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We need to better inform ourselves about mental health care

We have all been aware of the national debate on gun control and mental health in light of the Newtown, CT, tragedy. As I write this column on April 8, 2013, the political news continues to expose the deeply conflicted stances on gun control. However, the public discussion on mental health related to gun control seems to have waned a bit. Part of the reason for this was the clear and decisive information about the minimal relationship of mental health to gun violence. One helpful article was written by Richard Friedman, M.D, “In Gun Debate, a Misguided Focus on Mental Illness,” (www.nytimes.com/2012/12/18/health/a-misguided-focus-on-mental-illness-in-gun-control-debate.html) in the New York Times, published Dec. 17, 2012. Mr. Friedman stated that “there is overwhelming epidemiological evidence that the vast majority of people with psychiatric disorders do not commit violent acts. Only about 4 percent of violence in the United States can be attributed to people with mental illness. However, a general public understanding of and care about the pervasive presence of mental illness is still lacking.

When visiting the National Association on Mental Illness (NAMI) website (www.nami.org/Template.cfm?Section=By_Illness), we learn that one in 17 people can be living with a serious mental illness, such as major depression, bipolar disorder, or schizophrenia. Roughly one in 10 children lives with a serious emotional or mental disorder. However, it is also the case that nearly half of Americans in their lifetime will experience some sort of mental illness or substance abuse. The NAMI site notes that unfortunately many people struggling with mental illness also experience ongoing substance abuse issues and, in turn, many who abuse alcohol and drugs experience mental illness.

When the then-U.S. Surgeon General David Satcher published in 1999 the first ever surgeon general’s report on mental health, the study highlighted mental illness as a critical health concern, as it was the second leading cause of disability and premature mortality. “One in five Americans experiences a mental disorder over the course of a year. While 15 percent of the adult population uses some form of mental health service each year, nearly half of all Americans with severe mental illness do not seek treatment.” www.naswdc.org/practice/behavioral_health/surgeon_gen.asp

The report further noted that “in the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer (Murray & Lopez, 1996). These data underscore the importance and urgency of treating and preventing mental disorders and of promoting mental health in our society.” http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf

As important and pervasive as mental illness is, within the NACC few of our members have identified themselves over the years as working in a mental health facility. It has rivaled correctional chaplaincy as the ministry employing the fewest of our members. In 2006, we had 43 members who identified themselves with this ministry; today there are 16! In 2006, 30 identified themselves with correctional chaplaincy and today 17. I have no explanation at this time for this decline, and it might take some research to come to valid conclusions about this. Perhaps those in the ministry might help us to understand this trend.

Even if we do not have many members whose ministry is predominantly with people with mental illness, all of us realize, given the holistic nature of our health, that mental health is intimately and inextricably tied to our physical and spiritual well-being. Much research has been pursued in this area as well. The most recent issue of Crossroads: Exploring Research on Religion, Spirituality, and Health (April 2013, Volume 2, Issue 10), the publication of Duke University's Center for Spirituality, Theology & Health, notes the latest systematic review of research on religion, spirituality, and mental health by Raphael M. Bonelli and Harold G. Koenig. It quotes their conclusions based on various levels of criteria: "There is good evidence that religious involvement is correlated with better mental health in the areas of depression,
substance abuse, and suicide; some evidence in stress-related disorders and dementia; insufficient evidence in bipolar disorder and schizophrenia, and no data in many other mental disorders."

www.spiritualityandhealth.duke.edu/resources/pdfs/CSTH%20Newsletter%20Apr%202013.pdf

We are grateful in this issue of Vision for renewing this dialogue on mental health and illness and its relationship to our spiritual and religious health! We did not coordinate our themes with Catholic Health Association’s Health Progress, however, it was a blessed coincidence that their March-April 2013 issue was dedicated to this same topic, “Mental Health: Breaking Down Barriers” www.chausa.org/HP/. It is an excellent issue, and I encourage you to take advantage of the articles’ online accessibility and read them along with these Vision articles.

I don’t think we can do enough to inform ourselves in this field. Thus, I am all the more grateful to the Vision Editorial Advisory Panel for dedicating this May-June 2013 issue to this topic, and to those writers who contributed articles. We appreciate their lead as we need to be better prepared to understand mental health care as part of holistic care, and the role of the chaplain to help achieve better care for patients and families.

David A. Lichter
Assist the mentally ill to live full lives:
Approach all with dignity, personalize accommodations, educate, advocate

By S. Frances Smalkowski, CSFN, RN, PMHCS, BC, BCC

The Monroe convent home of 30 sisters of the Holy Family of Nazareth is less than nine miles from the December Newtown tragedy. Our sisters were and still are intimately involved in prayer and presence as the Spirit directs. The actual day and time of this horrific happening I was out of state with a college friend en route to breakfast. "Prophetically," as we were driving out of her living development, she commented on all the parents who were waiting with their children for the arrival of the school buses. Her words contained a word that was painful for me to hear (since I consider myself a mental health advocate). That I did not address that "word" was a testament to my own "lapses" in the same area of using insensitive and stereotypical speech about those who live with mental illness. She said: "It's a shame that the parents have to wait here until the last minute to put their children on the buses. They never know when any of the 'crazies' will come around."

Later on, I reflected on my seeming inability to address what seemed so simple. My friend and I had known each other for 50 years; we are both professionally educated and engaged in different ministries. Why is it so easy to slip into the street language that we both abhor? This made me ponder how often I, too, add unhealthiness to the pure drinking water our God has given us. Furthermore, how can I, as a chaplain in any setting, contribute to or teach those I am with about mental health?

Close to 15 years ago, I answered the question: "What psychiatric nurses should teach the public about mental health?" in the Journal of Psychosocial Nursing. During my chaplaincy internship 25 years ago, I wondered how differently a chaplain and a psychiatric nurse would approach situations. Needless to say, the parallels are more than obvious. Some suggestions for chaplains follow, and are already part of our basic education, and continuous education.

1. Approach each person with equal dignity regardless of race, color, creed, gender, orientation or illness. (For myself, I find that those prejudices simply "sneak" up on me in unsuspecting ways. Transferences, we know, are like that.)

2. Integrative (holistic), relationship-centered, consumer-driven care should be the norm for each person. Stigmatizing persons because of their mental illness deprives them of the necessary specialized service. (For me, since I have been involved in ministry with the aging, seriously ill and dying, it is easy to forget how dementias and chronic mental illness impact those areas. Also, outside of my long-term setting, I have had the gift of walking with persons in spiritual direction who also live with persistent mental illness in the community. It is very moving to witness God's Hand gently holding the directee's hand.)

3. Individuals coping with persistent mental illness can live full lives with personalized accommodations. Supportive, loving relationships facilitate that possibility. (Experiencing family members' love and support of their loved ones has been a wonderful witness to me. Seeing those living with mental illness make gains, and being there with them for those as well as for their setbacks is a regular reminder of God walking along with us in similar ways each day. Giving praise for holding a job for a short time, maintaining one's self in a room/apartment, or going on a vacation with a family member are monumental gifts for some among us whose challenges are beyond our comprehension at times.)

4. It is very important to take every opportunity to educate one's self about mental health/illness. New treatment methods and medications are the direct results of research and funding that need to be
supported in whatever ways are possible. (This can be clearly seen by how well so many can live independently and serenely in the proper environments with the needed services. What a difference from my experience of psychiatric nursing in my basic nursing education in 1967 at St. Elizabeths federal hospital in Washington, DC!)

5. ADVOCATE! ADVOCATE! ADVOCATE! How? Through one’s own personal relationships — we all have family and friends who struggle with mental illness. Can I find time to be with them or write them? Do I confront stereotyping words and behaviors? Can I give some time to be involved on mental health boards? (I had the privilege of being on the board of the Newtown State Psychiatric Facility – Fairfield Hills for many years before it closed. Besides being a presence there, opportunities for teaching about spiritual care with the residents and with those who were dying were afforded me. This was all very humbling. Also, being present for more than 10 years on the Connecticut Southwest Regional Mental Health Board was an enriching forum to surface concerns in the presence of other mental health advocates). And legislative efforts? Oftentimes, there are opportunities to speak, write, or sign one’s name in support of clearly needed legislation. (Recently, I gave testimony against the bill H.B. No. 6645, “An Act Concerning Compassionate Aid in Dying for Terminally Ill Patients” that would have allowed for self-administered physician prescribed medication.)

6. Remember that mental health can be cultivated throughout one’s life through practices that enhance one’s self esteem. Other self-care habits and counseling as needed point to one’s own recognition of need and maturity at given times. We need to remember that mental illness can be experienced in any family at any time through no fault of one’s own. (Inheritability is becoming clearer and poignantly more scientifically proven). We are regularly invited to walk with the Anawim, who were called “the weakest and the neediest” by Pope Francis I during his parting words to the Easter crowd in Rome. I feel this is our newest call!

*S. Frances Smalkowski, a nurse and psychiatric clinical specialist, is director of pastoral care at Pope John Paul II Care and Rehabilitation Center in Danbury, CT.*
Chaplains can let mentally ill know they don’t walk alone

By Elaine Chan, MSW, MDiv, BCC

On Good Friday I got a referral to see a Roman Catholic patient whose adult son had died recently. The woman was lying in bed and spoke very softly, almost inaudibly. As I listened carefully I learned that she was upset about her son’s death and that the staff would not give her medication to dull her emotional pain. She said she did not really want to talk, just to get her medication. A few days later I saw her again but she repeated her request for medication. The doctor had requested “spiritual care” because he did not see the need for more psychotropic drugs. But unfortunately the woman was adamant about receiving medication and was not receptive to spiritual care.

When I first started doing pastoral care a priest told me that while individuals come to the hospital for a physical illness, many may have underlying personal issues that adversely affect their well-being. Sometimes it may be the death of a close family or friend or some other personal issue. My sense is that the woman whose son had died had other issues besides his death. As chaplain, I am not trained to assess her mental state but rather to be present to her, listening and witnessing her pain and offering spiritual or religious support, as needed.

While I am not a mental health professional, I am familiar with mental illness, having experienced this with two of my siblings. My siblings from time to time have had to be hospitalized. I am happy to say that the pastoral care provided to them has been meaningful. One sibling, who had already been diagnosed with an illness, lived near the World Trade Center and was deeply affected by the events of 9/11. She was admitted to the hospital and felt better after receiving medication and care. In the hospital she also received regular visits and Holy Communion from a priest which gave her much comfort.

Another sibling needed surgery a few months ago due to the damaging effects of some medication which she had been on for years, and from which she has since been removed. She did not fully understand her medical condition and was quite upset. At the time I worked in another part of the city and was concerned about her during the day. The chaplain I asked to visit her assured me that my sister was getting a lot of attention and good care from the staff. This put my mind at ease until I got to see my sister in the evening.

This same sister used to attend services with a foster family she lived with. At these services she learned to pray out loud, asking God for help with various needs. When our father died, she offered a prayer, and my pastor was impressed with how well she spoke.

Spiritual care can be offered to an individual with mental illness. It is difficult to generalize about what spiritual care can be offered. Each individual is different, and each one is a person with feelings, needs, dreams and hopes. People with mental illness need to be encouraged and supported to reach their potential. Similarly, their families and caregivers need support as they deal with the stress, worry and emotional overload of their responsibilities. Individuals with mental illness need chaplains to be present, to listen and assure them that they are safe. Individuals who are psychotic may not be receptive to a chaplain but this may change once they are treated with medication. Schizophrenics may hear voices from God or Satan, telling them to do one thing or another. While chaplains can speak to some of this, the individuals will need more than pastoral care to deal with the voices.

Individuals with mental illness want the same things the rest of us want and are frustrated that their mental illness may prevent them from fulfilling their dreams and hopes. My siblings live in supervised settings and miss not being with family. They crave attention and love from family. Sometimes they call multiple times in the same period just to be reassured that someone is there for them. What my sister says does not always make sense, but it is not so much what she says but that she wants attention.
Thank God there are many resources to help individuals with mental illness as well as their caregivers. In the past I have been a member of The National Alliance on Mental Illness (NAMI) and have taught their Family-to-Family Course for family caregivers of individuals with serious mental illness. This is an excellent 12-week course which is taught by trained volunteers who have experienced mental illness in their own families. It covers a variety of topics including current information about different mental illness diagnoses, e.g. schizophrenia, major depression; up-to-date information about medications and their side effects; current research on brain disorder; how to understand and relate to the person with the mental illness; strategies for dealing with crises and relapses as well as self-care for the caregivers. NAMI is a national organization with offices throughout the United States. Catholic Charities may also offer resources for individuals and their families.

On Good Friday I gave a reflection on the Seven Last Words, noting that we cannot appreciate Easter and the Resurrection if we do not contemplate what happened on Good Friday. Individuals with mental illness as well as their families and caregivers daily walk the road to Calvary. We celebrate moments of grace when we see our loved ones do well and thrive. We also weep with them when they falter. Chaplains can walk alongside them, letting them know that they do not walk alone. As much as possible, we can try to include individuals with mental illness, their families and caregivers in various activities such as spirituality groups, worship services etc. Resurrections are possible as we help individuals reach their full potential and be the people God meant them to be.

*Elaine Chan is staff chaplain at New York Hospital in Queens, New York, and is a member of the NACC's Editorial Advisory Panel.*
Relationship key to integrating spirituality though small group meditation

By Kathleen Hagerty, CSJ, MA

In 1998, when I came to the Solomon Carter Fuller Mental Health Center in Boston, MA, my hope was to minister to the mentally ill and to be able to integrate spiritual care into the life of our three locked units as an interfaith chaplain.

Believing that our clients had the capacity for and an interest in spiritual care, I developed programs that assisted them in discussing their spiritual or religious concerns as well as offered opportunities for quiet time for prayer and reflection. My hope was that they might deepen their relationship with God and one another.

In this article I would like to share a program that I think has been both successful and meaningful to both clients and staff.

Preparation Stage

Initially, the spirituality group focused on a particular religious or spiritual concern and a discussion would follow. Slowly, our clients were able to articulate some of their religious beliefs as well as attitudes toward spirituality or religion. This interest as well as openness to quiet, reflective music developed into one 10-minute period of reflection on each unit once a week during the community meeting.

The focusing time at the beginning of the day provided clients with a motivation for centering their day in a reflective way. Clients were encouraged to reflect on their "best self," Higher Power or God. In this way, no spiritual or religious belief of any client was violated. As this focusing time continued on our units, clients grew to value the quiet music and prayer and often requested it during the community meeting.

Relationship is Key

Relationship was the basis of this undertaking. The clients on our units came to know me and other staff members and built bonds with our personnel over the years. This program was only as effective as its basis in relationship.

Spiritual care is all about relationship with one’s best self, others, God or a Higher Power. For this reason, we attempted to build on human relationships and to engage clients in a religious or spiritual relationship.

Incorporating Spirituality into Treatment Planning

An outgrowth of the focusing group came into being as we prepared for a presentation at the Mayo Clinic in Rochester, MN. We decided to do an inter-shift meditation group from Monday to Friday for one half-hour on each unit. As chaplain, I am at the center only part time, so we enlisted support from our Occupational Therapy department to assist with the meditation group.

These professionals were provided with materials for focusing and were instructed in the procedure to be used during the meditation sessions. On each unit, the clients were encouraged to participate. Each client was given the freedom to attend or not. Many availed themselves of this opportunity for quiet reflection and meditation.

An Experimental Journey
The sessions consisted of a guided meditation that focused on one's breathing and being led by the music to a calm place where participants were one with their “best selves,” Higher Power or God. As these sessions continued, clients became more adept at meditating and in their ability to speak of the calming effect these sessions had on them.

Some only listened to the music, others did visualize being in a calm place of oneness with self, Higher Power or God. Some were able to articulate their prayer during this meditation time. The mental health and skills of each came into play. All found this a relaxing experience and seemed to value it greatly.

In addition to reflective music, we tried to engage the senses of the clients as they meditated by providing some fragrance as well as a waterfall with sounds of water, nature sounds and light. This sensory experience was a touchstone for the clients should they become distracted or lose their focus during the meditation period. It assisted them in returning to the meditation period.

Commitment of Staff and Clients

The involvement of staff in these activities was most supportive. Staff members also were provided with an opportunity to participate in our 10-minute meditation time during community meetings.

The meditation sessions each week seemed to be attended by the same clients. Some clients who refused to attend other groups found these sessions most helpful and non-threatening. It had also been noted that some clients who attended the sessions approached the chaplain with faith questions never before raised with the chaplain.

Understanding Spirituality

Because “spirituality” and meditation are elusive, personal and individual, it was difficult to measure in ways other disciplines measure their effectiveness. We continually asked clients about the ways in which this group influenced their lives and behavior.

By assessing the spiritual growth of the clients, we attempted to provide a more holistic spiritual care program at the center. This in turn will enhance our physical and emotional efforts for our clients.

Fourteen years have passed since the introduction of spirituality to the center and I have come to believe that our clients and staff have grown in their understanding of God, Higher Power and of their “best self.”

Personally as I reflect on my ministry with the mentally ill, I know that the limitations of our clients have drawn them closer to our God. It is my hope that our spiritual care program provides the opportunity for our clients to deepen their relationship with their God, Higher Power or their “best self.”

Daily I marvel at their faith, trust and commitment to God or their Higher Power. As persons who suffer from major mental illnesses, I believe that their limitations provide them with the grace to turn to their God and utilize the spiritual power within themselves.

Kathleen Hagerty is interfaith chaplain at Solomon Carter Fuller Mental Health Center in Boston, MA.
Discovering spirituality in an addiction detox/rehab unit

By James J. Castello, MBA, MA, BCC (Ret.)

In January 2008, I was hired to be a chaplain/director of pastoral care of a small, community hospital in New York State. Being a former corporate marketing executive, I have been trained to look for the largest needs in the environment I serve. In this case, I was quickly led to provide the most spiritual care to the patients and staff of the hospital’s detox/rehab unit. While feeling called to this unit, I was apprehensive about being able to meet patient’s spiritual needs since I had no training on how to relate to and work with mental health patients. This article is about what I learned in this marvelous unit.

Thankfully, the Lord provided consistently strong connections with many of these beautiful, troubled and vulnerable people. After a few months in this unit, I discovered these patients had a lot in common: total unawareness of the spiritual warfare they faced; high percentage of childhood abuse; raised in highly dysfunctional families; definite control issues; perfectionism; extremely low self-esteem; guilt and shame; clinical depression; around half are bipolar; and most have real problems with forgiveness – i.e., trouble in forgiving others, in receiving God’s forgiveness and, most of all, an inability to forgive themselves.

Spiritual Warfare: Very few people in this unit are aware of the battle within themselves between good and evil, God and Satan. They are unaware that their addiction to drugs, alcohol or both may be an attempt to self-medicate their emotional pain or an attempt to “fill the hole in their soul,” a hole that only God can fill. They also may be unaware that Satan, the great deceiver, may keep playing the same old negative tapes in their heads. These tapes need to be erased and removed via prayer for healing and replaced by the grace of the Holy Spirit.

Childhood Abuse: We can never discount the tragedy of childhood abuse, whether it is emotional, physical or sexual. People need to know their pain has been heard, and that the reality of their pain has been validated and listened to with compassion and empathy. However, holding onto the victim role for an inordinate length of time only continues to hurt the victim, not the abuser. At an appropriate point in the grieving process, a person may be ready to pray for the strength and grace to forgive the abuser. This is usually quite hard to do but can lead to substantial healing in the abused.

Dysfunctional Families: The prevalence of these was not surprising since the rate of abuse was so high. We all have dysfunction in our families, but most of these souls were raised in “off the chart” levels of dysfunction. A ritual that helped some patients was to ask them to write out all the things that they were angry, hurt, and resentful about. We would review the list (sometimes four to six pages long) and then pray over them and burn them. A lot of the rage was able to be released in the smoke of the burning paper.

Control: Almost all of us have a strong desire to control situations in our life. I often asked patients this question, “In the play of your life, who is the creator, writer, producer, director, actor, music director, etc.?” Before entering this ministry, I am sure I would have answered “Me” for all of those roles, “After all, it’s my life, my play.” I have since discovered that I am only the actor in the play of my life – and God gives me the stage, the audience and even the script. All I have to do is show up and be open to the Holy Spirit. This is my only role but it is not my play; it is God’s play I am making a brief appearance in. When I realized that I was not responsible for every detail in my life and that I needed to trust God to care for me, it felt like a 500-lb. albatross was lifted from my shoulders. The point is: who is in control?

Perfectionism: Just like many of us, patients in addiction treatment centers are “perfectionists.” I would suggest their definition of “perfect” may be an “international standard without any flaws, anytime, anyplace.” If so, they are bound to be disappointed and frustrated since there is no way they can live up to that standard. A more realistic definition of “perfect” is – “I did the best I could with what I had on that
day.” That is all you can reasonably expect of yourself.

**Self-esteem**: The pervasive issue we need to address in our lives is one of self-identity, “who we are.” The answer is we are God’s beloved children whom he loves unconditionally no matter what we have done or have not done. The tape of our failures and low self-worth playing in our heads must be ejected and destroyed so our esteem can be fully restored.

**Guilt and Shame**: God cannot live in our dark caverns of shame and guilt, for God is pure love, pure light and, as light, cannot dwell in darkness. He calls us out of the darkness of guilt and shame and into the light, so we can live in joy and be a light to others.

**Forgiveness** (others, self and receiving God’s forgiveness): In my limited experience, the most common and the hardest to let go of is forgiveness of self. Most people will admit that God has forgiven them, but they cannot forgive themselves. Well, if God has forgiven us and we don’t forgive ourselves, what does that say about our relationship to God – perhaps we think we are “better or tougher” than God? Not!

**Depression and Bipolar**: I have firsthand experience with both of these in my family. One definition of “depression” I shared was “anger turned inward,” when we are actually angry at ourselves but are unable to process this anger in a healthy manner so we swallow it. Manic depression/bipolar is a chemical imbalance which occurs in some of us and requires a lifelong commitment to faithfully taking medication to keep it under control. As a chaplain, I have learned that these conditions can become a gift, as sharing about them with those you minister to almost always creates an instant bond.

As with all pastoral interventions, a primary goal is to listen to the person with your heart and try to love them as Jesus loves them. If they feel the love, they usually connect with you as being sent to them by God, who cares for them deeply, and that makes a difference.

*Jim Castello worked 35 years in executive marketing positions for two global manufacturers before becoming a chaplain in 1998. He is a member of the NACC Board of Directors as well as a member of the NACC’s Editorial Advisory Panel. Much of his time is devoted to his family, which consists of his wife, Frances, a retired hospice chaplain, their five adult daughters and 16 grandchildren.*
A case study: Using mantras in pastoral care to help patients with Post Traumatic Stress Disorder

By Gerald M. Gundersen, BCC

One of the inspirational leaders in my Clinical Pastoral Education (CPE) training at St. Elizabeths Hospital in Washington, DC, was Anton Boisen, a man suffering from mental illness who over the course of his long life contributed so much to CPE training and the grounding of chaplain candidates in “real world” spirituality. His ability to merge behavioral science with pastoral care is imbedded in CPE training and reflected in the basic elements contributing to his case study method: intergroup relations, verbatims, spiritual need assessments, a practical, “hands on” experience, and shared learning. Pastoral care was not to be isolated from other disciplines but linked in ways that would provide mutual respect and mutual support. His approach to CPE provided an enduring example of best practices.

My experience as a chaplain has been mainly with individuals suffering from mental illness, addictive behaviors and acute depression. The use of mantras as an aid to recovery is an effort to put into practice some of the values expressed by Boisen in promoting the use of faith-based and secular disciplines to support pastoral care. Among PTSD patients are some who barely have strength enough to connect to a “higher power” because of their mental anguish and pain. Others question whether anyone can help them, even God, because of their heightened state of vulnerability, horrific life experiences, and total devaluation of self-worth. Some have attempted suicide. Many experience what might be called a “spiritual dryness” that resembles what St. John of the Cross refers to as the “dark night of the soul.” PTSD patients experience flashbacks, nightmares, recurrent dreams, disturbances from noises and other events, any one of which can trigger fear and depression.

In an earlier paper made available through NACC and ACPE (www.nacc.org/docs/conference/2013/S6 - Best Practice, The Challege to Promote Shared Learning.pdf), I introduced mantras for consideration as an example of a type of strategy that seemed to show promise of helping some PTSD patients address issues of debilitating thoughts. I drew from the practices of monks in the early Orthodox Christian church. They used what has become known through the ages as the Jesus Prayer, a mantra said over and over to promote closeness to God: “Jesus, Son of God, have mercy on me, a sinner.” For PTSD patients, the words were changed to meet individual needs and preferences. Prior to presenting a mantra as an option for a patient, I would make a spiritual assessment based on discussions with the patient to determine whether a patient could benefit from such a strategy. Once a determination was made, I would give the patient a handout, explain its purpose and ask the patient to read and react to its content. The mantra used was: “Oh God, please save me from negative thoughts, I beg of thee, I beg of thee.” The strategy proposed was flexible and could be used at any time. It was not a short-term cure, but presented to patients as a life-long option to help them overcome invasive, debilitating thoughts, and to bring a transcendent power into their lives on a regular basis.

Generally, patients found value in having recourse to a spiritual option that could help them gain control over their afflictions while at the same time nurture a habit of turning to God for support. The same mantra did not appeal to all patients. Some preferred using “bad thoughts” or “harmful thoughts” rather than “negative thoughts.” Some suggested changing the content to fit their particular concerns and needs such as: “Oh God, forgive me my sins and help me to heal.” or, “Dear God, bring your love, peace and goodness into my life.”

One of the unanticipated outcome measures in working with patients who expressed lack of faith and skepticism about God’s presence was their recognition and appreciation for a visible sign of support, a handout with specific instructions to follow. Many patients might express doubt that God could or would help them, but most seemed to respond positively to pastoral care that included, as part of the action,
receiving something tangible. Such a gesture often appeared to open doors for discussions that otherwise might have remained closed. Another common residual effect was the positive response of patients to what they saw as pro-active pastoral care on their behalf, the effort to invite God into their lives in ways which they could understand even though they might not be ready to take advantage of such an opportunity.

From a research perspective, results were tied to a one-on-one, case study methodology and personal, idiosyncratic experience. Time constraints affecting number and duration of visits as well as lack of follow-up of patients greatly limited assessment of results. Although both the ACPE and NACC made the paper available to members for comment through their respective websites, the response rate from both sites was much lower than anticipated. I thought there would be at least 30 responses. Instead, there were fewer than ten. None of the respondents offered critiques of the proposed strategy. But, two readers provided substantive leads and insights in support of mantras as valid strategies for patient recovery and spiritual healing. One respondent cited a publication focused specifically on PTSD and traumatic brain injury (TBI) patients titled “Spiritual Care Handbook on PTSD/TBI” by Rev. Brian Hughes, BCC, and Rev. George Handzo, BCC.

A section of the handbook highlights Spiritual Mantram Repetition and some of the beneficial medical effects associated with the use of a mantra. The core training to develop meditation techniques could last up to six weeks. Some hospital sites were able to follow up on patients to assess longer-range outcomes. The inclusion of Spiritual Mantram Repetition in the handbook for the treatment of PTSD helped to confirm the connection between the use of mantras and spiritual healing.

A second respondent sought to strengthen the evidence-based value of mantra intervention by noting the collaborative works of a neuroscientist, Andrew Newberg, M.D., and a therapist specializing in spirituality, Mark R. Waldman. Their books, titled “How God Changes Your Brain” and “Words Can Change Your Brain,” provide scientific evidence of the benefits gained from active and positive prayer and meditation, including mantra repetition.

Both of the above examples in support of mantras require extensive time and cost commitments on the part of patients to acquire meditation skills necessary to achieve physical and spiritual benefits. The procedure I follow is a band-aid approach in contrast to such comprehensive and intensive strategies. A handout can be offered to any patient regardless of means or time constraints. With a little practice, patients can develop the necessary techniques to diminish the number and effects of intrusive thoughts by bringing God more readily into the healing process.

Since writing about mantras, I have started to make Handout No. 1 available to other patients at the hospital on a selective basis, particularly patients with substance addictions. I have broadened the suggested use of mantras to include any and all negative thoughts or temptations, no matter how minor, in order to help patients develop the habit of using a mantra on a regular basis. Once a mantra response becomes automatic, patients can adjust its use as needed. One of the lessons I have learned in working with mantras over the past three years that Anton Boisen would applaud is that best practices are only “best” for a while, and never remain static. They can always be improved upon as situations change and new information becomes available.

Gerald M. Gundersen is currently chaplain at the Psychiatric Institute of Washington and former resident chaplain at St. Elizabeths Hospital in Washington, DC. He serves on the NACC’s Research Task Force.
Four lines of pastoral inquiry aid chaplains to ‘comprehend the human soul’

By Rev. Craig Rennebohm, PhD

As chaplains, we are daily witnesses to the importance of faith and the power of spiritual practice in healing and recovery. We share our experience largely through narrative, through parable and personal story. We mine verbatim accounts of our conversations with patients for insight. We bring to bear a phenomenological approach, richly describing moments of the soul, drawing on the wide range of human knowledge to help us understand and explain, moving toward ultimate wisdom and theological truth. At our best a constant qualitative reflection guides our pastoral work. The practices of contemplation, meditation and discernment, individual and collective, help us shape the body of knowledge in spiritual care.

Researchers bring the tools of scientific method to explore the role of faith, religious practice and spiritual community in promoting human well being. Studies suggest a correlation between church attendance and health, or between prayer and health outcomes. Brain imaging studies have begun to illuminate areas of brain function involved in such spiritual practices as deep meditation. Researchers have found that a spiritual orientation is of strong importance to individuals in their recovery from the combination of mental illness and chemical dependency.

Research in spirituality and healing is in its relative infancy. There are a handful of academic centers devoted to the study of healing, spirituality and theology. As this field grows, what is our role as chaplains with respect to research being done by our science colleagues? Let me suggest that we have two basic responsibilities.

1. We have a responsibility to help define the terms of the discussion.

What is meant by “spirituality?” I accompanied a mentally ill homeless patient to an initial appointment at a local clinic. Going through the medical history and screening process, a practitioner asked the patient, “What is your spiritual orientation?” The patient asked “What do you mean?” “I guess,” said the practitioner, “it means are you ‘new age’ or something.” ”No,” said the patient. The patient was a baptized and practicing Catholic, but the way the question was asked and the term defined, data about the patient’s spirituality was not entered on her chart at intake. She was charted as having “no” spiritual orientation. Our task is to help give meaning to spirituality, faith, religion, soul, and other key terms, both in the context of our particular traditions, and in multi-faith and secular settings. Seeking clarity of language is important not only in our pastoral care conversations, but crucial to interfaith dialogue and to discussions with our care colleagues in other fields. When data collection or research on spirituality and healing is proposed, religious leaders serving in health care have a role to play in reviewing and shaping the terms of the discussion.

2. We have a responsibility for developing and sharing with one another our own lines of inquiry as spiritual caregivers.

I work on the streets, at various survival services, and in clinical settings with individuals who face serious mental illness, profound trauma and abuse, and chemical dependency issues. As a chaplain, I have developed four lines of pastoral inquiry in exploring spirituality with deeply troubled individuals.

I am interested in how a person experiences the holy, the sacred, the movement of the spirit in his or her life. This is for me, the most fundamental line of pastoral inquiry, creating a baseline of spiritual information. I bring to the moments of our relationship, my own particular understanding of “spirit” as a
creative, informing and loving presence in our lives, and am open to how each person I meet experiences the spiritual in their lives. I use a “holistic model of spirituality” developed by Ed Canda and Leola Furman (Canda and Furman, 1999), which explores spirituality as the center of a person, a dimension of a person’s life, and as the wholeness of a person in relation to all. I track and record the person’s faith narrative, the accounts of each individual’s fresh and immediate experience of the spirit over time. As the spiritual story is told and unfolds, I attend to the beliefs and practices that have helped shaped this person in their faith – the effect and influence of religious history, culture and community. I begin to appreciate and comprehend the soul, this person’s unique and particular spiritual identity.

As a spiritual caregiver, I am interested in how a person’s faith experience and religious background shape the way the individual names, describes and understands their symptoms and disease. This is a second line of pastoral inquiry, providing valuable insight into an individual’s current spirituality. While providers may be clear about the medical condition and the biological roots of an illness, patients may draw on their particular cultural and social framework in discussing and describing their illness experience, using a wide range of spiritual notions, faith terms and religious ideas. Such language may be foreign to the clinician, but it is an important signal to the pastoral caregiver. I listen especially for how the patient explains his or illness from a spiritual perspective. I am alert for confusion or conflict between the medical explanatory model and the patient’s personal spiritual understanding of the illness. As I begin to see how a patient interprets his or her illness and treatment through the eyes of faith, I am better able to support both the patient and care team in a collaborative healing process.

In order to provide maximum support for healing, I am interested in what spiritual practices and religious resources contribute to a patient’s recovery and well-being. This is a third line of pastoral inquiry, gaining us prescriptive spiritual wisdom. In the field of mental health care, we don’t have much in the way of data. Is prayer helpful to a person struggling with depression? A doctor colleague confided that in his depressive episodes, he simply cannot pray. He must rely on the prayers of another. That is important information, the beginning perhaps of some useful research.

I worked with a young man who was admitted to the hospital for two years in a row just after Christmas and just after Easter. He reported stopping his medications for bi-polar illness as the holy seasons progressed and became increasingly caught up in the rituals of Advent and Lent, and finally the glories, Christmas Eve and Easter morning. A pastoral prescription encouraging him to become part of a low-key, mission church community with the simplest of liturgies and a small, personally supportive congregation understanding of his illness vulnerability helped this patient steer a healthier life course.

As a chaplain who will be part of a person’s life for a comparatively short time and most often during a period of crisis, I am interested in how a person’s spiritual experience and orientation contribute to becoming part of a faith community, supportive of long-term stability, meaning and purpose. This final line of inquiry emerges most fully as we complete the caregiving journey together. What may block a patient from returning fully to his or her parish church? What steps are helpful in making connection with the congregation and new spiritual resources? What has changed in the life of the soul in the course of illness? Where does a person freshly in touch with their mortality and vulnerability, and perhaps new limits, now find hope, meaning and purpose?

I recall a refugee from Ethiopia. He was scheduled to be discharged from the hospital’s mental health unit at 11 a.m., after two weeks of successful treatment for a severe and paralyzing depression. At 11, his bag was packed and he sat on the edge of the bed, but refused to leave the hospital or even exit his room. He insisted on seeing a priest. As the unit chaplain, I was called, and visited quietly with the patient. He was a Coptic Christian, and we agreed that I would ask an Orthodox priest colleague to come as soon as possible to attend the man. The priest came, talked briefly with the patient. They stood face to face as the priest chanted a prayer and anointed the man with holy oil. The priest finished. The man picked up his suitcase and left. I asked Father Steven to help me understand.
“It was a prayer of blessing,” he said, “which reassures the patient and the community of God’s healing presence. The prayer signals that whatever of contagion, quarantine, or stigma may have been associated with this person’s disease, such conditions no longer pertain. There is no need for fear or distance. This blessing is a trigger for welcome and return to the community. It is a sign of hope.”

Over the years, following our own lines of pastoral inquiry, we accumulate valuable insights and information in our spiritual care records and notebooks. This raw data, drawn from what Anton Boisen called the “living human document,” provides content for reflection and the development of theory and practice in contemporary spiritual care. Pastoral inquiry also has heuristic value, helping inform the questions posed and the research done by our colleagues. Keeping our own accounts of discovery, we can help shape the questions worth asking and determine what studies might be most meaningful for us and those we serve.

Rev. Craig Rennebohm retired last June as chaplain of the Mental Health Chaplaincy in Seattle, WA, which he founded. Read about his work there at http://www.thefigtree.org/march11/030111rennebohm.html. Since retiring, he has served as the executive director of Pathways to Promise, a national mental health ministry resource based in St. Louis, MO. He is the author of “Souls in the Hands of a Tender God,” (Beacon Press, 2008) which goes into depth on the issues raised in this Vision article.
It’s time for Chaplain Group!

By Prudence Hopkins, MA, BCC

Two afternoons a week I am assigned to provide pastoral care at the freestanding psychiatric hospital that is part of the Mary Washington Healthcare System. The psychiatric facility is divided into units based on acuity and age. I see patients both in group settings and one on one.

Feedback is mostly positive. Overall, the patients like group time with the chaplain, saying it’s surprisingly different than they assumed it might be. There also have been times when the dynamic is not ideal and generating interest and discussion can be difficult at best. Fortunately these times are infrequent.

Structure for this group is extremely important as participants seek stabilization and a sense of inner well-being. This article shares what I have found to be a successful framework for holding group support, simply called “Chaplain Group.” Chaplain Group support meets with the less severely ill adults in the non-acute unit.

I begin with open eyes, open ears, open mind and open heart. I remain curious about what I will learn, and how the dynamic will unfold. When sharing is going on there is no judgment, no praise, no critique, as if focusing with the lens of a camera. We follow rules of respect and confidentiality as is expected in these settings. I am mindful of times when I might be a little closed-off or distracted and find it’s important to check myself and return to a place of openness. Then the dynamic flows better.

We begin with introductions. I introduce myself and make sure that I know the names of everyone before we proceed. This intentional getting-to-know-names witnesses to the importance of who we are and our narrative. Usually, the members of the group know one another. However, this cannot be assumed as there are times when this might be the first group for someone newly admitted. Routine introductions ease the newcomer into the mix.

The next endeavor is for each person to say in one word what they are feeling at that moment. Here we honor each feeling by remaining silent, witnessing with respectful presence. I request that each one remember the feeling words so that at the end of group they can reflect back to see if they notice any changes from within.

Next, I ask if there are any topics of a spiritual nature that could be brought up for discussion. When someone brings something to light I make an assessment. To prevent a monologue, if this is something that would be better talked about one on one, I invite that person to set a time to talk with me individually. There are times when the group decides to take on an item brought forth by a peer, and we run with it. As with any group process, as long as most of the group engages we have success. When someone comes to the group and does not share, that is also acceptable.

When there aren’t any spiritual issues brought forth from within the group, I have a theme or a themed activity to engender discussion. For example, throwing out the word “faith,” I may ask: What does this word mean to you today? When has faith kept you centered? Have you ever felt a loss of faith? What happened? What feelings arise when you hear the word ‘faith’? Frequently the group latches on to the topic and conversation ensues. My role at this time is to ensure that no one person dominates the group or hijacks the group off topic. This continues for about 45 minutes and then, “Unfortunately, we have to conclude,” denoting entry into wrap-up mode.

Wrap-up mode is the last part, and perhaps the most important part of this format. Participants are invited to verbalize a take-away thought or feeling that they now claim by virtue of the fact they showed
up. Often, persons with social anxiety, depression and other mental disorders find that it takes great effort to participate. Now is the time for insight and affirmation as peers validate each other's contributions to the discussion. This way they deepen connections with each other and in some cases "normalize" feelings that may not have been normalized before. Mutual support, understanding, and respect among peers become evident. It is a transformative time to behold. There is a different tenor in the room.

The importance of showing up becomes evident when discovery takes place. There are times when individuals who did not participate but only observed, now, speak to the others for the first time. This demonstrates that even though they are not engaging verbally, they are listening in and internalizing. Being there has made a difference. Simply being.

Some theological insights brought forth, perspectives of the holy, are quite unique. The beauty of chaplain group is that it can create a redemptive time through which the group witnesses a transformation toward a renewed sense of dignity and hope.

"It's time for Chaplain Group! All are welcome."

Prudence Hopkins, MA, BCC, is staff chaplain at Mary Washington Healthcare in Fredericksburg, VA.
Chaplain finds a path to hope with haiku

By Pat Van Den Heuvel, BCC

Chaplain Pat Van Den Heuvel found the book, "Scarred by Struggle, Transformed by Hope," by Sister Joan Chittister, OSB, helpful in mental health ministry. In the haiku poems below, Ms. Van Den Heuvel passes on gems she gleaned from the book.

<table>
<thead>
<tr>
<th>Struggle with Mental Illness</th>
<th>Hope with a Path</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CHANGE happens too fast</td>
<td>CONVERSION means what</td>
</tr>
<tr>
<td>Knocking the wind out of me</td>
<td>Being aware of options</td>
</tr>
<tr>
<td>Not seen or wanted</td>
<td>Chose to be open</td>
</tr>
<tr>
<td>2. ISOLATION hides</td>
<td>INDEPENDENT How</td>
</tr>
<tr>
<td>Understanding escapes me</td>
<td>Reaching out despite feelings</td>
</tr>
<tr>
<td>Alone in the struggle</td>
<td>Bondage no more</td>
</tr>
<tr>
<td>3. DARKNESS overwhelms</td>
<td>FAITH believes in truth</td>
</tr>
<tr>
<td>Wrestling the soul’s spirit</td>
<td>Trusting a Higher Power</td>
</tr>
<tr>
<td>Heart is cracked open</td>
<td>Brightens up the way</td>
</tr>
<tr>
<td>4. FEAR paralyzes</td>
<td>COURAGE is fear-less</td>
</tr>
<tr>
<td>Apprehending the future</td>
<td>Saying &quot;God Give Me Guts&quot; helps</td>
</tr>
<tr>
<td>Stuck in the present</td>
<td>&quot;Liquid&quot; courage does not</td>
</tr>
<tr>
<td>5. POWERLESSNESS steals</td>
<td>SURRENDER with peace</td>
</tr>
<tr>
<td>Hoping no longer is despair</td>
<td>Giving in not up is Huge</td>
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<tr>
<td>PLEASE do not go there</td>
<td>Freedom’s power trip</td>
</tr>
<tr>
<td>6. VINCIBILITY fragile</td>
<td>LIMITATIONS How</td>
</tr>
<tr>
<td>Exposing hurtful baggage</td>
<td>Defining your boundaries</td>
</tr>
<tr>
<td>Cripples inner child</td>
<td>Helps to keep you safe</td>
</tr>
<tr>
<td>7. EXHAUSTION from nerves</td>
<td>ENDURANCE sustains</td>
</tr>
<tr>
<td>Suffering anxiety</td>
<td>Persevering not running</td>
</tr>
<tr>
<td>Sleep is depleted</td>
<td>Relax in the pace</td>
</tr>
<tr>
<td>8. SCARRED and injured</td>
<td>TRANSFORMATIONS here</td>
</tr>
<tr>
<td>Shaming is so damaging</td>
<td>Scarring can produce wisdom</td>
</tr>
<tr>
<td>Illness is rampant</td>
<td>Tough lesson to learn</td>
</tr>
</tbody>
</table>

Note from Pat: When I worked in behavioral health for 10 years as a chaplain, one of the most helpful spirituality groups was what we called the "hope group." Using Sister Joan’s book, I simply would invite
the patients to share their struggles. Then I would number a board 1-8 under the title called “Struggle” and show the downward spiral that we can all relate to. After landing at the bottom with a “Scar,” the option was given to create a “Hope” column. Once again I numbered 1-8 on the “Hope” side, actually comparing the one side with the other. Patients were free to draw their own conclusions about where they were presently and where they would like to go with “hope.” That’s it in a nutshell without all the fun and laughter and drama and sometimes tears, shared by all. The reason that this article is in haiku is because I thought it would be the easiest way to condense Sr. Joan’s book (I was wrong!). In the actual “hope group,” I used just the first words from both columns and proceeded from there.

Pat Van Den Heuvel of Two Harbors, MN, was in the U.S. Air Force for 22 years, before working 10 years as a chaplain at Miller Dwan Medical Center, Essentia, in Duluth, MN. She retired recently. She reports that in 2012 Tim Serban, disaster spiritual care volunteer lead, recruited her to deploy to New Jersey as part of the Disaster Spiritual Care Team of the American Red Cross Team following Hurricane Sandy’s devastation.
Welcome to two members of NACC’s Editorial Advisory Panel: Elaine Chan and Isabelita Boquiren

The two newest members of the NACC’s Editorial Advisory Panel are chaplains Isabelita Boquiren and Elaine Chan.

Since February, Ms. Boquiren has been manager of spiritual care of Carondelet Health Network, which includes two hospitals in Tucson and one in Nogales, AZ. Prior to accepting this post, she was a hospital lead chaplain, a chaplain/patient advocate, and a hospice chaplain.

Ms. Boquiren studied at the University of California Davis Medical Center.

She said that she was drawn to chaplaincy by a "deepening affection to a new way of seeing, listening and experiencing God in others in their joys, celebrations, sufferings, wounds, and in their dying." In addition, she recalled, her mother was a "gentle influence" that inspired her to become a chaplain. "Seeing her be compassion, courage, faith, hope, and love to the family and to others, despite the cross and suffering, provided me the blessing to lean on the 'power at work in us.'"

Ms. Boquiren also has ministered as regional coordinator for the poverty community program of Catholic Charities, as missionary worker for the Pontifical Mission Societies, and as a lay member that “gave voice to the role of the laity in Vatican II’s call for lay participation in Rome,” and as copy desk writer for the Philippines’ Catholic newspaper, which she said "aimed to expose the cry of the poor and the trials of children of the garbage dumps, and the struggles of life in the slums." She also took lessons on how to care for the destitute and the dying with Blessed Mother Teresa in Calcutta, India.

Her away-from-work activities include nature walks, cooking, gardening, playing the Native-American flute, and writing. “I love belonging to the NACC community of gifted chaplain colleagues and especially the privilege of being on the Vision Editorial Advisory Panel, where I experience the interchange of stimulating ideas for articles to write and the honor of being able to contribute to a publication featuring the work of inspired, talented writers.”

She also enjoys being with her "chaplains in progress – my three children, six grandchildren, and a great-grandchild – all sources of delight and inspiration.”

Ms. Chan is the staff chaplain at New York Hospital Queens in New York. She has been in this position for six months. Previously she was the Catholic chaplain at Beth Israel Brooklyn where she served for nine years. She did two units of CPE with Sister Julie Houser at Queens General Hospital and another two at Beth Israel.

Ms. Chan is a first generation Chinese-American, the oldest of seven children. Her parents are originally from Toishan, China. Her parents left there for Hong Kong when the Communists began taking over China. They immigrated to the United States in 1958. In Hong Kong Ms. Chan’s father was baptized a Roman Catholic. Both Ms. Chan and her mother were baptized in the Church of Transfiguration in New York.

Ms. Chan helped out at her parents’ Chinese laundry while attending school at Our Lady of Pompeii in the West Village of New York. During the recession of the 1970s, her family lost their business and went to work in the garment factories of Chinatown. As a teenager, Ms. Chan helped out at the factory as well as at her aunt’s grocery store in Little Italy. All the while, she also helped to raise her siblings as well as to attend Chinese language classes after school or on Sundays.

Ms. Chan did her undergraduate studies at New York University and has a B.A. in journalism. After
attending a year-long Industrial Area Foundation leadership training program on how to put your faith into action, she decided to go for graduate studies in community organization and planning at Hunter College School of Social Work. Upon graduation, Ms. Chan worked at various faith-based organizations on the Lower East Side of Manhattan as well as served as a program officer for a women’s foundation.

In 1994, she attended a summer program at Maryknoll School of Theology. In 1995, she was a member of the Church Women United delegation to the Non-Governmental Organization Women’s Conference in Beijing, China. In 2002, Ms. Chan continued her studies at New York Theological Seminary where she earned a master’s of divinity. It was at NYTS that she discovered a call to chaplaincy.

She’s pleased to be a new member of the NACC Editorial Advisory Panel and hopes to be a frequent contributing writer to Vision.
Research Abstracts: Ministry to the mentally ill

By Austine Duru, MDiv, MA, BCC

In this issue of Vision, in lieu of publishing a research article, we present eight resources in hopes of assisting readers to sample a broad range of research and research related topics by chaplains and non-chaplain collaborators. Each resource is related to our current Vision theme, focusing on “Fanning the Spark Within: Ministry to the Mentally Ill.” A link to an open-access page has been included to access the articles featured here for further detailed reading.


Social media has been variously identified as a powerful means of communication among young people. Most families will agree that the “sacredness” of dinner time and other family gatherings have been routinely violated by teenage children who continuously text or check their Facebook profile during meal time. Little wonder then that the authors of the study chose to track the Facebook profiles of young people in an effort to glean some helpful information regarding mental illness. In their study, Megan Andreas Moreno, et, al., believed that social media play a vital role in the life of young college age people. This work draws on available research that shows young people display higher levels of self-disclosure when chatting on the computer, partly due to the sense of anonymity that it offers.

The authors reviewed 307 Facebook profiles of freshmen, sophomore and junior undergraduates in two large universities in the United States. Their objective was to “examine the validity of references to depression symptoms on public Facebook profiles by comparing these references to self-reported depression symptoms using the Patient Health Questionnaire (PHQ-9) depression screening tool.” The results were quite impressive and revealing. “A trend approaching significance was noted that participants who scored into a depression category by their PHQ-9 score were more likely to display depression symptom references. Displayed references to depression symptoms were associated with self-reported depression symptoms.” The study hints at the value of innovative ways to identify and provide appropriate mental health intervention to at-risk college-age students.


It is common knowledge that soldiers and veterans experience higher risks of post-traumatic stress disorder (PTSD) following their return from war. Among this group, National Guard soldiers have been identified as having high percentages of PTSD cases. Studies have shown that this is in part due to their exposure to combat situations. What is not clear, however, are which factors of the veteran’s experience abroad and/or at home directly or indirectly trigger PTSD. In this study, Lyndon Riviere and his colleagues attempt to fill this gap by studying a sample of National Guard soldiers deployed to Iraq. Their aim was to “examine whether financial hardship, job loss, employer support and the effect of deployment absence on co-workers were associated with depression and post-traumatic stress disorder (PTSD).” The authors did a cross-sectional study of two National Guard brigades comprising 4,034 soldiers, at two time points. This yielded some interesting results, as the authors noted. They said, "We believe that our study’s findings offer empirical evidence that the National Guard specific variables examined here are risk factors for developing post-deployment mental health problems after adjusting for combat exposure and
demographic variables.” This study is significant for those (including chaplains) who provide care for National Guard veterans, as well as for families, co-workers and employers of veterans.


The recent shooting and tragedy in Newtown, CT, has brought the problem of the mental health crisis to the national spotlight. Untreated mental illness is becoming a problem of epidemic proportions, according to Brian Marshal of the National Alliance on Mental Illness (NAMI). Various states have recently closed or significantly reduced the capacity of their mental health institutions, resulting in the transfer of mentally ill patients to correctional facilities, where they clearly do not belong. In most states, like Louisiana, the mental health institutions have been privatized, making it less accessible to those with little means and no insurance. Most healthcare institutions have significantly reduced the number of psychiatric beds or closed their psychiatric units due to lack of proper reimbursement from the government and/or insurance companies. The national and regional conversations on how to deliver and pay for effective healthcare (healthcare reform) have little consideration for mental health reform. In fact, the Mental Health Parity and Substance Abuse Act, passed in 2008, currently remains unenforceable, in large part, because the legislative rules are yet to be written. By 2014, the Affordable Care Act will fully go into effect. It is projected that more mental health patients will have a chance to obtain health insurance; however, some will remain without proper mental healthcare.

This study done by Yuhua Bao and his colleagues direct our attention to the uncomfortable truths regarding mental health issues in our nation, and seeks ways to bring the mentally ill into the mainstream of the U.S. medical care system. It uses a four-quadrant conceptual model of patient populations "defined by their behavioral health conditions and insurance status,” and it looks at the possible benefits and shortcomings of the three core care models being promoted by the Affordable Care Act: the Medical Home, the Health Home and the Accountable Care Organization. The authors evaluate each model within the context of their potentials and limitations, recommendations for accountability and payment policy. This study has enormous implications for behavioral health and those who work with or minister to behavioral health clients and patients.


Anecdotal evidence suggests that the line that separates mental well-being from mental illness is often narrow. This study done with the support of the Mental Health Foundation, a leading UK charitable organization working in mental health and learning disabilities, suggests that this line gets even narrower when individuals become more isolated and lonely. The author uses a number of resources to gather useful data for this study and draws on a number of interesting case studies as exemplars that support his research. The author misses important opportunities to add more clarity to some of the claims being made. His central argument is that loneliness, if unattended, can lead to mental problems and something could, and should be done about this. He writes, “One approach to loneliness is preventative: we can stop loneliness becoming chronic and tackle the needs of groups that are socially excluded and at risk of isolation. But the success of such measures depends on creating a new climate in which we can better manage our need for social connection” (pg.7). The volume of this work, though well written, prevents easy summary. However, this should not be alarming. A link is provided here to a short, concise summary of this work that touches on the important points in the findings (if you prefer to read a toned-down
version). This study has important significance for all healthcare workers. It is also a good resource for discussing self-care and burn-out.


It is clear from what is now a great deal of research data that helping professionals (including chaplains) often suffer the unintended “occupational hazards” of being exposed to highly stressful situations, which can lead to experiencing compassion fatigue, secondary traumatic stress, vicarious trauma and what is commonly known as burnout. These have significant impact on the mental well-being of these professionals. In this study, the authors attempt to examine those factors that could lead to stress disorders as well as identify those factors that contribute to “compassion satisfaction,” described as, “the positive feelings associated with effectively doing helping work.” Specifically, this study focuses on “mindfulness in relation to compassion fatigue or compassion satisfaction ... and the effect of empathy and emotional separation on compassion fatigue, burnout, and compassion satisfaction.” The article draws on numerous sources and data; it is pretty dense. However, the findings reveal important correlation between mindfulness, emotional separation, compassion satisfaction, and burnout. This work has great potential for reshaping training programs for chaplains and other helping professionals. It hints at the urgency of the need for ongoing self-care to promote mental well-being. It is worth reading.


The impact of poor adult mental health on parenting has been shown to be a significant risk factor for child development. The authors of this study seek to “examine the connections among parental mental health, stress, and engagement in child routine activities with children’s emotional regulatory competence.” Using a secondary data analysis with 2,977 children (birth to 3 years), this study focuses on early childhood interventions in high-risk families with low income for whom access to mental health is limited. The authors describe their methods and how they analyzed the results. Their findings further support behavioral parenting processes within attachment theory. Most importantly, this study implies that even when parents are unable to seek professional help with their own mental health issues, “reducing parental stress and encouraging engagement in a shared bedtime routine offer benefits to children’s regulatory competencies.” This work is a good resource for chaplains working with children and mothers. It is a helpful teaching tool for interdisciplinary collaboration, especially under the psycho-social-spiritual model.


In a world where resources are scarce, it is often a challenge to find meaningful ways to channel available resources to target those who will benefit the most from them. In the case of mental health in our society today, policymakers often lack proper knowledge of what is needed and where to channel resources to help an increasing population of mentally ill populations, most of whom are homeless. The authors of this study performed a pilot study to examine the “patterns of recovery from severe mental illness in a model integrated service delivery system using measures from the Milestones of Recovery Scale (MORS).” They argue that with proper intervention, recovery from severe mental health is possible. Recovery from mental
health as used in their work is defined as “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (SAMHSA 2004).

This study focuses on one example in the state of California where a mental health facility, Village Integrated Service Agency, received a grant from the state in 1990 to promote integrated service delivery systems. The agency’s success led to the expansion of Full Service Partnerships (FSP) across the state in the passage of California’s Mental Health Services Act. The result shows that after two years, almost half of their initial extreme-risk clients was labeled “coping/rehabilitation,” “early recovery” or “self-reliant.” The study highlights the significant impact of providing broad ranging mental services to severely mentally ill patients. It also makes clear that public policies on the problem of mental health can benefit from deeper analysis of best practices in the programs that work. In this study, 658 clients were observed.


The importance of having the conversation about advance directives cannot be overstressed, as most chaplains are painfully aware. This is truer in cases where the possibility of the onset of dementia is imminent in older populations. This randomized controlled trial done in four primary care clinics in Boston is, perhaps, the first of its kind. The methodology involved combining verbal narratives and a video support tool to aid in decision making at the end of life. The authors reach three important conclusions: 1. When presented a verbal description and a video of a person suffering from advanced dementia, older people are more likely to opt for comfort care at the end of life. 2. A video tool increases knowledge of advanced dementia, and end-of-life care choices are sustained over time. 3. There is a positive correlation between health literacy and end-of-life preferences among older patients.

*Austine Duru is staff chaplain at Franciscan St. Margaret Health in Dyer, IN. Chaplain Duru, a member of the NACC’s Editorial Advisory Panel, is also on the NACC’s Task Force on Research.*

*Involved in research on a topic related to chaplaincy? Looking for a venue to publish? *Vision* would be interested in learning about your research effort. Contact Austine Duru at gusduru@yahoo.com or Laurie Hansen Cardona at Lcardona@nacc.org.*
Q&A with Donna Markham, OP, PhD

By Sandra Lucas, MDiv, BCC

Donna Markham, OP, PhD, vice president of behavioral health services for Ohio- and Kentucky-based Catholic Health Partners (CHP), is convinced that over the past 20 years, the quality of effective treatment for the severely and persistently mentally ill has been steadily declining.

"Many healthcare facilities have closed acute care behavioral health units or cut back staffing to the extent that care is largely custodial," she told Vision. "Private, state and federal funding for mental illness has been drastically reduced. This has resulted in behavioral health being a loss leader in the healthcare industry and, as a consequence, caused many hospitals to discontinue serving this population. Many persons suffering from mental illness have thus been left to fend for themselves, often homeless and in critical need for care."

Sister Markham, an Adrian Dominican sister and board certified clinical psychologist, is leading the transformation of behavioral health services across the continuum of care in the seven regions of the system. In November 2012, she held a training program for CHP chaplains, "Leading Spirituality Groups with Those Who are Emotionally Fragile."

Prior to coming to CHP, Donna was president of the Southdown Institute in Ontario, Canada, and prioress general of her religious congregation. She is an internationally known author and speaker in areas related to transformational change, leadership formation and group psychotherapeutic treatment of the mentally ill. She answered the following questions for Vision readers.

Q Catholic Health Partners has begun a comprehensive program for the care of behavioral health patients. What is the vision and mission of this program? How will the process unfold?

A The president and CEO of CHP, Michael D. Connelly, with the support of the Board of Directors, made a bold commitment to address the needs of this underserved population. I was invited to join CHP with the mandate to effect the transformation of the delivery of behavioral health services to serve the health of the population encompassed by the regions of CHP. This includes initiating evidence-based treatment procedures in acute care, partial hospitalization and intensive outpatient services. It also involved embedding behavioral health clinicians in primary care physician practices.

Rather than treating mentally ill persons as pariahs who are kept out of sight and out of proximity to our healthcare facilities, CHP committed to a comprehensive plan that involves capital improvements, staff training and development, the initiation of treatment outcome measures and the expansion of services designed to assist patients in their process of healing. It is expected that this process of transformation will take at least three years to fully implement. This year’s focus is on the acute care treatment program and involves staffing realignment and training in best practices.

Q You advocate conducting spirituality groups rather than individual pastoral interventions. Can you share why this is a preferred pastoral practice? What are some of the guidelines for conducting a spiritual care group?

A Comprehensive research in psychotherapy has shown that groups are as effective as individual therapy when those groups are led by trained therapists. In the acute care setting, patients struggle with isolation and fear. Oftentimes they are responding to internal stimuli in the form of delusions or hallucinations. Structured, small group processes have been shown to be far more effective in breaking through isolation and instilling hope in persons struggling with mental illness.
Chaplains are of greatest assistance to this population when they are able to steer away from diagnoses and counseling and rather assist patients in focusing on their relationship with God and family in a supportive, interactive group setting.

Q What are some of the core principles of pastoral care when working with emotionally fragile persons?

A

- Do not focus on pathology, but rather on the strengths of individuals in their capacity to relate with God.
- Redirect and reframe interactions that are confused or disorganized.
- Do not sermonize! Listen and facilitate!
- Assist patients in engaging with one another in the small group rather than focusing on the chaplain.
- Always remember that the instillation of hope and the breaking through of isolation are key to the healing process.

Q What do you see as some of the challenges, or training needed for chaplains, when working with behavioral health patients? What isn’t needed or helpful?

A Chaplains are not needed to be therapists in the acute care setting but rather are important conduits of the care and compassion of God. Training in small group best practices is really essential for chaplains who are working in acute behavioral health units. Individual counseling can place the chaplain in an uncomfortable situation should delusional material surface. My bias is that chaplains should work with patients in groups as a general practice and, of course, be available should an individual patient request a visit or a time to pray personally with the chaplain.

Q Any additional thoughts you’d like to share?

A Thanks for the opportunity to share a few thoughts with you. I realize it is far beyond the scope of this interchange to address the detailed processes involved in the preparation of chaplains to serve in behavioral health acute care facilities, but hopefully this will spur more conversation and underscore the need for specialized training.

Sandra Lucas is regional director of spiritual care for Humility of Mary Health Partners in Youngstown, OH, and a member of the NACC’s Editorial Advisory Panel.
Encouraging God helps us navigate starts, stops of new beginnings

By Elaine Chan, MSW, MDiv, BCC

Last September I started a new job as chaplain at New York Hospital Queens. This year I prepared for my first Ash Wednesday, making arrangements to distribute ashes to about 200 patients and another 300 or more staff, volunteers and visitors on the various hospital units as well as in the first floor chapel throughout the day. Patients would also be receiving Communion upon request. Additionally I planned a prayer service in the chapel. I had about three or four Extraordinary Ministers of Holy Communion to help me, but knew I needed more.

The Holy Spirit prompted me to put up a notice in the volunteer office, asking for help. To my pleasant surprise, nine volunteers who work in other parts of the hospital, several of whom are also Extraordinary Ministers of Holy Communion, offered their services. I had planned an orientation for all volunteers, but individuals weren't available on the same day so I hoped to train them that morning. However, when I walked in on Ash Wednesday, folks were already lined up for ashes! Thank God the new volunteers were already present and ready to help. I explained to a eucharistic minister that she was to put ashes on the forehead while saying, "Turn away from sin and be faithful to the Gospel."

A little while later I noticed that the volunteer was putting three dots on everyone's forehead and not the cross. I quickly corrected her, but several folks had already gotten the dots including an administrator and the head of volunteers. The head of volunteers told me she realized this and had another eucharistic minister make the sign of the cross. God has a great sense of humor, but I was a bit embarrassed!

The rest of Ash Wednesday went well. We had a great turnout for our Ash Wednesday service, overflowing our little chapel. A few Spanish-speaking family members of patients came to the service, and I had a volunteer read the Scripture in Spanish. We also had a great response on the hospital units as well as in various departments of the hospital. We were still distributing ashes after 5 p.m., by which time I was exhausted!

All the Catholic volunteers, including those who had not previously volunteered for pastoral care, told me that they felt a great deal of satisfaction since patients, visitors and staff were most appreciative. Two of the women eucharistic ministers are in their 80s and told me that they had never distributed ashes before. They felt empowered by having this opportunity. In fact all of the Catholic volunteers told me that they had never distributed ashes before. It meant a lot for them to be able to do this and to be a part of this important religious day.

Another notable event in my first few months at the hospital was a pastoral visit with a Catholic Vietnam War veteran. The fellow had trouble speaking and kept apologizing for this but I felt he spoke eloquently both in word and action. He is still dealing with the trauma of his wartime experience. He showed me a scrapbook that he had made with a map of Vietnam, pictures of his fellow soldiers and him as well as pictures of terrified civilians affected by the war. Several of his comrades did not make it. The images were moving and powerful. The first page of the book read, "Thy Kingdom Come, Thy Will be Done." This simple phrase summed up his theology of what had happened to him during the war, his acceptance of it and his continued faith and trust in God.

I felt overwhelmed by what he was sharing with me and prayed to God for help about what I may need to say or do. I realized that I did not have to say or do anything, just listen and appreciate the gift that he was sharing with me. It was a privilege to see his notebook and witness his faith. The encounter also gave me a good idea for doing a scrapbook in a spirituality group for those with neurological damage or other traumatic injuries.
New beginnings are not easy. I have had my share of starts and stops. Through it all I know God has been present. God is aware of all that is happening. God reminded me of this one day when I complained to a eucharistic minister that I was running out of rosaries to give to patients. Later that day I met the daughter of two patients in the hospital who has a rosary-making group. She subsequently sent me 500 rosaries. I had never seen so many rosaries in my life. A religious sister friend of mine said I was in rosary heaven!

Chaplains have a special role to listen to those who are suffering and/or dying and witness God’s compassion and love to them. God encourages us and tells us what a good job we are doing. We may not feel that we are doing enough or doing it well. However, this is not the point, as God continues to tell me. Mother Teresa said, “We can do no great things -- only small things with great love.” ~May God bless you, yours and your ministry!

Elaine Chan is staff chaplain at New York Hospital in Queens, New York, and is a member of the NACC’s Editorial Advisory Panel.
Featured Volunteer: Timothy John Doody

*Chaplaincy is a profession ‘where creative solutions apply’*

**Name:** Timothy John Doody

**Work:** Chaplain II, Presence Life Connections, Casa San Carlo (Northlake, IL) and Bethlehem Woods (La Grange Park, IL) Retirement Communities

**NACC member since:** 2004

**Volunteer service to NACC:** I volunteered to be a state liaison at the first national conference I attended. Presently, Deedee Van Dyke and I serve as Illinois state liaisons. Two years ago, I discovered the joys of being a certification interviewer. I look forward to the spring and fall interviews.

**Book on your nightstand:** “The Art of Travel,” by Alain De Botton, suggests how imagination contributes to the qualities and perceptions of traveling.

**Resource you recommend most often:** The Irish Jesuit web site Sacred Space [www.sacredspace.ei] is a resource for guided daily prayer.

**Favorite spiritual resource:** Give Us This Day, Liturgical Press, a monthly publication that offers comprehensive liturgical resource for prayer and celebration.

**Favorite fun self-care activity:** I rowed 11.6 million meters on my Concept2 indoor rowing machine.

**Favorite movie:** "The Wild Bunch" for the theme of the authentic life that is other-centered and where self-sacrifice outweights self-centeredness.

**Favorite retreat spot:** University of St. Mary of the Lake-Mundelein Seminary for its tranquil beauty, expansive lake, practical accommodations, and library.

**Personal mentors or role models:** John “Jack” Hacker, CSsR, BCC, former chaplain priest at St Mary’s Hospital, St. Louis, who was my next door neighbor at Saint John Neumann House, and encouraged me to pursue hospital ministry.

**Famous/historic mentor or role model:** Dag Hammarskjöld was a person spoken of at the family table. When he was killed, it was as if a close family member died.

**Why did you become a chaplain?** For three reasons: Chaplaincy is an activity where creative solutions apply. I rely on the humble tools God gave to me. Finally, it is a professional ministry that I can follow my whole life.

**What do you get from the NACC?** I get three things from the NACC: the support of a national organization, inspiration from diversity of the activities of the members, and the continuing resource of the national office team.

**Why do you stay in the NACC?** I believe that the NACC promotes lay chaplaincy as a skilled mission call. The NACC provides the tools to empower its members to legitimate their partnership role in the healthcare profession. The NACC is reliant on member support to further the future of professional Catholic chaplaincy.
Why do you volunteer? As a volunteer, I am able to give back and to support the organization; to witness the beneficial power of membership; and to receive tremendous satisfaction from volunteering.

What volunteer activity has been most rewarding? Certification interviewer is the most rewarding activity. I appreciate the schedule of reading, reflecting and consulting with the other interview team members. The team spirit is evident throughout the interview processes. The constructive input of writing the final evaluations is exhilarating.

What have you learned from volunteering? What have you learned from volunteering? Serving as a certification interviewer helps to mentor others who are interested in the ministry of chaplaincy. It provides an opportunity to review the various professional skills. It is a time of witnessing the vast resources present in each member of the interview team.
Featured Volunteer: Kathy Ponce

Call to chaplaincy followed work as physical therapist

Name: Kathy Ponce

Work: Chaplain at Presence Our Lady of the Resurrection in Chicago, IL

NACC member since: 1991


Bok on your nightstand: “The God Factor: Inside the Spiritual Lives of Public People,” by Cathleen Falsani, and “Madame Pele: True Encounters with Hawaii’s Fire Goddess” – a gift from one of my sons, prompted by my having been accident-prone on long past and recent trips to the islands.

Book you recommend most often: Anne Lamott’s non-fiction books. I love her snarky observations and irreverent wisdom. “Not forgiving is like drinking rat poison and then waiting around for the rat to die.” “I didn't need to understand the doctrine of the hypostatic union; I just needed to turn my life over to whoever came up with redwood trees.” “People need us, to mirror for them and for each other without distortion – not to look around and say 'look at yourselves, you idiots,' but to say 'This is who we are.'” “You can safely assume that you’ve created God in your own image when it turns out that God hates all the same people you do.”

I don’t recommend books for patients. They have enough on their plates without reading assignments from me. I do like many of the pamphlets in the “Care Notes” series, and the resources available for patients and families from many of the national and local associations that advocate for persons with specific illnesses or disabilities (a carryover from my P.T. years)


Favorite fun self-care activity: Frequent short vacations with my friends, especially the friends who seek out quirky destinations.

Favorite movie: So many films, so many genres, so little time – hard to choose! I like Woody Allen movies, and I’m particularly drawn to his documentary parody, “Zelig” – lots of less than decorous relevance to the chaplain formation process.

Favorite retreat spot: A cabin with a table that is filled to the edges with bread made with bacon fat, turkey hotdish, and jello, and the boat that is moored outside that cabin at a fishing camp in Northome, MN, where I’ve spent a week with my sons, my late husband/their late father, and several close friends for a week each summer for the past 33 years. (We scattered a few of Jim’s ashes near his favorite fishing hot spot about six years ago.)

Personal mentor or role models: Florence Mahoney, a retired chaplain who has been an advocate for families who are dealing with mental illness in the Milwaukee community, and who has been a personal inspiration to me in her concern for all those who are marginalized or disenfranchised.

Why did you become a chaplain? I had worked as a physical therapist for 20 years when I became aware that some of my most effective moments with my inpatients were those informal times after they had finished with their exercises and I found myself staying with them as they explored the spiritual and
emotional responses to their illnesses. I took a short leave of absence from my profession to experience a unit of CPE, and then I enrolled in seminary to follow a call to hospital chaplaincy.

**What do you get from the NACC?** The NACC is our representative in the larger Catholic healthcare community, and it provides a chance to network with chaplains on a formal and on an informal basis, to continue to share ideas in clinical practice, and to give and get support in a ministry that very often can be very challenging.

**Why do you stay in the NACC?** The NACC remains and continues to grow as a haven where Catholic still means “here comes everybody.”

**Why do you volunteer?** I have lots of reasons to be grateful for the path that’s led me to the present, and I think it’s important to pay it forward.

**What volunteer activity has been most rewarding?** In NACC, certification interview team work, standing in respectful wonder of the amazing resilience, at the enduring faith, trust, and hope in God, and at the ongoing personal growth that are a part of the life tapestries of so many of our applicants for board certification. Within my parish setting, my most rewarding volunteer activity is serving as a spiritual director for the past six years for a group that helps women to recognize that they are loved unconditionally by God.

**What have you learned from volunteering?** There are many chances to use and to continue to develop skills that might remain undiscovered if not for volunteer opportunities. Much of the world’s most important work would remain undone if it weren’t for volunteers. I’ve also realized that, contrary to the de-motivation poster, “None of Us is as Dumb as All of Us,” the wisdom of the group is usually greater than the sum of its parts. And very importantly, I’ve learned that the staff members at the NACC’s office in Milwaukee are delightful.
Chaplains who encounter those on church margins would find book valuable

By John Gillman, PhD


Just one day before Pope Benedict XVI made his momentous announcement about resigning from the chair of Peter, I received a copy of Joan Reisinger’s book, the title of which surely echoes the sentiments of many in their hope that the new pope will be open to listening to the diversity of voices in the church, especially those on the margin. The result of her doctoral dissertation from the University of St. Thomas in Miami, FL, this study invites us to listen attentively to the lived experience of 50 people from the Catholic community who reflect on the challenges to live out their faith in an environment that too often does not foster open dialogue. Most of those interviewed still identify as Catholic, many belong to intentional faith communities, and all long to have their voices heard.

The dialogue partners interviewed by the author represent a cross-section of the faithful, lay, religious and ordained, from nine states across the country. Ms. Reisinger, a member of an intentional eucharistic community, engaged each person interviewed in one-hour conversations following a dialogue protocol (Appendix B). What they share in common is living on the margins. Not unlike Jesus, the Marginal Jew (the title of John Meier’s multivolume magisterial work on Jesus), these individuals live in the creative in-between space, often straddling both the center and the margin.

In the first chapter, Ms. Reisinger sketches the contours of the phenomenological approach to her research, and then develops a theology of marginality, drawing on the work of Korean-American theologian Jung Young Lee (Ch. 2). In subsequent chapters she lays out a Trinitarian theology and ecclesiology that is relational and dialogical, discusses models of the church from the perspective of marginality, and articulates a practical theology that privileges the voice of the other.

Regardless of our clinical setting or ministerial context, I suspect that many us spend much of our time listening to and journeying with those who live on the margins of the current culture of the institutional church, yet still within the center of the church understood as the People of God. As we read these pages, a plethora of our one-to-one pastoral care experiences will undoubtedly come to mind.

I believe that members of spiritual care departments and pastoral teams in parishes and other settings will benefit greatly from discussing this book. For those who want to read more widely in the areas of practical theology, there is an extensive 20-page biography. My only wish is that the author would have included more about her own personal context and narrative out of which she undertook this project.

John Gillman is an NACC and ACPE supervisor at The VITAS Urban CPE Program of Southern California in San Diego.
Gifted journalist reveals inner thoughts at husband’s diagnosis, hospital treatment, end of life

By Marilyn Williams, MSHHA, MTS, BCC


Amanda Bennett’s memoir spans the meeting of her husband, Terrence Foley – “Mr. Bow Tie” in Peking, China, when she was a Wall Street correspondent, to his death from cancer at the University of Pennsylvania in December 2007. As chaplains we have the privilege of seeing and hearing snippets of similar stories, but Bennett’s book is unique in letting us know an entire story through the eyes and words of a gifted journalist. Bennett says her story is about marriage and love, about a man and his life, and “about family and everything we did to try to save the husband and father at the core of it” (p.9).

Telling of the evolving of their improbable love, Bennett remarks, “we fight constantly, we fight from the moment we meet...” and “we spend hundreds of dollars on calls. We talk. We fight. We make up” (pp. 24 and 32). In telling of the early days of their love, one can also see and taste the China of the 1980s as well as their fascination with it. In speaking of Terrence Bryan Foley’s death at 67, Bennett reminds us that he was a father of two teenagers, a Chinese historian who earned his doctorate in his 60s, and a man who played more than 15 musical instruments, and spoke six languages.

However, “The Cost of Hope” is also about the diagnosis of kidney cancer at the end of 2000, 76 scans, procedures and hospitalizations, drug trials, and three end-of-life warnings within seven years, as well as the thinking reflective of let’s see if the new drug will buy more time and “keep him alive if you can.” Somewhat unique due to the mobility of Bennett’s journalistic career, this story also included four insurers and countless numbers of doctors and facilities from the time of diagnosis in Oregon to Terrence’s death in Pennsylvania in 2007. Moreover, their story is also about life despite cancer – about work, family, and friends.

In reading this story of diagnosis, treatment, and quest for life, I found myself asking: where are the chaplains? What pastoral or spiritual care did Bennett and her husband receive throughout the years? Finally in the book’s last pages there are two references to chaplains – neither unfortunately would make a hospital chaplain proud. The first reference is one name from pastoral care in a list of the 27 providers of care from the medical records of Terrence’s last hospitalization – a time, Bennett stated, that she couldn’t keep track of everyone who entered their hospital room. Then there is the following statement from Bennett saying after I signed the papers for hospice care: “A chaplain stops by to pray with us. She and I chat. She confesses that she does not like her work much. It leaves her exhausted and hopeless.” One can only surmise and hope that this woman was not a board certified chaplain!

In addition, although a story of the quest for life, Bennett’s book is also about looking back for answers to a number of questions. Why did I do what I did? Did I do the right thing? Why did the doctors do what they did? Why did Terrence do what he did? What were the medical costs or what Bennett calls the cost of hope? It is also a story of what she and Terrence did not know about the disease itself, as well as the costs. For example, Bennett writes early in the book about their blind trust regarding the first surgery, saying they knew little about the surgery or its cost and had done more research regarding their real estate purchase.

Bennett’s search for these answers led to meetings with the physicians around the country who provided her husband’s care as well as review of his medical records and bills of $618,616 of which almost two-thirds were for the final 24 months. She concludes that the system was designed for everyone but for
Terrence and her, and that their quest cost more than it should have. She also wonders if they would have made wiser, less expensive choices if they could have more clearly anticipated the costs.

Nonetheless, she writes: "Did I do the right thing? I’m not sure I found the answer, or that I ever will. What I found instead was the cost of our hope. Was that hope good for us? Without question. For us the fight for life, with all its frustration, confusion, and failure, changed what should have been the seven most dismal years of our lives into the seven most wonderful" (pp. 197-8). Also, in speaking of the last clinical trial, which gave them 17 more months (versus 14 months for the average patient), she reflects that it gave them an afternoon of looking at the Mediterranean with their daughter, the day of moving their son into the college dorm, their 20th wedding anniversary carriage ride through Philadelphia’s cobbled streets, and a final Thanksgiving with family.

Yet she also writes, "Surely we must come up with a better way of helping ease families to gentler and less costly transitions" after saying of herself and Terrence, "we knew neither of us would want to push on past the inevitable," noting that both had living wills but “neither of us could clearly see the inevitable until it was absolutely unavoidable” (pp.199-200). The unavoidable for them was Terrence’s return to the hospital with a stroke on Dec. 7, 2007 – hospitalization in intensive care and ultimate transfer to hospice. Bennett writes of this time: “Later, looking back, I will realize once again that the way I feel at this moment is one of the keys to the end-of-life debate: I still honestly don’t believe that it’s the final battle. Despite the overwhelming evidence, I believe only that we are facing long odds. Not hopeless odds” (p.188).

Not long before this, Bennett notes they were hoping for more time with one more drug. In reviewing the medical records of this hospitalization a month before Terrence’s death, she writes that she felt there was a silent battle being waged over the question of "Is Terrence dying or not" with her and the oncologist on one side and the other physicians and nurses on the other side. Bennett and the oncologist acknowledge that Terrence is dying on Dec. 10, 2007, after scans showed cancer in Terrence’s brain and a “cascade of hundreds of tiny strokes.” The discussion shifted to hospice, but even then Bennett said she still emotionally hadn't grasped that Terrence would die in six months or less – he actually died Friday morning of that week.

In conclusion, I would say that every chaplain should read “The Cost of Hope” and reflect on what effective spiritual care could have offered Amanda Bennett and Terrence Foley as well as countless others as they journey with cancer or any other life-threatening or life-altering illness.

_Marilyn Williams is director of pastoral care at St. Mary’s Health in Evansville, IN._

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