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Chaplain with mental illness faces stigma, gains wisdom

By Rev. Robert Lucas, CM

It has been about ten years since I was hospitalized with clinical depression. But that is a rather antiseptic way to say that one has been in a psych unit feeling awful and scared to death the feeling won't go away. Thank God for drugs and therapy! It is so good just to feel good.

Even though in therapy we were told how to deal with people's reactions to patients with mental illness, I was surprised when I was released from the hospital. One classmate said that he did not know what to do with me. He said he was used to solving problems and he did not know how to solve mine — and that was the last he ever said to me about my illness. In our community newsletter, I was never included in the space requesting prayers for sick community members, so that support from the wider province was not forthcoming because nobody knew I was sick. Other people with mental illness have told me they have experienced the same attitude — that if no attention is given to the person with mental illness, either the person or the illness will go away and no one has to get involved.

Some priests with whom I lived did not talk to me at all. Some never asked how I was doing. Others insisted I was not really depressed (including one who accused me of living off the community and making up a scenario). A few did have some sympathy and were quite supportive.

This pretty much mirrored the experiences of many psych patients I have listened to in the following years: a few people are supportive, but others react negatively. And some patients even judged themselves harshly, believing it was their fault they got sick. A great stigma is placed on mental illness. And that can add to the suffering of the patient.

One thing I learned in therapy is



that I cannot control how people look at me as a person with mental illness. And it is a waste of time and effort doing so. If somebody has a problem with my having a mental illness, that is their problem, not mine. I just have to learn how to care for myself and deal with life in a healthy way.

My experience has profoundly changed my pastoral ministry. I have gone from just knowing things that can be found in a book to actually living them. I have a much better feeling for the dynamics of having a mental illness since I have gone through it myself. I listen with greater empathy to mental patients. Knowing that with proper medication and therapy a person can live a good productive life, I try to communicate this to mental patients by treating them as people with an illness rather than as people who are "crazy." There is a big difference between those two attitudes. And that is the purpose of these reflections: People with mental illness are just like any other sick person who needs treatment and support.

A passage from the New Testament that clearly spoke to me as a person with mental illness is Romans 8:26-27: "And as well as this, the Spirit too comes to help us in our weakness, for, when we do not know how to pray properly, then the Spirit

I treat mental
patients as
people with an
illness

See [Mental illness on page 4](#)

Bishop thanks NACC for service, memories

Editor's Note: The NACC is saying goodbye to Bishop Dale J. Melczek, DD, of Gary, IN, who served more than six years as our Episcopal Liaison to the United States Conference of Catholic Bishops. In our next issue we will introduce you to Bishop Randolph Calvo of Reno, NV, our new liaison.

By Bishop Dale J. Melczek, DD

As I complete my years of service as Episcopal Liaison to the National Association of Catholic Chaplains, my heart is filled with much gratitude. I have been privileged to be more closely associated with and very edified by priests, deacons, religious, and lay faithful who in the name of the Church reach out with Jesus' compassionate love to those who are at critically vulnerable moments in their lives. Thank you for your deep love for Jesus and His Church. Thank you for generously giving of yourself in extending Jesus' compassion and healing on behalf of the Church.

Deeply rooted in prayer, you readily recognize the face of Jesus in the sick, in the dying, in those suffering in mind, heart, body, or soul. With much understanding and tender pastoral care, you bring to those in need the hope and healing found in the presence and prayers of the Church.



Bishop Dale J. Melczek, DD

I am also grateful for having been associated with the dedicated men and women on the NACC Board and on our national staff. They deeply appreciate that the NACC is a member organization and they are deeply committed to certifying future members with the highest standards for personal, theological, and professional competency, and to providing present members with opportunities for ongoing formation, education, and mutual support.

May God bless each of you and those whom you are privileged to serve. May all of you continue to know the Lord's blessings in your lives and ministry in rich measure! I will treasure wonderful memories of my time with you and of the valued ministry you provide on behalf of Our Lord and His Church.

Letters

Rabbi defends boundaries in reciting liturgical prayers

Editor:

I would like to respond to Mary Toole's letter in *Vision* (July/August 2007) wherein she replied to my review of her book *Handbook for Chaplains*, which appeared in *Vision* (October 2006). In that review, I suggested that it is inauthentic for chaplains to pray the liturgical or ritual prayers of faith groups that are not their own.

I admire Chaplain Toole's desire to be compassionately present for her patients. I respect her for learning traditions outside of her faith background. I applaud chaplains who offer spiritual care to patients/residents who are outside of their faith systems. The key words here are "spiritual care." I challenge the appropriateness of chaplains who affirm religious truths that are not their own. This happens when chaplains engage fixed liturgical prayer and specific religious rituals that are foreign to them without understanding the spiritual truth that "insiders" to the faith system have internalized.

When chaplains affirm religious truths that are not their own, they are inauthentic and – because they are "outsiders" to what

basically is a foreign system – they can send inadvertent, and unintentional, messages. As outsiders, they could not determine when they spiritually harm distressed individuals who are agreeable because of their vulnerability, politeness, or desire to please a chaplain who is in the "closer-to-Divinity" position. These individuals often give chaplains the answer that they think chaplains want to hear, even when they would prefer to say no.

It sounds right to say that, as chaplains, we endeavor to "be present with people where they are, wherever that may be." I believe, however, that there are boundaries beyond which chaplains should not go. The Common Standards, adopted by all of the major chaplaincy organizations in 2004, affirm limitations upon chaplains' individual expertise. The Common Standards are concerned that chaplains frequently do not understand when they are being disrespectful of other belief systems, when they are imposing their personal values upon others, when they are meeting their own needs first, or when they should make referrals to other professionals. I share this concern as well.

I have addressed this very issue more fully in the company of two certified chaplain colleagues, Deacon T. Patrick Bradley (NACC) and Rabbi Bonita E. Taylor (NAJC, ACPE). We have coauthored an article, which will appear this autumn in the Association of Professional Chaplains journal, *Chaplaincy Today*. The article's title is "The Chaplain as an Authentic and an Ethical Presence."

*Cordially,
Rabbi David J. Zucker, Ph.D., BCC*

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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The National Association of Catholic Chaplains is a professional association for certified chaplains and clinical pastoral educators who participate in the healing mission of Jesus Christ. We provide standards, certification, education, advocacy, and professional development for our members in service to the Church and society.

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Action to help NACC grow can have contagious effects

By Karen Pugliese
Chair, NACC Board of Directors

Last autumn, the Vision and Action Initiative was just beginning the nine-month *visioning* process that would give birth to a new articulation of our Mission, Vision and Values and Strategic Plan. Now it's time for *action*.

Literally hundreds of our members contributed to the visioning process. We need hundreds more to breathe life-giving energy and creativity into the implementation of our goals and objectives. We need dialogue and challenge and affirmation; we need to be in communication and in right relationship with one another (Executive Director, staff, members, board, committees, commissions, panels, task forces...) for our Mission, Vision and Values to have integrity.

Recently, in the *Literature and Medicine: Humanities in the Heart of Health Care* program at my hospital, we read *Saving the World* by Julia Alvarez. The book weaves together the stories of two women separated by two centuries in time, but bound together in history by the human need to be part of something more powerful and more enduring than ourselves. A subplot features a group of young insurgents living on a remote, impoverished and disease-infested mountain in Santo Domingo. I have been haunted by the words of one of the young rebels: "We will infect them with our questions."

Those of us in healthcare are all too familiar with the danger of infectious disease; but I have been praying and playing with the thought of "holy infectiousness" as an antidote of sorts to the viruses of indifference, isolation and estrangement within our association. Our Executive Director, David Lichter, our board of directors, and I depend on you to "infect us" with *your* questions, as well as your suggestions, recommendations, and ideas. We need your thought leadership and your servant leadership. Some of the ways we will be soliciting

your involvement are *Vision* and the E-Newsletter; personal visits to St. Louis, Boston, Seattle and Chicago (watch your e-mail for details); phone conversations similar to the Vision and Action focus groups last fall; and invitations to serve on special initiatives and task forces.

In each of these encounters, our aim is to engage our members, listen deeply, discern the needs for educational, spiritual, and communication opportunities, and respond with strategies for strengthening and supporting your active participation, and growing our association as a ministry of the Church. We hope and pray that our commitment to one another as members of NACC, our dedication to the ministry of the NACC, and our enthusiasm for living grace-fully and creatively into the Mission, Vision, Values and Strategic Plan will be *contagious*, and each member will catch the spirit!

Let me suggest a place to begin: Pastoral Care Week, October 21-27. Many of us traditionally provide thoughtful activities and programs for our interdisciplinary colleagues in our ministry settings. This year's theme is *Healing Faith*. My colleague, Chaplain Rod Accardi, recently wrote a song called "Leap of Faith" which begins with the lyrics, "We are standing on the threshold to take a leap of faith." Could *we* take a leap of faith this year? Could we challenge ourselves, could we encourage one another to experiment with ways to come together as chaplains in informal gatherings for reflection, prayer and conversation? Could we explore the possibilities for personal involvement in the Strategic Plan? With our NACC colleagues? With certified members of our sister chaplaincy organizations? With uncertified chaplains who might be interested in the NACC?

And would you even risk *contagion*, by sharing your learnings, wonderings, and dreams with us as we stand together on the threshold of a new beginning for NACC?

New mission, vision, values show what we are

**By David Lichter, D. Min.
Executive Director**

Upon being named executive director of NACC, my primary charge was to understand, embrace, and lead the implementation of our 2007-2012 strategic plan. I was excited and motivated as I compared the strategic plan from 2003 with this new plan. The 2003 plan had many strengths, as it aimed to strengthen the professional stature of chaplains. The NACC was well versed in its contents, and was still working on implementing elements of the plan when I arrived.

Our new plan was included in the last issue of *Vision*. I appreciate that it resulted from many spirited and Spirit-filled hours of discussion that aimed to both clarify the purpose of the NACC, and motivate and energize all members, numerous volunteers, board members, and staff to embrace the future. This is a LIVING document that provides a direction and priorities for us. The NACC board is already assisting me with my priorities for the coming months. Over the next several issues, I plan to offer you reflections on the plan, as well as to report to you on how we are moving forward. First, let us consider the plan's mission, vision, and values.

Key strengths of this new plan are revitalized mission, vision, and values statements. I always like to look at how a mission statement begins and ends for clues to its emphases. Our **Mission** statement begins with "advocates for the profession of spiritual care" and ends with the phrase "continue the healing ministry of Jesus in the name of the Church." "Advocates" is a rich and powerful verb. "Spiritual care" uniquely positions our profession among pastoral care providers, and "in the name of the Church" firmly states our Catholic identity. Why the NACC exists is clear and compelling.

The **Vision** statement uses the verbs "cultivating" and "transforming" spiritual care to signal both that we are intentionally and daily dedicated to living out the profession,

and that our profession over the next five years will continue to grow and evolve. Its sub-points emphasize the importance of life-giving relationships with our profession, creative educational and spiritual growth opportunities, and the dignity of persons of every age.

I sense in this Vision the call to grow and re-energize the membership, and to be a "light of hope" through you, the members, who are advocating for all "who are dedicated to the spiritual care of people experiencing pain, vulnerability, joy, and hope." This Vision reminds me of the passionate, inspirational opening lines that grounded and guided Vatican II's Pastoral Constitution on the Church in the Modern World, *Gaudium et Spes*, almost 42 years ago: "The joys and the hopes, the griefs and the anxieties of the people of this age, especially those who are poor or in any way afflicted, these are the joys and hopes, the griefs and anxieties of the followers of Christ." As *Gaudium et Spes* was a revolutionary document for the Church, I pray this Vision will be transforming for NACC as well.

The **Values** statements deliberately spell out DISCIPLE. That is also the first value, "reflecting on and following the mission of Jesus in head, heart, and action." Discipleship is the heart of our ministry, our profession. I am committed to help us become ever more a community of disciples.

Over the next five years, I encourage all of us to return to and reflect on these Mission, Vision, and Values statements, both personally and together as the opportunities are afforded us. So often leaders and members of organizations over time are struck by the richness and insight of such guiding statements as they strive to implement their plans.

In the next issue I will reflect upon the plan's first goal and priority, "To support association members with creative educational, spiritual, and communication opportunities." Even before you receive this *Vision*, you will have received at least two e-newsletters from our staff as a way to enhance our communication with you and among you, as members.

Mental illness

Continued from page 1

personally makes our petitions for us in groans that cannot be put into words; and he who can see into all hearts knows what the Spirit means, because the prayers that the Spirit makes for God's holy people are always in accordance with the mind of God."

My weakness is my illness. When I cannot pray or take care of myself, the Spirit does it for me. The Spirit touches my spirit to keep me alive. The Spirit gives me medicine, professional caregivers, family, and friends that keep me going. The Spirit puts me into ministerial experiences that fill me with gratitude that God still calls me, even with a mental

illness, to work in his vineyard. God sees through the illness and all its trappings to see the person created in God's image with love. And even if I have relapses or forget to take care of myself, the Spirit will help me get back into life according to the mind of God.

This is what helped me get through years of undiagnosed depression. This is what got me the help I needed. And this is how I live. The negative judgments people may have towards me, towards other people with mental illness, cannot touch this healing of the spirit that I have received from God in so many ways. I pray that others may receive this healing also.

Rev. Robert Lucas, CM, BCC, is a chaplain at Palos Community Hospital in Palos Heights, IL.

Spirituality groups create circles of hope

By Jane W. Smith

Spirituality groups have points of familiarity with mental health consumer participants and church leader facilitators alike.

One of the most effective ways of working with mental health patients is in small groups. In the psychiatric field, small groups have included counseling groups and encounter groups. They now co-exist in mental health settings with community groups, living skills groups, recreational and occupational therapy groups, bereavement groups, and a host of twelve-step groups such as Alcoholics Anonymous. Consequently, people being treated for any sort of mental problem today are likely to be well acquainted with group work as an integral part of their healing process.

Spirituality groups in a mental health setting seem like a natural outgrowth of the benefits of various therapy and skills groups, coupled with the small faith-sharing groups connected with today's church. They have points of familiarity with mental health consumer participants and church leader facilitators alike. They provide an arena for the education and sharing of faith for all members, leaders included, and, I believe, serve the growth of the community of the church in general. They are circles of hope for individuals and for communities of faith.

As spiritual beings, we yearn for honest, genuine relationships which move beyond superficiality, and are deeper than we have with acquaintances or friends. They are characterized by openness, acceptance, warmth, growth, and a sense of well-being and safety. People in general, and those with mental illness in particular, are used to thinking in individualistic and distorted patterns that belie the human need for one another. They may, on the one hand, seek community, and, on the other, fearfully reject it. Ambivalence about participation in spirituality groups may be caused by fear of exposure or fear of the truth.

Rather than an attempt to teach doctrine, a spirituality group in a mental health setting serves to evoke spirituality from its members. It provides enough emotional safety and encouragement so that members can discover, explore and experiment with deeper parts of themselves that may have been hidden from them for a long time. Pastor psychologist Howard Clinebell reminds us, "In the small sharing group lies the power which enables persons to love more fully and live more creatively. This power is the people dynamic – the power we have to recreate each other and ourselves through caring and sharing." [1]

When I lead spirituality groups, I often ask at the beginning what each client's understanding of the word "spirituality" is. While their answers are varied, they usually include some or all of: Your feelings; what you believe in; God; spirits; religion, or going to church; other life forms.

Spirituality is an elusive term and has as many definitions as people who write about it. Nelson S.T. Thayer, for one, in *Spirituality and Pastoral Care*, writes, "In the most general sense, spirituality has to do with how we experience ourselves in relation to what we designate as the source of the ultimate power and meaning in life, and how we live out that relationship. Spirituality is not merely feelings; it has to do with the integration and coherence of ourselves as experiencing and acting persons."

Over the years, Thayer and others have influenced my own working definition of

spirituality, as have people who attend my groups. I describe spirituality as that which gives us a sense of meaning, purpose, and direction in our lives.

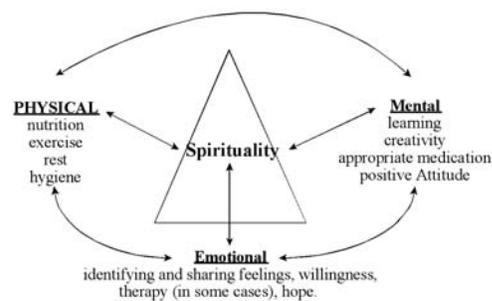
Derived from the Hebrew *ruach*, the breath of God, spirituality makes us one complete whole out of

our actions, thoughts, and feelings.

Spirituality is different from them, at the same time uniting them into a cohesive whole.

Spirituality has to do with our values (i.e. what we say is important to us and what is not); our morals (what is right and what is not); and our religious beliefs and traditions. It includes the serious questions of life such as, "Who am I?" "Where is my life going?" "What is my purpose in life?" "What will happen to me when I die?" "Who cares?" "How do I matter in this world?"

Spirituality addresses the basic spiritual needs of people: love, belonging, meaning, and significance. It unites physical, emotional, and mental aspects of ourselves and is enhanced by our efforts to keep each of those elements healthy and thriving. As we act to enrich each aspect of our lives, the others also are enriched and our spirituality grows. The following diagram illustrates the interaction:



For example, if we enhance our physical well-being by exercising regularly, we are also likely to feel more mentally alert and emotionally fit as well. We generally feel better about ourselves all over, more at peace and whole.

See [Circle of hope](#) on page 6.

Spirituality addresses the basic spiritual needs of people: love, belonging, meaning, and significance



CPE and behavioral health benefit each other

By **Barbara Brumleve, SSND**

The CPE program at Alegent Health is particularly blessed to have behavioral services as part of the clinical work. In the Omaha-Council Bluffs area, faith-based Alegent Health provides behavioral services across the continuum: inpatient and outpatient, child through geriatric. Pastoral Care, and by extension CPE, is an integral part of these behavioral services.

Last year, CPE residents and interns facilitated 331 spirituality groups in Behavioral Health. Usually 50 minutes in length, spirituality groups begin with an introduction that distinguishes between spirituality and religion, and the reminder that participants respect each person in the group.

Group themes include Preparation for Change, My Spiritual Home, Life's Storms and Trials, Fearfully and Wonderfully

Made, God's Gifts, Grief Cycles of Life, Using Positive Affirmation, Names and Faces of God. Formats come from chaplains and CPE students based on their experience. We give new CPE residents and interns a loose-leaf binder containing tried-and-true approaches to spirituality groups.



Chaplaincy & Mental Health

Beyond Spirituality Groups: CPE students

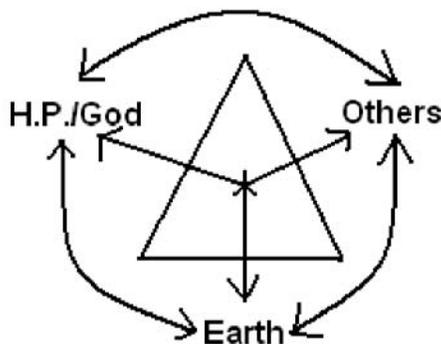
also provide one-to-one followup spiritual care upon request from patients and staff. At a residential treatment center for children and adolescents, they may share a meal in the hospital cafeteria with the residents. On Sundays, students conduct one of three worship services at an inpatient geriatric psych center, usually meeting around tables in the activity room. If weekend staffing allows, behavioral patients may attend Sunday service in the hospital chapel, conducted by a CPE resident or intern.

CPE students do fifth-step work with adolescents. With

Circle of hope

Continued from page 5

As our spiritual life develops, we become more able and willing to care for the physical, mental and emotional aspects of our lives and to improve relationships outside of ourselves with other people, with a higher power which many of us call God, and with the earth.



When a relationship in one area improves, other relationships improve as well, and we become more drawn to things that are generally described as spirituality, such as prayer, meditation, Bible study, etc. These activities are associated with the practice of religion, which is related to but different from spirituality. Religion, with its holy books, rituals, and codes of behavior, wants to help us develop our spirituality — this internal sense of wholeness and well-being and the quality relationships outside ourselves. The distinction between spirituality and religion is important among persons with mental illness, who often deny having spirituality because “I don’t go to church.”

This broad definition of spirituality is helpful with people who say that they have no spirituality, and whose institutional care views them as the sum of their maladaptive behavioral symptoms, to be remedied by drugs and/or positive coping skills. By themselves, however, these things do not address the spiritual nature and needs of persons with mental illness.

The broad definition also helps me to assure people that spirituality group work does not admonish people to read the Bible more and/or go to church. These subjects may surface in discussion, but my first concern is “who you are inside yourself, and the quality of your connections to whoever and whatever is important to you.” We are spiritual beings because we are human. We may or may not be connected with a formal religion.

I have a number of simple exercises I use to stimulate our spirituality group discussions. All of them strive to assist group interrelatedness of body, mind, emotion and spirit or the interrelatedness of my spirit, others, God and the earth. To the extent that the groups move our clients closer to connecting with other people in meaningful ways and come to know the joy of wonder in life, I count them as highly successful.

Jane W. Smith, D.Min., BCC, is Director of Mission Effectiveness at Fulton State Hospital, a long-term forensic psychiatric hospital in Fulton, MO. She is the author of Circles of Hope: Spirituality Groups Among Persons with Mental Illness – A Leader's Guide.

Notes

1. Howard Clinebell, Jr., *The People Dynamic: Changing Self and Society through Growth Groups* (New York: Harper and Row, 1972), quoted in Kirkpatrick, *Small Groups*, 23.

other staff, they participate in debriefings following sentinel events and in rituals surrounding discharge, especially with children and adolescents. Students helped chaplains initiate a continuing project of providing a homemade fleece blanket to each child or adolescent who is admitted to the acute behavioral unit. Staff, community volunteers, and patients themselves prepare the blankets, each of which comes with a tag:

This blanket was prepared for you
by your friends at _____.
Lots of hands worked on it.
We hope it will keep you warm and
remind you of all the people who care about you.

The CPE program provides behavioral health experience for all four of the residents and as many seminarians in the extended or summer program as possible. In end-of-program evaluations, students consistently rank the behavioral health experience high.

CPE Interns and Behavioral Health: Because of time limitations, students in an extended unit of CPE do not get as much experience in behavioral health, but when these same students are on call, they can be called to a Behavioral Health unit. To give basic guidelines for pastoral service when on call, we offer a one-page summary —*You Are Oncall and Are Called to Behavioral*. A slightly revised version is now provided to community clergy for their use when visiting patients from their church/synagogue. When the behavioral health education director presents a didactic in the extended program, students carry away with them that the patients are persons with schizophrenia or bipolar disorder or depression. They are not “schizophrenics” or “manic depressives.”

CPE residents' education in Behavioral Health: The Alegent Health *CPE Handbook* contains best practice for pastoral care on behavioral health. In the second month of the residency year, students attend a one-day mental health concepts course which is mandatory for all new personnel in behavioral health. Topics include spirituality and mental health; stigma and mental health (these first two presented by a chaplain); rapport, strengths and validation; depression, suicide and self-harm; psychoses and psychotic violence; creating a safe, supportive environment; substance disorders and co-occurring disorders. During that same month they participate in Alegent Health's Spirituality and Mental Health Conference.

CBTs (computer-based training modules) provide residents with additional information, and CPE didactics include the core competencies for clergy and other pastoral ministers in addressing alcohol and drug dependence and the impact on family members. Related materials are available at www.acpe.edu. The CPE library includes video and print stories about persons who suffer from a mental illness. Students are also encouraged, with the patient's permission, to observe electroconvulsive shock therapy, which is used with some patients.

In live clinicals, CPE residents interact with “the living human document.” A resident who is working on Behavioral asks a therapist to name a patient (usually close to discharge) who could be invited to share his/her story with the residents, the patient's therapist, and the CPE supervisor. Goals are to hear the patient's story, particularly its spiritual implications; see the patient as a whole person, not just a disease; and to debrief with

a clinical professional for greater understanding, primarily about the spiritual dimension. A 75-minute live clinical begins with the clinical professional giving an overview to the residents and supervisor (15 minutes); 45 minutes with the patient, and then 15 minutes of debriefing with the clinical professional. The patient takes the lead. Questions are appropriate, but the patient can choose whether or not to answer.

Every patient who has participated in a live clinical has affirmed its therapeutic effect. One older woman suffering from depression said she thought in retrospect that she'd been depressed since about age four. When a participant commented on the woman's strength, courage, and stamina in dealing with depression for so long, the woman smiled and said, “I hadn't thought about that. Thank you.” Another patient, with bipolar disorder, told the residents how she had been out of touch with reality during her manic phase at admission. She shared the story of her gradual return to health.

CPE residents contribute to Behavioral Health: One composed a checklist for churches who want to welcome members with mental illness. Another, an ordained pastor, prepared resources on chemical dependence for use by rural pastors, who are often the first to be approached. A resident working with Alegent Health's LIFE group (persons with chronic mental illness living in the community) planned an overnight retreat, complete with welcome bags, bonfire, music, and a schedule designed by LIFE members themselves. Another resident offered her acreage as a place for adolescents in a chemical dependence residential program to work on the land and then reflect on their activity. Most recently, a resident designed ten group ideas with activities for both younger and older children and adolescents (an age span of 6-17 in the same spirituality group is not uncommon).

CPE students, like chaplains, use themselves for their pastoral work. One Anglo student who had learned Spanish began speaking in Spanish to a young Hispanic male who was resisting therapeutic interaction with the staff. The young man answered the CPE student, first in monosyllables, then sentences, and — best of all — began working with the rest of the staff,

Never underestimate the Spirit: As in any other pastoral care, chaplain work on Behavioral Health has its surprises. One staff chaplain recalled his residency experience three years ago on Behavioral Health. After preparing an activity for eight or ten adolescents, he found himself with one 7-year-old boy. “Noticing a dry erase board, I asked the remaining boy if he had a favorite game. ‘Tic-tac-toe,’ was his reply. We probably played 25 or more games of tic-tac-toe as he opened up and shared his story. He talked freely about some of the struggles and issues he was learning to deal with in his life. ... That day I learned two valuable truths that continue to inform my practice of chaplaincy. Instead of being uptight and tense when things don't go as planned, be flexible, and follow the Spirit.”

How do I as CPE Supervisor evaluate? I look for the moment when the student says something like “Mental illness is an illness, like cancer or diabetes,” or more importantly, “All of us (the patients and I) are on a continuum. It's not them and me.”

Barbara Brumleve, SSND, Ph.D., is CPE Supervisor at Alegent Health Center for Healing Ministry in Omaha, NE.

God is present in mental patients' sufferings

Bill

Who am I that you should write to me?

Your letter (written with the jagged tremor caused by the medicine, which you so humbly apologized for) brought me to silence.

Silence, that always entered my heart while bearing witness to your agony.

Agony, that brought me to my knees through the experience of your darkness.

*Darkness, so thick, that black seemed to contain bright light in comparison.
Darkness so vast, it evoked fear.*

Fear, the greatest enemy of all, a fear that paralyzes with its lies.

Lies, continually spoken causing despair.

Despair, which led you to attempt to take your own life, a life that was somehow miraculously saved.

Saved for what?

More agony, more darkness, more fear, more lies and ultimate despair.

The only antidote being suicide.

Pray for me, Jane, would be your words, as I unworthily held your shaking hands in mine.

Where is God?

Is God angry with me?

I can't find HIM!

Once again, that sublime silence would descend.

As I recognized THE ONE you sought, gazing back at me though your tear-filled inquisitive eyes!

— By Jane Korins

By Jane Korins

"Why is my pain continuous, my wound incurable, refusing to be healed?"

— Jeremiah 15:18



Chaplaincy &
Mental Health

Diseases are a mystery. Great strides in medical science have provided us with many ways to tackle some symptoms and provide relief. However, some of the greatest perplexities in medicine are the diseases that attack human emotions.

7-East is the lock-down unit at the North Shore Medical Center, which houses God's beloved souls who suffer the greatest agony of all. Many illnesses attack the body, but mental illness attacks the spirit, the very essence of the individual. Its pain in many ultimately leads to suicide as the only relief from the darkness of debilitating depression.

Years ago I read *The Bell Jar* by the great poet Sylvia Plath. In this masterpiece, she draws the reader into the experience of clinical depression. At the conclusion of her book, she says that if the bell jar — her metaphor for depression — descends once again in her life, she would commit suicide. Tragically, the bell jar did descend and she acted out her threat.

I remember my reaction to her book was a deep understanding of the words of the prophet Jeremiah, when he calls out to God in his agony, "Cursed be the day on which I was born! May the day my mother gave me birth never be blessed! Cursed be the man who brought the news to my father, saying, 'A child, a son, has been born to you!' filling him with great joy. Let the man be like the cities that the Lord relentlessly overthrew. Let him hear war cries in the morning, battle alarms at noonday, because he did not dispatch me in the womb! Then my mother would have been my grave, her womb confining me forever. Why did I come forth from the womb, to see sorrow and pain, to end my days in shame?"

Ministering, as a clinical chaplain to individuals suffering the torments of hell, prompts within me the same questions about God that these patients wrestle with. I am called to be their witness and often experience the familiar darkness and despair that Sylvia Plath so eloquently described. These situations bring me to a strange silence, a spiritual sublime silence of standing at the foot of the cross.

The greatest mystery of all is the profound presence of God in this unit. God reveals to us that the Divine Presence can be found with the poor, disenfranchised and suffering souls. Perhaps they share the emotions of God for a suffering, broken world so far from home. Abraham Joshua Heschel in his book on the Prophets states, "The prophet feels with God, that is he feels what God is experiencing...his feelings are aroused because of what God is going through."

Could there perhaps be individuals feeling the deep suffering of God without understanding its source, while simultaneously being recipients of the agony?

My questions are without answers. However, this I know to be true. I see and experience the agony of God through their precious tears, as I sit in the question with them.

Jane Korins, MTS, BCC, is director of pastoral care at North Shore Medical Center in Salem, MA.

Suicide prevention skills were suddenly tested

By Michele Le Doux Sakurai

It was one of those calls that chaplains dread. The phone rang just after dark and the voice asked, “Are you the chaplain? I’m going to kill myself tonight and I want God’s forgiveness.”

I froze; initially, an array of emotions passed through me. First I was angry; I should not have been given this call; such calls were to be referred to the ER, not the chaplain. I also felt deep regret; I had not given credence to my colleague’s statement that every chaplain interaction should involve (implicitly or explicitly) a suicide assessment. I remember brushing this aside with excuses such as, “That could interfere with the patient’s agenda,” “Such issues would be handled by medical professionals prior to the chaplain walking into the room,” and “I’m not a mental health professional; it’s not my job.”

If I had listened to this counselor’s prophetic voice, perhaps I would have been practiced and prepared for the caller and his request for God’s forgiveness. But no, I was not prepared and I drew a blank; I panicked and knew in this moment the depth of my own ineptitude. I remember praying, “God, I can’t do this; I don’t know how to respond.” In desperation, and hoping that I had misheard him, I said, “Sir, I’m not sure I heard you correctly; please tell me once more.” As he repeated his intentions, I remembered my chaplain training — invite story. “Can you help me to understand what has brought you to this point?” Although he refused to give me his name, he freely told his story. I became engaged in the process, began to relax, and it was at this point I recalled my limited suicide intervention training.

Suicide is a reaction to a problem; it is not the problem. The caller spoke to me of his struggles; he had developed a chronic condition with complications that included unresolved pain. He had lost his job as a result of his health conditions, and his wife of 40 years had died in the past six months. His despair was evident as he said, “I’ve worked hard and never cheated anyone; I never did anything to deserve this. It isn’t fair. I played by the rules and this isn’t fair.”

As I listened to his story, I paid particular attention to factors that increased his chances of suicide. First, he was a widower, and 40 years of marriage had created a structure that disintegrated with his wife’s death. His sense of despair was a huge risk factor, as are all forms of depression. He had depended on his wife for support and stability; now he had only himself, and he lacked the needed coping skills. Secondly, his chronic illness was a contributor. Thirdly, although religious (he had wanted prayer), he was not connected to a church or community support. Fourthly, he lived in a state that valued personal autonomy above all else

(and has legalized physician-assisted suicide). Such individualism can increase risk of suicide, but commitment to community, church, and family make it less likely.

But he did not carry other important risk factors: Neither he nor any other family member had previously attempted suicide. He did not use alcohol (both alcohol and drug use raise the risk of a suicide attempt/completion). He did not hear voices or evidence a history of psychosis.

In speaking with him, I sought to identify the seriousness of the threat. Where was he (at home, at a bar, standing on a bridge about to jump)? How immediate was the threat (did he have a gun in his hand, was he planning to take an overdose, was he planning to drive into the mountains and freeze to death)? The caller told me that he was at home, and his plan was to get God’s forgiveness, take an overdose and be found dead in the morning. I asked him if anyone in his life would grieve his death. He was silent, and then he said, “I have a daughter who means the world to me.”

We talked about his daughter and what he wanted for her. He contracted with me that he would not act until he saw his daughter the next morning, and that if things became impossible over the course of the night, he would call me again. We did have prayer, and it focused on asking for God’s wisdom and strength to get through the night.

After the call, I contacted the nursing supervisor and debriefed with her. What did I miss? Was there anything else I could do to protect this man’s life? He would not permit me to transfer the call to the ER, and without his name, we had no options for followup.

This was a humbling experience for me. Even though I never heard from the man again, I hope his daughter got him the help he needed. And I chose to learn anew and to practice the skills required when confronting the deep despair of another. I learned how and when to ask the needed questions. “Do you ever imagine hurting yourself?” “Is that something you are now considering?” “Are you telling me that you want to commit suicide?” I learned the importance of establishing trust in order to learn the person’s name and plan for suicide. I learned NEVER to allow anyone to place an order of silence on me. Suicidal ideation is no one’s secret.

Most importantly, I learned that as a chaplain there are times that honoring a patient’s agenda is not the ultimate value; that the ultimate value is honoring the patient’s life.

Michele Le Doux Sakurai, D.Min., BCC, is Trinity Health System’s 2007-08 mission fellow in Boise, ID.



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As I listened, I paid particular attention to factors that increased his chances of suicide

Development influences kids' behavioral health

By Jim Manzardo

As she inserted the needle, the nurse was surprised to see that the baby did not even flinch.

Eight-year-old Amanda used to be an engaging and playful child, even with her chronic organ illness. After having an organ transplant and experiencing significant complications, she became withdrawn, not wanting any support staff visiting her.

Nearly a year after being told he could die following the relapse of his cancer, 14-year-old Juan continues his recovery but has not returned to school and remains home playing video games and watching TV. He says he is tired of people asking him how he is doing.

As professionals experienced in companioning people who are suffering, we chaplains know well that the behavior of these children is a normal response to severe illness. Understanding what is happening on a psychological and spiritual level in these children is more complicated. It requires an awareness of their developmental life journey, a collaboration with their primary caregivers, and a willingness to enter their world.

As with adults, children's psychological well-being is greatly influenced by the significant people in their lives, their environment, and their physical health. Yet the overall health of children also differs from that of adults in light of their ongoing cognitive, emotional, behavioral, and spiritual development.

Children are in an almost constant process of gaining independence, of developing their identity and of forming relationships. For a toddler, this growth is manifested through the sounds they make, their interest in different sensations and people near them, their walking, feeding, using the potty and trying out new behaviors. For preschoolers, this means exploring places, learning new things like language, colors, and numbers, and seeing the world through their very active imagination. For school-age children, this means applying, expressing and proving themselves in school, sports, the arts and games, becoming more aware and protective of their bodies, developing friendships, asking many questions, wanting to know about the world, distinguishing themselves, learning to share and be helpful. For adolescents, this means more increased reliance on friends, mastery of specific skills and talents, heightened self-awareness, self-respect, self-expression, insight and responsibility.



The mental and emotional health of children therefore is measured in part by milestones of their developmental stages. The baby that does not cry at being poked by a needle, makes no eye contact, nor is calmed by his mother's voice and embrace is cause for great concern.

Mentally healthy adults have a developed language which usually allows them to understand and name their thoughts, their beliefs, and their feelings. Children, on the other hand, have a different language, ever-changing, similar to an adult learning an entirely new language in a new and different culture. Thus, adults must evaluate children's mental and emotional well-being by observing their behavioral, emotional and cognitive expression and functioning. Children do not, for instance, have the language to describe depression. In very early childhood, we cannot

assess a child's thought process so we observe their play and other behaviors, such as the sounds they make, their body movements, their ability to soothe themselves. As children get older, what we may see on a feeling level in a depressed child is more irritability, helplessness and sadness; on a behavioral level, withdrawal, isolation or hostility; and on a cognitive level, thinking "I can't do something" or "I'm no good." The emotional health of children is intimately linked to their mental health, from the toddler's movement toward cognition, the preschooler's development of reasoning, and the school-age and teenager's process toward self-reflection.

Children's language difference also means that adults must step outside of their manner of connecting to other adults and enter the world of the child in order to understand and engage that child. This shift does not magically transform the adult into a child, as if walking through the wardrobe into Narnia. But with a little imagination, openness, humility, creativity, and yes, acting, an adult is able to tap into their own childhood, or inner child, and connect with a child.

One of the most common ways children reveal the state of their mental and emotional well-being is through play: their engagement in their particular interests, hobbies, games, the arts. During illness and hospitalizations, play will usually serve as both a distraction and safe haven for a sick child, and as a way of communicating what and how that child is thinking and feeling. But prolonged illness and hospitalizations and the awareness of one's possible death will often greatly dampen a child's enthusiasm for the play that would otherwise bring her joy and meaning.

Amanda's withdrawal from others and from what typically brought her joy and meaning revealed her state of depression and fear. Though professional support staff repeatedly asked Amanda what and how she was feeling

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and thinking, she only began to allow in others, like the music therapist, as she began to feel some physical improvement. Amanda little by little used music as a means of self-expression and coping. Some days she did not wish to engage musically but asked that the therapist remain with her, watching TV and conversing about the programs. Through these interactions, the music therapist observed in Amanda moments of brightened affect and laughter.

To understand children, we adults make the effort to enter their world. As a chaplain at a children's hospital, I strive to demonstrate and be a gentle, loving, sensitive, listening presence, paying attention to feelings, the child's tone of voice, inflection, emphasis, pauses, and the child's ability to label feelings and thoughts. If the child volunteers information, a feeling, a thought, or points out something about her experience to me, I acknowledge the feeling and invite her to tell me more if she likes. I respond to children in ways that honor their developmental level and I try to be sincere without talking down to them. With toddlers and preschoolers, I may talk through their stuffed animal or doll. With school-age children and teenagers, I take interest in their interests. I try to enter into the mental framework of the child, restating what the child has said in order to clarify and allow for accurate empathy. If the child asks me a question, I often first ask that child what she thinks.

One of my psychologist colleagues says children, unlike adults, do not come on their own with an issue to be resolved. So she begins with a disposition of having no idea what is happening within the child, asking open-ended questions, and inviting the child to teach her about what is happening and what has already occurred in that child's world. She uses a strengths approach to children, looking at what children think they are good at, what brings them joy, listening for how and with whom they play and to the quality of structure, home environment and attachment to their primary caregivers.

Everyone's mental health is influenced by family and social networks, and this is especially true with children. Children and many teens usually need their primary caregivers to motivate them and to make fundamental decisions for them, such as about going to school, going to the doctor, and taking medicines. Children do not generally seek treatment for themselves. They rely on their primary caregivers to bring them to a healthcare provider when the adult senses a problem. When the social worker spoke separately with Juan and his single mom, she discovered that Juan's mom's loneliness and fear of his returning to school significantly influenced Juan's own thoughts and feelings about school. To a great extent, a child's self-identity and self-esteem are shaped by how

their primary caregivers nurture and respond to their children. It is vital when evaluating a child's well-being and caring for them in time of illness to talk regularly with and assess the well-being of that child's primary caregivers.

A common concern of parents and other adults who interact with children, especially school-age and teens, is how to discern normal youthful angst from a serious psychological issue. My social work colleagues look for impairments and sudden changes in a child's normal functioning, such as in the classroom, in following basic rules, at play, with peers, in their sleeping and eating, in their frustration tolerance. They also listen for magnified responses to normal life stressors, such as cognitive distortions and prolonged, unusual, and risky behaviors. My colleagues pay attention to their gut, and when they feel they are not getting the whole story, that something is clearly amiss, they raise the question and review with the child all areas of their life.

In working with teens, an adult needs to establish good rapport before most teens will begin to share. Since teens can be very critical of themselves and of others and difficult to engage, it is important for adults to be real and sincere; to use humor; to talk about common interests; to be consistent, not giving up but letting teens see that you really care and are with them no matter what; to explain your role, letting them know how you can concretely help them; to give them choices, which makes them feel more respected; to have some transparency; and, of course, to assure confidentiality — with the limit that if they are being hurt or hurting themselves or others, you must take action.

We cannot know for certain what is happening in the mind of a child, but does this not also hold true for adults? In fact, perhaps you agree that we have more in common than different with a child as far as our psychological well-being and needs. Awareness of and attention to our inner child confirms this truth, as does our interaction with children. Through our becoming like children, we discover that, like us, what a hurting and troubled child needs most is the presence and attention of a compassionate and caring person — one who is developmentally sensitive, works closely with the child's primary caregiver, and is willing to enter that child's world.

Jim Manzardo, BCC, is a staff chaplain at Children's Memorial Hospital in Chicago, IL. This article was written in consultation with his colleagues, Shalu Thakral, LCSW, Emily Clarke, LCSW, Rebecca Paulson, CCLS, and Jill Weissberg-Benchell, Ph.D.

To understand children, we adults make the effort to enter their world

Tips can help spirituality group's organizers

By Elizabeth Couble

Six years ago, I was approached to facilitate a weekly spirituality group on the locked psych unit at Brockton Hospital. The experience has provided blessing, challenge, and the deep conviction that recovery of mental health must have a spiritual component.

I do not equate religion and spirituality. Indeed, in mental unhealth, religion is very often where the seed pods of illness cluster. It is extraordinarily difficult to sort out the personal wounds and needs from the denominational expressions of doctrine which adhere to them. This should be remembered when approaching a spirituality group. My framework has been a weekly 45-minute group, with individuals of mixed diagnoses in a community hospital providing acute care for this population. The hospital serves all economic levels, with a significant number of homeless and varied ethnicities.

There is a profound rationale for providing this type of ministry to the mentally ill or addicted. John Sandford, in *The Kingdom Within*, says that a paradox of entering the kingdom of God is that “those who have recognized that they have been injured” are those “who are most apt to come into the kingdom.” While all hospital work is done on holy ground, I believe that working with the mentally ill and/or addicted has us walking where bushes burn and the kingdom is within, among us, and ready to break through.

The patients' illness is not “the whole reality” of themselves. They are not their illness. There's so much more to be recalled and prepare for in the future. Hope and trust in God/one's Higher Power can be midwived at times like these.

At the beginning of each session, “ground rules” should be shared: we are about **spirituality**, that deeper level of each person's longing for the divine and for meaning. A good definition of spirituality should always be shared: that Spirituality is about where we find joy, courage, strength, meaning, peace,

and a power-greater-than-ourselves. (It is most helpful, if not a necessity, to have a good understanding of the 12 Steps of A.A.)

At this point, an occasional person will interject, “This isn't about Bible sharing? I've been saved. How can you talk about spirituality and not Jesus?” And that's all right. Affirming that Jesus is all about healing, strength, and life, I try to restate what spirituality is about, and perhaps, add my experiences with patients who were atheists. With some conversation, there was usually a place or time when they felt a power greater than themselves.

Confidentiality regarding personal sharings is requested, and agreement is waited for. Another initial rule is no cross-talking. Each person will have a turn to share, and whoever is speaking deserves the attention of the rest of us. (The ability to wait one's turn, listen to others and move with the group is often a measure of one's mental health and returning, appropriate self-control.) I always add, “I hope this time is a pocket of peace in the difficult time of being in the hospital.”

Through group activities, the chaplain can move through embarrassment, anger, and confusion in simple but meaningful ways. A good way to settle and calm a participant's misgivings is to read an introductory prayer, like Joyce Rupp's “In Difficult Times,” then ask each person to share their name and what line or phrase jumped out of the poem/prayer for them.

Often the introductory exercise becomes the meat of the whole session. I come to group ready with three or four possible activities, to be able to go with what I am hearing. It is quite helpful to have some tangible items to use, as the ability to focus can be severely affected by medications and the state of the person. I amassed a large collection of greeting card covers and postcards of art objects, which I place down the center of the table. Participants look at the pictures as they find a seat, and take one that catches their eye. Those could be used as intro helps: “Share your name and tell us about the picture you chose.”



I encourage all chaplains who might hear an echo within, while reading this article, to consider offering such a group in your healthcare setting. You might use the following proposal to initiate the adventure.

Therapeutic Spirituality Group

Group will offer a safe, non-threatening, nondenominational forum for examining and sharing one's personal spirituality (rather than religion), and how it impacts one's state of health, values, meaning — one's quality of life.

Program's Foundational Assumptions: 1. A human being consists of body-mind-spirit, and neglect of any element thwarts health and wholeness. 2. The human personality is essentially relational. 3. There is a God/Higher Power/Spirit Greater-Than-Myself, and each person is constituted/directed toward a life-giving relationship with this Entity.

Goals or values: The development of identity, agency, integrity, intimacy, power and values.

Resources: Music, Scripture, stories, sharing, guided imagery, relaxation response, meditation, A.A. resources, 12 Steps, pencil-and-paper activities.

Patients will: Recognize the difference between spirituality and religion; begin to experience and affirm their spiritual identity; examine and verbalize their understanding of God/Higher Power; examine and better understand what, if any, impact their religious or spiritual beliefs have on their presenting problems; identify one or two spiritual resources in their lives to assist their efforts to cope, heal and change; begin to examine and resolve spiritual concerns pertinent to their illness, and begin to choose what role spirituality will play in their lives.

Groups lead patients to see chaplains alone

By Rev. John L. Evans II

People who experience mental illness often feel that they are alone. They may meet the stigmas of “get over it,” “if you had enough faith,” and being blamed for their illness.

Some of the feelings that arise in the midst of mental distress are anger, abandonment, confusion, isolation, and the struggle to find some meaning or ways to cope with suffering. Often the role of a chaplain is to listen, validate, question, and perhaps help the person to re-frame their perspective — i.e. from “God has left me in my suffering” to “my Higher Power is with me in the *midst* of my struggle.” Frequent questions that are asked include, “Why is God doing this to me?” and/or “Why is the Great Spirit punishing me?”

Everyone wants to be listened to, taken seriously, and treated like a person. My colleague Rev. Sonja Kjar writes, “For many patients a part of being hospitalized is beginning to accept the idea of ‘living with,’ as opposed to ‘getting over’ a condition or disease. Healing may come with some sense of acceptance that there is no magic cure.”

Working at a freestanding inpatient psychiatric hospital, I experienced the importance of *both* individual therapy and group interactions (support groups, therapy or psycho-educational groups). Lutheran Pastor Sonja Kjar, Sr. Ann O’Brien, PBVM, and I led such groups in the inpatient and



partial hospitalization units for adolescents and adults. Subjects ranged from spirituality, forgiveness, guilt/shame, anger (at others, self, Higher Power), grief/loss, blame/empowerment, communication, fear, hope, and prayer/reflection/mindfulness.

The groups that seemed to provide the greatest turning points were on grief/loss, shame, and forgiveness. People tended to have multiple layers of losses, including the deaths / rejections of loved ones and the impact of their illnesses on careers, relationships, or lifestyle, which affected their personal self-image. Over 90 percent of the patients responded to the question regarding “grief/loss” on their spiritual assessments and listed multiple factors about their losses.

In regard to forgiveness, counselors and therapists stated that they could go so far in this area, but people really needed a chaplain to go to the depths required for further healing.

Facilitating groups brought the largest number of self-referrals for one-to-one appointments with the chaplains. The group time made it important for patients to initiate a relationship. The chaplain was no longer a name in their orientation package or someone confined to leading worship in a chapel. Now, a chaplain became an authentic person willing to deal with the real life events that had an impact on

See [Groups lead patients](#) on page 14

A favorite motif of mine is “The Wizard of Oz.” I pass around a box of seven Oz Christmas ornaments, and as people introduce themselves, they pick a character that they identify with or that just called out to them. It is a powerful vehicle to help folks see that they just might have what they need to get where they want; no, it’s not easy, but there are people in our lives who travel with us. Is there a Power outside us that might be like Glinda the Good Witch, or a faithful, unconditionally loving Toto presence? There have been so many great moments using this story over the years, amidst laughter and tears; I must recommend it to all. Lacking figurines, one could use Oz stickers on index cards.

Listening to a song, most often with the words printed out, is another good entrée to insightful discussion. I have used Garth Brooks’ “Unanswered Prayers,” Janis Ian’s “Don’t Rush The River,” and Leann Womack’s “I Hope You Dance” to very good effect.

There are many ways to address negative images of God. A board or newsprint exercise is “If we could create the ideal God, what would that God be like?” The brainstorming can lead to a burgeoning discussion: Isn’t your God like this? Why not? Parental ghosts? The book “Good Goats” by Matthew and

Dennis Linn and Sheila Fabricant Linn is a great resource to deal with this minefield.

In a community hospital psych unit, it is very difficult to sort out only the highest functioning patients. Many times the groups have crossed the whole spectrum of illness. When I asked staff later about why they sent in a particular individual, the reply was often that they wanted the person to get the positive effect others had received from this group. Color me caught between a rock and a hard place.

I always try to maintain a respectful tone and check to see if it’s too difficult for a really distressed person to continue. If the group will be disturbed, it’s better to suggest that they try again next week, and excuse them from the session. Again, respect for the patients gathered, as persons worthy of respect, no matter what they are presenting, is most important. In the activities, we grant the patient a bit of autonomy in a situation where they normally have little. In six years of facilitating, I have never had a threatening incident.

Bon voyage! Remember to remove your sandals before each group, and let the Spirit move!

Elizabeth “Betty” Couble, M.A., LMHC, BCC, recently retired as Director of Pastoral Care at Brockton Hospital in Brockton, MA.

God works through dialogue in therapy group

By Sr. Bernadette Selinsky, OSF

Years ago when I was a chaplain at Holy Family Memorial in Manitowoc, WI, I facilitated spirituality sessions in the mental health unit. One day I had about eight participants, including a 40-something woman and a teenage boy. The woman immediately took to the teenager and told him, "I have a son about your age and you remind me of him."

In the course of the session, this woman told of her active plan to kill herself. The other members of the group immediately came to her aid. They asked her questions to help her process her feelings, shared some of their similar feelings and actions, and talked about the lessons they had learned when trying to carry out a plan similar to hers. Each of them indicated from personal experience that trying suicide was not worth it and not the answer.

They asked, "Who would miss you? How they would be hurt?" But she answered, "No one will be hurt, because they don't care. My family might miss me for a little while but they'll get over it." Then she turned to the teenage boy and said: "You're so much like my son, I'm going to ask you a



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question. If your mother killed herself, would you feel hurt? Would you be angry with her for doing that?" He looked at her wide-eyed and said, "Yes."

The woman stared at the boy and said, "You would? Do you really mean that?" Again he said, "Yes."

There was a moment of silence when the whole world seemed to stop turning. Then she slowly said, "Oh. I didn't think my son would miss me. Maybe I'd better change my mind."

At that moment I got goose bumps thinking about the awesome power of God to use a simple, struggling boy to reach another human being. I saw how deeply God reaches out to every one of us, and I felt thrilled at God's freedom in choosing the most unsuspecting person to begin bringing another to healing. I felt gratitude to be a tiny link that helped these two people come together. God was palpably present in the group work that day!

Sometimes I need to "get out of God's way" so God can work through someone else. How I rejoiced in our loving, saving God that day!

Sr. Bernadette Selinsky, OSF, BCC, is a chaplain at Genesis HealthCare System in Zanesville, OH.

Groups lead patients

Continued from page 13

spirituality. Issues were opened up, and people would say things like, "I want to talk to you about..." "I have needed to talk about something, and it seems like you are someone who will understand," or "I feel safe to talk to you privately about..." Groups *and* individual sessions provided a greater opportunity for people to unload, find options, and to receive support.

The power of group dynamics cannot be underestimated. Remember back to experiences within CPE, where perhaps a person resisted the supervisor, but listened to and owned the challenges or life experiences of peers. The same is true within the psycho-educational groups in a hospital setting. People are able to relate and connect to other patients.

In groups dealing with anger, people talked about their anger with God over the failure from their attempted suicide. Others named the same feeling, and talked about their fear of admitting their anger, afraid that their Higher Power would punish them with greater sufferings. In naming their feelings

and fears, and finding support from others, they could move ahead with healing, instead of stagnating or getting stuck.

Kelly M. Trevino and Kenneth I. Pargament wrote in the June 2007 issue of *Vision*, "Various interventions are appropriate. First, spiritual struggle is a source of guilt and shame for many people, but it is a natural part of life. People often respond with relief and gratitude when their struggles are met with understanding and acceptance rather than threat and rebuke. By normalizing spiritual struggle and creating opportunities for individuals to talk, chaplains can encourage people to move beyond guilt, shame and silence. Second, chaplains can teach individuals to anticipate spiritual struggle and draw on personal spiritual resources *before* serious problems occur."

Healing can be like a three-legged stool that includes therapy, medication, and spirituality. Chaplains can provide a safe place for people to explore their life situations where they find their courage through the presence of God in such encounters.

Rev. John L. Evans II, BCC, is a staff chaplain at The Mayo Clinic in Rochester, MN.

Bring your varied gifts to our 2008 conference

NACC to meet in Indianapolis April 5-8

As we have told you in past months, the NACC will hold its next annual conference in Indianapolis, IN, from April 5-8, 2008. Our planning committee (see box) is hard at work to develop a rewarding experience for you around the theme of "Bringing Gifts that Differ in Splendid Varied Ways."

While you are meeting other NACC members in Indianapolis, we hope you will have time to explore the city's other attractions. The following information

is adapted from the website for the Indianapolis Convention and Visitors Association. For more information, visit www.indy.org or call (800) 323-INDY.

Indianapolis, the nation's 13th largest city, has gone through a dramatic revitalization and a stunning renaissance in recent years. The city balances cosmopolitan style and small-town charm to draw more than 21 million visitors a year for leisure travel, conventions and group tours.

Because of its central location, state officials rather abruptly created Indianapolis as the state capital in 1821 on the White River at the mouth of Fall Creek. That location helped boost its growth as a transportation hub that has become known as the "Crossroads of America."

Monument Circle is home to the 284-foot Soldiers' and Sailors' Monument. Dedicated in 1902 and made of Indiana limestone, this stands as a tribute to the Indiana servicemen who served in the Civil and Spanish-American Wars.

At the **Indianapolis Zoo and White River Gardens**, plants and animals are the main attraction. The nation's only accredited combined zoo, aquarium and botanical garden, it occupies 64 acres in White River State Park. Divided into biomes, it features nearly 4,000 animals and is home to the state's largest aquarium and the country's first totally submerged underwater dolphin viewing dome.



www.indyzoo.com/

Explore Indiana's past, present and future through a variety of interactive exhibits at the **Indiana State Museum**, a hands-on overview of the best Indiana has to offer. Constructed from all Indiana materials including limestone, sandstone, steel, brick and glass, the building itself is a work of art, with icons representing each of Indiana's 92 counties.

www.in.gov/ism/

At the **Indianapolis Museum of Art**, you will find paintings, sculptures, photographs and textiles from

African, American, Asian and European collections. The Museum also features national and international traveling exhibitions throughout the year. www.ima.museum/

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Ministry of healing applies to hospital or parish

By Rev. Richard M. Leliaert



Your faith has made you whole; go in peace (Lk 7:50)

A little over a year ago, I left my position as a chaplain and director of spiritual support services at Oakwood Hospital in Dearborn, MI. I embraced this ministry of healing for 14 years, but currently I'm pastor of St. Robert Bellarmine Parish in Redford, MI.

People often ask me, "Do you miss Oakwood?," and I say yes, but I quickly add how much I cherish and appreciate being a pastor of an 1,800-family parish with about 240 kids in our school. "A whole new ball of wax for me," I'd quip, but after my first full year as a pastor, I reflect often on the ministry of healing as I experience it in a parish, and how this ministry of healing is a theme that brings together and/or bridges my ministries as a chaplain and a pastor.

I see healing as an outflow of two other gifts of grace — the forgiveness of sins and then the experience of reconciliation.

Certainly when I was a hospital chaplain, healing was closely associated with recovering from a physical illness; we'd distinguish between a cure and healing in the sense that even if one didn't recover from their illness (read that there wasn't a hoped-for cure), one could still experience healing in the sense of wholeness or peace. The more anointings I was called to do, the more I kept reflecting on

the close connection between *the forgiveness of sins* and *the prayer of faith which saved the sick person*.

Every chaplain can realize the power of James 5:13-16. There is the presence of the elder(s) or the presbyter(s) of the church "anointing with oil in the name of the Lord. Yet, note the words: "The *prayer of faith* will save the sick, and the Lord will raise them up; and anyone who has committed sins will be *forgiven*." The next sentence needs to be taken in context, but we are told, "therefore, confess your sins to one another, and pray for one another, so that you may be *healed*." Healing then can be seen as a culmination of a *faith-rooted process* of prayer, forgiveness of sins, reconciliation and healing.

Of course we're still challenged by the sacrament of the sick as performed only by a priest, and we all know how frustrating this can be. But whenever a chaplain enters a pastoral situation, whether the chaplain is ordained or not,

that chaplain is Christ to that patient, that chaplain represents the presence of the church as the community of faith.

We have a phrase from canon law, *ecclesia supplet*, meaning "the church supplies." While a non-ordained chaplain cannot formally absolve sins or anoint with oil, it may be that a chaplain's prayer in faith, as a member of Christ's Body the Church, is effective and that his/her prayer for the forgiveness of sins could be mediated by *ecclesia supplet*, if, say, a third-person prayer is faith-fully proclaimed: *May* almighty God have mercy on you, forgive you your sins, and bring you to healing and life everlasting. Then couldn't the chaplain truly be empowered through the church as 'an agent of reconciliation' (cf. II Corinthians 5:17-21, especially vv. 18-19) and a facilitator of spiritual healing?

My purpose here is not to diminish or undermine the legitimate role of the ordained ministry in its sacramental context, nor even to propose anything new, but to emphasize how pervasive our ministry of healing is as chaplains and/or pastors. Even in the context of Jesus' life and ministry, the work of healing was paramount; he proclaimed basically that the reign of God (or the Kingdom of God) restores men and women to *wholeness*, a wholeness of body, mind, and spirit. To my knowledge, the only text in the New Testament wherein this unity of body, mind and spirit is explicitly mentioned as such occurs in I Thessalonians 5:23: "May the God of peace himself sanctify (i.e. make holy or whole) you entirely; and may your spirit and soul (mind) and body be kept sound and blameless at the coming of our Lord Jesus Christ."

We might make two observations here. One, the whole dynamic of modern medicine seems based on the premise that first the body is healed/cured, then this leads to psychological or mental peace, and almost as a tack-on, then a kind of religious and/or spiritual peace. Even patients often speak more of faith in their doctor(s) before a critical surgery than they speak of faith in God. As chaplains, we've often experienced a kind of eleventh-hour mentality, especially after everything else fails medically or at the point of death. Or we're called in to do the grief work as the doctor rushes off after a death. But what if it's completely the other way around? What if the healing of the spirit is the real source of peace of mind and then the healing/cure of the body? This perspective may be gaining ground, especially in greater openness to the power and role of spirituality in people's lives.

Secondly, peace or healing as wholeness, or the

Whether the chaplain is ordained or not, that chaplain is Christ to that patient

experience of healing, comprises a fourfold reconciliation — first within ourselves, then with others, then with God, then with God’s whole creation. The Scriptures speak of a new creation, of a new heaven and a new earth. (Native American healing rituals capture this beautifully, as these rituals embrace all four directions — north, east, south, and west — to symbolize totality and wholeness of healing.) Again, a close look at the rite of anointing or the sacrament of the sick can validate these aspects of healing.

If we look more closely at the total process of Jesus’ healings in the Gospels, it seems to me that the primacy of the healing of the spirit as mentioned above, as well as the fourfold aspects of healing, come together consistently. Jesus’ words, “Go in peace, your faith has made you whole” (e.g. Luke 7:50), is the consistent ending. The best example of this, at least as it speaks to me, is Jesus’ healing of the paralytic, mentioned in each of the Synoptic Gospels. My favorite is Mark 2:1-12. The process of healing begins with the *faith* of the four people symbolizing the community of faith, bringing the paralytic to Jesus. He first forgives the paralytic’s sins, the healing of his wounded spirit.

Inner healing. Then there’s a reconciliation with the community as his inner and outer paralysis are healed; “they were all amazed and glorified God.” Thus, healing with the community. Then, healing of the body: “take up your mat and walk.” Regarding the reconciliation with the beauty of God’s creation, v. 13 has Jesus immediately going out again to the sea.

Each of us as chaplains and pastors can find more meaning and power in healing stories like Mark 2:1-12. But I want to conclude with what I call a personal anchor image, an image or story that grounds or encapsulates all my experiences of healing as embracing and flowing from forgiveness and reconciliation.

Shortly after World War I (1920 to be exact), my father was seven years old, living in Belgium. His father and mother were having marital difficulties, and one Sunday afternoon his father said to my dad (all decked out in a sailor suit), “Maurice, we’re going on a little trip, come with me.” Dad was then taken to a boat in Antwerp harbor, a boat preparing to leave for America. His father had a third-class ticket. So without his mother’s

knowledge, my dad was taken to America. The crossing was horrendous; seasickness, vomiting, other illnesses took their toll. When they arrived in America, Dad lived with his father’s sister, Aunt Emma.

Four years later, in 1924, my dad’s father went back to Belgium. The reasons are blurred in others’ memories, perhaps to effect a reconciliation. But his father died in Belgium and never got back to America. So my dad was raised by his caring aunt, but the house was not conducive to a healthy lifestyle. “I saw everything,” my dad would tell me later. For 50 years, Dad never saw his mother. He judged that she had abandoned him. He was not forgiving; he saw no need even to attempt reconciliation.

My mother, however, tried often to convince my father to go to Belgium to meet his mother, to hear her side of the story. Nothing doing. “She abandoned me,” Dad said, and that was that. But mothers and wives are persistent, and after a complex series of letters back and forth, and other tedious efforts, my mother located Dad’s mother in Belgium. In 1970, fifty years later, Mom prevailed on Dad to go to Belgium to see his mother. Within two days, Dad was reconciled with his mother. Forgiveness and reconciliation and healing brought new life to both of them, and we all experienced the healing fruits of this long and complex journey.

Dad made three more trips to see his mother and family before he died. His mother died in Belgium at almost 102. My mother and I made two more trips to see Grandma in Belgium, and as I gave the homily (in Flemish) at the Mass celebrating Grandma’s 100th birthday, I thanked God for this anchor experience which spoke so richly to me in all the other experiences of healing I’ve had as a chaplain and pastor. All of us can get in touch with our anchor image(s) which empower each of us as agents of God’s life-giving forgiveness, reconciliation and healing.

Rev. Richard M. Leliaert, Ph.D., is pastor of St. Robert Bellarmine Church in Redford, MI.

What if healing the spirit is the real source of peace of mind and then the healing of the body?

Praying for others may produce personal benefits

By Larry VandeCreek

The intercessory prayer research continues, and gradually researchers begin to explore alternative strategies and even better research designs. Many people offer intercessory prayer for others, and researchers try to tease out the benefits experienced by the “others.” Whether these “others” are benefited remains an open question among researchers.

But what if the search for benefits is focused too narrowly? Why not examine whether those who pray for others experience benefits themselves? That’s the intriguing question explored in this study.

The author writes, “It is proposed that praying for others benefits prayer agents because it helps them cope more effectively with the stressors that arise in their own lives.” The stressor of interest in this study is chronic financial strain brought on by insufficient money to pay bills. Do those who more frequently pray for others and who experience financial strain report better health than those who report the same amount of financial strain but do not pray for others? Additionally, the author asked if there is a health difference if persons pray for material things rather than for others, and whether any differences were noted between European- and African-Americans.

To test his thesis, the author arranged for data to be gathered by telephone interviews from a nationwide random sample of adults aged 66 years and older (748 European-American and 752 African-American).

As described in this report, they responded to five items: how often they prayed for other people, for material things, how much difficulty they had paying monthly bills, how they rated their overall personal health, and how often they attended religious services.

What were the results? As regards race, African-Americans pray more often, both for others and for material things. As regards prayer, financial strain, and health, “as financial strain increases, older people tend to rate their health less favorably.” Further analyses refined these results. The author reports that those who had more financial strain and who prayed more frequently for others reported better health than those who reported just as much financial strain but did not pray for others very often. Furthermore, no significant health differences were found when prayers were made for material things. Praying for others seemed to make the health difference. Praying for others did not offset the entire noxious effects of ongoing financial problems. Rather, its impact on health was reduced by about one-half. While this is beneficial, the need for additional coping resources is obvious.

The author closes by suggesting many questions that merit further attention. For example, is praying for others helpful in coping with stresses other than financial, and is it helpful with short-term stresses? Again, this study did not investigate whether these prayers for others were spontaneous or in response to requests. Does a request for prayer influence the effects on the intercessors? Additionally, does praying for loved ones as compared to those in more distant or even antagonistic relationships make a difference?

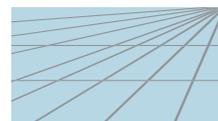
Why would praying for others influence the self-reported health status of the intercessors? The author suggests various possibilities from secular literature. He notes that individuals attempt to cope with chronic problems by creating positive experiences in other areas of life. One way to do this — helping others — has three distinct implications. First, helping others bolsters the self-esteem of the helper because he or she feels they are helping someone in need. Second, helping others diverts the helper’s attention from their own difficulty. Third, noting the benefit of their helpfulness, helpers are reminded that they can also receive help from others.

The article closes with a discussion of the study’s limitations. First, all of the data were self-reported without the use of objective measurements. Consequently, the results are valid and reliable only to the extent that the responses during the interview were accurate. Second, these are cross-sectional data; no conclusions can be drawn regarding causation.

Reference: Neal Krause. 2003. Praying for Others, Financial Strain and Physical Health Status in Late Life. *Journal for the Scientific Study of Religion*, 42(3), 377-391.

Rev. Larry VandeCreek, BCC, is a retired APC chaplain living in Bozeman, MT. This article originally appeared in the APC News.

Praying for others seemed to make the health difference



In Memoriam

Please remember in your prayers:

Rev. John Francis Mullin, SJ, who died May 22 at age 72 in Lebanon, NH. He was ordained in 1965 and took final Jesuit vows in 1972. He taught English in three Jesuit high schools in New England and was an administrator at several Jesuit communities before becoming a chaplain at Dartmouth Hitchcock Medical Center in 1981, when he also joined the NACC.

Priests need endorsement from diocese of incardination

Editor's Note: Certification and renewal of certification are very important to the NACC and its members. But they are long processes with many steps, and it is natural that questions will arise about the requirements. In an attempt to provide answers, we are beginning a new monthly feature in Vision. "Certification Update" will address some of the most frequently asked questions about the processes, as well as provide new information and clarification as the NACC moves to implement its revised standards.

Q: I am an ordained priest, but the hospital where I minister is outside of my home diocese. When I fill out the application for certification or renewal of certification, should I list the bishop of the diocese where I work, or the diocese where I am incardinated?

A: The NACC's current standards (420.3, 520.17, 530.15, 540.15, 550.15, 840.142, 850.153) require that members "provide a current letter of endorsement" for formal approval for ministry. Diocesan priests or deacons need current endorsement from their ordinary



(the bishop of the diocese in which they are incardinated). The NACC will request this directly from your bishop.

For religious, a current endorsement by the member's major superior is required. The NACC will request this directly from the major superior.

For laypersons, a letter of recommendation from your pastor or from a priest in active ministry in your diocese is required. This letter should be addressed to the Certification Commission Chair and sent to the NACC. Secondly, a current endorsement by the bishop in the diocese of your residence is also required. The NACC will request this directly from the bishop and will enclose a copy of the priest's letter of recommendation.

We suggest that you make an appointment with your bishop as you move through the processes, so that he is familiar with you and your ministry.

"Current endorsement" means that the endorsement was written within 12 months of the receipt of application date.

If the endorsement letter is delayed, the process will still proceed, but final action will wait until the NACC receives the endorsement.

Revised NACC Standards close to taking effect

By John Gillman and Mary Lou O'Gorman

After two years of diligent work, the NACC Standards Commission has developed a revised set of Standards for the NACC. These Standards were approved by the NACC Board of Directors in July and will be reviewed by the United States Conference of Catholic Bishops/Commission on Certification and Accreditation in November. Pending approval by the USCCB/CCA, the revised standards will go into effect January 1, 2008.

This means that candidates applying for a certification interview for the fall of 2008 must use these revised Standards to demonstrate their competencies. The postmark deadline for materials for a fall 2008 interview is February 15, 2008. The deadline for the narrative statement incorporating the revised NACC standards, once approved, is June 1, 2008.

The six largest healthcare chaplaincy organizations in North America (ACPE, APC, CAPPE, NACC, NAJC, and AAPC) committed themselves in 2003 to develop Common Standards for chaplains, supervisors and professional ethics. NACC members Mary Lou O'Gorman, John Gillman, and Ann Hurst were the respective chairs of these three working groups.

One of the challenges was to recognize what was common to all chaplains and what was unique to a denominational organization such as the NACC. The boards of directors of

the cognate groups had decided to focus on what we held in common, and agreed that individual organizations would subsequently add their own denominational standards. The joint cognate group boards approved the Common Standards in November 2004 in Portland, ME.

In June 2005, the NACC re-convened the Standards Commission under the leadership of Alan Bowman. We were to review the four documents and add standards essential to Catholic identity and theology. We began by examining the NACC standards and materials from the USCCB/CCA to identify essential elements that were not included in the Common Standards. In addition, we also separated standards from processes, which were embedded in the standards we have used until now.

In the spring of 2007 the Board appointed John Gillman as the new chair of the Standards Commission. The Commission completed the revised Standards in July, and the NACC's Board of Directors approved them the same week. At its meeting this fall, the commission hopes to finalize its work on the procedures for certification and renewal of certification for chaplains and CPE supervisors, along with procedures for ethics violations.

Mary Lou O'Gorman, M.Div., BCC, is director of pastoral care at St. Thomas Hospital in Nashville, TN. John Gillman, Ph.D., is an NACC and ACPE supervisor at VITAS Innovative Hospice Care in San Diego, CA.

Angie Vorholt promotes profession of chaplaincy



Name: Angie Vorholt

Work: Director of Pastoral Care; DePaul Health Center, Bridgeton, MO

NACC member since: 1995

Volunteer service: Site coordinator for certification interviews in St. Louis, several years

Favorite book:

Spiritual—*Hinds Feet on High Places*. Any Disney business book—*Be Our*

Guest, If Disney Ran Your Hospital, Imagineer Workout.

The Disney books help me stay creative and approach concerns with a more global view.

Favorite spiritual resource: Spiritual direction is the gift that keeps me going. I am also a member of a spiritual movement called Focolare—the Spirituality of Unity.

Favorite movie: *Meet Me in St. Louis* (love Judy Garland!); *The Power of One*

Favorite retreat spot: Il Ritiro, Dittmer, MO

Personal mentor or role model: I have had several to this point.

Famous/historic mentor or role model: Jesus, of course. I

have always admired and tried to follow Francis of Assisi.

Another major influence is Louise de Marillac. All three served the sick and poor and relied on God and their communities for their needs. I also admire Gandhi.

Why did you become a chaplain? I worked with a religious sister in the early 1970s who served in city hospitals in St. Louis — Catherine Shallom, CPPS. She was fantastic and had such a passion for the sick and the staff who cared for them.

I wanted to assist people at one of their most vulnerable times — illness.

What do you get from NACC? We must ensure that chaplaincy remains as professional as possible and becomes even more than it is. The credentialing and networking that occurs to make this happen is life-giving. It is important to me, also, that Catholic chaplains have a network on which to rely.

Why do you volunteer? I believe in NACC and in the certification process. I want my profession to remain a stable force, and that happens when many come together to support the initiative.

What do you learn from volunteering? Before I serve as site coordinator, I review the Standards again in an effort to be as sharp and well-versed as possible to assist the candidates as well as the interview teams. It is a learning experience for me to hear what others perceive of the experience and the process.



Ex-NACC board member Sr. Maryanna Coyle dies

Sr. Maryanna Coyle, SC, a longtime friend and board member of the NACC, died Sept. 15 at age 73.

“Maryanna was a visionary, a leader, and a challenging and discerning board member,” said Sr. Monica Ann Lucas, SC, an NACC supervisor. “She was a dear friend and an enabling strategic planner who helped the NACC to face the important and far-reaching consequences of who and what it wanted to be in the 21st century.”

Sr. Coyle served as director of mission effectiveness for the Sisters of Charity health system, based in Cincinnati, OH, and joined the NACC in 1982. She served as parliamentarian at many national conferences in the 1980s and remembered, “With hundreds of proposals and some 800 members eager to speak, this was no small challenge.”

She ceased to be a full member in 1992, but remained a friend and affiliate of the association. When the NACC created a national board in 2001, she became one of the charter extern members, serving until 2005. “It was a blessing to have her,” said Joan Bumpus, former chair of the board. “She helped mentor the board on our way, and she

helped mentor me. She was the right arm of the board. ... She just had a passion and an energy around our work.”

Sr. Coyle also served as president and executive director of the SC Ministry Foundation in Cincinnati and participated on the boards of several hospitals, schools, and other organizations.

In the NACC’s 40th anniversary book, published in 2005, Sr. Coyle discussed the challenges ahead but concluded, “The lodestar, the constant sustaining each member throughout these new ways, is a deep relationship with God, a faith life that is nourished in prayer and communion with others, and a generous openness to God’s invitation to transformation. For people rooted in faith, risk is not a threat but an opportunity.”

Sr. Lucas shared a quote from Sr. Coyle that was used on her funeral program: “Take the responsibility and the opportunity to make a difference. Believe that your interaction is essential to the life and survival of the Earth. Let your vision be a belief in the possibility that the world can change and that we as individuals, in fidelity and commitment with others, can perform small miracles.”

NACC members earn certification

Congratulations to Ms. Kim Rodriguez-Beuerman of Madison, WI, and Rev. Moses Chikwe of Venice, CA, who were granted certification following their interviews in the spring.

NACC Now offers faster communication

By the time you read this newsletter, if we have your e-mail address, you should have already received several issues of NACC Now, our new biweekly electronic update to our members.

We hope that communicating with you by e-mail will keep you more abreast of timely chaplaincy news; encourage you to share your talents, ideas and concerns with the national office; and promote dialogue with other members and build a sense of connection. Consider this to be a new membership benefit made possible by the widespread availability of e-mail.

NACC Now is a supplement to *Vision*, not a replacement for it. *Vision* will continue to offer in-depth articles about chaplains at work, theological reflections, pastoral-care research, and other significant topics. And it will continue to be our publication of record; important announcements about the association are not going to go all-electronic.

The electronic newsletter, however, will let us communicate with you more quickly and more often. If you are not currently receiving NACC Now but would like to, please send an e-mail to webmaster@nacc.org from the address that you would like us to use.

Briefs

Tanzanian supervision experience available

Certified CPE supervisors are invited to consider a "tour" supervising 12 weeks of CPE in Tanzania on the shores of Lake Victoria. Participants immerse themselves in African cultures and supervise Tanzanian students with Fr. Matthias Maufi, a Tanzanian supervisor.

Bugando Medical Center in Mwanza, governed by the Catholic bishops of Tanzania, is a three-hour drive from Serengeti National Park. Ngorongoro Crater and Olduvai Gorge are an easy second-day excursion.

Visiting supervisors receive room and board and a \$750 stipend. They must cover their own air fare, medical expenses, and game park fees.

Fr. John Eybel, an NACC member and American Maryknoll priest at BMC for many years, recommends this CPE tour as a fun, safe yet challenging opportunity to inquire into "what God's love looks like on the other side of the globe."

The 2008 dates for three CPE 12-week units are: Jan 21 to April 13; April 28 to July 20; and Sept 1 to Nov 23. For more information, write to Fr Matthias Maufi at: frmathias63@yahoo.com

▼ CHAPLAIN, PART TIME

Sacramento, CA – Mercy General Hospital (CHW) has a chaplain opening, 56 hours per pay period. This position requires NACC or APC certification or eligible for certification (with four units of CPE). Bilingual candidates are strongly encouraged to apply. Master's in Theology, Divinity, or related field. Candidate must be experienced in providing pastoral support to culturally diverse populations with religious diversity. At least one year of healthcare experience is preferred. The chaplain provides spiritual/religious counseling and ministry to patients and their families, demonstrating competency in spiritual support and pastoral counseling, as well as dealing with grief, death, and the dying process. Please apply online at www.chwcareers.org or by e-mail at s2russell@chw.edu.

▼ DIRECTOR OF PASTORAL CARE

Belleville, IL – The Apartment Community of Our Lady of the Snows is a Catholic continuing care facility located on the grounds of the National Shrine of Our Lady of the Snows. The Apartment Community, sponsored by the Missionary Oblates of Mary Immaculate, provides a continuum of care for seniors: apartments, assisted living and skilled nursing care. The Director will plan, organize, and direct pastoral care services on behalf of older adults, their families and employees while working in partnership with a Catholic priest chaplain and a Protestant minister. The Director is responsible for leading the

Positions Available

mission enrichment program. Experience as a director desirable but not necessary. Send resume to: Apartment Community of Our Lady of the Snows, 726 Community Drive, Belleville, IL 62223 attention D. Robert McCardle, Executive Vice President; or e-mail bob.mccardle@apartmentcommunity.org.

▼ DIRECTOR OF SPIRITUAL CARE

Lawrence, MA – MI Nursing/Restorative Center, a 250-bed skilled nursing facility, seeks Spiritual Care Director to lead chaplains in providing spiritual care services to residents, families and staff. Promotes relationships with local parishes, works with other departments for palliative care, end of life care initiatives, ethics consultations. Master's degree in divinity, theology or pastoral counseling or expected completion of same within 12 months of employ. Minimum 2-3 units of CPE. NACC, APC or ACPE certification preferred. Familiarity with ERDs, strong interpersonal skills, experience in long-term care preferred. Resume to: MIHCS, Director of Human Resources, 172 Lawrence Street, Lawrence, MA 01841. Fax: 978.682.8768. www.mihcs.com. Equal Opportunity Employer.

Positions Available

▼ COORDINATOR OF SPIRITUAL CARE IN CHILDREN'S

Tampa, FL – This is your opportunity to join St. Joseph's-Baptist Health Care, a member of the BayCare Health System family. We are located on the beautiful Gulf Coast of Florida, where we enjoy exceptional weather, a wide array of entertainment options, professional sports and a short drive to some of the world's best beaches. Not to mention the added benefit of no state income tax! We are currently seeking a full-time Coordinator of Spiritual Care in Children's to assist the Director of Pastoral Care in making the mission and values of the BayCare Health System vital and operational within the hospital. Occasional weekends may be necessary. Qualified candidate will possess a master's degree in theology, pastoral studies or related fields and be certified by APC, NACC, or NAJC. Ecclesial endorsement and Pediatric Chaplain Network membership also required. Minimum three years experience in pediatric spiritual care necessary. Bilingual (English-Spanish) preferred. Interested applicants, please contact heather.thomas@baycare.org, (813) 554-8425, or visit us online at www.BayCareJobs.com. Equal opportunity employer, drug-free workplace.

▼ CHAPLAIN

Springfield, MA – Baystate Medical Center is seeking a Roman Catholic priest or men and women religious to serve as staff chaplains to provide both spiritual and sacramental ministry to Catholic patients and families. Licensed at over 700 beds, a tertiary care referral and level one trauma center, we are the largest health care provider in western New England. To collaborate on the spiritual services team with interfaith chaplains and CPE students ministering to persons of all faiths. On-call responsibilities will be shared with other providers. Eucharistic ministers (50-plus) help with daily distribution of communion. As both the flagship hospital in Baystate Health and the western campus of Tufts University School of Medicine, this teaching hospital places keen emphasis on learning and growing. This is a dynamic and appreciative environment for the role of spirituality in the healing process. We are looking for experienced people with effective interpersonal skills and a strong commitment to holistic care. Western New England offers natural beauty and distinctly marked seasons with activities unique to each. Artistic, cultural and academic opportunities abound. Qualifications include ordination or ecclesiastical endorsement and a master's degree from an accredited school of theology, four units of CPE, certification through NACC, or eligible for certification. A competitive wage and benefit package is offered. Resumes may be sent to Kym O'Brien, Recruitment Office, Baystate Health, 280 Chestnut Street, Springfield, MA 01199. AA/EOE

▼ MISSION/SPIRITUAL CARE DIRECTOR/SOCIAL WORKER

Valdez, AK – Are you looking for an exciting place to live and work? Then consider a career at Providence Valdez Medical Center! The Director is responsible for promoting the

understanding and integration of the Providence Health and Services mission and core values. Ensures spiritual care is made available for all patients, residents, employees as needed. Oversees Ethics Committee and Community Benefits/Services. Provides individual, group, and family therapy. Provides marital therapy for couples. Provides social work services that comply with state, federal and local requirements for long-term care and swing bed services. This position reports to the administrator and also works closely with the Director of Providence Valdez Behavioral Health and the Regional Director for Mission Leadership for Providence Health and Services Alaska. Requirements: Master's degree from an accredited college, seminary, university or theological institute; master's degree in social work preferred; 3-5 years' pastoral experience; ordination and endorsement by established ecclesiastical or church authorities and/or religious superiors; three years' experience in the behavioral health field is preferred. Board certified chaplain preferred. Minimum of two units CPE from the National Association of Catholic Chaplains or the APCE, or full certification achieved (four units). Full certification required within two years. Must hold a current clinical license with the State of Alaska, Licensed Clinical Social Worker (LCSW) is preferred. Apply online at www.providence.org/careers. Providence Health & Services is an Equal Opportunity Employer.

▼ CHAPLAIN/PASTORAL ASSOCIATE

Palos Heights, IL – Palos Community Hospital is truly a family of professionals focused on care for the community. Unlike large networks with numerous hospitals, we are uniquely one-of-a-kind with the ability to recruit and retain the highest caliber of professionals and patient caregivers. Patient centered care is the heart of our philosophy and makes us the provider of choice in our area. Unique, individual – one of a kind, that's you and Palos Community Hospital. We are in need of a caring and passionate individual to provide spiritual counseling and pastoral care and support to patients, their families and staff by assessing and caring for their spiritual needs. Must be committed to working as a member of an interdisciplinary team. Our ideal candidate is a graduate of an accredited college or university. Ordination to the priesthood and/or ministry and continuing ecclesiastical endorsement by the bishop of the dioceses/religious order is required. Certification with the National Association of Catholic Chaplains or agreement to work towards certification while on the job, as approved by the Director of Pastoral Care, is also essential. You must be a compassionate individual with empathy for patients, family and staff as well as a good listener and able to handle/deal effectively with people in an emergency situation. Experience in spiritual care in a health care setting is preferred. Please call Holly Brasher at (708) 923-4878, apply on line or send/fax/email your resume to: Employment Office, 12251 S. 80th Ave., Palos Heights, IL 60463. Fax: (708) 923-4888. Email: hbrasher@paloscomm.org EOE. www.paloscommunityhospital.org

▼ PRIEST CHAPLAIN, STAFF CHAPLAIN

Fort Smith, AR – St. Edward Mercy Medical Center seeks a Catholic priest chaplain and a staff chaplain to join a multi-cultural, ecumenical group of chaplains in providing ecumenical ministry at the premier healthcare provider in western Arkansas. Affiliated with Sisters of Mercy Health System, 349-bed St. Edward Mercy serves over 400,000

people in 13 counties and offers the highest caliber medical and clinical staff and leading-edge technology. Clinical pastoral education required for the full-time staff chaplain position. SEMMC offers competitive compensation and an excellent benefit package. Apply in person or contact St. Edward Mercy Medical Center, Human Resources Department, 7301 Rogers Ave., Fort Smith, AR 72903; (479) 314-6111; teresa.nichols@mercy.net.

▼ SENIOR VP OF MISSION AND MINISTRY

Chattanooga, TN – Memorial Health Care System, located in scenic Chattanooga, Tenn., seeks candidates for senior vice president of mission and ministry. Memorial is a 400-plus-bed acute care system and part of Catholic Health Initiatives. Responsible for guiding and leading an organizational culture that actualizes the mission and values of CHI and Memorial and integrates them into operational activities and organizational policies. Extends the mission of Memorial through involvement in community benefit outreach promoting healthy communities among the poor. Provides leadership in maintaining programs that deepen mission, values, and spirituality for administration, Board, leaders, associates, volunteers, and physicians. Qualified candidate will be a practicing Catholic, with preference for a member of a religious congregation; possess a master's degree in theology, healthcare administration, pastoral studies, or a related degree; have at least five years of leadership experience in a related role; possess a solid understanding of the mission and values of Catholic healthcare. Previous pastoral and leadership experience in a hospital setting preferred. Send resume to: 2525 de Sales Avenue, Chattanooga, TN 37404, Attn: Brad Pope; or e-mail resume to brad_pope@memorial.org or apply online at memorial.org.

▼ STAFF CHAPLAIN

Long Island, NY – To become a member of a multifaith department at Winthrop University Hospital (www.Winthrop.org) on Long Island as a staff member of The HealthCare Chaplaincy (www.healthcarechaplancy.org). The chaplain will have the opportunity to become part of a growing pastoral care department in a first-class 600-bed medical facility with a Level I trauma center as well as being part of one of the country's pre-eminent pastoral care and training organizations. Winthrop was ranked one of the top ten hospitals in cardiac surgery by Modern Maturity magazine while maintaining the feel of a small community institution. Qualifications: APC, NACC, or NAJC certified or certification eligible, high energy with excellent clinical skills. Send resumes to: The Rev. George Handzo, Vice President, Pastoral Care Leadership & Practice, The HealthCare Chaplaincy, 307 E. 60th St., New York, N.Y. 10022; ghandzo@healthcarechaplancy.org.

▼ CHAPLAIN

Urbana, IL – The Carle Foundation Hospital, a 295-bed, not-for-profit, teaching facility is seeking an additional chaplain to join their Pastoral Care department. The chaplain will be responsible for providing pastoral care to patients, families and staff with a focus on the pediatrics and NICU departments. This is a full-time day shift position with call rotation shared with other chaplains on staff. Bachelor's degree required, master's degree preferred in divinity, counseling, theology, or spirituality. Endorsement by religious body; certification by or willingness to pursue board certification by Association of

Professional Chaplains or by either NACC or NAJC is required. One unit of ACPE with willingness to complete four CPE units and achieve board certification as a chaplain is also required. Carle Foundation Hospital is located in family friendly Champaign-Urbana, IL. The community population is 170,000 and is home to the University of Illinois. Interested candidates can apply online at www.carlecareers.com or call 1-800-22-CARLE.

▼ MANAGER – SPIRITUAL CARE & ETHICS

Torrance, CA – Providence/Little Company of Mary Hospital is a progressive, community-based hospital dedicated to caring for the whole person — body, mind and spirit. The Manager of Spiritual Care and Ethics is a full-time professional chaplain who, through a staff of four, is responsible for providing, organizing and implementing a comprehensive program of spiritual care (sacramental and pastoral) and ethics for patients, families, staff and physicians within LCMH. Requires board certified chaplain with current management experience in a US hospital or health system. Contact Dan Potter, Potter Associates, 949.673.5900 or potterdr@pacbell.net.

▼ PRIEST CHAPLAIN

Marshfield, WI – Ministry Health Care, with over 14,000 employees, is a values-driven healthcare delivery network of aligned hospitals, clinics, long-term care facilities, home care agencies, and many other programs and services in Wisconsin and Minnesota. We are currently seeking a full-time priest chaplain to join the spiritual services department of St. Joseph's Hospital in Marshfield, WI. Our spiritual services department provides ministry 24 hours a day, seven days a week with a designated priest chaplain. In this role, you will be responsible for providing pastoral counseling and support to patients, families, and the hospital staff, which includes responding daily to the diverse spiritual needs of patients regardless of age, race, ethnic background or religious traditions. As a priest chaplain you will participate in educational programs for physicians, hospital staff, volunteers and the larger faith community, as well as working with hospital committees related to the priest chaplain's area of ministry. Qualified candidates must have a bachelor's degree in a theological, ministerial, or related field from an accredited college, university, or seminary and completed four quarters of clinical pastoral education in an accredited educational program. At least three years of general ministerial experience and one year of hospital/healthcare experience preferred. Apply online at www.ministryhealth.org. EOE.

Position Wanted

NACC member in the process of certification is looking for a full-time chaplain position in any part of the USA. I am from South America and therefore a bilingual and bicultural chaplain who finished his fourth unit of CPE last May at The Chaplaincy Center in Providence, RI. M.Div and STL from Weston Jesuit School of Theology in Cambridge, MA. Please contact Wilson Villamar at (617) 240-3852 or wilsonvillamar@hotmail.com

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Calendar

November

- 8-9 NACC Board of Directors meeting, Milwaukee
- 11-13 Standards Commission meeting, Milwaukee
- 12-15 USCCB meeting, Baltimore, MD
- 26 Copy deadline, January *Vision*
- 22 Thanksgiving; national office closed
- 23 National office closed

December

- 17 Copy deadline, February *Vision*
- 24 National office closed for Christmas Eve
- 25 National office closed for Christmas Day
- 31 National office closed for New Year's Eve



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