positive prayer and meditation. They conclude that spiritual beliefs and practices change the brain for the better. A second book by the same authors, Words Can Change Your Brain supports scientifically the benefits gained from prayer repetition and prayer based interventions. The authors provide added empirical evidence showing how prayer and meditation incorporating mantram repetition affect the brain and aid healing.
Both of the above approaches require extensive commitments on part of patients to acquire meditation skills necessary to achieve physical and spiritual benefits. The time and cost involved for healing purposes differ significantly from the strategy proposed in Handout #1 cited above in this paper. Handout #1 enables PTSD patients, usually in the hospital for a week or less, to try out a simple technique for blocking negative thoughts and drawing on God’s help in the process. The handout is self explanatory, easy to follow and relies on the patient to anticipate and interrupt negative thoughts through a pattern of behavior similar to a conditioned response. Within my hospital environment, the handout is a useful pastoral intervention for many PTSD patients seeking alternative and viable options for healing. Admittedly, the procedure is a band-aid approach when considered in relation to other more comprehensive and intensive strategies. But, it is also has the advantage of being available to all patients regardless of means or time constraints. With a little practice, patients can develop the necessary techniques to diminish the number and effects of intrusive thoughts by bringing God more readily into the healing process.

Since writing this paper, I have started to make Handout #1 available to other patients at the hospital on a selective basis, particularly patients with substance addictions. I have broadened the use of mantras to include any and all negative thoughts or temptations, no matter how minor, in order to help patients develop the habit of using a mantra on a regular basis. Once a mantra response becomes automatic, patients can adjust its use as needed. Also, Handout #2 will be modified to add greater emphasis to “self-forgiveness”. Even though the majority of PTSD patients I see are victims and have been hurt severely because of the actions perpetrated by others, a major part of their pain is an inability to forgive self. One of the lessons I have learned in working with just two strategies over the past three years is that best practices are only “best” for a while, but never remain static. They can always be improved upon as situations change and new information becomes available.

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