vision

National Association of Catholic Chaplains

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# Chaplaincy is profession as well as a ministry

**By Michele LeDoux Sakurai**

The difference lies in the training. It is not like any other training; it is Clinical Pastoral Education, and nothing about it comes easy.

I remember being accepted into my CPE program. I was energized because the application process had taken months and I had survived all the hurdles. I was also quite nervous, because I was entering the program late. The supervisor's first choice had been a clergyman who dropped out of the program during the first week. I recall thinking that if someone ordained couldn't make it, how could I, a Catholic laywoman, succeed?

My first morning of CPE, I arrived early and waited outside the classroom. Bounding up six flights of stairs came a woman in her 40s. "You must be Michele. Welcome! Come on, let's get you settled and I'll make the coffee." As she opened the door, I asked the question that was most pressing: "What am I to expect? I mean, CPE … what's it like?" She smiled and was thoughtful for a moment. "Well … it's a bit like birthing barbed wire."

My heart stopped. What had I gotten into? I steadied myself and attempted to stay focused on simply hanging on.

As the days and weeks passed, I found truth in her words. Everything in CPE seemed a struggle. My life, my attitudes, my theology were all held to close scrutiny. If I prayed with a patient, I'd better be able to show how this was the patient's agenda and not mine. If I concluded a visit with prayer, was it because I wanted to escape, or was it truly a summation of the pastoral interaction?

I was constantly being challenged by my supervisor, my peers, staff, and patients. Again and again, I learned how my own theology co-opted or interfered with the spiritual life of another. Again and again, I was reminded that a pastoral visit is NOT about me, but about the person in the bed; that the visit is less about prayer and more about presence. CPE taught me that prayer is not in the words but rather in the state of mind. I was constantly reminded of the wisdom of St. Francis, that we are to preach the Gospel always and use words only if absolutely necessary. Ultimately for me, preaching the Gospel became honoring the silence and respecting the dignity of the other without needing to fix their theology or their life.

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Chaplaincy as a profession has been slow to claim its boundaries

As CPE helped me to confront my own theological assumptions, so too this program challenged me to confront my lack of boundaries. I became aware of the many ways that I get "hooked" by patients, buy into the agenda of staff members, and allow my own issues from my family of origin to interfere with the sacred space that lies between myself and the patient. Like an onion being peeled, layer after layer of ego was laid open and questioned. It was both painful and enriching. Birthing barbed wire comes close — but although descriptive of the process, it does not reveal the beauty of the gifts of CPE.

After a year of CPE training, I came to a place of awareness: what my issues entailed, when these issues interfere in the journey of another, and finally, when to name my own vulnerability and weigh whether to

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## In This Issue:

# Online program offers continuing education

**By Susanne Chawszczewski**

As our members continue to seek out new sources for continuing education hours for their renewal, the University of Notre Dame has set up an economical way to attain personal, professional, and theological education.

In 1999, the Satellite Theological Education Program (STEP) was established at the university as a mission of outreach to the Church. This program offers theological education for both spiritual rejuvenation and personal growth.

Through STEP, an individual may pursue online theological education in a variety of ways.

Continuing education e-courses are offered online and taught by either a Notre Dame professor or a facilitator with an advanced degree in theology. The courses are concentrated in Catholic Doctrine, Christian Life, Church History, Liturgy, and Scripture, and range from four-week book review sessions to seven-week professor-led courses. E-courses include video lectures, readings, weekly assignments, class discussion utilizing an online discussion area, and a course evaluation. The cost ranges from $29 to $149 per course.

One of our own NACC-certified chaplains is an instructor in the STEP program. Michelle Lemiesz, M.Div., is currently teaching "Biblical Literary Forms" and "On Prayer."

Students who register for these courses can earn continuing education hours for their renewal of certification with the National Association of Catholic Chaplains. For example, a current five-week course, "Women and Catholicism in the United States," requires 3-5 hours per week to be devoted to the course. Once you have completed the course and satisfied all requirements, you are awarded a certificate for 20 contact hours. These contact hours would then translate into 20 continuing education hours for your renewal of certification.

In addition, students who are enrolled in the University of Notre Dame Graduate School may take for-credit courses in theology that also employ online teaching methods. Application information is available through the University's Department of Theology, (574) 631-4254.

Another option for chaplains looking for ongoing education is the Catholic Lecture Series. This set of twelve individual lectures on core theological topics is available on CD-ROM. Information about continuing education hours for these individual lectures will be posted on the NACC website.

Utilizing STEP as a tool for continuing education provides chaplains in any geographic location with a great opportunity to interact with highly regarded teachers in a truly technological environment. In addition, dialogue with engaged Catholics from across the country will edify and enrich your faith. Further information about STEP can be found at:

http://step.nd.edu; 1-866-425-7837 (STEP); or stepnd@nd.edu.

*Susanne Chawszczewski, Ph.D., is the NACC's Director of Education and Professional Practice.*

## A Place Like Any Other

**By Rev. James F. Buryska**

"Where are you from?" I asked, making small talk
with this man – forty years old, maybe less –
as we waited for his daughter to arrive.
"Chicago," in English fluent enough,
though accented. "We came to U.S.A.
from Poland. Seven years ago." I placed
the accent then. (My ancestors came from
a village near the Polish border.) "Where
in Poland?" I pursued the question. "Oswiecim."
His eyes held questions of their own, alert
if I would recognize the name. I did.
Some wouldn't, but most would identify
easily the German version of the name:
Auschwitz.

Visions of electrified barbed wire
flashed in my head, barracks, chimneys belching
their dreadful smoke. I couldn't help myself.
"What is it like," I blurted, "to live where
there are so many ghosts?" He paused, not sure
he fully understood the question. Then,
"About the same as living anywhere
else."

I don't know what answer I expected,
but his took me aback at first. Again,
on second thought, why should it? Someone has
to live there. Unless, that is, we don't want
anyone to live there ever again.
Or else demand that those who do, be weighed
by crimes committed before they were born.
A third alternative: forget, or worse,
deny. Instead, we do the best we can:
we build or leave memorials to our
atrocities, our aspirations and
our victories, and learn to live with them,
alongside them, hoping in time and grace
to sort out which is which. A place
like any other – Oswiecim.

*Rev. James F. Buryska, NACC Cert., is an NACC and ACPE supervisor at the Mayo Medical Center in Rochester, MN.*

## vision

Vision is published 10 times a year by the National Association of Catholic Chaplains. Its purpose is to connect our members with each other and with the governance of the Association. Vision informs and educates our membership about issues in pastoral/spiritual care and helps chart directions for the future of the profession, as well as the Association.

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# Partnerships enhance chaplaincy, patient care

**By Lawrence G. Seidl**
**Executive Director**

*Humpty Dumpty sat on a wall,*
*Humpty Dumpty had a great fall.*
*All the king's horses and all the king's men*
*Couldn't put Humpty together again.*

The familiar children's nursery rhyme serves as a metaphor of the American healthcare system.

The health system is becoming fiscally broken because it exists, if not thrives, at the bottom of that wall. Humpty arrives in an ambulance, but in a miraculous 4.2 days, Humpty leaves the hospital to live once again at the top of the wall. And in a system which pays little attention to prevention or to the environment in which vulnerable people live, we watch as with great predictability Humpty falls again sometime in the next six months. And the cycle of the emergency room-ICU-rehabilitation starts all over again.

In the 32 years I have been in healthcare, the story, the scenario and the solution all seem to be re-created, day in and day out, in every American city and healthcare facility. Today in America, we **can** put Humpty together again, but we are no better than the king's horses or men at keeping him together.

To change this model would be to change the way we think about health and healing. It would require new partnerships and the development of new mindsets.

What if the underlying origins of much of the disease and injury which arrives in the emergency room could be seen with a different pair of glasses? Could conflict resolution skills ever replace the suturing of a human scalp? Could pastoral counseling ever replace the battered wounds of a young abused infant? Could the questions of the sacred be precursors to the routine physical assessment?

Treating the whole person, the spirit and mind as well as the body, makes a difference. As chaplains, we know that the faces of human suffering often require a spiritual healing as a prerequisite to physical healing. And yet, with what assurance do we conclude that our presence will be as supported, reimbursed and recognized in the future as it is at the bedside today?

We can start by helping the medical establishment put together a better system that prevents illness and injury by recognizing the whole person. The NACC, as an organization and as individual chaplains, must take control of our future. And we begin with new partners. What does it mean for you? Embrace the wellness counselor. Welcome the parish health minister. Reach out to the family practitioner. Take the school principal to lunch. We are striving to make these connections at the organizational level; you can help yourselves and the profession by doing the same as individuals.

As organized systems of delivery and care become more challenged to reinvent the services they offer, the spiritual care department must do the same. It is up to us to teach or remind decision-makers of the vital role that chaplains play in creating a healthier population. The chaplain's presence at the bedside will not become obsolete. Chaplains will continue to be called to ritualize the deepest moments of human suffering and loss. But pastoral professionals will also see their historic presence complemented by programs and activities which at every level call us into new partnerships and new prayers.

Where will you minister tomorrow? With whom will you partner?

# Chaplaincy

*Continued from page 1*

hand a patient into another chaplain's care. The secret to effective chaplaincy is in continuing to nurture this awareness — to be constantly questioning one's own professional practice. This means utilizing spiritual direction, peer groups, and continually inviting other chaplains into dialogue.

Four units of CPE, graduate theology, endorsement, and the certification process all come together to create a profession. Over the past 10 years, NACC has consistently raised the professional bar. Certification implies that forty competencies in three areas — theological, professional, and personal — have been met. It is an arduous process, and nearly 20 percent of the candidates are not granted certification on the first attempt.

Without in-depth training, volunteers are placed in a difficult position

As healthcare as an industry continues to demand greater accountability, so too has spiritual/pastoral care as a discipline. The skills of assessment, intervention, crisis management, ethics, and diversity advocacy must now be articulated in ways that show administrators that chaplains bring added benefit to organizations. This is becoming increasingly a challenge — in part because chaplaincy as a profession has been slow to claim its boundaries.

Many hospitals, due to fiscal constraints, use volunteers to assist in spiritual care and permit these volunteers to use the title "Chaplain." Some of these volunteers are ordained while others are lay; I believe all have the best of intentions. But the best of intentions does not best serve the patient's needs.

I have heard many stories from patients and family members about the interactions of those who are not certified, but call themselves chaplains — stories that range between humorous and tragic. Perhaps the most tragic story came from the wife of a patient who had become a quadriplegic after an accident. The wife told me that her husband had received a visit from "a chaplain" while in the hospital. The "chaplain" was actually an area clergyman who serves this rural hospital. During the interaction, the "chaplain" told the patient that the patient was paralyzed because he sinned earlier in his life. The patient spent six months reflecting on what he had done and concluded that God was capricious. Angered, the patient rejected God and refused to allow the name of God to be mentioned in their home. They had been churchgoing Methodists prior to this event, and now they had nothing.

I believe the clergyman was well-meaning, but he was trained to meet the needs of a particular community, not the broader population. This clergyman was a volunteer chaplain in part because the hospital assumed that all Christian clergy share the same values and theology. But in this case, this faulty assumption resulted in spiritual abuse.

Not all visits by volunteers are so dramatic. After surgery in a rural Oregon hospital, my mother reported to me that three chaplains had visited her in one day. "Well," she said, "They call themselves chaplains, but they really aren't. They are volunteers from their churches." When I asked how the visit went, she replied, "Oh, they just wanted to pray, and well, I didn't want to disappoint them." Of course, since my mother knows what I do for a living, she knows better than most patients the difference between chaplains and church volunteers.

These volunteers focused on a ministry of prayer, and perhaps this was appropriate and expected from members of their own congregations. But I suspect that if these volunteers had permitted my mother her own journey, their visits would have been very different. Perhaps they would have learned what had meaning for my mother: her family, her independence, her love of genealogy, and her Catholic faith, especially communion. In reality, that is what she yearned for, but there was no one to offer to call a local Catholic church; the volunteers did not come out of a sacramental tradition. How could they have known?

Without the in-depth training that programs like CPE offer, volunteers are placed in a difficult position. How are they to assess the spiritual needs of another? How do they know if their theology or own life issues are problematic in a pastoral visit unless they have been trained to this awareness?

Using "Chaplain" as a generic term for spiritual caregiver is confusing and has led administrators to close departments and use volunteers only. After all, why pay for a service when you can get it for free? Several years ago, I gave a presentation in Tennessee at a large hospital with over 100 trauma beds. The hospital was staffed for one chaplain per shift, and the administrator asked me if I thought it possible to simply use volunteers. I was aghast and very discouraged, because this administrator had previously worked in Catholic healthcare.

Finally, using "Chaplain" to encompass any and all direct spiritual caregivers undermines the profession of chaplaincy. When we as chaplains do not set the boundaries that identify who we are and how we are different from other spiritual caregivers, we give the impression that anyone can do what we do. It is time for us as chaplains to name our roles. We are professionally trained and certified for a specific purpose — to attend to the suffering of others through the ministry of presence and theological reflection.

Such boundaries are being recognized by national organizations such as JCAHO. Over the past few years, JCAHO's administration has moved from not knowing the difference between pastoral counselors and chaplains, to clearly recognizing chaplains as professional members of the interdisciplinary team. JCAHO delineates a difference between paid staff and volunteers; this delineation has become clearer since HIPAA regulations came into being. The profession is held to a level of accountability that volunteers aren't.

This is not to say that volunteers aren't important. They are incredibly

valuable in the arena of pastoral care. In times of tightening budgets and JCAHO's shift to safety issues in health care, chaplaincy services are wise to utilize volunteer support. Many hospitals use eucharistic ministers as a followup to a priest/chaplain visit and assessment. Hospitality ministers or pastoral care visitors have been used to assist with the basic screening and initial pastoral visits of patients. Community clergy, in the denomination of the patient, can be very effective when a chaplain is not available and spiritual support is requested. Volunteers are vital to many spiritual care programs; they and their ministries need to be nurtured and honored.

Chaplains and volunteers strive to serve a community in crisis. As we work together, let us remember let us remember the words of St. Paul, "Now there are varieties of gifts, but the same Spirit; and there are varieties of service, but the same Lord; and there are varieties of working, but the same God who inspires them all in every one. To each is given the manifestations of the Spirit for the common good." (1 Cor 12:4-7) As each of us embraces our particular ministries, may we all strive together towards this greater good.

*Michele Le Doux Sakurai, D.Min, is a chaplain at Providence/St. Vincent Medical Center in Portland, OR, and the NACC representative to the JCAHO Liaison Network.*

## Educational Opportunities

▼ **The Association of Professional Chaplains** will hold its annual conference in Atlanta, GA from May 6-10. The theme is "Our Rising Presence: 60 Years of Compassion, Commitment, Consistence," highlighting qualities inherent in our history and our ministry: compassion, commitment, and consistence It celebrates sixty years of service through the combined service of the Association of Professional Chaplains and the former College of Chaplains and the Association of Mental Health Clergy. Contact information: phone: (847) 240-1014; e-mail: info@professionalchaplains.org
Web: www.professionalchaplains.org

▼ The University of Saint Michael's College, Regis College, L'Arche Daybreak and the Henri Nouwen Societies of Canada and the United States will host a symposium, **"Turning the Wheel: Henri Nouwen and Our Search for God"** from May 6-10. Planned to honour the tenth anniversary of Nouwen's death, this event will include a one-day gathering at L'Arche Daybreak in Richmond Hill, Ontario, and a two-day symposium on the campuses of Regis College, Saint Michael's College, and the University of Toronto to honor the life and legacy of one of the great spiritual masters of the 20th century. "The wagon wheel shows that the hub is the centre of all energy and movement, even if it often seems not to be moving at all. In God all action and all rest are one." — Henri Nouwen, Here and Now (1994). Contact information: Colette Halferty, phone: (905) 460-9114; e-mail: colette@halferty.ca; Web: http://www.utoronto.ca/stmikes/nouwen/conference/

▼ **The National Association of Lay Ministry** will hold its 30th annual conference in Cleveland, OH from June 1-4. The National Association for Lay Ministry is a professional organization that supports, educates and advocates for lay ministers and promotes the development of lay ministry in the Catholic Church. Contact information: phone: (202) 291-4100; e-mail: nalm@nalm.org; Web: www.nalm.org

## Prayers for Healing

Bro. Edward Smink, OH
Houston, TX
Surgery

Sr. Betty Anne Darch, SFCC
Evansville, IN
Ovarian cancer

Charlotte Leas
Las Vegas, NV
Surgery

If you know of an association member who is ill and needs prayer, please request permission of the person to submit their name, illness, and city and state, and send the information to the *Vision* editor at the national office. You may also send in a prayer request for yourself. Names may be reposted if there is a continuing need.

# Volunteer training extends chaplains' reach

**By David Lewellen**
**Vision editor**

Fifteen casually dressed people crowd a table in a nondescript conference room at Froedtert Memorial Lutheran Hospital in Milwaukee. They are earnest and eager to learn about pastoral care, but they have little experience. But in ten weeks, they'll be finished with their volunteer training, meeting patients in a variety of settings.

It's a situation that is repeated in many hospitals around the country, in times of tight budgets and more demand for spiritual care. But "there are good [programs] and bad ones," cautioned Sr. Anita Lapeyre, RSCJ, chair of the NACC's Certification Commission.

'There's a desire for a spiritual presence, and that desire far exceeds chaplains' availability'

- Rev. Janis Blean Kachigan

At Froedtert, the average volunteer's age is probably around 50. Most are mainline Protestants, with a few Catholics and a few evangelicals. What are their reasons for seeking out this training?

"I've been doing volunteer work, and I'm looking for something meaningful."

"I need to learn to listen. God gave us two ears and only one mouth, and it seems like we tend to reverse that."

"I want to enrich my shut-in ministry."

"I'm here to follow God's will."

Many people in the community have "neither the time nor the money to go through a CPE program, but are good people with a mission to share," said Peter Ruta, supervisor of chaplaincy services at Froedtert Hospital.

But that still doesn't make them chaplains, which concerns Sr. Lapeyre. Too often, she said, a volunteer program "encourages administrators to try to get by with a director of pastoral care, one trained, qualified person, and fill out the rest with volunteers. … We've had too many bad experiences of people being mistreated in vulnerable positions by volunteer clergy."

Froedtert, a major teaching and research institution, has a well-staffed pastoral care department of its own, but the volunteer program grows from the fact that there is always more to be done. "We'd like to make an initial visit for every admit, but we can't do that with the way we are staffed," said Ruta. The hospital has five full-time chaplains and 12 part-timers for 414 beds, and "the more people get to know you, the more they use you, the more they need you."

The program, funded by a grant, is free to the volunteers. Every applicant must write a letter describing their interest, have a recommendation from their pastor, and be interviewed by Ruta and Rev. Janis Blean-Kachigan, who leads the course. The demand has been encouraging, with more applicants than slots.

Ruta got the basic idea for the initiative from Michael Moran, who offered a workshop on the topic that 100 people attended at the 2003 conference in Toronto. Moran, an NACC chaplain at Brooklyn Hospital Center in New York, developed his program from scratch six years ago. As the only full-time chaplain at a hospital with 300 beds, he had an especially acute need to extend his reach.

Now about 50 volunteers help at Brooklyn — which Moran sees as disappointing, given the several hundred he has trained. But many more use their skills to visit within their own parishes.

That's actually another big worry for Sr. Lapeyre. "It gives us all gray hairs and nightmares" to think about people with a little training offering their pastoral care services with no supervision, she said. "There are enough loose cannons out there, and we're very leery of what it can lead to."

But, she added, "I understand the pressures." A chaplain who is overworked and overextended has a legitimate need for help; "it's their own self-care."

In Brooklyn, Moran sees true diversity. "The current class, I looked around and there wasn't one Caucasian," he said. "It's mostly African-American and Caribbean, and we have two Muslims and a Hindu. … I'm always very explicit at the first session that if you're here to preach or convert, this is not the place for you. Surprisingly, I don't lose very many when I say that."

Once volunteers are on the floor, Moran supervises them closely. "I keep my ear to the ground, in terms of what the staff is saying," he said, and volunteers will frequently ask him to visit patients who need more than they can offer.

Hospitals realize they can't replace paid chaplains with volunteers, Moran said. But his employers, he said, love the community outreach and publicity that the training program creates.

At Froedtert, visiting patients is "something volunteers do only in collaboration with chaplain mentors," Blean-Kachigan said. "There's good accountability."

Edith DeBrue, a volunteer from a previous class, said that she may visit a patient who chaplains think would be a good match for her, or she may make initial contacts and give notes to the full-time staff. "If you have a problem, there's always something that can be done," she said.

Ruta said that volunteers are instructed to introduce themselves as pastoral care volunteers, and to tell patients that they can see a professional chaplain if they want one. Volunteers have a form to fill out for each patient, but do not write in the charts. "If they find anything significant, they bring it to their resource chaplain," Ruta said. "It's not deep, but at least they have a chance to lis-

*Rev. Janis Blean-Kachigan (center) helps pastoral care volunteers understand their future roles. After 40 hours of training, the volunteers may be qualified to visit patients at Froedtert Hospital in Milwaukee under the supervision of a resource chaplain.*

ten to whatever's going on in [patients'] lives."

"I go in and see what chaplain needs help, so I've been on many different floors," said Pat Seftar, who's been volunteering for several months. But if a chaplain is out, she'll take the list and "make cold calls, walking in and trying to invite the story, just listening with the ear of our heart. More often than I could imagine, it ends with the patient wanting to pray. It's a blessing for us, and hopefully for the patient."

Another purpose of the program is to put trained volunteers into the parish setting, where they can work in conjunction with their pastor to visit shut-ins. Ruta said, however, that the hospital has not tracked how many people are doing that.

DeBrue has been volunteering weekly in the hospital's palliative care department. But she's also a regular home visitor for her church, and the training made that easier. "I feel more confident about the way I approach people," she said. "It's good for the whole life experience, too."

Over the course of a training session, Blean-Kachigan, a Methodist minister and former CPE supervisor, walks the students through some basics of chaplaincy. She gives them a list of dos and don'ts — a helpful tool when the instructor has only 40 hours, but something a full-length CPE class would learn on its own.

A few people in the group come from an evangelical, proselytizing background. "That will be the greatest growing edge for them," Blean-Kachigan said afterward. "If someone really understands their call to be more Christocentric, they're not going to be comfortable in an institution that acknowledges and respects all faith traditions." If, at the end of the course, a volunteer is still focused on evangelizing, they will be gently steered back to their home church to minister.

The instructor covers some don'ts. Don't make promises you can't keep, either about getting better or about coming back for another visit. It's easy to do, Blean-Kachigan said, because "we want to try to make the patient feel better. And who else?"

"We want to make ourselves feel better," Sherri volunteers.

Don't tell the patients they're wrong. "We're not there to judge, we're there to serve," one student says. But, he says, his sister is a pagan; if he had to minister to her in the hospital, "that would be uncomfortable for me." Blean-Kachigan promises they'll come back to that later.

Don't initiate discussion of medical topics, but follow the patient's lead. "Suppose the patient says, 'I've just been diagnosed with cancer,'" Blean-Kachigan says. "What do you say?"

"Oh," says Chris, tentatively. A few people laugh nervously, but the instructor says, "Actually, 'Oh' is a great response. You have to let the patient lead."

The program is "not designed at all to replace professional chaplains," Blean-Kachigan said later. "There's a desire for a spiritual presence, and that desire far exceeds chaplains' availability." For instance, in the palliative care unit, one volunteer is sometimes paired with one patient, to journey until that person's death. "It could be a couple hours of just sitting with them," she said. "But the person who's doing the sitting has to have some comfort with that."

'I'll make cold calls, walking in and trying to invite the story'

- Pat Seftar, volunteer

"We're making sure someone's not dying with no one around," Ruta said. "That is a very important ministry, and trained volunteers can do that. The specific requests that are given to them are well-defined."

Also, Blean-Kachigan said, several people who have taken the class so far are "feeling the nudge to look at chaplaincy or ministry in the broader sense for their livelihood. This is testing the waters."

Froedtert's program is a model, Sr. Lapeyre said, because it already has a full staff of professional chaplains; it screens volunteers; it defines their duties and supervises them closely. "That's a really unique situation," she said. "And it works because of that."

# Ongoing training enriches volunteers, hospital

**By Peter Ruta**

We began a pastor-care volunteer training program at Froedtert Hospital due to the need for spiritual presence in the hospital setting and in the community — which far exceeds chaplains' availability. The program is not designed at all to replace professional chaplains. On the contrary, professional chaplains collaborate with the program instructor to help volunteers respect their boundaries in making referrals to them as needed.

The PCVTP was started at Froedtert Hospital in the spring of 2004. The training is offered twice a year, in the spring and in the fall. To accommodate the diversity of scheduling needs of participants, the spring session is on Saturdays and the fall one is on Monday evenings. The class size is 15 participants. The course consists of 40 hours of education – 30 classroom hours and 10 hours of supervised patient visiting. Participants must attend all training sessions and provide 10 hours of patient visiting in order to graduate.

We constantly marvel at the gift of these generous men and women

Those who successfully complete the course gain pastoral care skills to use in parish/congregation or hospital settings and are awarded a Pastoral Care Volunteer Training Certificate. If participants are interested, the training may make them eligible, after interview, to become pastoral care volunteers at Froedtert Hospital. Of the 60 individuals who have gone through the program, 20 of them are currently paired with staff chaplains and are volunteering at Froedtert Hospital. An annual meeting of the alumni from the program allows them to share stories of how they are using the skills they have learned. Those who volunteer at Froedtert have opportunities to meet periodically to update their skills and share growth in the ministry with their colleagues and their assigned resource staff chaplain.

Perhaps most significantly, three of the alumni have gone on to full-fledged CPE to become professional chaplains. The volunteer program gave them a taste of pastoral care but convinced them to pursue more training.

The applicants must show in their letter of intent and interview that they are people of generosity and compassion. They must believe that spirituality is a necessary part of patient care. They must be recommended in writing by their pastor/rabbi/imam. The topics covered during the sessions include: listening and responding appropriately to patients; awareness and acceptance of feelings; dealing with illness, loss and grief; role-playing to develop visiting skills; developing empathy with appropriate boundaries; prayer in pastoral care; visiting patients and receiving feedback on the quality of those visits; observing health and safety precautions, privacy, and confidentiality; self-care in care giving; and cultural diversity in pastoral care. The program instructor, Rev. Janis Blean-Kachigan, was a CPE supervisor for many years at St. Luke's Medical Center in Milwaukee. Her long and rich experience of educating chaplains is an invaluable asset to the program's quality.

When Blean-Kachigan explains the program to the candidates during their interviews, she says that the PCVTP is designed primarily for laity (the ordained and religious are also welcome) to grow in their ability to provide pastoral care. It is emphasized that the focus of pastoral care is to support people they are caring for in accessing their own spiritual resources.

Learning happens in the training program in different ways. Participants consider their own stories and life experience, paying attention to how their story may support as well as limit them in pastoral care giving. They are affirmed in their gifts and strengths and become more aware of and respectful of their limits. Secondly, participants learn essential pastoral care skills through didactic input and exercises. They have the opportunity to practice their pastoral care in two different ways. Each participant is matched with a chaplain mentor whom they work with during the clinical portion of their training. In addition, during the classroom portion of the training, a spirit of authentic community is fostered. This frees the participants to share with one another in real and meaningful ways while respecting the spiritual and cultural diversity of the group. Here a natural giving and receiving of pastoral care occurs. Real spiritual growth becomes the unexpected gift that is offered and received.

The screening process for admission, the definition of duties and responsibilities, and the close supervision are key to the quality of PCVTP. The stories of graduates from the program, the comments from staff chaplains working with volunteers from the program, and community feedback are all very positive. As we go through the interviews of candidates, Blean-Kachigan and I constantly marvel at the gift of these generous men and women who dare to respond to the call to share God's healing love with God's people in the diversity of their spiritual needs.

Our continuing task is to nurture the program and fine-tune processes of integrating pastoral care volunteers in our chaplaincy department without compromising the quality of spiritual care provided to patients, families and staff at Froedtert Hospital.

*Peter M. Ruta, NACC Cert., Ph.D, is Supervisor of Chaplaincy Services at Froedtert Hospital, Milwaukee, WI.*

# Monitored collaboration helps everyone

**By Alan Bowman**

The mission and vision of the NACC calls us to focus on the healing ministry of Jesus Christ. As the Chair of the NACC Standards Committee, I am very aware that the Standards exist to serve the membership in a way that promotes and empowers excellence in spiritual care services. The Standards assist the NACC in its mission to educate and certify professional chaplains and supervisors who will provide quality compassionate spiritual care.

But within the communities our members serve, we see an immense scope of needs. Certified chaplains and supervisors can quickly find themselves spread far too thin to address the multiple demands that include inpatient, outpatient, home, hospice, long-term care, staff education, community education, and other needs and opportunities such as disaster relief efforts and Third World health ministries. I have asked myself, as I am certain many of you have, "How might I best address both the breadth of needs as well as the depth of issues brought by so many?" I quickly concluded that it would require a team effort to have any measure of success.

How can I develop a team to effectively meet these challenges? First, I seek opportunities to increase the numbers of professional chaplains and supervisors, as well as promoting competency development called for in the NACC Standards and in the Common Standards approved by us and our five cognate groups (for a full list, see www.nacc.org). The second strategy for expanding the spiritual care team is to add a CPE program accredited by USCCB/CCA or ACPE. The CPE students extend the ministry of the professional chaplains and supervisors.

A third strategy is for professional chaplains and supervisors to educate nurses, doctors, social workers, and other healthcare team members to identify spiritual/pastoral care needs. This empowers them to partner with the chaplains in providing spiritual screening — which is distinct from the more thorough spiritual assessments completed by the professional chaplains. As these allied health partners are educated, more spiritual/pastoral care needs and opportunities are appropriately identified and referred to the chaplains. In some cases, this documentation of increased scope empowers mission leaders and directors to hire more professional chaplains.

A fourth strategy to address the increased complexity of scope is to develop a spiritual care volunteer program — but several factors are critical to its success. The program must have clear criteria for admitting participants. Expectations must be clearly defined and communicated, including the scope of services to be offered by the volunteers. For example, participants might serve as Extraordinary Minister of the Eucharist per diocesan guidelines; serve as hospitality ministers to inform patients of the services offered by professional chaplains; perform fundamental spiritual care screening and make appropriate referrals to the professional chaplains; and/or contact the patient's clergy per their request. Also, it is important to communicate within the organization that the volunteers on the spiritual care team are complements, not replacements or equivalents, for professional chaplains. Another critical factor is ongoing education and supervision of volunteers by certified chaplains and supervisors.

Healthcare professionals and educated/supervised volunteers can form a diverse team to address the ever-increasing scope of spiritual/pastoral care needs and opportunities. In my experience, this collaboration can only be accomplished by dedicated professional chaplains who have the diversity of skills and pastoral identity included in the NACC Standards and the Common Standards.

This collaboration can only be accomplished by dedicated professional chaplains

An added blessing of collaborating with volunteers is that the volunteer often grows in his/her spiritual life and becomes an advocate within the community for the mission of the organization. And sometimes, through the spiritual care volunteer program they discern a call to become a certified chaplain. This added benefit comes at a time when the average age of our NACC chaplains is 63 and many facilities are currently or soon will be looking to hire more certified chaplains. I for one urge my fellow members to welcome those who discern a call to this ministry and collaborate with them to better discern their ability to contribute to this call.

*Alan Bowman is a NACC-certified supervisor and chair of the Standards Committee. He serves as the Director of Spiritual Development for Catholic Health Initiatives in Denver, CO.*

Seeking, Finding

# Nursing home resident was essence of love

**By Pat Gavula**

Eleanor died. She lived in a nursing home, where death happens frequently. But why was Eleanor's passing so significant? Rarely had any death so affected the entire nursing home as had Eleanor's. Her death was an event, her absence palpable throughout the building.

Eleanor lived at the nursing home where I work as a member of the pastoral care team. I only knew her a few months before her death. We would chat on almost a daily basis — anything from exchanging a few words about the weather to long talks in her room.

Prior to becoming a resident at the nursing home, she had been a volunteer and spent time visiting the residents. She gracefully made the transition from visitor to visited. Yet she continued to make her rounds. Eleanor made it her job to get to know everyone — residents, staff, and families. She knew everyone's name and cared deeply about them.

Her faith was a part of the fabric of her being

Eleanor was the welcome wagon, official greeter, mother hen, the epitome of hospitality. She was never pushy, never critical; she never complained. She took everything in stride. Her diminishments were just another part of life — changes to be accepted, nay, embraced. Her arthritic fingers somehow managed to continue to reach the right keys on the piano. She loved to harmonize and would sing descants to any song or hymn in her high soprano voice. Prior to her death, she was practicing duets for an upcoming variety show, and she played the piano, sang, and helped plan the weekly worship service on the Alzheimer's unit of the nursing home.

Though I'm sure she had her faults and would be the first to admit she was far from perfect, any who knew her would be hard pressed to think of anything negative about her. She was simply one of those extraordinary people one meets perhaps once in a lifetime.

Eleanor met and accepted her Lord at age 11, and from that time on she served him faithfully. I've never met anyone who so perfectly lived the admonition to love one another. If Eleanor saw anything negative in anyone, she never let on. She never spoke ill of anyone.

A devout Baptist, Eleanor at age 88 was still expanding her understanding of the Lord. She attended Mass daily and received a blessing at communion time. Eleanor could think of no better way to begin the day than in prayer. She prayed using her own rosary at the weekly gathering for this devotion. About two months before her death, she borrowed a book about Mary. Though she agreed to disagree with Catholics on the role of Mary as intercessor, she still wanted to learn why Catholics were so devoted to the Mother of God. A few weeks later she requested information on the rosary, curious about its origin and appreciative of its connection with the psalms she so loved.

A number of religious sisters live at the nursing home. One of them commented that Eleanor was "more Catholic than us Catholics." What did she mean by that? Do Catholics have a corner on the market of generosity, hospitality, faithfulness, graciousness, and love? Of course not. Eleanor simply belonged to that group of extraordinarily devoted Christians who live their faith moment to moment. Her faith was a part of the fabric of her being, not something done out of fear or sense of obligation. I'm tempted to say that Eleanor practiced what she preached, but, truth be told, she never preached, only practiced, and to a level of perfection that was a privilege to witness.

I have several regrets regarding Eleanor. One is linked to her very specialness. I regret that there are not more like her. Didn't she live the way we all should? Why are there so few people like her? Why is everyone commenting that there will never be another one like Eleanor? Reflecting on Eleanor, one resident wondered: "Are people born that way or do they become that way?" Good question. We are all born with the potential to be generous, kind, faithful, loving, hospitable, and gracious. The challenge is to recognize that potential and act upon it.

My second regret is not being able to share the Eucharist with her. Recognizing how close Eleanor was to the Lord and how intimate an experience the Eucharist is for me, I wish she could have experienced the same. Yet that is an issue more for me than for Eleanor. She would never have presumed that she should take the Eucharist, so solid was she in her Baptist faith and so respectful of others' faith traditions.

The day before her final surgery, one week before her death, she gratefully and graciously accepted a blessing from one of our resident priests. He suggested that perhaps she was interested in converting to Catholicism. She responded that she did not want to convert but simply desired to continue to broaden her faith in, relationship with, and understanding of the Lord. If only we could all be so open and so honest and willing to let God lead us to a greater understanding of the Lord in all His manifestations. She was quite comfortable with the truth that God draws us to Himself in different

but equally valid ways.

I was privileged to witness her reciting Psalm 23. Of course, she knew it by heart, and it came from her heart with total conviction and confidence in her Shepherd Lord. Afterward, she commented on the phrase "walk through the valley of the shadow of death," emphasizing that we walk *through*, we don't stay there — God is with us every step of the way to lead us through and out into peaceful places. And that while in the dark valley we are steadily walking our way out with God at our side.

Eleanor was a shepherd. She gathered the flock on her unit and checked on those who were left behind — those too ill to leave their rooms, those unable to communicate, those with head injuries, stroke, or dementia. They were as precious to her as every sheep is to the Good Shepherd.

I never felt a need to comfort Eleanor, even as she approached death. She accepted the stroke and pneumonia that followed her final surgery as just another part of life and not something to rue or question. Throughout her time with us and through her dying process, she comforted us. As streams of residents, staff, and their families stopped in to say their goodbyes, Eleanor managed a smile, a touch for each one. She said through simple gestures "It's all right." It was as if God were leaving us and saying: "I must go, but everything will be fine. I'll be with you always and I'll be looking down on you."

But God also said: "I'll send you another." Who will be the next Eleanor? Who will rise up and follow her footsteps? That's our challenge — to live like Eleanor.

How to describe Eleanor? Eleanor was love. It says in scripture (1 Cor 13:4-8): "Love is patient, love is kind. It is not jealous, is not pompous, it is not inflated, it is not rude, it does not seek its own interests, it is not quick-tempered, it does not brood over injury, it does not rejoice over wrongdoing but rejoices with the truth. It bears all things, believes all things, hopes all things, endures all things. Love never fails." This is the essence of Eleanor.

She gathered the flock on her unit and checked on those who were left behind

*Pat Gavula is a chaplain at Mount St. Joseph Nursing Home in Waterville, ME.*

## Chaplains earn NACC certification

Congratulations to Rev. Raymond Iwuji of St. Louis, MO, and Ms. Barbara Sorin of Harrisburg, PA, who have been approved for certification following their interviews in the fall of 2005.

## Kentucky bishops urge healthcare for all

**LOUISVILLE, Ky.** (Catholic News Service) — Saying all people have "a moral right" to basic healthcare, the Catholic bishops of Kentucky have called for "a new commitment" in the United States and Kentucky to provide access to affordable care.

Among the signers was Archbishop Thomas C. Kelly of Louisville, former episcopal liaison to the NACC.

"It is not acceptable that millions of people in our country and hundreds of thousands in Kentucky do not have access to affordable healthcare," the bishops of the state's four Catholic dioceses said in a statement released in December. In addressing one of the major national issues today, the bishops said access to healthcare is "a fundamental human right" that is "necessary for the development and maintenance of life and of the ability of human beings to realize the fullness of their dignity."

The statement, titled "Health Care Is a Moral Right, a Safeguard of Human Life," was also signed by Bishops John J. McRaith of Owensboro, Roger J. Foys of Covington and Ronald W. Gainer of Lexington.

# Briefs

## Catholic Charities promotes disaster recovery

**TALLAHASSEE, Fla.** (CNS) — Catholic Network Florida, the nonprofit organization which represents all seven Catholic Charities agencies in the state, has received a $200,000 grant from Catholic Charities USA to fund a graduate program in long-term disaster recovery management.

The grant will enable Catholic Network Florida to work with the College of Social Work at Florida State University in Tallahassee to develop a specialized curriculum in emergency management and disaster recovery.

The curriculum will have a nondegree track that will be available on the Internet and a component on compassion fatigue and critical-incident stress management. The College of Social Work will create the curriculum in cooperation with the university's Reuben Askew School of Public Administration.

# Spirituality may help mood of women with cancer

**By Nadia Boscaglia**

A diagnosis of cancer represents a major and catastrophic life event. Patients must cope with the stress of a life-threatening illness, the cancer treatment and its side effects, as well as changes to their work, relationships, and physical abilities. Together, these physical, psychological, financial, and social changes are potential sources of emotional stress, anxiety, and depression in cancer patients.

Following diagnosis and surgery, a proportion of cancer patients experience significant emotional disturbances — usually in the form of *anxiety* and *depression*. People with cancer or other seriously illnesses may also develop *demoralization* — a syndrome in which hopelessness is the core feature. In this brief report, I describe the nature of these disturbances and their assessment, and report on research that examines whether spirituality has a mood-protective role in individuals with cancer.

The most important factors in predicting distress were worldview and self-blame.

## Anxiety

Anxiety is a feeling of tension and uneasiness that is experienced as apprehension or dread. Generated when we feel threatened by life's stresses and upheavals, anxiety has many physical signs and symptoms such as diarrhea, dizziness, tachycardia (rapid heartbeat), muscle tension, nausea, palpitations, sweating, frequent urination, and rapid respiration. When anxiety reaches distressing levels, and/or the anxiety is interfering with day-to-day functioning, it is considered to be problematic, and a clinical diagnosis of an anxiety disorder may be made.

There are significant sources of anxiety (i.e., potential threats) during the course of a serious medical illness. Potential threats include waiting for test results, receiving a threatening diagnosis, anticipating or undergoing invasive medical procedures, and fear of recurrence. Not surprisingly, researchers report that seriously ill people often experience levels of anxiety that are greater than those in the general population (e.g., Derogatis et al., 1983).


## Depression

In current thinking, depression tends to be viewed as a clinical syndrome defined by the presence of a set of maladaptive symptoms. These symptoms include depressed mood; loss of interest or pleasure in nearly all activities; changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; and recurrent thoughts of death or suicidal ideation, plans or attempts. Subsequent to a cancer diagnosis, approximately 20% to 25% of patients experience some form of depression (Derogatis et al., 1983; Massie & Holland, 1990).

## Demoralization

Demoralization, somewhat different from depression, is a syndrome common in the medically ill. The core features of demoralization include hopelessness and helplessness, which arise from feeling trapped or not knowing what to do; meaninglessness; and existential distress, which encompasses feelings of despair and angst associated with a loss of purpose and meaning to life. Demoralized persons often desire death with impatience, and experience suicidal thoughts, intense anxiety, lowered self-esteem, avolition, alienation, and isolation from others (Kissane & Clarke, 2001).

## Assessing Mood in Cancer Patients

In both clinical practice and research, the measurement of mood in cancer patients can be problematic. There are two main reasons for this. First, there may be profound suffering and psychological disturbances which are not usually included in typical screening measures (Rodin, 2003). Second, traditional diagnostic criteria for mood and anxiety disorders are difficult to apply because of the heavy reliance on somatic (bodily) symptoms, which may be a consequence of the cancer, rather than a mood or anxiety disorder. For example, weight loss, lethargy, and sleep difficulties are symptoms of depression; however, they are also symptoms of cancer progression and/or cancer treatment side effects.

To assess more accurately distress in cancer populations, it is proposed that, in addition to the traditional measures of depression and anxiety, researchers and clinicians consider other measures of distress, such as demoralization (Kissane & Clarke, 2001; Rodin, 2003). Further, when assessing for depression, it is better to focus on evaluating the emotional symptoms (e.g., sadness and guilt), rather than the somatic symptoms (e.g., weight loss).

## The Role of Spirituality

Amongst those with a serious physical illness, spiritual and/or religious beliefs may help to protect against mood disturbance. Drawing from the multitude of definitions in the literature, spirituality can be defined as the feelings, thoughts (i.e., attitudes and beliefs), experiences, and behaviors which empower and transcend the self, and which give meaning and purpose to life through a sense of connectedness with the self, others, the natural environment, and/or a higher power (Jenkins & Pargament, 1995; Narayanasamy, 2004; Reed, 1992). Typically, in contemporary literature, *spirituality* is viewed as a broader construct than *religion*, which can be defined as an organized social entity, with prescribed beliefs and practices that are associated with formal denominations or recognised systems of theological ideas (Jenkins & Pargament, 1995).

In the context of a serious stressor, such as cancer, an individual's spirituality may help to buffer the effects of stress on mental and physical health via several pathways. Spiritual beliefs may help a person to find meaning in his/her life, and thus limit the mental health consequences of adverse experiences; spiritual involvement may fulfill innate needs of related-

ness and thus reduce negative emotion; and spiritual practices may help develop supportive social networks and therefore promote health behaviors (Kim & Seidlitz, 2002). Additionally, an individual's spirituality may be used as part of his/her coping in many ways, including: the shaping of appraisals, the construction of attributions about the nature and controllability of situations, and the reframing and reinterpretation of the meaning and implications of stressful life events (Pargament, 1997).

## Research with Women with Gynecological Cancer

In my doctoral research[1], conducted at Monash University under the supervision of Associate Professor David Clarke, I set out to explore the predictive and protective factors of distress (i.e., anxiety, depression, and demoralization) among women within one year of diagnosis of gynecological cancer. In selecting the predictors, I aimed to be as inclusive as possible and thus explored the role of medical, disease, and demographic factors; spirituality; coping; worldview; social support; and negative life events.

The final sample comprised 140 women with gynecological cancer (mean age = 52, mean time since diagnosis = 21 weeks). Women in the sample were primarily Australian born (66%), and most of the sample (71%) had been diagnosed with early stage cancer. A series of chi-squares, correlations, and hierarchical regression analyses were used to analyze the data.

Analyses revealed significantly more cases of likely depression and greater levels of anxiety in the sample, compared to women in the general population. Interestingly, medical and disease variables were not predictive of distress, nor was a history of negative life events. The most important factors in predicting distress were *worldview* and *self-blame*. That is, women who tended to view the world as meaningful, understandable, and manageable were *less* depressed, demoralized, and anxious; whereas women who blamed themselves for their cancer were *more* depressed, demoralized, and anxious.

The role of spirituality amongst study participants was small though significant. Spirituality was not related to measures of distress for the *total* sample. However, when the sample was restricted to the 87 women who used some form of religious coping to deal with their cancer, there were weak though significant inverse correlations between spirituality and all measures of distress ($r$ = -.27 to -.29). Thus, it seemed that, for women who were inclined to use their spiritual/religious beliefs and practices in their coping, a stronger sense of spirituality (i.e., connection with the self, others, the natural environment, and/or a higher power) was protective against distress.

Spirituality was also identified as a predictor of having a view of the world as meaningful; in turn, women who tended to view the world as meaningful were less distressed in their first year after a gynecological cancer diagnosis. These data can be interpreted to mean that spiritual/religious beliefs and practices function as a source of meaning, which can in turn, help people to understand and process difficult life experiences. Longitudinal research is needed to verify this interpretation.

## Conclusion

Mood disturbances are common in those with cancer. In recent research on women with gynecological cancer, spirituality was shown to be weakly, though significantly, related to mood for women who used spirituality/religion in their coping. Given this association, mental health professionals who work with the medically ill may want to consider a patient's spirituality when conducting an assessment. Additionally, the lines of communication between chaplains and mental health professionals (e.g., psychologists) should be open as possible. With a lack of education reported on both sides (i.e., psychologists not receiving adequate training in spiritual/religious issues, and clergy not receiving adequate training in mental health; Oppenheimer et al., 2004), it is a good idea for members of both professions to be willing to share their respective skills and knowledge, and to educate one another about appropriate referral.

1 Selected data from the first 100 participants is published in the *International Journal of Gynecological Cancer*, vol. 15, pp. 755-761.

*Dr Nadia Boscaglia teaches in the Department of Psychological Medicine at Monash University in Australia.*

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# Physicians often miss need for spiritual care

## *Recent study investigates factors that block communication*

**By Larry VandeCreek**

When I was part of a family medicine faculty (1975-1988), part of my job was to help family medicine residents recognize and respond to the psychosocial/spiritual (PSS) concerns of their patients. But they were busy learning clinical medicine and had little interest in such issues. To my amazement, one senior family medicine resident bluntly told me one day that none of the 300 families for whom he provided medical care had any PSS concerns. Naturally, the title of the study referenced below caught my eye, and it explains why physicians find it difficult to recognize the need for spiritual care and to provide it.

The study reports results from 17 physicians who engaged in 20 non-agenda group discussions, each 75 minutes long. After the tape-recorded discussions were transcribed, the analysis identified content domains and themes that described barriers.

What barriers were identified? Analysis revealed three domains: cultural (48% of the transcribed text), organizational (33%), and clinical (19%). The cultural domain contained four themes. The first concerned medical training as a substantial barrier because, from the beginning, it taught them "expectations and attitudes that marginalized PSS aspects of care," emphasizing that they were "tangential" and "potentially detrimental to objective medical care." This emphasis was compounded by the "distancing effects of technology."

The second theme in the cultural domain described the medical-school selection process as one that chose only persons who were "intellectual, empirical, skeptical, rational, and competitive." The study adds, "Thus, soft areas of medical care … are less likely to be understood and valued in this world view."

The third theme in the cultural domain was the medical practice environment in which physicians keep their own PSS concerns hidden from view "with no safe haven or system in place for discussing them." The fourth theme, titled "debt and delay," pertained to lost idealism under the pressure of training and concerns with how to pay off the debt accumulated during training.

The organizational domain contained two themes. The first concerned "dissatisfaction with medicine" brought about by "changes in healthcare, insurance regulations, and expectations regarding patient volume." Participants often expressed the feeling "of not being able to do what I was trained to do." The authors summarize the second theme as "Time/busyness." "Many participants seemed overwhelmed by the sheer pace of their days." Trying to talk with patients about PSS concerns was experienced as risky because it would use up valuable time needed for the next patient.

The authors identified one theme in the clinical domain, namely communication difficulties. "The participants (believed) that communicating about subjective issues (e.g. emotions, relationships, spirituality) are difficult in general but more complicated within the patient-physician encounter. … The participants also felt ill-trained, in general, to handle the type of communication characteristic of PSS discussions."

The authors conclude, "The results of this study suggest that the culture that selects and trains technically competent physicians does not value PSS and creates a work environment hostile to PSS concerns. The results also suggest that these forces may act directly, by marginalizing PSS aspects of terminal care, and indirectly, through their effects on the emotional, relational, and spiritual lives of the physicians themselves." They close by describing additional research possibilities and possible educational interventions.

My experience, as described above, suggests that the forces shaping the medical culture are extremely powerful and not likely to change soon. I believe it is unrealistic to expect physicians, particularly those in training and in the early years of practice, to conquer the technological aspects of medicine and to give any substantial attention to the spiritual concerns of patients. If the reader believes that nurses can provide spiritual care, I refer you to a 1999 article in *Psycho-Oncology* (8:451-458), the title of which begins, "I would if I could …" Spiritual care is the unique contribution of chaplains.

**Reference:** J. Chibnall, M.Bennett, S. Videen, P. Duckro, & D. Miller. 2004. "Identifying barriers to psychosocial spiritual care at the end of life: A physician group study." *American Journal of Hospice and Palliative Medicine, 21(6), 419-426.*

*Larry VandeCreek, DMin., BCC, is a retired APC chaplain living in Bozeman, MT.*

### Editor's Note

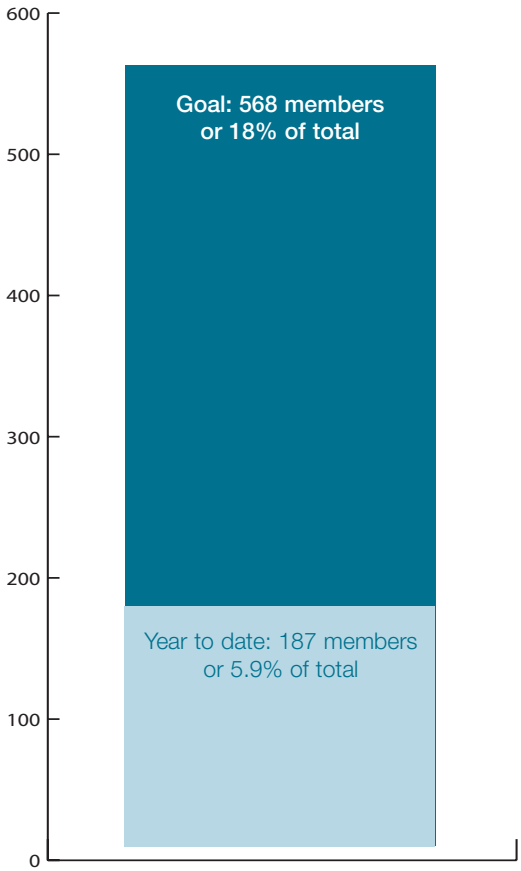
With this issue, we initiate a new sharing arrangement with the Association of Professional Chaplains. Larry VandeCreek, long a respected name in pastoral care research, has regularly contributed updates and summaries of significant new findings to chaplains in the *APC News*. Now, Dr. VandeCreek's reports will also appear in *Vision* six times a year as part of our commitment to providing readers with more news of pastoral care research.

# Annual Appeal reports progress

The NACC would like to thank all of its members and friends who have contributed generously to our Annual Appeal. As of Jan. 31, we have raised slightly more than half of our budgeted monetary target for the year.

However, we have set another, more ambitious goal for ourselves. Last year, only 8 percent of our members contributed to the appeal. This year, we are trying to raise that figure by 10 percentage points. By the time we close our books on Dec. 31, we hope that 18 percent of our membership, or 568 individual members, will have contributed.

The graph at right shows our progress. So far, we have received checks from 187 members, which represents 5.9 percent of our total. We thank you all for your gifts, and we hope to issue many more thank-yous in the coming months.




## Easter Wings

Lord, who createdst man in wealth and store
Though foolishly he lost the same
Decaying more and more,
Till he became
Most poor;
With thee
O let me rise
As larks, harmoniously
And sing this day thy victories:
Then shall the fall further the flight in me.

My tender age in sorrow did begin:
And still with sicknesses and shame
Thou didst so punish sin,
That I became
Most thin.
With thee
Let me combine
And feel this day thy victory:
For, if I imp my wing on thine,
Affliction shall advance the flight in me.

*George Herbert (1593-1633)*

## In Memoriam

**Please remember in your prayers:**

**Deacon Matthew F. Teolis,** who died in December at age 78. He was ordained a deacon in the Archdiocese of Chicago in 1975; in 1990 he received a degree in pastoral care and joined the NACC. He moved to Fort Lauderdale, FL, during the 1990s and retired in 2001.

**Sr. Corinne Yepson, SMP,** who died Jan. 12 at age 85. Of Native American and French heritage, she spent her novitiate in France and was held in a German internment camp for 18 months during World War II. She spent most of her career as a nurse anesthetist, but went into pastoral ministry in the 1980s at St. Andrew's Hospital in Bottineau, ND. She joined the NACC in 1987 and earned certification a year later. She retired to Maryvale Convent in Valley City, ND, in 2002.

**Carol A. Shepherd,** who died Dec. 26 at age 67. She was a chaplain at Lowell General Hospital in Massachusetts for 10 years, and at the time of her death was a pastoral associate at Holy Family Parish in Lowell. She had been an NACC member since 1985 and wrote the cover story of the April 2005 *Vision* about the work of parish chaplains.

## Book Review

# Author looks at spiritual side of aging

***Creating a Spiritual Retirement: A Guide to the Unseen Possibilities in Our Lives***

By Molly Srode. Woodstock, VT: Skylight Publishing, 2004, 170 pages, softcover; $14.99

**By Linda F. Piotrowski**

Author Molly Srode attempts in this book to help readers prepare spiritually for what she describes as "a stage in our life journey … a time to gather around us what we will need physically and spiritually to sustain us during the last stage of our journey."

Separated into three sections *(The Individual Spirit, The Great Spirit and Practical Spirituality)*, the book is further divided into 36 chapters in which the author shares her retirement experiences and assists the reader in reflecting on his/her retirement. She encourages the use of meditation and quiet reflection as ways to connect with the mystery of God.

Each chapter contains a narrative section followed by a poetic reflection, concluding with questions and/or suggestions for thoughtfully reflecting and integrating the fruits of the reader's reflections into his/her life. The author encourages the reader to write responses to each chapter.

Openly sharing her life story, Ms. Srode writes of the pains and the joys of a life lived in service to others. As a Sister of Notre Dame of Namur, she spent 28 years in the classroom as an elementary school teacher. But after a period of discernment, Ms. Srode applied for and received a dispensation from her religious vows. Two years after leaving religious life, she married a friend and former priest. When burnout left her looking for a different career, she prepared for and served as a chaplain for seven years. She writes, "Many of the spiritual insights that I will share in this book have grown out of my rich and life-giving experience as a chaplain."

Drawing from a number of religious traditions, personal experience, prayer and study, Ms. Srode employs an eclectic approach to spirituality. Encouraging the reader to be attentive to the spirit, she introduces the image of a round house. The house consists of an outer circle of "doing" rooms, an inner circle of "thinking and feeling rooms" and an innermost central room which is the "powerhouse of our being." She offers this reflection on this inner room where our spirit dwells:

"You, gentle spirit, are here.
As I walk through this forest of feeling
I carry your light
like a small star
cupped in my hands.
With this handful of spirit,
the night has light enough to see
and the next step is made visible.
This cup of spirit-light
dispels the creatures of the night
and warms my heart."

From the eager anticipation of time to call one's own to the shadows and ghosts that may haunt the early morning hours, the author attempts to assist the reader in preparing for and/or successfully negotiating retirement.

While this book does not break a lot of new ground, it is a gentle and honest exploration of the powerful and sometimes painful lessons life has to teach us if we take time to become reflective. It can be a starting point for one's own exploration of the spiritual implications of retirement. As I read it, my husband and I talked about a number of the topics based upon his experiences as a retiree. Chaplains might use the book as the basis for a group process with seniors in assisted living facilities or nursing homes.

By focusing on the spiritual, Ms. Srode presents a fresh perspective on a frequently overlooked aspect of retirement. She provides a structured way to reflect upon and integrate one's own life experiences, helping the reader to navigate retirement's challenging waters.

*Linda F. Piotrowski, MTS, NACC Cert., is the Interfaith Chaplain at Central Vermont Medical Center in Barre, VT.*

## Positions Available

### ▼ DIRECTOR OF PASTORAL SERVICES

**Oklahoma City, OK** – Mercy Health System of Oklahoma is a faith-based, full-service tertiary healthcare system. We are seeking qualified candidates for the position of Director of Pastoral Services. This full-time position is responsible for leadership of Pastoral Services Mercy Health Center and the Oklahoma Heart Hospital. The Director will demonstrate clinical expertise and the capacity to lead a staff of 15 chaplains. Witnessing to the healing presence of Christ, the Director will perform her/his ministry in accordance with the mission, vision, and values of the Sisters of Mercy Health System and the rich heritage of the Catholic moral tradition. Requires a master's degree in theology, spirituality, pastoral ministry or related field. Also requires certification through National Association of Catholic Chaplains. Interested candidates may apply at www.mercycareers.net or call Kerri Beasley, RN at (405) 936-5652.

## ▼ DIRECTOR OF PASTORAL CARE

**Baton Rouge, LA** – Our Lady of the Lake Regional Medical Center is a 763-licensed bed, not-for-profit, healthcare facility. We are seeking a full-time director to lead our ecumenical pastoral care team in meeting the religious and spiritual needs of our patients, their families and our hospital employees. Must have 4 years pastoral health care experience and proven managerial skills. Preferred qualifications include a master's degree in theology or related field, and NACC certification. We offer a competitive salary and an attractive benefits package. Please visit our website at www.ololrmc.com to apply online.

## ▼ CHAPLAIN

**Temple, TX** – Scott & White has an immediate need for a chaplain to work the 10 a.m. – 7 p.m. shift. Chaplain will interface with CPE in providing pastoral care and seminars, expected to integrate with medical staff in a teaching hospital, have a working understanding of bioethics and advanced directives, and build relationships with area community clergy and church laity. Requirements: Must be certified by NACC or APC or have completed prerequisites and ready to meet certification committee prior to employment; undergraduate 4-year degree; master's of divinity, master's of theology, or equivalent that meets criteria for APC or NACC certification; ordained or equivalent recognition by denomination. There's no better place in Texas, and few in the whole country, to build a world-class career. At Scott & White, you will have the resources of one of the largest multi-specialty practices in the country that includes a 503-bed teaching hospital with a Level I trauma center, more than 500 physicians, a nationally-recognized cancer center and 15 regional clinics; over 100 years of providing patient- and family-centered care in Central Texas; recognition as one of the nation's top 15 major teaching hospitals; and the primary teaching facility for the Texas A&M University College of Medicine. One of the country's best places to live. Escape the hassles of the city without giving up its modern amenities. Temple (just an hour north of Austin) is a thriving mid-size community with a low cost of living, good schools, and the lush meadows and sparkling lakes that make Central Texas so desirable. E-mail ghollie@swmail.sw.org; phone (254) 724-7655; fax: 254.724.5591; mail or apply in person: Scott & White, HR Dept., 2401 S. 31st St., Temple, TX 76508. An equal opportunity employer/tobacco-free environment.

## ▼ CPE RESIDENCY

**Milwaukee, WI** – The Village at Manor Park, September 6, 2006 to May 11, 2007, 9-month residency in geriatric ministry. $19,500, plus health insurance & other benefits, tuition scholarships. The Village is an award-winning senior healthcare system, offering all levels of care, including hospice. Minimum of one CPE unit required. A theological degree and some pastoral experience are preferred. Apply to: Chaplain Kate Sullivan, The Village at Manor Park, 3023 S. 84th Street, Milwaukee, WI 53227-3798; telephone: (414) 607-4123; email: Kate.Sullivan@vmp.org; website: www.vmpcares.com

## ▼ CHAPLAIN

**Wilmington, DE** – St. Francis Healthcare Services has an immediate opening for a part-time chaplain to minister to patients, families and staff at our long-term care facility, Brackenville Care Center. Candidate must have experience in ministering to geriatric residents, a working knowledge of the Ethical and Religious Directives for Healthcare, and NACC board certification. If interested, please send information to Human Resources Department, St. Francis Hospital, 7th and Clayton Streets, Wilmington, DE 19805-0500. Fax: (302) 421-4265. EEO

## ▼ CHAPLAIN

**New York, NY** – The largest health system and the largest employer in New York City, NewYork-Presbyterian Hospital is consistently recognized by U.S. News & World Report as one of "America's Best Hospitals." And while no hospital can say that they care more than others, we can say that we put great emphasis on the compassionate support of our patients and those who love them. We are seeking a Chaplain to help provide that support, through pastoral care and counseling to patients and significant others, both individually and in groups. You will consult with clinical staff and administrative leadership regarding your patient contacts, as well as act as liaison for our Center for Special Studies with community religious organizations and institutions. In this important role, you will be an active and contributing member of the Department of Pastoral Care and Education and the Pastoral Care and Education Advisory Committee. You will also write for publications relevant to pastoral care and education, particularly relating to ministry with persons and families dealing with HIV. To qualify, you must have a Master of Divinity or equivalent, along with certification by the Association for Clinical Pastoral Education, the College of Pastoral Supervision and Psychotherapy, the Association of Professional Chaplains, the National Association of Catholic Chaplains, or the National Association of Jewish Chaplains. At least three years' experience in ministry is required, and you must have a demonstrated record of significant professional service in ministry to patients with HIV. For immediate consideration, e-mail your resume to ama9004@nyp.org. We are an equal opportunity employer.

## ▼ MANAGER, PASTORAL CARE

**TUCSON, AZ** – Through the Pastoral Care department, this position ensures integration of spiritual services among patients, families and staff within Carondelet Health Network, a Catholic system of three hospitals in southern Arizona. Member of Ascension Health, the largest Catholic healthcare system in the country. Certification by NACC, APC or other national organization required. Bachelor's degree in philosophy, religious studies, theology or healthcare management required. At least four years progressively responsible experience in pastoral care. Management experience required. Send resume and salary requirements to Lsellner@carondelet.org or fax to (520) 872-7847.

## ▼ VICE PRESIDENT, MINISTRY FORMATION

**Denver, CO** – Catholic Health Initiatives, one of the country's largest health care systems, seeks a pastoral professional to serve as the mission group representative to shape CHI's ministry culture through integration of ministerial formation and leadership development. This important role is based in Denver and brings expertise in theology and the hallmarks of Catholic identity in health care to

# Positions Available

develop programs and training for CHI executives, clinical leaders and staff, incorporating spirituality and reflection into organizational life. Requirements include at least three years of pastoral experience directing organizational efforts for ministry formation in the Roman Catholic tradition. Must also have significant experience in theology and be willing to travel (30-40%). Enjoy life in Colorado and make a difference with an organization dedicated to making health care accessible for all people. For consideration, please email resume to traciegrant@catholichealth.net or fax to (303) 383-2717. EOE

## ▼ DIRECTOR OF MISSION SERVICES

**Marshfield, WI** – A desire to heal ... to help ... to make a difference. Saint Joseph's Hospital, a member of Ministry Health Care, is a 504-bed tertiary care teaching hospital and the largest rural referral center in Wisconsin. We share our medical campus with Marshfield Clinic, which is a large multispecialty clinic with about 700 physicians. Saint Joseph's Hospital provides comprehensive services and specialty care to people in a large geographic area of Wisconsin. The Director of Mission Services is a leadership role with primary responsibility for developing new and creative ways in which the mission and values of Sisters of the Sorrowful Mother remain visible and highly integrated into the operational functioning of Saint Joseph's Hospital, in conjunction with Ministry Health Care, our parent organization. You will assure spiritual services are delivered in a high quality, contemporary and effective manner and that Mission and Value initiatives within the context of our Catholic identity are well integrated into the organization's strategic and operational activities. We require master's degree in theology, religious studies, pastoral studies, ethics or related field, and 5 years' experience in a leadership capacity in a role similar to this position. CPE certification or units of CPE from an accredited site highly preferred but not required. Must possess an understanding of and commitment to spiritually based patient care, knowledge of bioethics and its application in a health care setting as well as knowledge of issues related to Catholic health care ministry, sponsorship and social teachings of the Catholic Church. To apply online, visit "Career Opportunities" at: www.ministryhealth.org. Where caring makes the connection. An AA/EEO employer.

## ▼ DIRECTOR, PASTORAL CARE

**Yonkers, NY** – To begin a pastoral care department at St. John's-Riverside Hospital (www.riversidehealth.org), a 300-bed community hospital with an adjacent 120-bed nursing home, a 100-bed substance abuse facility, and a nursing school located on the Hudson River just north of New York City. The successful candidate will join a dynamic leadership team to establish a new Department of Pastoral Care in these institutions, which have a very culturally and economically diverse patient population and staff. Qualifications: ACPE, APC, or NACC certified, high energy with a well developed sense of the role of professional chaplaincy, excellent clinical skills, and an ability to handle all aspects of pastoral care administration. Send resumes to: The Rev. George Handzo, Vice President for Strategic Development, The HealthCare Chaplaincy, 307 E. 60th St., New York, NY 10022 (ghandzo@healthcarechaplaincy.org)

## ▼ STAFF CHAPLAINS

**Albuquerque, NM** – The Presbyterian Healthcare Services Department of Chaplaincy Services has two openings for board certified chaplains: women and children's chaplain and cardiac chaplain. The women's and children's program includes a family birthing center, maternal special care, pediatrics, pediatric intensive care, and neo-natal intensive care. The cardiac floors include coronary critical care, telemetry, surgery, and a cardiac catherization lab. Applicants must be board certified by either the APC, NACC, NAJC, or CAPPE. Please apply online at www.phs.org and type in Job Requisition Number 15851 or 15852. Presbyterian Healthcare Services is the largest health care provider in New Mexico, offering the following clinical services: women and children, hospice, critical care, senior health, behavioral, oncology, and medical/surgical. In November of 2005, the "Spirituality and Health Program" area was dedicated, which includes a chapel, the Healing Garden, Healing Sounds, and administrative offices. The two new staff chaplains will collaborate with the critical care staff chaplain, and serve as a mentor to the CPE students (residents, extended, summer). Chaplaincy Services is well integrated into patient and family care, as well providing support to the staff. To learn more, contact Rev. Jenny T. Lannom (jlannom@phs.org) or call1-800-545-4030, ext. 1218. You are encouraged to visit our web site at www.phs.org/pastoralcare for additional information about PHS and the Department of Chaplaincy Services.

## ▼ DIRECTOR OF CPE

**Corpus Christi, TX** – "Our Lord Jesus Christ, suffering in the persons of a multitude of sick and infirm of every kind, seeks relief at your hands." This request, written by Bishop Claude Dubuis to the founding sisters over 135 years ago, continues to be the foundation of our ministry today. CHRISTUS Spohn Health System is seeking an innovative Clinical Pastoral Education Supervisor to provide leadership for the CPE Center. Our health system consists of six hospitals, outpatient clinics and other health services. The Spiritual Care Department includes chaplains and volunteers from many faith traditions, and our Clinical Pastoral Education program was established over thirty years ago. Qualifications: Master of Divinity degree or equivalent, supervisory certification through the Association of Clinical Pastoral Education, endorsement by faith group, and chaplaincy certification by the NACC, APC, or NAJC. The ideal candidate will have 5 years experience as a CPE supervisor and 2 years administering a CPE program. Competencies required for this position are: Knowledge of the Standards and practices of ACPE and proven abilities in successfully administering a CPE program; skills in organizing, writing and presenting reports, including CPE student evaluations and ACPE reports; facility in establishing effective working relationships with health system employees, volunteers and physicians, community clergy, and seminary representatives; ability to organize and present a variety of educational programs; ability to provide effective pastoral/spiritual care and provide mentorship to students in this area; ability to work as a member of the interdisciplinary team, provide professional consultation and documentation regarding patients' spiritual

needs and plan of care. Corpus Christi is located on the Gulf of Mexico about 150 miles from San Antonio and 200 miles from Houston. It is a growing city, but still small enough to be easy to get around, with a population in the county of approximately 330,000. Being a tourist destination lends a relaxed feeling to the community, and we enjoy an abundance of sun and gentle sea breezes. Interested applicants can see more about our health system on the website at http://www.christusspohn.org. For more information, please contact Tim Samet by phone at 361-881-3135 or email tim.samet@christushealth.org.

## ▼ DIRECTOR OF SPIRITUAL CARE

**Corpus Christi, TX** – "Our Lord Jesus Christ, suffering in the persons of a multitude of sick and infirm of every kind, seeks relief at your hands." This request, written by Bishop Claude Dubuis to the founding sisters over 135 years ago, continues to be the foundation of our ministry today. CHRISTUS Spohn Health System is seeking a dynamic person to lead the Spiritual Care Department into the future. Our health system consists of six hospitals, outpatient clinics and other health services. The Spiritual Care Department includes chaplains and volunteers from many faith traditions and our Clinical Pastoral Education program established over thirty years ago. Qualifications: Master of Divinity degree or equivalent, minimum four units of CPE, endorsement by faith group, and certification by the NACC, APC, or NAJC. The ideal candidate will have 5 years experience as a professional chaplain; two to five years as a department director is preferred. Competencies required for this position are: Ability to build and maintain collaborative relationships with the CPE program, health system leaders, community members; excellent written and oral communication skills, including public speaking, planning and organizational skills; ability to effective use goal-setting techniques. Corpus Christi is located on the Gulf of Mexico about 150 miles from San Antonio and 200 miles from Houston. It is a growing city, but still small enough to be easy to get around, with a population in the county of approximately 330,000. Being a tourist destination lends a relaxed feeling to the community and we enjoy an abundance of sun and gentle sea breezes. Interested applicants can see more about our health system on the website at http://www.christusspohn.org. For more information, please contact Tim Samet by phone at 361-881-3135 or email tim.samet@christushealth.org.

## ▼ PART-TIME CHAPLAIN

**Weston, WI** — Saint Clare's Hospital, opened in October 2005, is the newest member of Ministry Health Care, one of the Midwest's largest health care systems, where caring professionals are teamed with leading-edge technology to bring a full continuum of high quality care to north and central Wisconsin and eastern Minnesota. We require a BA in a theological, ministerial or related field from an accredited college or university and one to three years experience as a chaplain in a healthcare setting. Must be certified and in good standing with NACC or ACPE. Apply online at www.ministryhealth.org

## ▼ PRIEST CHAPLAIN

**Coconut Grove, FL** – As an award winner of the noted and prestigious JD Power Customer Satisfaction Award, Mercy Hospital is a quality place for professionals to practice. We're a highly respected 512-bed hospital affiliated with Catholic Health East, known for outstanding care within our community. Mercy is located right on Biscayne Bay, in suburban Miami, beautiful Coconut Grove. We are seeking an individual to join a group of dedicated chaplains and associates. The Priest Chaplain helps to meet the spiritual and pastoral needs of patients, family members, staff and physicians at Mercy. You will accomplish this through your adept art of listening as well as observing nonverbal behaviors. You will celebrate Mass as scheduled, provide the Holy Sacraments to all those who can receive them, and may serve patients of all ages and illnesses at Mercy Hospital. The Priest Chaplain assumes responsibilities such as being on call at night and on weekends. A master's degree in theology, spirituality or similar is required, in addition to chaplaincy certification or eligibility for certification. If not certified, two or more units of CPE are preferred. English/Spanish abilities are also preferred. We offer a salary commensurate with certification or experience and good benefits. Visit us online at www.mercymiami.org to find out more. To apply, email your qualifications to MGibson@mercymiami.org or fax to (305) 285-5015 or apply at Mercy Hospital, 3663 South Miami Avenue in Coconut Grove, FL. Mercy Hospital is committed to equal opportunity hiring.

## ▼ CATHOLIC PRIEST CHAPLAIN

**Beverly Hills, CA** – In 2005, as Cedars-Sinai Medical Center continued to receive increasing national and international recognition for the quality of our programs, we were frequently asked, "What is the secret to establishing and maintaining your organizational culture?" While many things contribute to this, the essence of our organizational culture is our people. There is an intangible thread running through all of them, and this is why they work here, to learn here, to volunteer here, to support us and to practice medicine here. Serving their spiritual as well as their material needs is an essential component of our devotion to the art and science of healing, and to the care we give our patients and staff. Responsibilities: Under direction of the senior vice president, you will provide and administer Catholic chaplain services for Cedars-Sinai Health System. This encompasses patient visitation rounds, administering the sacraments of the Catholic Church, providing patient and family counseling, conducting religious services throughout the year, acting as Catholic Chaplain for Medical Center staff, and providing for the spiritual needs of patients and their families. Qualifications: You must be an ordained Catholic Priest in good standing with current faculties from the Archdiocese of Los Angeles. Must be a graduate of an accredited seminary or school of theology, or related education and training, and have at least five years of experience. Certification in hospital or pastoral ministry is desirable. The preferred attributes are the ability to be open, sensitive, flexible, and ecumenical; to deal with life-threatening illness and death; and to work cooperatively as a member of an interdisciplinary care team. For consideration, please e-mail resume to: mascorrog@cshs.org; fax: (310) 423-0377; mail: Cedars-Sinai Medical Center, Staff Recruitment, 8723 Alden Dr. SSB-110, Los Angeles, CA 90048. To find out more and to apply online, visit: www.cedars-sinai.edu/careers. Please reference ER#1050466 on all correspondence. Cedars-Sinai welcomes and encourages diversity in the workplace. AA/EOE.

# Board of Directors



# Calendar

## April

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|---|---|
| 14 | National office closed for Good Friday |
| 16 | Easter |
| 27-29 | AAPC national conference, Louisville, KY |

## May

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| 1 | Copy deadline, June Vision |
| 6-7 | Chaplain certification interviews in Atlanta, Baltimore, Milwaukee, Los Angeles, St. Louis |
| 6-10 | APC annual conference, Atlanta |
| 29 | Memorial Day; national office closed |

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

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