

Pastoral Care with Youth Offenders and Victims

Gene Hausmann

At the EPIC Conference in Toronto this past February, two of the more than 100 newly certified NACC chaplains who were recognized during the program were caregivers to the high-risk youths who have been adjudicated delinquents. We are a small but growing part of the NACC. This event at least tripled the number of certified chaplains to juvenile offenders in the NACC and in the Pastoral Services Department at Holy Cross Children's Services (HCCS) where I serve as Director. I came to HCCS in 1981 and I felt like a "lone ranger" in the NACC when I was certified in 1993. Now there are three of us and hopefully more on the way. We have the equivalent of seven chaplains including three CPE residents covering the five HCCS regions in Michigan.

HCCS serves over 1,000 delinquent and abused boys and girls each day at nearly 30 locations in the State of Michigan. It is a Catholic agency owned by the Bishops of Michigan, administered by the Holy Cross Brothers from Notre Dame, sponsored by the Knights of Columbus, and is one of the largest private non-profit agencies in Michigan serving high-risk youths.

Holy Cross programs pioneered Positive Peer Culture, a peer group counseling model, in Michigan during the 1970s; multisystems family treatment in the 1980s; clinical and management information systems and research in the 1990s; and Clinical Pastoral Education, integrated pastoral and social services (treatment teamwork), and pastoral care research in the 1990s. In



NACC-certified chaplains at Holy Cross Children's Services: (l-r) Sister Mary Laurel Smith, HM, Mr. Gene Hausmann, DMin, and Sister Kathleen O'Donnell, HM.

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2000, I completed my doctoral dissertation on the positive clinical outcomes of chaplain contacts with the youths in treatment. We are one of only two ACPE satellites providing CPE with this population.

Sister Kathleen O'Donnell and Sister Mary Laurel Smith, both members of the Humility of Mary Sisters of Villa Maria, Pennsylvania, and veterans of years of ministry in Catholic schools, changed careers, moved to Michigan, and completed their CPE and certification during the last three years in HCCS programs. They were among the newly certified chaplains recognized in Toronto.

The three of us have also been elected recently as officers of a small but growing National Chaplains Association for Youth at Risk

(NCAYR). Part of our agenda for the organization includes the publishing of a journal (*NCAYR Digest*) and the development of standards for pastoral care modeled after what we have learned in the NACC.

My long-range goal includes NCAYR participation with the NACC and other large cognate groups in our field. Currently, the three of us are busy organizing our NCAYR national conference for 2003 on the theme of "Restorative Justice: The Roles of Chaplain and Church in Reconciliation of Victims, Offenders and God." It is scheduled for September 29–October 2, 2003, in Detroit, Michigan.

In the accompanying articles, Sister Kathleen O'Donnell offers a sampling of her ministry of reconciliation in the case of Marla and Sister Mary Laurel Smith offers the case of Matt. These articles begin on page 6.

(Gene Hausmann, DMin, is Director of Pastoral Services at Holy Cross Children's Services in Clinton, Michigan; ghausman@hccsnet.org.)

Prayer Service for Peace and the Safety of Men and Women in Military Service

Sister Margaret Washington, ASC

Almost as soon as the war in Iraq started, employees at Holy Spirit Health System began requesting prayers for their loved ones in the active military service. The pastoral care staff—two priests, a deacon, two religious sisters, a minister, and two lay chaplains—realized there was a need to provide support to these employees. A coordinated effort began to gather as many names as possible to include on the prayer list. At the same time, the pastoral care staff began planning for a prayer service.

On March 27, the “Prayer Service for Peace and the Safety of Men and Women in Military Service” was scheduled for 30 minutes and began at noon. More than 60



Family members came to the altar to light candles as the names of persons in active military service were read at the prayer service.

Holy Spirit Health System Prayer Service

Remembering the Men and Women in Military Service and for World Peace

Welcome: President/CEO

Harp Music

Invitation to Prayer

Hymn: O God, Our Help in Ages Past
Prayer

Hymn: The Prayer of St. Francis

Reading 1: Cosmopolitan prayer based on Psalm 27. From *Prayers for a Planetary Pilgrim* by Edward Hays.

Prayer with Cantor: My Shepherd Is the Lord

Reading 2: Mark 12:28–34

Harp music and quiet reflection

Lighting of candles

Family members are invited to come to the altar to light candles as the names of the persons in active military service are read.

The Lord's Prayer

Benediction

Closing Hymn: America

employees and volunteers attended the service. Two music therapists played their harps, an employee served as cantor, and several members of the pastoral care staff participated in the service, while the president and CEO welcomed the attendees to the service. During the reading of names, family members lit candles in honor of their loved ones. A keepsake booklet listing all the names was given to everyone in attendance.

While the service was brief, the lasting impact on the families and others was greater than the pastoral care staff had anticipated. The spirit of caring at Holy Spirit Hospital was rekindled. In a note of thanks to the pastoral care staff, one employee stated, “My husband and I wanted to thank you for the prayer service. I try to be strong and I

hold my emotions in even though I want the tears to flow. I know God will place his protective arms around all the men and women serving our country and keep them safe. This service was very special to me and took some of the weight off my shoulders.”

A few days after the prayer service was held, a bulletin board display was created with the names of all the men and women (70+) we are praying for in our Holy Spirit Health System family along with pictures of their loved ones lighting candles in their honor. This prayer service brought many people together in difficult times.

(NACC-certified chaplain Sister Margaret Washington, ASC, is the Director of Pastoral Care at Holy Spirit Hospital, Camp Hill, Pennsylvania; Swashington@hsh.org.)



Members of the pastoral care department (back row) pray with members of the hospital staff.

Vision

Vision is published 10 times a year by the National Association of Catholic Chaplains. ISSN: 1527-2370

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The National Association of Catholic Chaplains is a professional association for certified chaplains and CPE supervisors who participate in the healing mission of Jesus Christ. We provide standards, certification, education, advocacy, and professional development for our members.

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The Call for Catholic Chaplains of Color

I write this as I sit here and look at the picture of the newly certified chaplains that appeared in the May issue of *Vision* and rejoice at those newly certified, but I am aware of the pain in my heart when I don't recognize a single face as mine or of my colleagues who are people of color. (I know that not all who were certified in the last year are pictured here, but that raises yet another question of why the newly certified people of color did not or could not attend the conference in Toronto.)

We as a national organization are aware of the decline of "nearly 200 members last year (many from full member to emeritus status reflecting the aging of our membership)." So what are we committed to do to welcome, to invite others to join us? We are also aware that the number of Hispanics is increasing, making Hispanics the fastest growing group of people in the United States. The number of Hispanic Catholics is also on the rise. Are our numbers of Catholic Hispanic chaplains increasing in the same numbers? If not, why not?

The Church has been preparing for this growth with Pastoral Letters, with Encuentros, with Diocesan Hispanic Offices, with Hispanic Youth and Young Adult Ministries. How are we plugging in our need for Hispanic chaplains? What are we doing at the grassroots level to invite young men and women to join our ministry? How are we inviting those whose skin color might be different than ours to join our association? Do people of color experience us as willing to mentor them into this ministry? Or (dare I say this) have we made this ministry a "white person" ministry?

What keeps people of color away

from becoming chaplains? Or maybe they are out there, but they are not becoming members of the NACC. So what keeps them from membership? Are we not inviting or are our requirements and our standards not welcoming to people of color? Should our interviewing teams be trained in interviewing people of color or people whose second language is English? Is there a difference and is that difference big enough to incorporate into our training, into our association?

What do we need to do? I ask this because it affects all of us in each region, with the influx of Hispanics all throughout the United States and not just one particular area.

I invite each you as NACC members to look around and see how many people of color are ministering alongside you. Now that you know who they are, ask them if they are NACC members; if they are not, ask why. Maybe they aren't even aware that we exist. I didn't! I trained at an ACPE center and was not even aware of the NACC, even though there were several NACC members in the hospital surrounding my training center. I met these sisters and deacons at several meetings, but "Are you a member of the NACC?" never came up in conversation. I also believe that it is now that the NACC must put the faces of people of color in our materials.

So maybe all we need to do is talk about our membership with the NACC. I for one am committed to increasing our membership, especially our Hispanic membership. Me quieres ayudar?

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Many Rooms in the One House

Rev. Joseph J. Driscoll
President and Chief Executive Officer

Night unto morning and morning unto night—30 of them to be accurate, on my month-long retreat two years ago—I dozed and rose to the rhythmic roll of the ocean outside my window on the Gloucester coast of my native New England. A tireless motion of this strong woman scrubbing with suds the jagged rocks on the one side of the house, and simultaneously mopping up the smooth sands on the other side. Nature always replenishing, refreshing, and renewing her beauty after men and women scuff the floor, or dirty the walls, in our carefree wandering around this earthly house of God.

The rhythm and the roll of those waves are as universal as the moon behind them. Always moving; always the same. As the psalmist says, “Deep calling deep . . . day unto day takes up the message, and night unto night tells the story.”

But Gloucester is a particular room in my Father’s house. And there are many rooms. On this continent alone, there is the pristine panoply of emerald green of Prince Edward’s Island, or the majestic cascade of cliffs along California’s Big Sur, or the solitary plateau of Padre Island’s gulf beaches, or the necklaces of turquoise jewels in the Caribbean and South American islands. Each place is different; each place is particular.

No wonder water is the essence of life, physical and spiritual. Water in its simple, yet life-sustaining essence is one and the same, and yet this same water in its complex and diverse forms is many and varied.

- A roaring waterfall; a still pool.
- A massive ocean; a beaded raindrop.
- A winding river; a rounded pond.
- And so on.

Water holds life, transports life, gives life, sustains life. Water is universal in its essence; water is particular in its form.

Universality and particularity are two words that we will be hearing a lot about during the next few years as chaplaincy is transported and given new life. Our ministry is being transported into a new and ever-changing environment with potential new life born in the plentitude of opportunity.

We, in the association, are at an historic turning point in ministry, both in our identity as a universal profession, and in our particularity as a Catholic ministry in the Church. The two have been intimately linked from our beginnings; the health care world demanded a specialized minister, the Church world recognized a specialized ministry.

Universality

Last November, in the midst of an animated and engaging discussion among board members, national office staff, and strategic planning task force chairs, Sister Jean de Blois, CSJ, formulated what would be a critical question not only for our association, but in turn, for the other cognate groups in our later discussions. She said, “You claim yourself as a profession, but the question is, ‘Do others claim you as a profession?’”

The answer that came immediately to me was “no.” Why? Simply put, JCAHO—the arbiter of the health care profession in general—does not require certified chaplains in their accreditation review. Physicians, nurses, pharmacists, respiratory therapists, physical and



occupational therapists, social workers, even dieticians need certification or licensure to practice. Spiritual care providers are not required to have professional certification or licensure to operate in a health care institution according to the JCAHO standards.

Jean went on to say, “Nursing went through the same thing years ago. It wasn’t until we had one clear set of agreed upon standards for everybody that we then would be recognized as a profession.” Rev. Walter Smith, SJ, from his own background concurred that same thing happened with the psychologists.

So while it may be somewhat disconcerting to hear that we are not fully a “profession,” at the same time we can take assurance from the knowledge that we are walking a well-worn path that has been trodden by other professionals coming of age.

As a profession, chaplaincy, pastoral counseling, and pastoral education are disciplines that require certain competencies and skills that transcend any or no religious affiliation. When someone is facing a life-threatening illness, for example, there are universal emotional and spiritual “symptoms” that are present, calling for universal emotional and spiritual interventions that are common to all of us in the profession.

The initial response of denial, or anger, or fear, or depression, is the same in the Roman Catholic patient as it is in the Jewish patient. The culture may be different, but the underlying dynamic is the same. Attached to the emotional response at some level, and expressed in some form, is the spiritual question(s). The intervention that the chaplain offers in this pastoral encounter is the same whether or not the chaplain is Presbyterian or Muslim. The culturally appropriate way of approaching the patient may be different, but not the underlying response in caring for this person’s spirit.

The pastoral care, counseling, and education movement has known the truth of universality since our beginnings over 70 years ago. Training of specialized ministers transcended religious denominations, and in fact, it soon became apparent that the learning environment was enriched by the particularity of the different faith traditions.

If you were to look at the current standards of our five or six organizations, it is amazing how similar are the competencies that we articulate, oftentimes borrowing from one another. When looking at the development of our organizations from this historical perspective, it now appears that the next logical step would naturally be the adoption of one set of universal standards.

One of the most exciting aspects of this collaborative venture is the innate treasure of wisdom that will surely be unearthed in the dif-

ferent organizations each bearing the gifts of a particular culture. This wisdom was already evident in the conversations in Toronto, as well as present in the subsequent regular communication of the presidents and executive leadership in our monthly conference call meetings since that time.

We are at this exciting time in history as we are transported along a life-giving journey toward full recognition as a profession in health care.

Particularity

We belong to one universal profession, but each organization has its particularity. For us, the particularity is our Catholic identity that is core to our mission. Catholic identity is who we are, and why we exist as an association of those sharing in the healing ministry of Jesus Christ, founded out of, and ministering by, the authority of the United States Catholic bishops.

Until very recently, we were pretty much alone in our denominational identity. Historically, the Association of Professional Chaplains was affiliated with the American Protestant Health Association, and was viewed as the traditional "Protestant" organization, though in fact the then College of Chaplains, and later APC, was interfaith.

Newer to the professional pastoral care, counseling, and education movement has been the National Association of Jewish Chaplains (founded in 1987). After the early years of forming its own identity, the NAJC emerged as a collaborative partner in the white paper project on chaplaincy written by the major North American pastoral care, counseling, and education organizations. Now we had a sister organization who likewise had a religious identity rooted in its own faith tradition. We were not out there alone.

The presence of the NAJC the last few years as a collaborative partner has, I believe, challenged us to claim our own Catholic identity in a new and more vigorous way. For a while it seemed that we felt a need to downplay our particularity, in order to emphasize our common identity with the other organizations. And while this was, and still is, important to our collaborative work together, the presence of NAJC affords us an opportunity to celebrate our particularity, not only for and among ourselves, but more important, to share that gift with others.

At the Toronto meeting, the NAJC had select workshops open only to their members. Many of these workshops sounded great and conference participants were initially disappointed that they were closed. The Jewish chaplains explained that they did not intend to exclude anyone, but rather they needed time together to dialogue about common concerns. If they opened those workshops, they would be explaining the Jewish customs and religious practices to participants rather than deepening their own understanding and practice.

A few of the NAJC leaders told me that they assumed that we would be conducting our own closed sessions for Roman Catholics to dialogue on internal concerns. I smiled when I heard this, and thought to myself, "We would never have imagined such a possibility," but you know, in a world of particularity and universality, why not have some time to process our own internal issues?

Particularity, our Catholic identity, is very important to our mission, and very important to our bishops who mission us. This clarity of our identity will be even more important as we move toward

one set of universal standards for the profession of chaplaincy, for supervised pastoral education, and for one code of ethics. Attention to both will in fact strengthen both.

During the last few years, the bishops have become more aware of the NACC, our extensive training and professional certification processes, and the reality that this one time priestly ministry has evolved into an impressive ecclesial lay ministry. In the words of one of the nation's most prominent leaders among the bishops to me, "I know your organization prepares for, and judges competency for the profession, and rightly so. But how can you assure me as a bishop that these men and women have been through a formation process for ministry in the Church?"

I thought his question was excellent. My response is that our standards do attempt to identify personal, theological, and professional competencies that I would hope ascertain whether or not the person has responded to, and been formed in a call to ministry. But I do think this archbishop poses a challenging question to us as we move ahead in a universal profession conducted by chaplains and supervisors who understand and appreciate what is particular to a Catholic identity ministering in the name of the Church.

The identification of universal standards for the profession may indeed result in a shared certification process for the profession. If this turns out to be the case, then we will need some sort of process to ascertain the readiness and call to be not only a chaplain for the profession, but also a Catholic chaplain for the ministry of the Church. This need not be burdensome as an added challenge, but rather this may be an opportunity to strengthen our particularity alongside strengthening our universality.

In many ways we are already about strengthening Catholic identity. Six or seven years ago we began an official commissioning ceremony at the annual conference presided over by the Episcopal Liaison of the United States Conference of Catholic Bishops. This past fall, with monies donated by individual bishops through our donor drive, we incorporated the handing over of the Church's official ritual to the sick to the newly certified as part of the Eucharistic Liturgy commissioning ceremony.

Like the evolution of the profession, we are evolving into a formidable, and more recognizable, specialized ministry in the Church. Again the question asked of us about the profession can be applied to the Church: "You claim yourself as a specialized ministry in the Church, but the question is, 'do others (the broader Church) claim you as a specialized ministry?'" In other words, do the people (of God) know who chaplains are, that ours is a call to ministry that is fully commissioned by the Church, what that ministry entails, where the ministry is found, and how that ministry contributes to the overall healing ministry of Jesus Christ in the Church?

Toronto in 2003 will forever mark the turning point in this final coming to age of chaplaincy and supervision as a profession in the health care world. So too, Washington, D.C., in 2003 may very well mark the turning point in the coming of age of Catholic chaplaincy in the Church, if, as we hope, the bishops choose to commission a national pastoral plan for comprehensive spiritual care for our sick and dying.

Many rooms in our Father's house may look quite different after this historic year in health care and the Church. ▼

Universality and particularity are two words that we will be hearing a lot about during the next few years as chaplaincy is transported and given new life.

Marla's* Story: A Girl Abused

Sister Kathleen O'Donnell, HM

“My mother was a prostitute and a junkie . . .” That’s what 13-year-old Marla told me when I met with her for her spiritual assessment. I’m a chaplain at Corcoran House, a residential treatment program for girls and a day treatment program for boys and girls near Flint, Michigan.

Can you imagine life with a mother whose business was selling her body and selling drugs? Can you imagine your own mother selling YOUR body to her “clients”? Marla can. She was sexually used and abused by several of her mother’s “johns.” She was a motherless child. In fact she would have been better off if she had had no mother. Actually, mom is now in prison for her illegal businesses.

The department of social services took Marla away from her mom and placed her in foster care. For the previous six years, Marla has lived in five different homes. Why so many? Marla has been diagnosed with “explosive disorder.” She is so filled with rage that she is a time-bomb wherever she lives or attends school. Her medications—Depakote, Risperdal, and Zoloft—can’t keep her from exploding from time to time. Her last explosion was an assault of her pregnant middle school teacher. The assault subsequently caused the death of the baby.

Marla’s spiritual assessment is summarized as follows:

- Religious background: Marla’s mother did not have any church involvement. However, Marla identifies herself as a Baptist and was active in a church with her some of her foster families. Moving from foster home to foster home has not helped her sustain a church relationship. She likes reading the Bible and sharing prayer.
- Spiritual issues: Some key responses to questions on the SPIRIT survey:
(4) *Do you feel guilty about some of the things you have done?*
“A great deal . . .”
(20) *What are the losses in your life?*
“My mother is not dead but she is truly dead to me. I love her but she has hurt me much. I need to do something about her. I want to say stuff to her like you did with some of the other kids . . .”
(37) *Do you feel ashamed of who you are?*
“Sometimes.”

My assessment was that Marla needed spiritual treatment plans focused on the grief process (loss and abandonment by mom) and on the guilt process. I met with Marla weekly for four months. After a particularly bad day, Marla asked me for some time. The following is a “verbatim” dialogue from this session.

C1 Hi Marla. You asked to see me?

Y1 I sure did. Did you hear I got restrained for over two hours yesterday? (She says while shaking her head back and forth.) I just couldn’t stop myself. I tried to think about my triggers and touch my heart and pray but nothing worked.

C2 (Pause . . . From reading the log, I know that some of her feelings were processed yesterday in group.) How are you feeling now?

Y2 Do you want me to point to a feeling? (I nod my head yes.) Lonely. (I was going to ask her more about the feeling when she jumped in.) I feel better when God is with me than when I’m pulled apart. (She looks at me and says) Oh, I know we’ve talked about God with me all the time but I need this “God” time with you. Can we talk about my mom? Lisa [a peer] told me you were working on a letter with her. (Marla has spent much time sharing feelings about her mom as part of her loss-grief recovery work.) Before I couldn’t do it. Now I can. (She seems to be talking faster.)

C3 Why do you feel you can do the letter [to her mom] now?

Y3 I have to do it now cause I’m leaving soon (said in a high pitched voice). (As a result of meeting with the state worker she is going to be in the foster home. They are willing to try and work with her.)

C4 How do you feel about going?

Y4 I’m not ready but this is my last chance. Too many group homes and now my fourth foster family. If this doesn’t work out I’ll go to [long term] residential. (She says this with disappointment and resignation.) (I flip into my frustration of dealing with the systems. The state has the power and they make the decisions. Since they’re a willing family the decision is made. I had aired some of my frustrations during the meeting with the state worker. I need to focus now.) PLEASE, CAN WE DO THE LETTER? (pleading) (The letter is to her mom so she can work on forgiving her.)

C5 Marla, I am a little hesitant that we

might not have enough time to share your feelings after you do the letter. (pause) Why do you want to do it now?

Y5 I told you. You won’t be with me and I don’t know who will listen to me like you do. (I am touched. I realize if we do the letter it can be a tool she can continue to use. She has so many problems it probably couldn’t hurt.)

C6 There will be different people in your new place who will also care about you. (It pops in my head maybe this is also closure from me.) REMEMBER, this letter is only a tool, like your journal, or your art work. It can help you share some of your feelings. You can write and share this letter or even do a different letter at different times in you life.

(I gave her the forms and explained them. I was careful to explain that forgiveness does not mean the abuse didn’t happen.)

(The following is taken directly from her written letter.)

Y6 Dear mom,

I forgive you for what you did to me. I am sorry for what I had did to got on your nerves. I am so sorry. I can forgive you for yelling at me. Yelling at us when we eat too many donuts. We were starved. Kept putting it in.

I ACKNOWLEDGE:

You did not take care of me or my brothers and sister. We were hungry and very afraid. You hit me and made me bleed. I acknowledge how you banged my head and throw stuff at me and my little brother. You hit me with a book and broke my nose. I acknowledge you did bad stuff to me. I cannot forgive you yet.

I FORGIVE:

I can forgive you for yelling at me. Yelling at us when we eat too many donuts. We were starved. Kept putting it in.

EMOTIONAL STATEMENT:

You broke my heart and my head and almost broke my hand. You were not a good mother but I love and miss you. I wish you never let men in our house. I wish you never took pictures of me for the men. I am sad that you did not help me and that I have to go from home to home.

CLOSURE: [A statement for this moment and time.]

I must say good-bye. Today I cannot say love because I have a trouble day. I wish if

(Continued on the next page.)

Marla's Story

(Continued from page 6.)

I say good-bye all my pain go away but it is still here. I want to say good-bye now.

I say it loud . . . GOOD-BYE . . .

Y7 (We sit in silence for two minutes. She then reads the letter aloud. It takes her a good 10 minutes since she cries and stops in between.) (Silence three minutes.) Right now I want to shout good-bye but I know later my heart will be looking for mom. (More silence. I want her to take the lead and she does.) Can we pray now like we do? (Before I can respond she says:) Will you forget me?

C7 Marla, I think I will remember you for

a long time. I have your name in my "Pray Heart" (I have a book that I have the youth write in and tell them I pray for her/him each day.) I think you will be in my heart. (I look at her.)

Y8 OK. I will pray first. Sometimes I do wrong things and I get restrained and now I lost another family. Please help me God.

C8 Loving God, help Marla remember "Even if her mother forgets her you will not forget her" (Is 49). (Marla leans over and grabs my hand). (We sit in silence. Then Marla starts to say the words. We say The Lord's Prayer together. After this time of prayer, Marla and chaplain made plans for a church service.)

Y10 I want to do like the other. I want to go to church, read from the Bible, light a

candle, playing music and burning the letter. I want to ask God to help me forgive my mom and also have God give me big help to be sorry for all the things I have done to my teacher.

We celebrated the memorial service together. Marla had chosen the music and Bible reading (The Lost Sheep). Marla read her letter out loud again and said good-bye to her mom again . . . and let go some of her pain for now.

* Not her real name.

(Kathleen O'Donnell, HM, has been a chaplain for Holy Cross Children's Services for two years and was certified in 2002.)

Matt's Story: The Boy Who Killed His Father

Sister Mary Laurel Smith, HM

Matt entered our program, and unlike other youths who frequently have a long history of criminal behavior he had only one offense. But it was a big one: Matt killed his father.

Matt was 13. His brother, Nathan, was 15. They were physically abused all their lives. And they witnessed their mother's abuse by dad as well. Matt and Nathan were at least the third generation in a family line of abuse. Their dad was a product of violence in his family of origin and an alcoholic. Jenny Gray didn't know what to do with her husband. The kids didn't know what to do. The kids couldn't take it anymore.

Matt was 15 when he walked into my office for his initial spiritual assessment. He had been through a lengthy court proceeding and placement in detention prior to arriving at Holy Cross Children's Services, Clinton, Michigan, campus. Now he was sitting in my office and I was wondering how open he would be about his crime on this first visit.

C1 Hi, Matt. I'm Chaplain Laurel.

M1 I'm Matt. What are you going to do?

C2 I would like to talk about your spiritual life—what you believe . . . I see from your survey that you believe in God.

M2 Yeah. I'm not Catholic or anything like that. In fact, I don't go to church much. We never went to church much . . .

C3 We?

M3 My mom, my brother and father—well, he's dead now.

C4 How did he die?

M4 I shot him. That's what I'm here for . . . (He was looking straight at me and waiting for my reaction. I took a minute to answer as I was quite shocked that he blurted it out with no visible emotion.)

C5 Wow, I'm shocked . . . Do you want to tell me what happened?

M5 He was always drinking. When he wasn't drinking, it was better.

C6 Would it be easier to start from the beginning?

M6 I guess. I've told so many people—police, lawyers, doctors—he takes a deep breath). Things were all right till I was about six.

C7 How old was your brother?

M7 Nathan was about eight. We had just moved into a new house. That's when dad started to hit us and yell at us. We knew to get out of his way and do what we were supposed to do when he was drinking.

C8 Were you going to school?

M8 Yes. We had time in the morning with mom. That was good. I was happy not to see him in the morning.

C9 He'd go to work early and then he'd be home about 4:00. Mom went to work at 2:30 and didn't get home till late. We'd get home from school at about 3:00 and do our homework. When I was about eight, he started really hitting me around—with his open hand or with his fist. Once he hit me with something and knocked me out. I'd try to tell him to stop.

C10 What did you do then?

M10 We had our chores to do—inside and out. Dad said we had to help mom because she was working, so we did the dishes and the cleaning. Then we went outside and had to do the yard work. We had a big yard. That was hard work.

C11 Did your school friends come over?

M11 Mom would sometimes tell us we could have kids over when my dad wasn't coming home. We never had kids over when dad was there. You'd never know what was going to happen.

C12 Did he go to work every day?

M12 Yeah, but when things didn't go right at work he'd really be mad.

C13 What happened when he was mad?

M13 He'd keep drinking.

C14 Do you think your dad loved you?

M14 At the beginning, when he wasn't drinking. No, I don't think so. He told us we were responsible for the problems between him and mom. Said it was all our fault. It wasn't. It was him drinking. If he really loved us, he would have stopped drinking. Stopped hitting us and knocking us around.

C15 Were there any happy times?

M15 Once, when I was about 10 we went to Disney World. That was pretty fun. Dad didn't drink too much . . . It was the alcohol. If there wasn't any alcohol, he would be OK.

(Continued on page 8.)

Matt's Story

(Continued from page 7)

C16 Nobody was forcing him to drink. That was a choice he made.

M16 Yeah, but if there wasn't any alcohol, he wouldn't get drunk.

C17 How do you feel right now?

M17 I'm OK.

C18 Do you want to continue?

M18 Yeah. Then when I was 13, mom was working and Nathan and my dad were staining the deck. They were almost done and my dad was drinking. Dad said, "I wish my parents were dead because I never see them." He then turned to Nathan and asked him to shoot him. Nathan had a target he used to shoot at and dad said, "You could say it was an accident." Nathan said, "NO" and he turned and saw me standing there. He started toward me and asked me to shoot him. He said, "I know you want to." And I'm saying, "NO!" putting a wheelbarrow between us. He had been drinking a lot and turned toward the door to go into the house. He fell down—must've passed out. We stepped over him to get into the house. I went into my dad's room and got his gun and gave it to Nathan. I took the case and put it in my room.

C19 What is going through your head at this time?

M19 I knew that we needed to protect ourselves. Then we went to see if he was still there on the ground. We waited in the backyard.

C20 Wasn't there anywhere you could go? A relative?

M20 We all had talked about that before. He said no matter where we went, he'd find us and it would be too bad for us.

C21 What happened then?

M21 We heard someone calling. It was Nathan's girlfriend and we were talking to her when we heard someone moving. I said, "Dad's coming. Come on." Nathan hung up and ripped the phone cords out of the wall. We didn't want the phone to wake him up. I had put the gun under the mattress, and Nathan was sitting in the room when dad called me to come. He wanted me to scratch his feet. Then he fell asleep again. Nathan had gotten the gun and hid it under a chair in the living room. We were waiting to see what happened.

Dad called me again to scratch his feet and was telling me it was all our fault for the marriage problems. He looked real stern. He started swinging at me and saying it was all my fault. I kept saying, "It's not!

It's not!" He was hitting me in the head when Nathan came in and screamed, "Stop hitting him!" and he told me to come into the other room. I got the gun. Dad followed us in and started saying, "Shoot me right here!" (pointing to his forehead). "Tired of me abusing you?" "Nathan, call 911." "Don't play with my guns!" He looked at me like this (Matt makes a hate-filled look). I shot him. He fell over and just laid there. Nathan asked me if he was dead . . . told me to go see. I went over, very close, and put five more shots in him. (Matt was afraid that the dead man might suddenly spring up and get him, like they do in the movies.)

C22 How are you feeling right now?

M22 Some people asked me if I would do it again. And I said I would.

C23 Could you have done anything else?

M23 We knew that if we left, he'd find us . . . If he didn't drink, things could have been different.

What does a chaplain do with such a case of violence? Well, the first thing she does is consult with the treatment team. Tim was the group therapist on the case and the head of the treatment team. He remembers how Matt began treatment fairly guarded about his story. Gradually, he came to trust his peers and staff.

As it became clear to Matt that he could talk about what he had done, including his thoughts and feelings about it, he began to change. He opened up, took risks, and talked about the abuse at the hands of his father. The whole family became involved, including some supportive aunts and uncles. I teamed up with the family social worker to do much of the family work.

After several months of sorting out the story and working with Matt, his brother, mother, aunts and uncles, the story ended up much like Matt had described it: Mom, Matt, and Nathan didn't know what to do to stop dad. Matt acted in the only way he knew how to stop dad forever. He could have, should have, found another way, but he didn't. His motivation was to protect himself and his family from injury by dad. Self-defense.

The whole family was led through a grief process around this story. Mom was grieving severely the death of her husband while she understood Matt's motivation. Nathan was afraid to act and was glad Matt did. Matt took responsibility for his rash decision. By the end of his treatment, I led a memorial service for dad in which Matt read his letter to his father.

Dear Dad,

I am sorry for the things I put you through. I am sorry I did things I should not have ever done, like lie to you, and not do the things you asked me to. I am sorry our lives did not turn out the way we wanted them to, and will always regret the decision I made. I am sorry for messing up some of the good times we had, and I am sorry I messed up for the good times we could of had. Dad, more importantly I am sorry for taking away your life.

You did things that hurt mom, Nate, and myself. I want you to understand that I forgive you for what you did to us. I forgive you for the times you abused mom, and threatened her life. I forgive you for all the times we could have played all day but couldn't because you had us working. I forgive you for raising us the way you did. I forgive you for the abuse that you put my brother and I through for all those years.

I want you to know that I don't feel the same as I used to. I start to feel sad when I think of you, knowing you'll never come back. I also feel afraid that not having a dad will make life more difficult, as I would not have you around to guide me through everyday life. I feel bad you are not around anymore, although I do have a certain level of relief knowing the abuse is over. I have feelings of anger at times I think about how good things could have, and should have been.

I remember a lot of bad things that went on. I recall the times we had long fights that seemed not to end, and when you put your hands around my mother's neck. I remember when you would come home drunk, and yell and hit at Nate and me. I remember the time I lied and said I had no school work, but I did. When you found out, your punishment to me was a beating I thought would never end. I do have memories that are good to hold on to also like the trip to Disney, and the few times we went to Cedar Point. I remember taking bike rides and fishing in our pond.

(Continued on page 9)

Matt's Story

(Continued from page 8)

Things are going good for us, and I wish you were here to be with us. I wish you never started drinking, and none of the abuse never occurred. I wish that the times I lied to you, and did not listen to you never happened. I wish that there was a way I could have helped you instead of losing hope. I wish I was not so afraid of you, and that I did not take away your life. I wish that we could have had more happiness in our lives as a family.

I am thankful for the good times we had together. I am also thankful for keeping me from doing wrong and keeping me away from harmful things like drugs and gangs. I am thankful for the times you taught me the things you knew and helped me. I am thankful you did not physically abuse mom as much as you did Nate and me.

I must move on now, and leave the pain behind me.

I love you dad,

Good-bye,

Matt

It is now more than a year after Matt was discharged back into his family home. His mom is still grieving the loss of her husband, but she and her family are doing well. She is proud that Matt has done so well in school and is preparing for high school graduation in June 2003.

(Sister Mary Laurel Smith, HM, been a chaplain for Holy Cross Children's Services for three years and was NACC certified in 2001.)



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Look for updated information in future issues of *Vision*.

In Memoriam

Please remember in your prayers:

Sister Olivia Prendergast, CCVI, of Paris, Texas, who died on March 18, 2003, at CHRISTUS Santa Rosa Hospital in San Antonio. A certified midwife and registered nurse, Sister Olivia served on the staff of Santa Rosa Hospital and as faculty at Incarnate Word College. She ministered to the sick at Spohn Hospital in Corpus Christi, St. Joseph's Hospital in Albuquerque, Saint Anthony's Hospital in

Amarillo, and St. Joseph's Hospital in Paris. Among her greatest achievements was her recognition as the woman who founded hospice in the Texas Panhandle. Under her leadership, Saint Anthony's Hospital created the Life Enrichment Department in 1980. This innovative center provided assistance and resources to terminally ill patients. The program was honored in 1984 with the Most Outstanding Hospice award from the State of Texas.

In 2002 Sister Olivia published a book that serves not only as a tribute to those who helped her found the first free-standing hospice center west of the Mississippi, but also as "the inspiring story of a woman who allowed God to enter her life in a powerful way and to lead her into a unique healing ministry where few had practiced the art before" (Most Rev. L. T. Matthiesen, retired Bishop of Amarillo).

Rallying Points

Improving Community End-of-Life Care through Coalitions

African American Aging and Health Care Relevant to Care and Caring Near and at the End of Life

[This article is reprinted with permission from *Diversity Notes*, September 2002, a publication of *Rallying Points*. National Resource Center on Diversity in End-of-Life Care (NRCD), 4201 Connecticut Avenue, NW, Suite 402, Washington, DC 20008; (866)670-6723.]

Culture/Ethnicity

African Americans comprise a very diverse population. Variations are based on regional, urban, and rural differences, age, education, and socioeconomic status. Depending on the region of the United States, immigrants from the Caribbean Islands and countries in Africa may be included in the African American diaspora. However, their experiences, language, and culture add to the diversity of African Americans in the United States.

Aging in America

By the year 2030, there may be as many as 7.3 million African American elders in the United States. African American elder adults continue to live in the community, with and because of the support and assistance of their family members. African American families cling to values of responsibility to family, the extended family network, and home care for relatives for as long as feasible.¹ As a result, African Americans traditionally have a low use of formal caregiver services.

Caregivers and African American Families

In a 1994 study of mother-daughter dyads, the finding was that African American daughters have a strong sense of filial responsibility which made them less receptive to the use of formal services.² In another 1994 study, the findings were similar—a strong sense of filial obligation and intergenerational ties among caregivers caring for elders with dementia.³ Thus, family assistance continues as the primary support.

In a 1993 study of family caregivers, caregivers were predominantly female and care recipients were also primarily female. The majority of elders lived with and were primarily cared for by family members. The cultural values of these families supported family care as opposed to institutional placement. A significant portion of the caregivers were caring for aunts/uncles supportive of

strong family values which extend to relatives outside of the immediate family.⁴

Health Care Disparities

Significant disparities in the health care system have resulted in unequal access to health care including hospice and palliative care:

- According to an AARP report (May 2002) on health and insurance coverage, Hispanics and African Americans aged 50 to 64 were more likely than their white cohorts to not have seen a health care professional in the past year. While one in 10 whites aged 50 to 64 are uninsured, the rate for Hispanics is one in three and for African Americans one in five.

The process of dying, more than other moments in the course of medical care, can accentuate cultural differences between patients, families, and providers.

- Forty-three (43) percent of seniors (70 and older) who lack prescription drug coverage and who are either minorities, have an annual incomes of less than \$10,000, or have high out-of-pocket prescription drug costs greater than \$100 a month, restrict their use of prescribed medications because of cost.⁵
- Numerous studies have found that African Americans are more likely to be undertreated for pain than whites in emergency rooms, during hospital stays, in outpatient clinics and nursing homes.
- In addition, in a recent national survey of over 6,700 individuals who reported having a regular physician found that African Americans, Asian Americans, and Hispanics are more likely than whites to experience difficulty communicating with their physician.⁶
- The National Hospice and Palliative

Care Organization estimates that of the more than 600,000 Americans who died while receiving hospice care in 2000, eight percent were African American.

- African Americans are less likely to have advance directives in place, although they support the concept of planning for end-of-life care by using planning tools (*American Health Decisions*, 1997).
- African Americans are more likely than Caucasians to mistrust the health care system and its providers.
- Both African American patients and African American physicians value the length of life at the end of life as a measure of successful medical treatment and are more likely to employ life sustaining treatments and other aggressive measures.

¹ African American Voices: African American Health Educators Speak Out, Ruth Johnson, Editor, 1999, Aging, Caregiving Effects, and Black Caregivers, Sandra Sayles-Cross, 165–177.

² Price, M. (1994). African American daughters attitudes about caregiving to frail elderly parents. *The ABNF Journal*, 112–116.

³ Kelly J. D. (1994). African American caregivers: Perceptions of the caregiving situation and factors influencing the delay of institutionalization of elders with dementia. *The ABNF Journal*, 106–109.

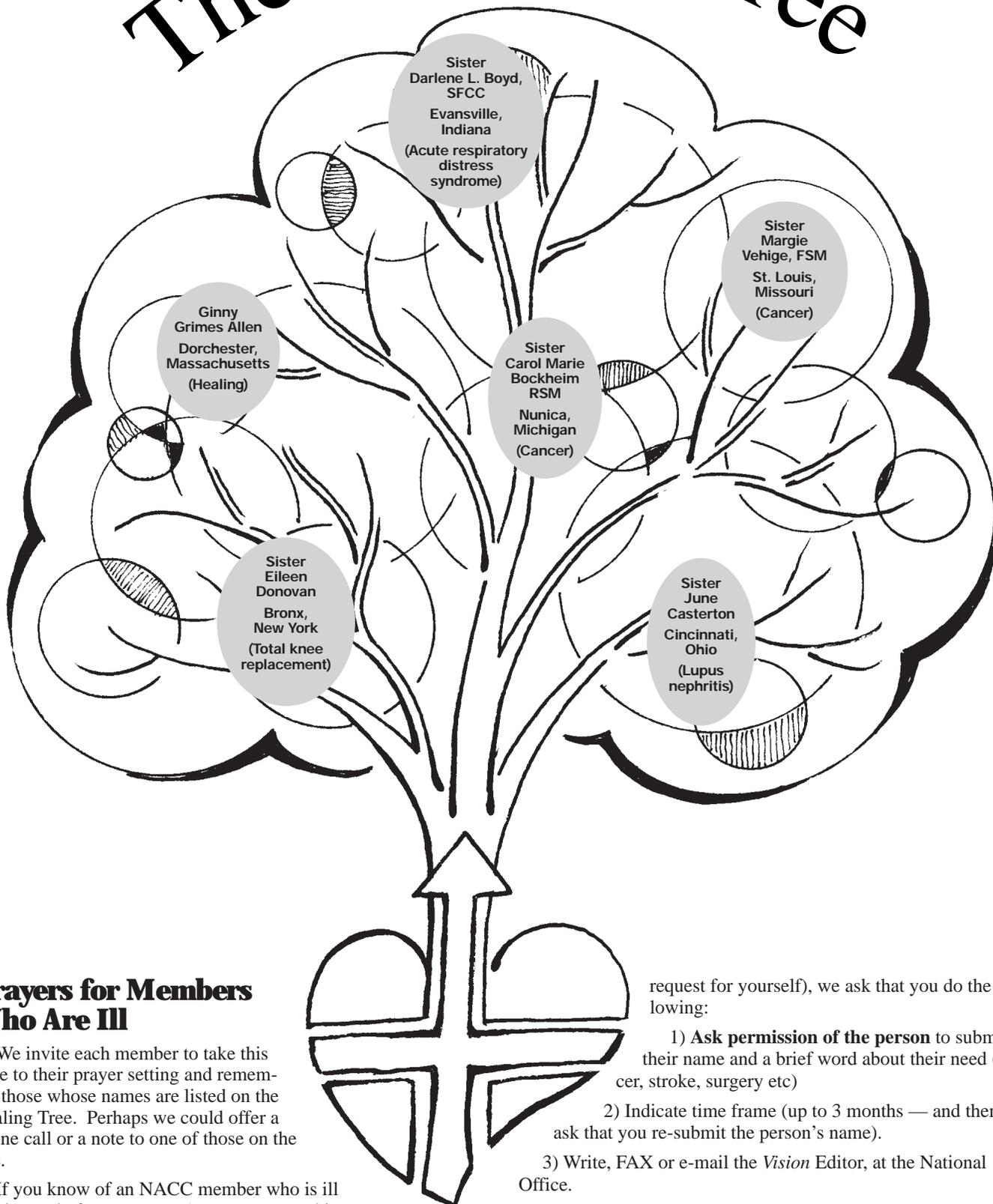
⁴ Sayles-Cross, S. (1990). Perspectives of familial caregivers of elder adults. *Image*, 88–92.

⁵ *Journal of General Internal Medicine*, December 2001.

⁶ Testimony of Lisa Cooper, MD, MPH, Associate professor of Medicine and Health Policy and Management, Johns Hopkins University School of Medicine and Bloomberg School of Public Health – Hearing on Racial Disparities in Health Care before the House Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources—May 2002.

For more information contact: National Resource Center on Diversity at (866)670-6723. *Rallying Points* is an initiative of The Robert Wood Johnson Foundation's Last Acts campaign to improve care and caring near the end of life.

The Healing Tree



Prayers for Members Who Are Ill

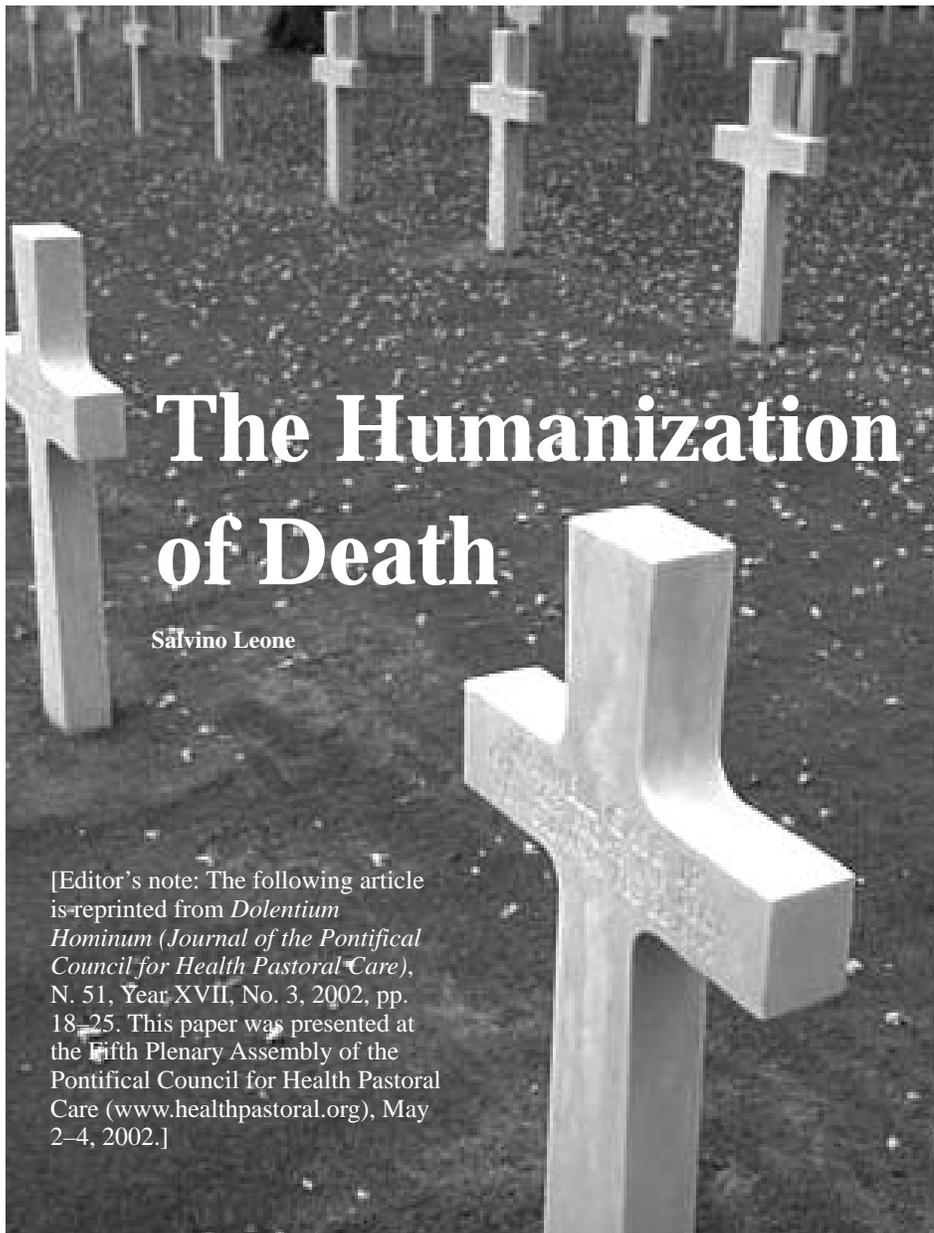
We invite each member to take this page to their prayer setting and remember those whose names are listed on the Healing Tree. Perhaps we could offer a phone call or a note to one of those on the tree.

If you know of an NACC member who is ill and in need of our prayers, (or you may send in a

request for yourself), we ask that you do the following:

- 1) **Ask permission of the person** to submit their name and a brief word about their need (cancer, stroke, surgery etc)
- 2) Indicate time frame (up to 3 months — and then we ask that you re-submit the person's name).
- 3) Write, FAX or e-mail the *Vision* Editor, at the National Office.

-Joe Driscoll



The Humanization of Death

Salvino Leone

[Editor's note: The following article is reprinted from *Dolentium Hominum* (Journal of the Pontifical Council for Health Pastoral Care), N. 51, Year XVII, No. 3, 2002, pp. 18-25. This paper was presented at the Fifth Plenary Assembly of the Pontifical Council for Health Pastoral Care (www.healthpastoral.org), May 2-4, 2002.]

1. Man Faced with Dying

Down the centuries, the sets of questions and issues connected with the culture of death have helped to form a certain "idea" of death, or better a different way of "living death," according to the different cultural sensibilities of the various historical periods.

Philippe Ariès is the historian who more than any other has studied the subject, and his work has become an obligatory work of reference.¹ In his inquiry he identifies four great periods.

a. The first period was that of **tamed death**. In practice, it lasted for millennia and continued until the medieval period. Man knew that he had to die and waited for this event with a certain peace of mind; often he knew that little time living remained to him, but he was not worried

about this fact. At times, indeed, he prepared himself to wait for death with ritual acts (he crossed his arms over his chest, he lay down in the direction of Jerusalem, etc.). The event was not experienced in the darkest loneliness, indeed it was almost an organized public ceremony: "the room of the dying person then became transformed into a public place. People could enter it freely. The physicians of the end of the eighteenth century who discovered the first rules of hygiene were little concerned about the crowding of the rooms of the dying. Still at the beginning of the nineteenth century, the passers-by who in the street met the small procession following the priest who was carrying the viaticum accompanied him and behind him went into the room of the sick person. The relatives, the friends and the neighbors of the sick person had to be present. Children were brought

in: until the eighteenth century, indeed, there is no picture of the room of a dying man which does not have children in it. When one thinks about the precautions that are taken today to distance children from the room of a dying person! Lastly, a final observation, and the most important one: the simplicity with which the death rites were accepted and carried out, in a ceremonial way, but without a dramatic character and without excessive emotion."²

b. From the twelfth to the eighteenth centuries the "socialized" dimension to death began to retreat, and death came in an increasingly exclusive way to involve only one individual. This is what Ariès calls **death on one's own**. "The generally apocalyptic tomb paintings of the past were substituted by 'personalized' elements which contained judgments on one's own works: Christ the judge, Our Lady and the saints asking for intercession at her feet, the 'book' of works hung around a person's neck, etc. In the iconography, the rooms of dying people are crowded with new figures: angelic and infernal forces struggling for the soul. Because of the influence of the mendicant orders as well, the assessment of the works done by the person during his life acquired an increasing relevance. Lastly, the macabre themes appeared: skulls, bones, corpses, lugubrious and shadowy images. This was the sign of a horror which began to advance and which emphasized the element of detachment from the goods enjoyed during one's lifetime. In practice "a drawing near of two categories of mental depictions took place: those of death; of the knowledge that somebody had of one's own biography; of passionate love for the things and beings possessed during one's lifetime. Death became a place where man became most aware of himself."³

c. Beginning in the eighteenth century, death underwent a new process of socialization that did not retrieve the taken for granted aseptic character of "tamed death" but developed, added to and projected the experience of "death on one's own"—**this is the death of the other person**. "Death in one's own bed, as once happened, had the solemnity but also the banality of seasonal ceremonies. Everybody expected them and participated in the rights established by custom. Instead, during the nineteenth century a new passion gained hold of the onlookers. Emotion agitated them; they wept, prayed and gesticulated. They did not reject the gestures dictated by custom—on the contrary. But they carried them out in a way that deprived them of their banal and customary character. By now these gestures were described as though they had been invented for the first time, as though they

were spontaneous, inspired by a passionate pain, which was unique of its kind. Certainly, the expression of the pain of the survivors was due to a “new intolerance towards separation.” But the disturbance did not survive only the bedside of the dying person or the memory of those who had passed away. “The idea of death in itself was emotionally moving.”⁴

d. The final period, which goes from the nineteenth century to today, is that of **forbidden death**, the fruit of a vast cultural movement that probably originated in America and from there was extended for the most part to the countries of the Western world.⁵ A profound change in sensibility, attitudes and forms of behavior towards death arose, which, given the repercussions for the ethical questions that we are addressing in this paper, requires detailed analysis.

2. “Forbidden Death” in Contemporary Western Society

In seeking to investigate the characteristics of this “forbidden death,” as it is so defined by Ariès, we can summarize them with a few key concepts of an anthropological-cultural character. They may be deliberately confined at the level of analysis to Western society given that experience of such forbidden death has been clearly of a very different nature in oriental or tribal cultures.

a. **Denial.** This is expressed essentially in the various forms of “censorship” to which contemporary culture has subjected death. First of all, there are *social forms of censorship*, as result of which, as a very effective phrase of one scholar would have it, a real “pornography” of death has now become established.⁶ What was once the taboo of sex is now the taboo of death—it is simply that the object subjected to a taboo has changed.

From this springs various forms of oral censorship: it is no longer children who are born under cabbages but grandparents who

go off for a long trip or for a walk in a large garden.⁷ Death is no longer talked about, addressed, or discussed; its very name is euphemistically masked and avoided—the loved person “is no longer with us”; he “has gone away,” or he has been “lost.”

The masking of death is even more evident in the *visual forms of censorship* that take place *de facto* in the common American practice of the *maquillage* of corpses, a practice by which the dead person must not appear as such but must almost appear as a living person who is asleep. The *physical forms of censorship* could also be seen in this light. These take concrete form today in the increasing preference for cremation in the place of more customary burial, which may be seen as almost the expression of a wish to bear witness to a refusal of that physical nature which is destined to decay.

But the greatest example of the application of a taboo is certainly achieved in *cognitive forms of censorship*, where death is often concealed from the dying person himself. From a correct criterion of “psychological proportion,” of adaptation to the receptive capacities of the subject, we have passed, in fact, to the arbitrariness and by now almost universal custom of concealing the seriousness of a pathological state or the imminent possibility of death from the interested party. The idea of harming him thus provokes a certain “expropriation” of the event, which belongs to him and which he has the right to experience in full knowledge. This praiseworthy but superficial sensitivity towards the dying person even leads to the request, on the part of the relatives of the comatose person, “not to speak because he can hear us” or to the construction of very complicated intrigues marked by lies involving the medical doctor who is asked by the relatives to take part in the game that is being played.

b. **Privatization.** At one time death was a kind of death that was greatly participated in by people. Those in the neighborhood expressed their solidarity in a notable way

providing meals for a number of days or by doing the housework. Close at hand during joyous events (marriages, births, baptisms), other people were also near at the moment of pain.

All this has been progressively disappearing. Pain, but also death as a “social” event, has been increasingly interiorized, and to such a point that the “other person,” who was at one time sought out for his comfort and help, now is a factor of disturbance. He is told: “Forget about the visits.” Twentieth century man wants to be left alone with his pain, but above all else he wants to be left alone with his death.

This privatization does not only affect the individual sphere, it also affects the social sphere. Although, on the one hand, the idea is to leave people alone with their own pain, on the other hand, it is not felt necessary to point out such suffering to society. The external trappings of mourning disappear; indeed, they give rise to irritation. Obituary notices on walls no longer exist, and often the death of a relative is not communicated at all. Today, funerals, and not only funerals that are strictly religious in character, are becoming increasingly simple: a *simple* coffin is wanted, a *simple* funeral, and a *simple* grave. The baldachins in front of the church are disappearing, as are the eight days of mourning, the lengthy examples of “accompanying.” Undertakers, for their part, have become transformed linguistically—they have become “funeral companies.”

c. **Loneliness.** On another front, however, such radical privatization is also an expression of the loneliness that surrounds the dying person. Everybody flees from him. First of all, his family relatives flee from him, either because they are weakened by being present in a powerless way at the side of a long experience of suffering or because they are incapable of transmitting the inevitability of the event to their loved one.

(Continued on the next page.)



Secondly, the health care workers flee from the dying person. From this point of view, the usual question of whether to tell the truth or not to the sick person should be inverted. Too often, in fact, one is dealing with a false problem which in reality conceals the difficulty that is encountered—the embarrassment felt by, or the real and effective inability of, the medical doctor when it comes to communicating a bad prognosis to the patient or to being prepared to answer the many questions that the sick person will ask him because of that communication.

Lastly, the whole community, both in its civil and church forms, also flees from the dying man. Reference has been made previously in this paper to the irritation that a visit of condolence, or in some way an approach to a person who is in mourning, provokes. This irritation also continues afterwards, during the subsequent stages, when in fact the community should be of determining importance in favoring the evolution of the mourning itself, which, instead, in most cases, comes to be abandoned to the person's own rhythms, separately from any positive help provided by other people. But the Church as well, and this point has to be conceded, is also to be blamed. An overall and rich pastoral approach to the dead is absent. In parish communities, the various groups that are present are concerned with many different kinds of activity, all of which are, it must be recognized, admirable, but they find notably little space to accompany the sick people of their parishes to their final point of arrival.

d. Secularization. Having touched on the question of the responsibilities of the Church, we cannot but bring out another failing, which from certain points of view is even more serious: the process of secularization, which has pervaded our society, has had some undoubted repercussions as regards people's ideas about life, death, and the life beyond.

This is not the place to analyze the possible responsibilities of the Church as regards this process. What we must certainly emphasize is how from all of this there has derived, in the theological-pastoral sphere as well, a weakening of the original eschatological tension of the Christian message. Naturally, this does not in the least mean that we should retrieve or propose once again the “exercises of a good death,” the thundering sermons on the fires of hell, the obfuscation of Christian joy and so forth. We must, instead, find new paths, with wise pastoral creativity, to give impetus to an eschatology that is suitable to the third millennium. Such an eschatology should be based upon resurrection more than upon eternal punishment, but it should also be informative as regards the whole existential journey of man.

Perhaps we should also attribute this catechetical void to an undoubted impoverishment of the cult of the dead, which is now in large measure a cult connected with the cemetery or even at times reduced to a mere cult of corpses. It is not to be excluded that some of the concern about the donation of organs is rooted specifically in this cultural background.

e. Medicalization. This is one of the saddest and most inhuman aspects of contemporary death. The increase in average life expectancy, the advances in medicine, and the increase in individual and social prosperity all mean that people die in their homes increasingly rarely and that increasingly often they die in hospitals, where death is no longer the concluding event of a long life but rather the terminal event of and illness.⁸ The general validity of this statement becomes of even greater contemporary relevance when it is applied to the death of young people, or, in any event, to cases of people who have not yet reached the so-called “third age,” for whom, indeed, every kind of medical treatment, even the most extreme, is sought after, asked for, and demanded in every way.

In contrary fashion, “death at home” is limited to terminally ill people for whom it is thought nothing can be done, or to elderly people who have been rejected by hospitals or abandoned to themselves because of the laziness of their family relatives. Death in such cases becomes an almost anomalous event. One can thus well affirm that a “natural” death no longer exists.

The “medical” dehumanization of death, in addition, is not only a question of social context but also of social relations. I mean by this not only that it is in some way unnatural to medicalize death to this point but also that it is unnatural to handle it in such an inhuman way. Here the *humanitas* of the medical doctor comes into play, as well as his ability to empathize with the sick person (in this case with a dying person) and with his family relatives without distancing them from one another. This is, therefore, a very complex phenomenon but it is of primary importance that the absolute and incumbent aseptic approach of the medical doctor/technician (which cannot be and must not be in any way disturbed by emotional factors) is mixed with the warm capacity for relationships of the medical doctor/man who is fully and qualifiedly involved in the event that he is following.

f. Objectification. Whereas in the past death was an event that deeply involved the subjectivity of the individual and did not go beyond that boundary, today death presents itself in its “objective” dimension and it is possible to experience it as such. The first change in direction took place during the last century with the advances in *pathological* anatomy. Death was no longer only ascertained but also explored, analyzed and defined. The causes of its occurrence were looked for, it was studied on the anatomical table, the alive existential nature of an individual was transformed into the cold objectivity of a corpse. Far from wanting to demonize the benefits that accrued from such advances, I should nevertheless state that it is evident that they affected the intangible sacredness of the deceased per-



son much more than the simple anatomical studies had previously done. Such studies, in fact, confined themselves to a descriptive account of a corporeal reality that was no longer alive; they dug deep into that corporeal reality in order to discover the causes of death.

A second objectifying element came from *representative fiction*. It is certainly the case that theater, from time immemorial, has portrayed death, but only with the advent of cinema and television did fiction reach such a high and sophisticated level in imitating reality. The result has been that people have grown used to the—albeit fictitious—death of another person seen in a calm way from an armchair. From here to witnessing “online death” is a but a short step, and at the time of some natural catastrophe this takes place, certainly with great exterior distress, but in actual fact with absolute indifference on the part of the average viewer.

The last contribution to this progress in the objectification of death took place, once again, with science, and in particular with the *medicine of transplants*. The most elementary of ethical analyses (which for that matter overlap with usual common sense) believe that for the individual to be “dead” is an indispensable element before proceeding to the removal of unique and vital organs of the body such as the heart, the liver, and the pancreas.

However, whereas, on the one hand, death must be certain, on the other hand, death cannot be so advanced as to no longer allow the use of the organ. Hence the need to define the reality of death with absolute certainty—on the one hand, without committing the tragic error of having people who are only clinically and not cerebrally dead (who are described at the level of the mass media as people “apparently dead”), and on the other hand, without going beyond the time limit when the organ is no longer available at a biological level. For that matter, the equation “he is no longer breathing = he is dead,” given the

modern advances in resuscitation, is no longer possible for those who want once again to “anatomize death” by defining those characteristic features beneath which there is life and above which there is its irreversible loss.

g. **Paradoxes.** Side by side with the forms of behavior which have just been analyzed and which tend to censure, distance, deny, and conceal the reality of death, we find others in which death is the protagonist and the specific subject of human action. First of all, *there is the wish to inflict death*. I am not speaking here so much of the criminal murderer or of the psychopathic killer but of the very large number of people who are absolutely in favor of the death penalty. This, for that matter, is not seen as a painful but inevitable necessity but as a correct punishment which delegates personal vengeance and the inability to dispense capital punishment oneself to the state.

Suicide, instead, can be a paradoxical denial of death, where the request for death is that times only a request for meaning, and thus a wish for life, for a good life, and for that joyful life that the person is unable to obtain—it is not life that is denied, but, in a certain sense, the component of death that life involves.

In the same way, a kind of confrontation with death takes place, almost a desire to challenge it in a competition, through *forms of behavior at risk*, such as games involving death (Russian roulette, racing in cars with the headlights turned off, and so forth) or the more innocuous but symbolically no different “extreme sports.” From certain points of view, even if only implicitly, a component of this kind can also be found in drug-addiction.

Lastly, the strong resurgence of forms of animism should not, in the cultural global context of rejection of death and also, as has already been observed in this paper, of the absence of a strong eschatology, escape our attention. Such phenomena are not so

much the spirit worship of the past or dabbling in the occult as the animistic component of parapsychology or a large number of oriental religions. Here, one needs only observe the popularity of television personalities who teach people to communicate with the “world beyond” or the “accounts” of the life beyond this which in various forms are present in the mass media.

3. Humanizing the Culture of Death

From what has been said hitherto in this paper springs our first task in the humanization of death—to humanize *the culture* of death. It is precisely this culture that constitutes the humus from which spring the contemporary approaches of “incomprehension” towards death, from which, in turn, forms of behavior involving anti-values derive (first and foremost euthanasia and exaggerated forms of treatment).

a. **Overcoming taboos.** The first task in this sense should be that of the removal of taboos from death. This is not an impossible undertaking. In the case of sexuality such a radical change has taken place; indeed, there has been a move to the opposite extreme. To remove the taboo of death means to be able to speak about death, to speak its name and to speak about every other reality with which it is connected. If today we promote sexual education, and this certainly is a correct policy, has not perhaps the time also come to think about “death education”?

Certainly, there are different ways of speaking about death. Not hiding the reality of death does not mean to slap it in the face with great violence. Yet at the same time it means “managing” to speak about it, managing not to conceal it, and first of all from ourselves. It is very evident that the difficulties that are encountered in speaking about death, in the absolute and with the dying person, are a projection of one’s own difficulties in addressing one’s own death. For this reason, the first process of this

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removing of taboos from death must concern first of all ourselves. A real distancing from the lugubrious presence of death cannot be carried out with varyingly elegant forms of superstition, but by overcoming the barriers of an inability to communicate which separates it from us.

b. Giving a meaning to the event of death. It is clear that this process cannot be achieved if it is not located within the ultimate meaning of life. The real meaning of death, in fact, is the meaning of life. An unknown death, which ends an empty and fatuous life (which clearly does not mean a life full of “successes” or rich in “important” things), is a death that provokes fear and as such cannot be referred to. But a death that is an epilogue to an authentically and fully human life passed to the best of one’s potential becomes a “mentionable” death; because it is full of mystery, and in the case of the death of another person also of pain. We need, therefore, to manage to install a sort of dialogue with our own death; we need to discover its face. The *estote parati* that the Gospel urges us to engage in (Mt 24:44), has a meaning that transcends a purely religious logic by acquiring an absolutely universal dimension which every person should make his own.

c. Renewing eschatology. The shadowy over-emphasis of past centuries has been rightly contrasted with a horizontal dimension of Christianity which has remained far too much in the background, which, in its turn, runs the risk of being eclipsed or of portraying itself in tones that contemporary man is not able to understand and accept. Vatican Council II profoundly renewed ecclesiology, the liturgy and ecumenism, and established the foundations for a renewal of morality, but I believe that we still have in front of us the arduous task of a profound reconsideration of eschatology. It is not the case that this has not been done at a theological level, but it is still com-

pletely lacking at the catechetical and sermonizing level.

The difficulties that are today encountered in accepting the very idea of a “hell” (the word itself provokes profound discomfort); the difficult reconciliation between the earthly dimension and the achievement of the Kingdom; and the nebulous meaning attributed to the resurrection of Christ (which in general is perceived as the prodigious self-resuscitation of a corpse) are all elements that should lead us to a pastoral reflection that is more concerned with the sensibility of contemporary man. Furthermore, the desire for, and the “fascination” of, a life beyond this one is as alive as ever before. This is something that is demonstrated by an increasing recourse to the occult to “communicate” with one’s deceased loved ones or by the interest provoked by so-called “pre-death experiences.” What has been said, once again, does not only have value in the sphere of Christian faith but through it acquires an inevitable and much broader consequence at a cultural level.

d. Rethinking the cult of the dead. Still today the cult of the dead matches in practice the “cult of corpses.” With the exception of some liturgical moments when death draws near or in the first religious remembrances after death, our cult of the dead is a cult largely based on the cemetery. There can be no doubt that gathering together around a grave can have a strong symbolic role just as praying at the foot of a statue of a saint or going to a famous sanctuary can do the same. But this must not lead us to an undue sacralization of the body of the corpse, a practice that runs the risk of having dangerous implications—for example, the difficulties encountered in giving organs which encounter in this attitude one of the obstacles in the way of a more generous approach to this practice.

e. Placing death in the home. Even though hospitals are an almost obligatory or at least intermediate stage, we should

manage to create an approach which serenely, and without fearing forms of behavior that conceal intentions involving euthanasia or feelings of not having done the utmost, leads the sick person, when this is possible, to die in his own home surrounded by his own family relatives (if, indeed, they have not run away!), by his things, by his memories, and by his affective and emotional experiences. It is possible that all this will shorten his existence by a day or two, but to do it enriches that existence with a sense of profound humanity. Today, there is a great deal of talk about quality of life. Well, there is also a quality of death and if we believe that it is Christian and human not to oppose life, then we should be able to perceive the incumbent need not to oppose in an extreme way a death which is by now imminent, but, rather, to make its drawing near as less traumatic as possible.

4. Humanizing Our Relationship with Death

The general ethical commitments that were previously analyzed at the level of the cultural humanization of an anonymous society, acquire a countenance and a specificity that require a more direct and mediated approach to the general questions, when, that is, such a question bears upon man.

a. Forms of “painist” consolation. Even though this phenomenon has been left behind at the level of philosophical reflection, and for the Catholic Church also at a doctrinal level, there remain in the approach to the dying person major distortions at the level of pain. This is not the place to investigate this question, which, indeed, has remote origins and complex configurations. In a few words, we can say that “painism” is an interpretation of pain which attributes to it a value which exalts it, and in some cases involves it being deliberately sought after. It is by now only too obvious that in the Christian vision pain is never a good in itself, rather it can be transformed and lived for the benefit of good. The emblematic summary that John Paul II makes of this in *Salvific Doloris* is



that "Christ has taught man to do good by his suffering and to do good to those who suffer" (n. 30). Now, precisely in this perspective, the good to be done to other people lies in leading them to an objective overcoming of their suffering and this should involve active resistance and not passive resignation.

The "painism" to which reference is being made is expressed in frequent pseudo-Christian or pseudo-consolatory approaches with an invitation, for example, "to abandon oneself to the will of God." A very great deal of emphasis in this perspective has been placed on matching the reference to the will of God with the occurrence of an unpleasant event. Such "painism" has often led to people being invited to feel "that they are ill because they are the chosen ones of God" and not, as is right, the "chosen ones of God because they are ill."

b. The approach of listening. Unfortunately, we live in an epoch which has totally eliminated the ability to "listen"; this ability has been replaced with the ability to "see." Ancient cultures, which certainly had very significant modalities of visual expression (one need only think of forms of painting and sculpture that were certainly more important than their equivalents today), laid stress on the dimension of listening: the approach of the mentor who listened to the disciple, for example, or the oral transmission of literary or historical memories, or the religious dimension itself of listening.

With regard to the approach to the dying such an aptitude for listening must involve the active renunciation of omnipotence that we often attribute to our words. In many meetings with groups of voluntary workers or agents of pastoral care in health we often ask ourselves "what we should say" to the sick person or to the person who is near to death. This is a sign of an oral concern which pushes in front of what should be the real concern, that is to say a concern to hear.

The most correct question should be: "How should I listen?" There are no magic recipes, nor should we fall into the opposing extreme of a "silent" listening that does not know the right moment to intervene with intelligence and discretion. A listening approach means an ability to allow ourselves to be filled with what the person in front of us wants to communicate to us, even in a non-oral way, with a gesture, a sigh, or an act of reticence. It means knowing how to understand "what is not said" more than what is said, to bear witness through one's own presence to the fact that there is somebody who is interested in that person's experience, especially when that experience is the last of the meaningful experiences that he will undergo.

c. The appreciation of the past as an inheritance for the future. There is an approach which is almost constant in the unfolding of mourning. This consists in a "positivization" of the figure of the deceased person whose positive aspects are remembered and exalted and whose negative aspects are minimized or denied. This process of positivization, which in the case in question arises spontaneously, should also be promoted in the company of the dying person. One of the most frequent causes of sadness is a very low view of one's own past which seems to be empty, inconclusive, wasted, or a lost opportunity to realize all the potential one feels within oneself. The good death that we all want to have, and thus that we should help others to have, involves, in addition, dying at peace with ourselves. This should not only be said in religious terms but also in strictly human terms. No past is really "empty." Behind the most "useless" life there is a set, if nothing else, of forms of suffering and erroneous choices which can be re-read in the light of the present situation.

d. The mediating function in the relationships of the sick person. To humanize death means not so much to abolish human forms of reaction in the face of the nearness of death, which are in some way "normal"

and belong to the process of adaptation to its reality, but to channel them, direct them and transform them into active resources with which the patient can face up to his situation with strength. This means first and foremost taking seriously into consideration the object itself of his reactivity, which is not a distorted vision of things or the approach of a person who feels that he is a victim, but an effective interior tension which lacerates the balance that the person has with realities which until yesterday were not considered a problem. Once again in this work of mediation, great space should be given to listening because it is also through the progressive process of verbalization on the part of the patient that that journey is followed which from initial denial leads to a final acceptance of his condition.

e. Understanding the cultural universe of the patient. This does not only involve the choices as regards values to which reference has already been made in this paper, but, on a larger canvass, the entire horizon of meaning that the dying person attributes to his existence. Obviously enough, sharing is a process which is equidistant between assimilation and detachment. To understand means in a certain way to see the world with the eyes of the person who is in front of one, without necessarily having to share his vision. It is to a certain extent a filter to be adopted to understand the perceptions and the provocations that the dying person is receiving, in the same way as they are deciphered from his personal cultural codes. It is clear that this task becomes easier the more such codes are known. And it is precisely for this reason that I believe that of special importance here is an adequate knowledge of the cultural background that can most frequently be encountered in a geographical area in which there is a strong Jewish or Muslim community, or a context in which a strong migratory flow has taken place.

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Every culture and every religion (as well as every individual) has a specific way of feeling about death and this is a way of thinking that should be respected because it intimately structures the existence of the subject.

f. The prudential proposal of the Christian horizon. What has been said in this paper regarding respect for the religious cultural universe of the subject does not in the least mean that one must not offer the dying person the resource of Christian hope. Indeed, having an approach which is sensitive to the values of the dying person and the rejection of an “exaggerated desire to convert” must not hide the duty to engage in evangelization which, until and precisely at the point of death, can appear even stronger.

It is certainly the case that we need to know how to be discerning in relation to various situations, have the capacity to do all of this without the obsessive idea of seeing next to one only “souls to be saved,” and to understand that when a person is about to die as well the administration of the sacraments is not the only salvific path that God employs. The primary importance of evangelization, as people love to say today, must be kept present in such circumstances as well. God leaves man free and uses sensitivity and respect towards him. The person who addresses himself to a dying person can do no less, even if he has the duty to offer, with tact and human sensitivity, the horizon of the Christian eschatology in those ways and forms that are most in harmony with the sensibility of contemporary man.

g. The acceptance of defeats. Lastly, I believe that whoever draws near to a dying person, as in the case of any person who is in a state of need, must also bear in mind a sense of the limitation of his own action. There is always the risk, indeed, of a subtle messianic temptation. It is not rare to see people animated by the best of intentions (above all in the case of groups of voluntary workers) ready to draw near to the sick person with the strong intention of “con-

verting him” or at least of making him accept death in a serene way, or, as far as I know, of making him become reconciled with his wife and children. In reality, it is necessary to be ready to accept failures as well, which in this field as in others are often more frequent and painful. Above all in the absence of a horizon of faith which opens the door to hope, there remains the bitter feeling of a “success” that could not be attained. The sense of “free giving” inherent in the approach to the dying person must then constitute a sort of guiding value for the direction of one’s actions.

5. Two Concluding Metaphors

Obviously enough, one can never say that the analysis conducted in this paper is ever complete. But if I had to find a concluding formula, I would like to do so with two formulas: The first is the one that the film director Bergman depicts so admirably in “The Seventh Seal”; the second is provided by the ancient but always topical ascetic devotional exercise of the Via Crucis.

a. The seventh seal. As is well known, this film takes its title from the description that we find in the Apocalypse regarding the opening of the last seal, closed with a ring, that the Lamb opens. The text reads: “When the Lamb opened the seventh seal there was silence in heaven for half an hour” (Ap 8:1).

The film by Bergman centers around this strange “wait” which is expressed in this half hour of silence. The action is set in the medieval period and a knight meets death, who is ready to take his life. But the knight challenges death to a game of chess and asks death to keep him alive until the end of the game. If the knight wins, he can go free, but if death wins, the knight will have to surrender to his destiny. Death accepts the agreement. The chess player thus takes advantage of this period of time to deal with various situations of his existence, giving his existence the time that previously he had not known how to give

or wanted to give. In one of the episodes described in the film, the knight confesses, but in reality the confessor is death dressed as a friar who asks him how he will manage to win the chess game. At this point, death abandons the pretence, learns the secret of the knight and takes his life.

In this unfolding of a fear of an inevitable event, but at the same time of a strange kind of agreement that is made with that event, I seem to see all the taboos and contradictions to which reference has been made in this paper. The last is specifically the one that the film by Bergman, seen again in a positive light, proposes to us: victory over death does not exist at the level of material defeat, because the game being played is always a losing one. Instead, it can be won in an existential sense by giving meaning to life, from which, indeed, all its positive elements can be drawn.

b. The Via Crucis. A metaphorical reading of the Gospel tale and its renewed proposal at the level of devotion appears to us, in fact, to be a tragic example of accompanying a person to death with all the variegated emotional universe that accompanies such a process: from the flight of loved ones (in the abandonment on the part of the apostles we can see the contemporary flight of family relatives and friends) to the unsuspected presence of people who are thought not to be strong (in the culture of the time, women, for example).

At the foot of the cross, on the other hand, a dismayed small group of people remain when everyone else has gone away. It is precisely these people who help the dying man not to be “alone,” to look into the eyes of a friendly face who offers him an expression of affection as the last memory of the life that he is leaving.

The event of death often “forces” people to help a dying person, if only because that person is within a family unit to which he belongs: like Simon of Cyrene who returns





Cardinal Receives Update on Symposia

Father Joe Driscoll met with Cardinal William Keeler of Baltimore on April 8 at the Cardinal's residence. Father Driscoll updated the Cardinal on the fall 2002 symposia, which were in follow-up to the symposium held in Baltimore in May 2001, and the proposed national pastoral plan for our sick and dying that is now under consideration at the United States Conference of Catholic Bishops. He presented the Cardinal with the book, *Recovering the Riches of Anointing: A Study of the Sacrament of the Sick*, the published proceedings of the 2001 symposium.

from the fields and is forced to carry a cross that is not his, a cross and a form of help that irrupt into the routine of his day.

If, on the one hand, some people are forced to do this, on the other hand, some voluntarily offer to dry his tears, and like that woman to whom the name of Veronica (in reality true image, "real icon") was given by the author of an apocryphal work, go back home carrying within them something of the person whom they wanted to console.

And the care of the person who is dying towards those who stay is born witness to by that entrusting of Mary and John to each other, which is not only an invitation to look after a mother who has been left on her own but an invitation to the "reciprocity" of giving each other the gift of welcome.

Even in the dividing up of the clothes by the soldiers we can read not only the sad and still present conflicts over inherited possessions but the inheriting in the highest and most noble sense of the legacy of the person who is dying. What remains belongs to who

remains: not only a tunic or an article of clothing, but also, and above all else, a memory, the memory that the Evangelists handed down to us with their account of the cross.

Lastly, when everything seems to be over there emerges the courage of people like Joseph of Arimathea, who had the courage to take Christ down from the cross. Every person who seeks (beyond every effective "success") to take his neighbor down from the cross should identify with Joseph of Arimathea. This will not always be practicable at a material level (even though every effort should be made to help one's neighbor), but it must also be possible at a psychological and human level. A person can be taken down from the cross by eliminating the cross or by helping that person to give a meaning to it by knowing how to look "beyond": the ethics of the humanization of death can be summed up in this commitment.

(Professor Salvino Leone is Lecturer in Moral Theology at the Theological Faculty of Sicily and Consultor of the Pontifical Council for Health Pastoral Care.)

Notes:

¹P. Ariès. *Storia della morte in occidente* (Milan, 1980).

²Ibid., pp. 24–25.

³Ibid., pp. 24–25.

⁴Ibid., p. 53.

⁵Ibid., p. 68.

⁶This is the thesis of G. Görer in his "The Pornography of Death," *Encounter*, October 1955, in which he in effect argues that today "death occupies the place of sex in the area of the unmentionable."

⁷P. Ariès, op. cit., p. 73 (where, however, he repeats the thought of Görer).

⁸C.A. Malliani, "La morte improduttiva," in AA.VV., *La morte oggi* (Milan, 1985), pp. 102–106; see also I. Illich, *Nemesis medica* (Mondadori, Milan, 1977), pp. 214–233, who even speaks about "fear of immediate death."



BOOK REVIEWS

When the Caregiver Becomes the Patient:

A Journey from a Mental Disorder to Recovery and Compassionate Insight

Daniel L. Langford, MSW, DMin, and Emil J. Authelet, DMin. Haworth Pastoral Press, Binghamton, New York, 2002. ISBN: 0-7890-1294-4. Softbound, 195 pages with notes, bibliography, and index. \$24.95.

Reviewed by Dennis McCann, SFO, PhD

When the Caregiver Becomes the Patient centers around the experience of school teacher/pastor/social worker Daniel Langford's several months of intense panic attacks. The book is an attempt to understand that experience and the journey to recovery. The book is co-authored by his good friend and pastor/therapist Emil Authelet to whom he turned and who successfully helped him to recovery. Both of these men as caregivers from a religious perspective have something to offer chaplains through their reflections on the patient/therapist relationship, or for our purposes, the patient/chaplain relationship.

The beginning of the book relates the experience of Langford's mental disorder honestly and humbly. It is then followed by a review of the literature on this disorder with a few sparse reflections on what the mainstream treatments offer for sufferers. Langford, or perhaps the editor for allowing it, then makes a deadly mistake. He includes a chapter that records an interview with the physician who first treated him. This interview reveals a deeply committed Seventh Day Adventist with so literalist a view of the Bible that it comes off as almost comical. This physician offers little insight into the panic disorder and an incredibly bleak understanding of the increasing depravity, as he sees it, of humankind.

The fourth and fifth chapters, however, redeem the book with Authelet's reflections on Langford's mental disorder. Authelet draws from the insights of Transactional Analysis (TA) to explain some of the origins of Langford's harrowing experience. The insights are valuable and applicable to us. I found myself once again impressed

with the TA model, which I haven't given much thought to for some years.

In fact, reflecting on some of the patients in the psychiatric unit I work in, and with the increasing depression I have been feeling with the bombing of Iraq, I found the TA model useful, insightful, and comforting. In its simple elegance, it draws attention to our "inner child" that always needs attending to as it is caught in obsolete beliefs that distract us from our work as loving adults. According to this model, any negative feelings we experience about ourselves can be traced back to some unresolved need coming from our "inner child."

Four chapters follow this portion of the book on the sufferer/caregiver relationship. While these may not be startling insights for the seasoned chaplain, they would make great discussion themes for CPE students. In fact, they pretty much, though not intentionally, outline the purpose and process of CPE. I think if I had read this book before starting CPE, my experience of CPE would have been enriched. The paragraphs are given headings for easy reference. Several of the topics addressed by Authelet are written as a numerically ordered list of pithy insights convenient for the purposes of discussion.

Finally, the book concludes with a reflection on the insights of John Powell's book *Fully Human, Fully Alive*. This was the book that Authelet recommended to Langford when Langford called him in the middle of his crisis, and the middle of the night, asking for help. Powell's relational theology had a profound effect on both these men. Langford writes, "When I think of Powell, I think of being free from negative thoughts and negative perceptions of the self."

I would recommend this book for beginning chaplains, chaplains who might need a jump-start to reenergize the way they do their work, and to all CPE supervisors and students. From this personal journey to professional insight Langford concludes with the beautiful insight that to bring about the Kingdom of God is to bring about a world of caregivers, an entire planet of wounded healers.

(NACC-certified chaplain Dennis McCann, SFO, PhD, is Director of Pastoral Care, St. Vincent's Medical Center, Bridgeport, Connecticut; e-mail: dmccann@svhs-ct.org.)

Redirection of the Heart

Deborah Gordon Cooper. Cover illustration by Joel Cooper. New Song Press, Dayton, Ohio. Softbound. 40 pages. \$6.95

Reviewed by Becky Evans.

Recent readers of *Vision* may recall the name of Deborah Cooper as the author of the "Prayer for Caregivers" on the front page of the February issue. Long-time readers of *Vision* may also recall other prayers and poems by Deborah published in issues in the late 1990s, including the poem, "Circle Dance," which is reprinted in the recently published book of poems, *Redirection of the Heart*.

Admittedly, this is not an impartial book review, for I have been an enthusiastic admirer of Deborah's poetry ever since I first read and published one of her poems in *Vision* in the years I served as its editor. Deborah ministers in hospice care as a NACC-certified chaplain. She is an extraordinarily gifted poet whose work has been published in numerous journals, little magazines, and anthologies. *Redirection of the Heart* was the winner of the 2000 New Song Chapbook Contest.

Chaplains will be interested in this chapbook not only because Deborah is a chaplain, but the subject matter that ties these poems together is the 14-year descent into dementia and the death of her beloved father, Jack Gordon, a prominent physician in his prime. Some of the poems also focus on the failing health of her mother, suffering from both a stroke and Parkinson's.

Other sensitive poems recall stories told of the parents' romance and courtship, and their separation and sacrifices during wartime. The book is dedicated "with undying love" to both parents, love that graces these poems. These deeply moving, personal poems share emotions and experiences that are readily accessible to all readers, but speak especially to anyone with an ailing or frail parent.

Deborah's poems often contain and sometimes end with a moment of surprise, a moment of thoughtful reflection, revelation, or sudden insight. In a poem describing a visit with her father, whose sadly changed appearance and behavior make it evident to the reader that he is living in a state of limbo, she concludes: "We drive home in the dark/ in the thick, sad silence/ that always comes after./ I imagine my real father/ in his wing-tips, perfect shirt/ and tie, waiting somewhere/ for the rest of him to come./ From

the backseat/ my son's hand/ finds my shoulder/ and I remember telling him/ once years ago/ that there was no such thing/ as purgatory."

While her father, who once "knew by heart all of/ the Sonnets from the Portuguese," loses the meaning of words, the poet chooses the precise words and concrete images that make grief and sorrow bearable and give a lyric voice and wings to undying love, to "the threads unsevered," and gratitude "for all we have been granted/ and for all we/ have been spared."

While her father loses the faculty of memory to disease, the poet demonstrates how the gift of memory and imagination keep her "real" father present while he is fading, and close in spirit after death, perhaps watching over her or even returning to give comfort and blessing. In the final poem, "Visitations," when, in a grocery produce aisle, the poet is "choosing my oranges by feel/ and by their fragrance," she suddenly hears her father whistling a Scottish lullaby in her ear. Her image that the dead are close to us, just on the other side of a thin membrane, gives comfort to all of us who have survived someone we dearly love:

There is a tenderness no border can contain./ A web that may be glimpsed in certain, unexpected plays of light./ or felt/ like a shawl/ across one's shoulders./ laid by unseen hands. . .

The wall between the living and the dead/ is as yielding as a membrane./ is as porous as a skin./ Lay your palm against it/ and you can feel their voices/ in your hand/ and in the place where the chest opens/ like a flower.

They are not far away./ no farther than the breath/ and enter us as easily./ in pine and peonies./ in oranges and rain./ Our mouths fall open in surprise./ a quiet radiance/ erupting, in our eyes.

These are beautiful poems of light and seeing, of touch and sound, full of sensory experiences and feelings that become palpable on the page. Her poems help us see that thin membrane between the living and the dead. The inescapable, hard realities of pain and grief, the awful grayness of dementia, and death, all yield without self-pity or sentimentality to the luminous "plays of light" that Deborah captures and lets shine in this remarkable volume of poems.

Deborah Cooper lives in Duluth, Minnesota, with her husband, Joel, a visual artist. They have three grown children and one

grandchild. She uses her poetry extensively in her ministry and has conducted workshops on the interfacing of poetry and spirituality. Deborah is currently on leave from hospital chaplaincy to care for her mother.

To purchase a copy of *Redirection of the Heart*, contact New Song Press, P.O. Box 629 WBB, Dayton, OH 45409-0629; (937)294-4552; <http://newsongpress.com>; e-mail: nsonpress@aol.com. A selection of other poems by Deborah Gordon Cooper appears on the website of her brother, Greg Gordon, MD, at: <http://greggordon.org/poetryDGC.htm>.

(Becky Evans was the editor of NACC Vision from its inception until July 1999. In retirement she does freelance editing and pursues many literary activities including writing her own poetry. One of her poems will be published in the next issue of Chrysanthemum, a small magazine of poetry.)

EDUCATIONAL OPPORTUNITIES

Rallying Points' National Conference on End-of-Life Care

November 16–18, 2003
Boston, Massachusetts

The date is set for the Rallying Points' 2nd Annual National Conference hosted by The Hospice of the Florida Suncoast at Boston's Park Plaza Hotel. This **free** conference is an educational and networking opportunity for everyone working to improve care and caring near the end of life.

The conference will explore new ways to expand outreach efforts and visibility for coalitions, nationwide. It will provide information on how to go beyond traditional outreach campaigns and create true, sustainable social change initiatives to improve end-of-life care and services. Participants will have the opportunity to meet and network with other coalition leaders and learn from their past experiences.

A special, pre-conference bonus session on fundraising will be held on November 16 from 1–4 p.m. Space is lim-

ited—please sign-up early.

Rallying Points, an initiative of Last Acts and funded by The Robert Wood Johnson Foundation, helps community leaders develop effective community coalitions to improve care near the end of life. The Hospice of the Florida Suncoast is a not-for-profit agency committed to caring for individuals dealing with chronic illness, facing the end of life or grieving the loss of loved ones. The Hospice offers comprehensive hospice and palliative care, emotional counseling, spiritual support, and other services to the people of Pinellas County without regard for race, age, faith, diagnosis or ability to pay.

For more information about the conference, contact Rallying Points National Coordinating Center, (800)341-0050; www.rallyingpoints.org.

Symposium on Pediatric Palliative Care

November 6–7, 2003
New York, New York

The New York Academy of Medicine (NYAM), along with several co-hosts, will sponsor a two-day symposium on pediatric palliative care this fall. The event is titled, The Initiative for Pediatric Palliative Care National

Symposium: Enhancing Family-Centered Care for Children Living with Life Threatening Conditions. This symposium will take place November 6 to 7, 2003, at the New York Academy of Medicine in New York, NY.

For further information, contact Sheila Gray, Program Coordinator, by e-mail at sgray@nyam.org or by phone at (212)822-7204. To learn more about the NYAM, go to: www.nyam.org.

Institute on Sacred Scripture

July 27–August 1, 2003
Dallas, Pennsylvania

College Misericordia, in Dallas, Pennsylvania, announces its 35th Annual Institute on Sacred Scripture, from July 27 through August 1, 2003. This is a week of inspiring and thought-provoking scripture study at a location of quiet beauty and

seclusion for meditation and respite, with many recreational activities on campus or nearby. The College is 35 minutes from the Wilkes-Barre/Scranton airport, and free shuttle service is available with advance notification.

Presenters include Gina Hens-Piazza, PhD, Associate Professor of Old Testament at the Jesuit School of Theology and the Graduate Theological Union, Berkeley, California; Francis J. Moloney, SDB, PhD, the Katherine Drexel Professor of Religious Studies at The Catholic University of America; and John Reumann, PhD, retired Ministerium of Pennsylvania Professor of New Testament Studies and Greek and Lutheran Theological Seminary in Philadelphia.

For more information, contact Marie Noel Keller, RSM, ThD, Executive Director, Institute on Sacred Scripture, College Misericordia, 301 Lake Street, Dallas, PA 18612-1090; phone: (570)674-6776; e-mail: srnoel@misericordia.edu; www.misericordia.edu.

National Migration Conference

July 6–10, 2003
Washington, D.C.

The U.S. Conference of Catholic Bishops/Migration and Refugee Services and the Catholic Legal Immigration Network, Inc., present “All Come Bearing Gifts . . . Will You?”, the 2003 National Migration Conference, on July 6–10. The location is the Omni Shoreham Hotel in Washington, D.C. The conference offers the latest information about worldwide migration and its domestic implications; interactive workshops that focus on many topics including multicultural approaches to pastoral care, diocesan multicultural planning, and ministries with Asian and Pacific, African, and Hispanic Communities. More information about specific workshops as well as a more complete description of this one-of-a-kind event, go to: www.nmc2003.org.

You can register online (see website listed above) or obtain a registration form by contacting: NMC2003/BlueSkyz, 3614 Connecticut Ave., NW, Suite 43, Washington, DC 20008; (800)300-9524.

IN BRIEF

New report on end-of-life care and hospice access released

The Hastings Center and the National Hospice Work Group, in collaboration with the National Hospice and Palliative Care Organization, have released a valuable study on end-of-life care. “Access to Hospice Care: Expanding Boundaries, Overcoming Barriers,” examines the current state of end-of-life care in the United States and explores recommendations for a new vision of hospice and palliative care. Holding firm to the traditions and highly regarded values of hospice, the report identifies opportunities that will provide more flexible care, increase access, and reduce suffering for those coping with life-limiting illness.

To order a copy of this report, contact Bruce Jennings with The Hastings Center by e-mail at Jennings@thehastingscenter.org or by phone at (845)424-4040. To learn more about The Hastings Center, go to: www.thehastingscenter.org.

A Concise Guide to Catholic Social Teaching

Kevin E. McKenna. Ave Maria Press, Notre Dame, Indiana, 2002. ISBN: 0-87793-979-9. Softbound. 123 pages plus appendix, sources list, glossary, index. \$12.95.

This book presents a distillation of social principles presented in both papal encyclicals and pastoral letters developed by American bishops. Following the structure of the U.S. Bishops’ document, *Sharing Catholic Social Teaching*, the book speaks to seven significant themes: life and dignity of the human person; call to family, community, and participation; rights and responsibilities; option for the poor and vulnerable; the dignity of work and the rights of workers; solidarity; and care for God’s creation. Each chapter includes reflection questions ideal for individual or group usage.

Rev. Kevin E. McKenna is the president of the Canon Law Society of America and pastor at St. Cecilia Parish in Rochester, New York. He is the author of numerous articles and two books: *The Ministry of Law in the Church Today* and *A Concise Guide to Canon Law*.

Creating a Spiritual Retirement

A guide to the unseen possibilities in our lives

Molly Srode. SkyLight Paths Publishing, Woodstock, Vermont, 2003. ISBN: 1-893361-75-6. Hardbound. 170 pages. \$19.95.

Deciding to retire means leaving behind a person’s workplace identity. When that role is taken away, part of the individual goes too. Many are left grieving for the person they left behind. Molly Srode helps readers understand that retirement offers a time for spiritual growth. The book includes questions and insights designed to help retirees transition into this new, exciting phase of their lives.

Ms. Srode is a retired hospital chaplain. A spiritual seeker, she easily shares details of her own spiritual journey with readers of all faith traditions. She and her husband, Bernie, are publishers of the *Senior Spirituality Newsletter*.

New report discusses advance care planning and patient preferences

A new report by the U.S. Agency for Healthcare Research and Quality, titled, “Advance Care Planning: Preferences at the End of Life,” discusses how advance care planning can help ensure that the medical care preferences of patients who are terminally ill are honored by hospital doctors. The problem, according to the report, is that fewer than half of severely ill and terminally ill patients have an advance directive in their medical record. It goes on to assert that part of the reason for this is that physicians, who should help patients plan end-of-life care, are largely unaware of the existence of advance directives. The report also shows that most patients are willing to discuss end-of-life options with their doctors.

More information about “Advance Care Planning: Preferences at the End of Life” is available at: www.ahrq.gov/research/endliferia/endria.htm.

Juvenile Offenders: Their Victims, Restoring Lives

September 29–October 2, 2003
Plymouth, Michigan

The National Chaplains Association for Youth at Risk announces its 53rd annual

conference: "Juvenile Offenders: Their Victims, Restoring Lives. The Roles of Chaplains and Churches in Reconciling Victims, Offenders, and God." This conference will be held September 29 through October 2 at St. John's Retreat Center in Plymouth, Michigan, which is 25 minutes west of downtown Detroit and the Detroit metro airport. The conference hosts a number of workshops and features plenary speakers Sue Anne Keagle, a trainer in Balanced and Restorative Justice (BARJ); Joe Williams, founder and CEO of Transition of Prisoners, Inc., a ministry to prisoners, ex-prisoners, and their families; and Anne Sey-

mour, principal of the Washington, DC-based non-profit, Justice Solutions, which specializes in criminal and juvenile justice, crime victims' rights and services, and public safety.

For more information, call (517)423-7451, extension 575.

On-the-job Spirituality

Finding God in work

Marianne E. Roche. St. Anthony Messenger Press, Cincinnati, Ohio, 2002. ISBN: 0-86716-456-5. Softbound. 152 pages plus index. \$10.95.

By reflecting on the very nature of work and on the internal and external forces that distort attitudes toward work, Marianne Roche challenges readers to see the work of God in all their jobs and chores. She examines in four parts the many facets of the experience of work: work as prayer; overcoming personal barriers; confronting cultural opposition; and creating a personal spirituality of work. Each chapter ends with reflection questions and implementing practices.

Ms. Roche is an attorney, retreat leader, and bookseller.

Positions Available

▼ **St. Catherine Hospital, Garden City, KS** – a leader in health care, is seeking a FULL-TIME CHAPLAIN OR A FULL-TIME PRIEST CHAPLAIN. This position offers the opportunity to join an ecumenical staff of spiritual care givers of both paid chaplains and volunteer clergy. Our team approach involves a multidisciplinary creative approach to meeting the spiritual needs of patients, families, staff, and outreach ministry to the surrounding communities of Garden City. The successful candidate must be committed to personal health and healing, to development of required professional skills for innovative approaches to spiritual services, and to ministry, consistent with the mission and values of St. Catherine Hospital. Teaching skills and an understanding of holistic ministry are preferred. Bilingual skills are a plus, with Spanish preferred. Candidates must have a current ecclesiastical endorsement, have current NACC or APC certification or eligibility and be willing to pursue certification. St. Catherine Hospital is ideally located just hours away from the mountains, desert, and high plains of the western United States. St. Catherine offers a competitive salary, excellent benefits, and opportunities for continuing professional education. For consideration, please send a resume to: Leslie Petz, Recruiter, Human Resources, St. Catherine Hospital, 410 E. Walnut, Garden City, KS 67846; phone: (620)272-2557 or (800)565-6486; fax: (620)272-2528; e-mail: human_resources_gck@chi-midwest.org. Catholic Health Initiatives.

▼ **Mayo Clinic CPE, Rochester, MN** – CPE RESIDENCY POSITIONS beginning September 1, 2003, through August 31, 2004, for Resident I and Resident II applicants. Residents are offered a broad array of clinical opportunities, which include medical and surgical subspecialties, diverse intensive care unit ministries, organ transplantation, a children's hospital, a psychiatric hospital, and a regional trauma center. Two different hospital campuses and three different certified supervisors make this a uniquely powerful learning environment. Mayo Clinic health and dental benefits available to Residents at a reasonable rate. The Resident stipend is \$24,000 for 12 months, four consecutive quarters of CPE. For program information e-mail cpeprogram@mayo.edu, or write Mayo Clinic CPE, 201 West Center Street, Rochester, MN 55902; phone: (507)266-7275; fax: (507)266-7882; website: www.mayo.edu.

▼ **Elliot Hospital, Manchester, NH** – CPE SUPERVISOR. Responsible for pastoral care services to patients, families, and employees. Must have a master's degree from an accredited theological school, ACPE/NACC or USCC certified, endorsement by an appropriate faith group, have demonstrated successful supervisory experience, and a pastoral background in a health care environment. For consideration, please send your resume to: Elliot Hospital, Human Resources, One Elliot Way, Manchester, NH 03103. Visit us at: www.elliotohospital.org. EOE.

▼ **QueensCare, Los Angeles, CA** – CHAPLAIN. Seeking part-time or full-time Catholic priest to join the Pastoral Care Division of QueensCare.

CHAPLAIN would provide pastoral care for Catholic patients in the Queen of Angels Hospital in Los Angeles, California, assist with noon masses at the hospital and have some on-call responsibility. Applications from retired priests are welcome. Compensation would include salary and could include housing and some meals. Send resume to Rebecca O'Neill, Director of Human Resources, 1300 N. Vermont, #706, Los Angeles, CA 90027; fax: (323)953-9979 or e-mail to rloNeill@queenscare.org. Please visit our website at www.queenscare.org. QueensCare is a faith-based nonprofit that provides innovative health services in the multicultural communities of Los Angeles County. EOE.

▼ **Our Lady of the Lake Regional Medical Center, Baton Rouge, LA** – DIRECTOR OF PASTORAL CARE. Our Lady of the Lake Regional Medical Center is an 850+ licensed bed, not-for-profit, JCAPS-accredited medical center. This challenging position develops and directs the pastoral care programs for the organization. Qualifications include a master's degree in theology or related field, four years' experience in pastoral health care and proven administrative skills. Applicants must have NACC or ACPE certification or equivalent. We offer a competitive salary and an attractive benefits package. Please visit our website at www.ololrhc.com to apply online.

▼ **Palos Community Hospital, Palos Heights, IL** – HOSPICE CHAPLAIN, PASTORAL ASSOCIATE. Immediate opening in the growing hospice division of our progressive southwest suburban community hospital. Minimum of two years' experience in pastoral counseling, preferably in a health care setting. Provides or arranges for spiritual counseling and pastoral care to patients, families, and staff. Assesses the needs and responds to patients while demonstrating an understanding of the hospice concept, policies, and procedures. We offer competitive salary and benefits package. Please send or fax your resume to: Palos Community Hospital, Home Health Services, 15295 E. 127th St., Lemont, IL 60439; fax: (630)257-1115; phone: (630)257-1111; e-mail: Maureen_Fitzgibbons@PalosCommunityHospital.org. EOE.

▼ **Mercy Medical Center, Durango, CO** – CHAPLAIN to join our collaborative team of an NACC board certified Director and two part-time chaplains. Responsibilities include spiritual assessment and support, pre-surgery visits, sacramental support, participation in interdisciplinary team meetings, and crisis intervention. 80 hours per pay period plus on call. Four units of CPE required. Residency in a trauma center and NACC certification preferred. Mercy Medical Center is part of the Catholic Health Initiatives health care system and is a non-profit level III trauma regional medical center; licensed for 83 acute care beds. Durango, Colorado, is nestled in the Animas Valley in the San Juan Mountains of southwest Colorado. For more information, contact Pati at (800)345-2516 ex. 2408. Resumes may be submitted to Mercy Medical Center, 375 E. Park Ave, Durango, CO 81301; fax: (970)382-2410; website: www.mercydurango.org. EOE.

CALENDAR

Board of Directors

July 2003

- 1 Postmark date for materials for fall certification interviews
- 4 Independence Day
National office closed
- 10-13 National Certification Commission meeting
Milwaukee, Wisconsin
- 11-13 Interview Team Educator training
Milwaukee, Wisconsin
- 13 Deadline for nominations to the Board of Directors

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NACC
Milwaukee, Wisconsin

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St. Vincent Hospital & Health Center
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Brains on Fire
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Director, Master of Arts in Health Care
Mission Program
Aquinas Institute of Theology
St. Louis, Missouri

Walter J. Smith, SJ
President and Chief Executive Officer
The HealthCare Chaplaincy, Inc.
New York, New York

September 2003

- 1 Labor Day
National office closed
- 2 Copy deadline for October 2003 *Vision*

NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

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