



**CONTENTS**

**Chaplaincy Amid Disaster**

Fifteen years of helping Red Cross respond with compassion to disasters  
*by Tim Serban*..... 3

Deployments after Missouri and Oklahoma tornadoes reveal despair and resilience  
*by Logan Rutherford, MDiv, BCC*..... 5

Responding to tornadoes in Missouri and Oklahoma brings renewed sense of grace and love  
*by Joseph G. Bozzelli, DMin, BCC*..... 7

Watching Red Cross respond to disaster offers inspiration  
*by Marjorie Ackerman*..... 9

Chaplain at Newtown and Boston knew she wasn't alone  
*by Marilyn Bucheri*..... 11

Disaster chaplaincy in the research literature  
*by Austine Duru, MDiv, MA, BCC*..... 13

For chaplains at disaster scenes, self-care is vital  
*by Logan Rutherford, MDiv, BCC*..... 15

**News and Views**

New-old editor returns to *Vision*..... 1

CPR, dignity, and choices at the end of life - *Joe Cull*..... 16

**2014 National Conference**

Spirit of St. Louis: Reflections of a Conference Task Force Member - *Peg McGonigal*..... 18

We announce a new 2014 Conference speaker, Tracy Balboni..... 19

Conference speaker Balboni has published significant research on spirituality, illness - *Austine Duru*..... 20

**Regular Features**

Executive Director's column: Critical need for research unabated; thankfully new efforts abound..... 2

Research Update: Disaster chaplaincy in the research literature - *Austine Duru, MDiv, MA, BCC*..... 13

Seeking, Finding: Ministering to same-sex couples in healthcare settings - *Elaine Chan, BCC, MDiv, MSW*..... 22

Featured Volunteer: Kay Gorka..... 24

Featured Volunteer: Matthew Kammer..... 24

Book review: *Principles of Neurotheology*..... 25

Book review: *Dementia. Living in the Memories of God*..... 26

## New-old editor returns to *Vision*

By David Lewellen  
*Vision* Editor

To all old and new NACC friends, welcome to our new issue of *Vision*, the first one I have edited in my return engagement. It is good to be back with you.

Since I left the association six years ago, I have been hired, downsized, and rehired at the Milwaukee Journal Sentinel, had two kids, seen them grow old enough to enroll in school, and done a lot of writing about paint, roofing, and ductwork. I am excited that once again with *Vision* I will have a chance to work with writers about spirituality, meaning, and connection.

This issue also includes many first-person stories about how chaplains respond to disaster, and I encourage you to take some time to read their accounts. Even if you don't see yourself rushing to the scene of the next tornado, the stories of our chaplains who do feel that call make absorbing reading. They have witnessed great suffering and great strength, endured minor hardships of their own, and found some lighter moments in the gloom.

The theme of our next issue, scheduled to post in May, is the value of chaplaincy, to both institutions and patients. We are still accepting submissions; if you have an idea, please write to me at [dlewellen@nacc.org](mailto:dlewellen@nacc.org). And if there is anything else on your mind that you wish to share with the membership, please let me know as well. I look forward to working with you to create the best piece of writing that we can.

---

## From the Executive Director: Gratitude for our NACC members, and all chaplains, involved in Disaster Spiritual Care

By David Lichter

Each of us in some small way, if not a dramatic and tragic way, has experienced some sort of disaster. When we reflect back on it, we recall how disorienting it was and how it infected every part of our life – emotional, spiritual, physical, financial, etc. How filled with anxiety and terror we were; how preoccupying it was! Perhaps it resulted in the dislocation of home and disconnection of relationship.

Spirituality is defined in the *Clinical Practice Guidelines for Quality Palliative Care, Third Edition* ([www.hpna.org/multimedia/NCP\\_Clinical\\_Practice\\_Guidelines\\_3rd\\_Edition.pdf](http://www.hpna.org/multimedia/NCP_Clinical_Practice_Guidelines_3rd_Edition.pdf)), as “the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to the self, to others, to nature, and/or to the significant or sacred.” So when we consider the experience of disaster, it cannot but be inextricably tied to one’s spirituality as one’s whole framework of meaning and purpose, and connectedness, is threatened and disordered.

From this perspective, we are all the more grateful to our NACC members who have committed themselves to not only being trained and available for disaster spiritual care, but also surrender abruptly their normalcy to throw themselves into the lives of those who have experienced disaster. While they willingly give themselves to this ministry, they still encounter the fallout of the experience as people sort through the debris and loss, try to make meaning, and seek connection to the self, other, what nature has done, and how God is involved. Thank you, our brothers and sisters, for this ministry!

### The Business Side of Chaplaincy

I recently met a businessman at a local fundraiser. He is head of a firm that provides diverse services to healthcare systems, particularly working on data support systems within the Accountable Care Organizations. When I explained what I did, he showed his interest and belief in the value of spiritual care. I mentioned that some research evidences the impact of spiritual care (or the lack of addressing spiritual/religious distress) on health outcomes, length of stay, treatment choices. He quickly commented, “I am not aware of such research.” He asked if I would send him some articles, which I did. Within days I heard from his secretary, and we scheduled a meeting.

When we spoke further, he commented that we need to identify the data sets to track. Right now, we do not have them. We both agreed that if the data of chaplains’ work does not somehow tie to improved patient well-being, fewer readmissions, less expensive and risky treatments, and more reliance on community resources, it will be a tough ride ahead to keep chaplaincy. He was a supporter, but from a business perspective, needs to have the data to advocate for it. Sound familiar?

If you did not recently read an article in the APC E-News, February 2014, Volume 16, No.1, by James Backing, M.Div., I encourage you to do so (see <http://archive.constantcontact.com/fs196/1101810986071/archive/1116389728270.html>). As a businessman, he too provides an outside look at chaplaincy. He is the director of clinical integration at Thyssen-Meinhoff Group in Troy, MI, and has been an affiliate member of APC. He observes the challenges to making a case for chaplaincy, but believes chaplains can do so. He notes that research into the profession is only a limited part of the value equation. He states that chaplains must be able to make their case as, “We know exactly who we are, exactly what we do and have the data that demonstrates why we do it.” He makes the plea that “the least expected position for chaplains to take is that they can leverage the emotional intimacy and spiritual connection they have with clients to ensure an improved sense of well-being, a reduction in litigation and a reliance on community resources rather than hospital visits.”

So, these two businessmen are on the same page and provide the challenge we hear every day directly or indirectly. As hours are reduced and positions eliminated, we need to press forward on all fronts to build the case. In that light, we are also grateful to HealthCare Chaplaincy Network’s efforts to drive recent research efforts with funding through the John Templeton Foundation ([www.templeton.org](http://www.templeton.org)) and presenting results of the six research projects at the Caring for the Human Spirit: Driving the Research Agenda for Spiritual Care in Health Care Conference, March 31-April 3, 2014 in New York ([www.healthcarechaplaincy.org/caring-for-the-human-spirit-conference.html](http://www.healthcarechaplaincy.org/caring-for-the-human-spirit-conference.html)). While the program is long, the conference fee is very reasonable. They are also offering a virtual conference/webcast option. This will be a very worthwhile, even historic event.

## Fifteen years of helping Red Cross respond with compassion to disasters

by Tim Serban

I first encountered American Red Cross and Disaster Spiritual Care at the very first NACC training in 1999. I went forward blindly, hoping that I would learn everything I needed to learn before deploying to an air disaster. Deploying was not even a word in chaplaincy vocabulary. This was my introduction to the para-military nature of the Red Cross, with its million acronyms and references to forms, processes and DROs, or Disaster Relief Operations.

My colleagues and I were anxious and excited to learn and help create something new. The initiative had begun after a personal request from the families of those who died in several airplane crashes in the 1990s. The National Transportation Safety Board tapped Red Cross, which in turn tapped NACC, APC and NAJC to train and respond.

Through these past 15 years, the American Red Cross has really come to appreciate the difference between the role of the professional chaplain and the leader of a faith community. With its strong principles of neutrality and impartiality, Red Cross initially felt that supporting spiritual care might conflict with these principles. But after many deployments and experiences with professional chaplains across America, they clearly understand today that chaplains honor the voice of the voiceless and ensure that the spiritual needs of everyone affected by the disaster are honored.

On the morning of Sept. 11, 2001, I learned of the planes hitting the World Trade Center and Pentagon on my way to medical grand rounds in Everett, WA. Within a few days the call came: I was needed to deploy to the World Trade Center site. My son, Joseph, was just 2 at the time, and when the skyline of New York was shown on TV, he said, "That's where Daddy is helping the people where the planes crashed." Joseph's words through each deployment will forever be my strength and my burden.

At the World Trade Center site, we supported over 600 chaplains across the city in 24-hour shifts. From the Family Assistance Center at Pier 93 to the temporary mortuary, the disaster mortuary at St. Vincent Hospital, three respite centers around the towers, and the Staten Island landfill where the debris from the site was sifted and sorted in multi-level conveyor belts as far as the eye could see. The friendships I developed with Ron Oliver (APC), Stephen Roberts (NAJC), Therese Becker, Glen Calkins, Greg Bodine, Sr. Laurentilla Back, and Fr. Joe O'Donnell (NACC) were key to my healing and commitment to carry on.

My next deployment came in 2005, immediately following Hurricane Katrina. Here the size and scope of a complex disaster was beyond anything I have ever seen. This deployment expanded our role and highlighted a unique expertise that chaplains provide, which is support to rescue workers and families in grief. Spiritual care leaders partnered with the disaster mortuary teams responsible for the recovery of every person who died in New Orleans. Here I learned the concept of using "spiritual duct tape" to keep the team of recovery workers focused. They had no backup teams, and as chaplains we had to ensure that they stayed on track until they were disengaged from the scene. We honored the dead through the autopsy process, advising the teams to add a symbolic washing station to honor those who required this for their faith. We met families at the fence line searching for someone who might recognize the photo of their loved ones. We comforted survivors in mega-shelters who clung to their 5-foot-square corner of carpet in a convention center as the only safe place they knew. And we escorted families as they boarded planes at midnight bound for unknown destinations. In turn, we sat with dying persons in makeshift airport mortuaries as companions and witnesses to their life.

In 2009, three simultaneous earthquakes hit 150 miles off the coast of the tiny South Pacific island of American Samoa, creating four massive tsunami waves that hit and wrapped around the entire tiny island 18 minutes later. Nearly 200 people died, and homes were simply erased off their foundations. Our 50-person delegation supported nearly 2,000 children from grade school through junior college. We honored the lives of those who were lost and supported families who lost children and parents.

The experience in American Samoa was the most moving of my life. The gift of presence was so palpable there because everyone on the island knew we were there and why. Their gratitude for our presence was unbelievable. It was among the harder deployments; we slept outdoors under a metal gymnasium roof, and the rains and wind would come unexpectedly. Each night the swarms of shad flies arrived at sunset, the waves of frogs came from the jungle to feast on the flies, and in three hours they were gone. I would call Joseph, now 10, from a mountaintop to say I was safe and could my wife call the families of the other 10 relief workers, because they couldn't get a call out. And we watched as 21 fifth-grade students

played "Amazing Grace" on ukuleles at the ocean's edge, standing on the foundation of what remained of their classmate's home. As they honored the lost lives, a whale and her baby came into the cove very close to where the children played, sprayed mist in the air and swam back to the sea.

Last May, during the NACC conference in Pittsburgh, I happened to pass a television to see the news that a bomber had detonated two bombs at the Boston Marathon. Within an hour, a call came to deploy me to support leadership at the Cambridge headquarters. This time Joseph, now 13, dove underwater in the hotel pool, hoping that he could stay under long enough not to hear the words, "Red Cross called."

In Boston, our teams supported families and survivors who were seeking support through the grief and shock. With the bombers still on the loose, we experienced the city-wide lockdown beginning around our hotel, when news of an officer shot sent shock waves through the neighborhood. The work was complex, helping local relief workers and faith communities as they honored those who were lost and trying to recover themselves. Creative memorials were held for staff who had been working nonstop for the entire week.

My role as Disaster Spiritual Care volunteer lead has evolved significantly through the years. Many of us knew Earl Johnson as the face of Disaster Spiritual Care; he led the effort as a volunteer from 2001 to 2009, while I served as an NACC representative on the leadership team. Earl's full-time paid position was eliminated after two years in 2011, but Red Cross wanted to affirm their commitment to the program, and I was asked to serve as DSC volunteer lead. We quickly formed an administrative team to ensure the DSC work could continue, and we now have 10 divisional leads, including myself.

I volunteer with Red Cross because of the honor and opportunity to support and build the most diverse and comprehensive team of over 650 spiritual care leaders one could ever imagine. I have always loved the verse: "Wear out the doorstep of a wise person." (Ecclesiasticus 6:36). Through this work I have had the honor of working with so many people of wisdom, and I have secretly been the student learning from their gifts.

Together we have honored the lives of those who have been lost. When I began in 1999, I never expected where my path would lead, yet I know that the experience is a gift with which I have been honored to share in places where even I would normally fear to tread.

Joseph, now 14 and a wise and deeply prayerful young man, says, "Dad, I won't give money to Red Cross, because I have already donated my dad too many times." Disaster Spiritual Care is incredible and life-giving, but requires balance and a strong commitment to a team approach.

*Tim Serban, BCC, is chief mission integration officer for the Oregon region of Providence Health & Services in Portland, OR.*

---

## Deployments after Missouri and Oklahoma tornadoes reveal despair and resilience

By Logan Rutherford

I am fortunate to be part of the American Red Cross Disaster Spiritual Care leadership team, a group of chaplains throughout the country who are trained to respond to natural disasters and mass casualty events.

I'm no stranger to the shrill effects of shock and devastation, which is one reason why I feel I can be effective in disaster situations. For nearly five years, I have worked at the Texas Trauma Institute at Memorial Hermann-TMC in Houston, one of the busiest Level 1 trauma centers in the country, providing spiritual and bereavement counseling to trauma patients and their loved ones.

My first deployment was to Joplin, MO, after the catastrophic 2011 tornado. In 2012, I deployed once again when Hurricane Sandy struck the East Coast. My most recent deployment was in 2013 to the tornado that hit Moore, OK, as a manager for the Disaster Spiritual Care team.

One of my jobs was to provide care to community members as they returned to their properties for the first time after the wind and rain subsided. Nobody knew what they would find, if anything. They were looking for pets, photos – whatever they could salvage. I remember comforting one couple that came back to the ruins of their home to search the rubble for their cat and dog. Miraculously, the cat was retrieved under a large amount of debris, but the relief and joy from his survival was numbed by the loss of their dog. All this family wanted was for another person to hear their story and to bear witness to the pain of their loss. That's why I continue to deploy to disasters across the country.

However, it's impossible not to feel overwhelmed by the resilience and generosity displayed by the people in each community. It became clear to me that one of the reasons there were not more casualties was because the community was close-knit and compassionate. One family I met was at home right before the tornado hit. They didn't own a storm shelter, but their neighbor across the street – who wasn't home at the time – called and told the family to use his. Just a few minutes later, both of their homes were directly hit.

One boy in Joplin, who had lost everything and was in a shelter, found his prized piggy bank in the rubble. He cracked it open and handed his entire collection to his parents and said, "Mommy, I want to give my money to the Red Cross so they can help another little boy who has lost everything." Some folks we tried to assist financially took the assistance and turned right around and donated it back so the needs of others could be met.

One of the hardest work assignments at Moore was an event for Plaza Towers Elementary School, where seven children had died in the tornado. I listened to the story of a student who had been saved by his teacher – she shielded him during the tornado to keep him from falling debris. As a thank-you, his family gave the teacher a framed picture of the two of them with messages of gratitude around the border.

But then I met another teacher who had lost multiple children in her classroom. She had just been released from the hospital and could barely walk. She told me about how she had tried to save them but that her arms just weren't long enough. My heart sank for her. I tried to help her understand that the parents of the deceased children knew the pain she felt and that she had done everything she could. I couldn't stop thinking about the framed picture that had just been given to her peer, and how I hoped she'd never have to see it. It was one of the most heart-wrenching events I have ever been a part of.

My day-to-day experience with trauma survivors and their families has allowed me to understand the physiological effects of trauma, which are numerous. The impact on cognition is very apparent. In Joplin, survivors of the tornado came to seek assistance from multiple agencies in one stop. In order to begin the process, the families needed to complete some preliminary paperwork. I noticed a woman sitting by herself who looked extremely distressed and was just staring at the paperwork in front of her. I approached her and began a gentle conversation. I could tell she was struggling to complete the paperwork and offered to help her, while at the same time acknowledging how difficult simple tasks can be to complete. As we muddled through it together, she was unable to recall simple everyday information such as her phone number and Social Security number.

During many family conversations, I could tell that not a lot of the information and details were sinking in. The "deer in the

headlights” look was extremely common. We had to really simplify the information we provided, repeat it, and also provide it in written form. In the hospital, the same approach is necessary. A simple, short document needs to be provided outlining the step-by-step process, and with pertinent phone numbers. We must avoid the temptation to load people up with numerous resources during a time of shock. An overabundance of material will likely just be discarded, or left in a bag somewhere and never referenced.

On some deployments, chaplains worked within Integrated Care Teams to connect and meet with the families who had experienced deaths. Many of the family members were still in a state of shock and dismay. In Joplin, I took the lead in making the initial phone contact with bereaved families, which worked well. Many were very leery on the phone, but identifying myself as a volunteer chaplain with the Red Cross Care Team seemed to lower their level of concern.

The presence of board-certified chaplains on major disaster operations is imperative. Having a solid pastoral identity, authority and sound framework enables us to work well with other disciplines.

Part of our job was to assess and document the family’s financial needs. Some members of the team felt that if they did not give the family the maximum financial assistance available, their meeting was not as successful as it could have been, and the services provided were not enough. This was not accurate. As the chaplain, I continually tried to remind my team that our care is invaluable, no matter what amount of money the client was given. Don’t get me wrong; all of the families we met with received some financial assistance. What we provided too, though, was a deep emotional and spiritual connection with these folks and we joined them in the pain of their journey.

Similar to working in large hospitals, with many moving parts and departments, working within a large structure of disaster response requires effective assessment skills and effective allocation of human resources. Just as in individual pastoral encounters, no disaster is the same. At the core of Disaster

Spiritual Care is service to the community, through leveraging and coordinating the existing networks of pastoral-care givers. For instance, in Moore, the First Baptist Church became the major distribution hub of supplies and services. Since this faith community was so well organized, there were already many volunteer chaplains to support their people. It was important that we were seen as partners, and not individuals who were descending on their community to take over.

The presence of board-certified chaplains on major disaster operations is imperative. Spiritual care in these types of events is not simple. It is a dance between direct and indirect care to those affected while working within a complex structure. Having a solid pastoral identity, authority and sound framework enables us to work well with other disciplines. Competent certified chaplains can naturally think on our feet – a necessary trait during a disaster. For instance, in Joplin, we were assured that the death notifications had occurred prior to our contact with any family. This, in fact, was not 100% accurate. One chaplain effectively muddled through a telephone conversation after realizing that a notification had not been made.

Training is available to board-certified chaplains at the NACC conference each year, including the upcoming conference in St. Louis. If you are interested in learning more about supporting the needs of those impacted by disaster and mass casualties, register for the four-hour orientation to Disaster Spiritual Care (see [www.nacc.org/conference/default.aspx#dsc](http://www.nacc.org/conference/default.aspx#dsc)). I highly recommend getting involved.

*Logan Rutherford, BCC, is adult trauma chaplain at the Texas Trauma Institute at Memorial Hermann Hospital in the Texas Medical Center in Houston, TX.*

## Responding to tornadoes in Missouri and Oklahoma brings renewed sense of grace and love

By Joseph G. Bozzelli

*"Lord, when did we see you hungry or thirsty or a stranger or needing clothes or sick or in prison, and did not help you?" (Mt. 25:44)*

On May 20, 2013, as I was watching TV from the comfort of my home in Kentucky, I saw that a tornado, later to be classified as an EF5 with over 200-mph winds, had devastated the town of Moore, OK, and surrounding areas. I felt helpless as this horrific experience unfolded before my eyes. All I could do was pray. I had no idea that three days later, I'd be walking among the ruins of Moore, as a chaplain with the American Red Cross Disaster Spiritual Care team, trying to help survivors of that disaster find comfort and hope.

DSC responders are certified chaplains who have completed the American Red Cross Disaster Spiritual Care orientation. It's offered at various times nationally through the Red Cross, and yearly at our NACC national conference. The training is extremely beneficial in offering pastoral care at a disaster, but it's also useful for crisis events in our daily ministries or in our communities.

At the airport, I met up with Stan Dunk, BCC with the APC. We became friends when Stan led our DSC team in response to the 2006 Lexington, KY, plane crash. Our chaplain team consisted of NACC and APC certified chaplains who had completed the Red Cross DSC training. They each chose to volunteer on a moment's notice.

It's not just a sacrifice of time; sometimes, it's a sacrifice of comfort and well-being. The conditions can be challenging, both physically and emotionally. As you can imagine, precautions have to be taken among the rubble from a tornado. Just a week after I had arrived in Moore, another EF5 tornado hit the area. Creature comforts must be sacrificed. When I was in Joplin, MO, after that devastating tornado, I slept on a cot in a gymnasium with 200 other men ... talk about snoring! Of course, in comparison to all the people you meet who have lost their homes and possessions, it was a minor inconvenience. And when I talk with chaplains who provided support following 9/11, it's obvious that the pain from that tragedy still weighs heavy on their hearts. Though there may be risks involved, for most chaplains, the rewards are well worth it.

In Moore, Stan led our team of 10 chaplains. Every morning we met as a team and planned our day. Some of us were assigned to a Red Cross team with a mental health worker, a nurse, and a case manager. Our team would spend the day meeting with family members whose loved ones had died in the tornado. Together, we provided assistance for their immediate personal and spiritual needs. Other chaplains went to mass agency relief centers, a one-shop stop where survivors sought aid from such groups as FEMA, food banks, insurance agencies, and housing assistance. Often, our ministry involved helping people navigate the maze of bureaucracy that is just part of such events. Other chaplains went to the disaster sites, talking to survivors, assisting at Red Cross relief sites where survivors sought items like shovels, gloves, coolers, and food. We also met with other Red Cross volunteers as they too, were emotionally impacted by the disaster.

But at least for me, the most valuable part of what we offered is what we chaplains do: a listening presence. I met Julie as she was scavenging through the crumpled remains of her home. She showed me the only remaining room, the bathroom, where she had taken shelter from the tornado as her house collapsed around her. Bill, a rancher in his 70s, lost his home and his cattle, which was his livelihood. The most personally difficult experience was being with a woman whose four children and two grandchildren died in a flash flood that resulted from the tornado. When the tornado sirens sounded, the children, fearful that their apartment would be hit, sought shelter in a sewer drain that had protected them in previous tornados. If they had remained in the apartment, they would have survived; it was untouched by the tornado. As terribly sad as these stories are, my hope, as each person expressed their feelings, was that it helped in some small way, to bring a sense of healing and hope in the midst of their deep grief.

The camaraderie of the DSC team is truly special. There is no room for egos or personal agendas. The bond we established as a team provided support and healing for us, as well. Besides gathering in the morning and at the end of the day to process our experience, we had our lighter moments, too. When we finally convinced Stan to take a needed day off, he went to a wildlife reserve with free-roaming buffaloes. When Stan impersonated a buffalo's grunt for us – well, needless to say, it was a source of great humor for the next several days.

As chaplains, we deal with emergencies and critical situations on a daily basis. But what makes this ministry unique for me is that I've been a part of intense and enormous relief efforts to help people, often whole communities, find some comfort and support. It is truly humbling and deeply spiritual.

You know how we often say in ministry that we get back so much more than we give? Well, that's the same experience for me with the Red Cross. When I returned from Oklahoma, I had a renewed sense of my life, my values, and above all, my awareness of God's grace and love. I had the privilege of being with people who literally lost everything, except their hope and their compassion for one another. I ministered with chaplains and other Red Cross volunteers who inspired me with their quiet dedication and commitment to serve the needs of others. Back at work, the principles of teamwork and organizational support that are so much a part of the Red Cross guided my interactions with our hospital staff. In addition, I believe that my sensitivity and compassion found a new depth and understanding.

Yes, there is suffering in this world, and tragedies like the Oklahoma tornados happen. But through God's grace and compassion, normal, everyday people respond to such events with kindness and support for their sisters and brothers in need. I was physically and emotionally tired from my experience in Oklahoma. But as Grandpa Walton from TV fame used to say at the end of a hard day, "It was a good kind of tired."

*Joseph G. Bozzelli, BCC, is director of pastoral care services at St. Elizabeth Healthcare in Edgewood, KY.*

---

## Watching Red Cross respond to disaster offers inspiration

By Marjorie Ackerman

Certified chaplains have many varied opportunities available to serve people in a special way. My time as an American Red Cross spiritual care provider was one of the most important and rewarding chapters in my chaplaincy story.

During my first career as a financial planner, I felt the call to chaplaincy, got my master's degree, and was certified by NACC. I had begun to plan a strategy for moving away from advising and into "being there" when tragedy struck: My husband of 45 years died. Two days after the funeral, I began my life as a certified Catholic chaplain. After some time in hospital and jail ministry, I called FEMA to ask if they needed chaplains at disasters. A good friend who worked there told me that the American Red Cross was developing a program to help the families of those affected by transportation disasters. Since the Red Cross' national headquarters was in Virginia, not far from where I lived, I worked there three or four days a week.

The group designing the spiritual care component of the disaster program were seasoned veterans of the American Red Cross response team. They were mental health people who had great respect for the different job we would be doing. With the help of the InterFaith Conference of Washington, we put together a "go box," filled with religious books for prayer and items used at funerals and memorials for our diverse participants. It was extremely gratifying in times of trauma to observe how people who are hurting relate to the familiar. We also discovered that the only symbols acceptable to all religious groups are an angel or a dove, and that for the service following a tragedy, the instrument that does not seem to offend anyone is the harp.

Circumstances often prevented me from leaving the D.C. area for an extended period, but I was able to help at Red Cross headquarters during deployments. The tragedy of 9/11 was different. I was in Texas visiting my daughter and her family, and their son was in the second tower in New York. But he got out safely, and I am happy to say that he and his wife had their first baby, a son, last November.

A few days after that horror, I arrived back in Washington and went immediately to Shanksville, PA, the site of the crash of United Flight 93. By the time I arrived, the American Red Cross leadership was in control of the situation and the basics were in place. There are always problems, such as well-meaning people who self-deploy and those who do not follow instructions, but it is interesting to watch the clear, firm way the problems are handled.

The morning meetings allowed us to exchange thoughts and suggestions, and many potential problems were resolved there.

The morning meetings allowed us to exchange thoughts and suggestions, and many potential problems were resolved there. Our role was to meet the families as they arrived and to reassure them in any way we could. We assembled local clergy from various faith traditions and explained the needs and the caveats. Almost immediately, we began to plan the memorial service. Laura Bush would be there with other dignitaries, and everything had to be sensitive to the needs of the families. The service was powerful, and the words spoken touched everyone's heart without pathos. A second memorial was held several days later for those who could not attend the first gathering. The people of Shanksville were thoughtful and caring in every way. The parade of buses carrying the families to

the site were honored by the Pennsylvania Highway Patrol in uniform, saluting each bus as it passed. The slow raising and lowering of the hands and the bagpipe music in the background brought tears to everyone's eyes. We arrived at the site to flags flying, a riderless horse, and a single bugle playing softly.

The days I spent with the families of the victims, as well as the American Red Cross family, will always be with me. I feel honored to have been there.

My next response to a major disaster was in 2005, when I was called to help in Washington after many people were displaced by Hurricane Katrina. The American Red Cross converted the D.C. Armory into an interim home for hundreds of people, and I was asked to manage the spiritual care component of the operation. We immediately encountered an unforeseen problem. The mayor's office sent their director of religious services to meet and greet visiting clergy and dignitaries, but when I arrived, several groups were wandering about, even in the private family area.

The Red Cross has strict rules during a shelter operation. Not crossing the boundary into the private sleeping area of the displaced individuals and families is one; being properly badged for entry into the shelter is another. Since neither rule was being observed, I was asked to do something about it. The problem was not intentional and called for a diplomatic solution. I met with the official from the mayor's office, and we agreed she would be responsible for her group. She would choose people to monitor a separate entrance, and a special badge would be issued. Records of visitors and their affiliation were to be kept, and the visitors would sign a memo of understanding, with the Red Cross rules spelled out. The agreement also stated that anything offered to one faith group would be available to the others, and under no circumstances would anyone go into the private family area. The needs of the people living in the shelter were respected, and the mayor's office was happy.

I will never be able to fully show my appreciation for the privilege of representing my Catholic faith tradition as well as the American Red Cross in situations that called upon everyone to have understanding, tolerance and compassion. Taking care of ourselves as well as each other and the population we serve is ingrained in our training. It makes a difference to work in such an environment with very special people.

*Marjorie Ackerman, BCC, is a retired chaplain.*

---

## Chaplain at Newtown and Boston knew she wasn't alone

By Marilyn Bucheri

"How do you do it?" I am often asked. "How do you go into such horrific situations – 9/11, Newtown, Boston?" But I know I don't enter those situations alone.

My entire life has prepared me for ministry that I now have been doing professionally for over 20 years. I grew up in an Italian family and spent a great deal of time with relatives, including going to wakes and funerals at a very young age. I learned very early on that death was a part of life. Through my varied ministries, my CPE education and my spiritual directors, I have grown in ways I could never have imagined when I first started on this journey. I learned that the important lessons of listening, being present to people and walking in their journey for a short but significant time are central to being a chaplain.

In 2001, I was a chaplain at Yale/New Haven Hospital. On 9/11, I was not working. As soon as the shock of the attack registered, I called to see if I needed to come in to help. But as the tragedy unfolded, we realized that there were not going to be many survivors. The next day when I went to work, I was asked to prepare a prayer service for the next day for the staff and patients at the hospital. We continued prayer services for several days, responded to staff and patients to listen and provide a spiritual presence as we all processed the devastating attack.

Several weeks later, I received an email from the NACC saying that the American Red Cross was looking for chaplains to be trained for a spiritual response team. I answered their appeal and flew to Chicago for a training program. While there, I met chaplains from all over the country. Up until that time, Red Cross chaplains deployed mainly for air disasters, but 9/11 brought chaplaincy into a new era.

For me as a chaplain, I see that ministry is a call and response. When I responded to Red Cross, it was a call – the type that comes from very deep within my belief that God calls us many times. I said yes to that call, not knowing what it was going to mean to me or how it would change me. I came back from training in Chicago and joined the local chapter in Farmington, CT, trained locally and became part of a disaster action team.

I have been deployed to many disasters with the Red Cross, but the deployment to Newtown in December 2012 left the most lasting impression on me, both as a chaplain and as a mother and grandmother. It was so close to the holidays, when families gather to celebrate the joy of being together. The tragedy in Newtown changed that for all who were directly affected, extended family and friends, the nation and the world. But my training prepared me to respond to the call. My first assignment was the Family Assistance Center, where families came to learn what financial and personal help they could receive from several agencies. I was available to offer spiritual support to the families. Since I was originally from Connecticut and had worked at Yale New Haven Hospital, I was able to reach out to former colleagues to gather nine chaplains for a large prayer service. This past December, at the one-year anniversary of the shooting, I found my emotions were still very raw.

When I responded to Red Cross, it was a call – the type that comes from very deep within my belief that God calls us many times.

Last April, I responded from my home on Cape Cod to the Boston Marathon bombing. I arrived during the second week, when several prayer services were being planned and a family assistance center was opened. At a very small prayer service for people who were directly affected by the bombing, I along with a rabbi helped wheel a person who had lost a leg in the bombing. It was very emotional for her and for us. Again, the gift of presence is what we offer to people we support as chaplains. The day of the very large prayer service for the MIT policeman who was killed, I along with other Disaster Spiritual Care members, offered support where policemen from all over the country came to

board buses to the service. We all rode different buses to be a presence to the more than 1,000 police who attended. I witnessed Boston Strong rising from what was a horrific act of terrorism to a coming together of a city, state and nation. I've even converted from being a Yankee fan to a Red Sox fan!

When I joined DSC as a chaplain, I didn't realize how it was going to impact and expand my ministry. As I reflect back, I see that my role over the years as a chaplain had prepared me for this type of crisis ministry. I was always very comfortable being in emergency situations which are fluid and changeable.

In 2009 while on hiatus with the Red Cross, I volunteered with Mercy Corps, a Sister of Mercy Volunteer Corps. I was assigned to Mercy Medical Center in Baltimore, MD, to be a member of their Spirituality and Health Initiative at the hospital. This ministry was a natural extension of my own desire to explore spirituality and how it affects not only our understanding of God's presence in our life but how our health is impacted.

I believe one reason I can do this ministry is because I have heard the call so many times in my life and have responded with the deep belief that I don't do what I do alone. My lived spirituality shows me that God is very present with me, and – along with family, friends, my spiritual directors and CPE supervisors – was the avenue to growth in ministry.

*Marilyn Bucheri, BCC, is a chaplain at Falmouth Care and Rehabilitation Center in Falmouth, MA.*

---

## Disaster chaplaincy in the research literature

By Austine Duru

In this issue of *Vision*, we present five resources that cover a broad range of research and related topics by chaplains and non-chaplain collaborators. Each resource is related to our current *Vision* theme of disaster chaplaincy. A link to a safe, open access site has been included for further detailed reading.

Curtis, J. B. (2012). **Clergy-Psychologist Collaboration in the Aftermath of Technical Disasters: Lessons Learned from the Upper Big Branch Mine Explosion.**

Major disasters are often traumatic event for victims, their loved ones and the entire community. As Louis Judith Herman correctly observed, traumatic events shatter the sense of connection between individuals and community, creating a crisis of faith. The community clergy and the mental health professionals are therefore important resources in dealing with the aftermath. In this study, which is part of a doctoral dissertation, Joy Beth Curtis makes an important case for collaboration between clergy and psychologists in the aftermath of the Upper Big Branch Coal Mine explosion in West Virginia in April 2010, which took the lives of 29 coal miners and devastated the community ([espace.wheaton.edu/lr/a-sc/archives/theses/201307-PsyD-PSYC-CurtisJoy.pdf](http://espace.wheaton.edu/lr/a-sc/archives/theses/201307-PsyD-PSYC-CurtisJoy.pdf)). Curtis' investigation yielded seven important themes that describe the post-disaster interventions of local clergy, identifying important lessons and opportunities for growth. She makes the point that the local clergy are usually the first mental health responders to provide emotional and psychological support in historically underserved populations, and makes recommendations for the continuing interdisciplinary collaboration between clergy and mental health professionals. Although this study is dense, it offers important insights about dealing with disasters in rural populations and the significant role of spiritual care providers as integral to the healing of the community.

Meredith, L. S., Eisenman, D. P., Tanielian, T., Taylor, S. L., Basurto-Davila, R., Zazzali, J., ... & Shields, S. (2011). **Prioritizing "Psychological" Consequences for Disaster Preparedness and Response: A Framework for Addressing the Emotional, Behavioral, and Cognitive Effects of Patient Surge in Large-Scale Disasters.** *Disaster Medicine and Public Health Preparedness*, 5(1), 73-80.

Experienced disaster chaplains and emergency responders will confirm that effective intervention after a large-scale disaster often begins before the disaster happens. The national Hospital Incident Command Systems for emergency management is one example of an interdisciplinary emergency preparedness system that can be activated in the event of a disaster, whether natural or man-made. In the last few decades, much attention has been given to preparation for medical emergencies; however, preparations for and the psychological aspects of large-scale disasters still lag behind. Dr. Lisa Meredith and her colleagues identify and describe two conceptual frameworks ([http://206.251.244.141/client/Prioritizing Psychological Consequences for Disaster Preparedness.pdf](http://206.251.244.141/client/Prioritizing%20Psychological%20Consequences%20for%20Disaster%20Preparedness.pdf)) to guide healthcare facilities in responding to such disasters. One framework is the "psychological triggers" (restricted movement, limited resources, limited information, trauma exposure, and perceived personal or family risk). Another framework, "consequences of reactions to psychological triggers," looks at structural components that can lessen the consequences of a disaster before it happens. Examples include organizational structure and chain of command, resources and infrastructures, knowledge and skills, coordination with external organizations, risk assessment and monitoring, psychological support, and communication. The authors include a handy table of possible psychological triggers and associated recommended actions. This study breaks new ground in emergency disaster preparedness by identifying specific evidence-informed interventions for dealing with the psychological surge in the aftermath of major disasters.

Kaminsky, M., McCabe, O. L., Langlieb, A. M., & Everly Jr, G. S. (2007). **An evidence-informed model of human resistance, resilience, and recovery: The Johns Hopkins' outcome-driven paradigm for disaster mental health services.** *Brief Treatment and Crisis Intervention*, 7(1), 1

Modern medicine is often guilty of minimizing the significance of the individual person in the healing process. We now know that the individual is more complex than previously thought, and that people respond differently to different triggers or stressors. Chaplains know how to adapt their pastoral intervention and styles to meet the needs of each individual in their care. This is not different after a disaster. Not all victims of disaster will need assistance, and people who do need assistance vary in their specific needs. Often, emergency disaster protocols do not take into account the uniqueness of individual victims and their needs. Michael Kaminsky and colleagues offer a new paradigm, a human model, in the conversation on disaster mental health interventions (<http://btci.stanford.clockss.org/cgi/content/full/7/1/1>). This model takes into consideration the triple concepts of resistance, resilience, and recovery as a strategic and integrative process in dealing with the immediate and the long-term aftermath of major disasters. This is valuable information for chaplains and emotional and

spiritual care providers in the event of a disaster.

Boldor, N., Bar-Dayana, Y., Rosenbloom, T., Shemer, J., & Bar-Dayana, Y. (2012). **Optimism of health care workers during a disaster: a review of the literature.** *Emerging health threats journal*, 5.

FEMA divides post-disaster operations in two phases: response and recovery. Healthcare workers are usually the first responders, often unwittingly experiencing vicarious suffering and trauma. Optimism is certainly one resource available in such stressful situations. Noga Boldor and colleagues explore the impact of optimism among healthcare workers as they cope with stressful daily work in times of crisis or disaster ([www.ncbi.nlm.nih.gov/pmc/articles/PMC3267412/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3267412/)). Current research has shown that optimism can improve morbidity outcomes while enhancing team and organizational performance in times of crisis or medical emergencies. The authors of this work were interested in finding the “linkage between optimism among healthcare workers during disaster and their active response, with special emphasis on the relationship between optimism and knowledge, feelings or behavior.” The results were promising, leading to recommendations for strengthening optimism through initiative programs and making provision for optimism training as part of disaster preparedness for healthcare workers.

Matsa, R. M., & Min, D. (2007). **A New Model for Disaster Chaplaincy.** *Journal of Jewish Communal Service*, 83(1), 92. Systematic disaster chaplaincy is still in its infancy; it was only in 1996 that the first official national disaster response team was formed to address spiritual care after aviation disasters. Since then, disaster chaplains have realized that the mandate leaves more room for improvement and needs to be flexible enough to meet different kinds of spiritual care needs during other kinds of disasters. In this work, Rabbi Myrna Matsa shares important findings from her work as a pastoral counselor after Hurricane Katrina (). The paper does not seek to expand on the conceptual underpinnings of measurable outcomes in disaster chaplaincy; rather, it considers how disaster response initiatives, self-care structures, and narratives and networking approaches can contribute to effective disaster chaplaincy. It interrogates the notion of measurable outcomes in relation to disaster chaplaincy. This project raises important questions about the funding necessary for a systematic study of disaster chaplaincy and ways to build on the progress that has been made. It is a practical model for the provision of spiritual care in post-disaster situations. It also offers some tools and resources to deliver effective disaster chaplaincy.

*Austine Duru, BCC, is director of mission and pastoral care at St. Elizabeth Regional Medical Center and Nebraska Heart Health in Lincoln, NE.*

---

## For chaplains at disaster scenes, self-care is vital

By Logan Rutherford

In addition to caring for victims and rescue workers at a disaster, chaplains must also be able to take care of their own teams and themselves as they absorb countless stories of tragedy. I feel like a large porous sponge soaking up the extreme pain from the families I met with. I needed to wring myself out from time to time. Rabbi Steven Roberts' quote from *Disaster Wisdom Sayings* could not have been more accurate for me: "Everyone responding to a disaster needs to practice self-care and seek the support of others so they leave the disaster experienced changed not damaged."

Once, I knew that a fellow team member was about to over-function and over-identify with a family. The next appointment we had on our schedule was a family who had lost a 17 year old, and the EMT of our group had previously lost a child as well. She said, "Oh, I will be able to help this lady. I know exactly what she's going through." I knew it was a time to educate her on effective support for the family, while at the same time giving her an opportunity to share the story of her child that died. Subsequently, she was able to function very effectively during the family meeting.

A peer at the Joplin operation commented, "Large disaster responses like this feel like loosely organized riots." I concurred. I like everything to fit nicely into a word table and to have things very orderly, but I had to let this go and just roll with the program, despite obvious flaws and not having all the facts and supplies I wanted. NACC chaplain Tim Serban, a regional lead for American Red Cross Disaster Spiritual Care, illuminated something very important for me on my first deployment. He said, "Hey, you're from a Level 1 trauma center; you need to realize that everything is not as fast-paced and organized. There are going to be times when you feel like you are just sitting for a bit and not being fully utilized. Be OK with that. Disaster work is not a sprint, it's a marathon. The needs will continue in the area long after you leave." How true this was.

Some of the most valuable support I received came electronically. I received texts from time to time from some of my nurses in Shock-Trauma offering words of encouragement and support. They will never know how much this meant to me. Most texts were simple and came with the frequent instruction – "I know how busy you are, I don't need you to respond, just know I am thinking of you, and love you." Maintaining connection with others back home in chaplaincy is paramount.

I feel like a large porous sponge soaking up the extreme pain from the families I met with. I needed to wring myself out from time to time.

Since the majority of the day was hearing and absorbing other people's experiences; attending procedural meetings; and other responsibilities my form of self-care involved just getting away with my iPod and journaling for a short time. Because there were approximately 100 Red Cross volunteers staying in the shelter where I was, I took a stroll outside or found a quiet space to sit alone.

Re-entry back into my normal life at home took some adjustment. While journaling was my savior on operations, it took me about two weeks to reflect on the accounts of pain and suffering. Upon immediate return, many people wanted stories and pictures. As a self-preservation method, I had to respond with, "I'm

not quite ready for that yet."

While it is emotionally challenging and painful work, I feel it a privilege to accompany those whose lives have been turned upside down from the effects of a disaster. I learn from everyone I meet on deployments about the resiliency in the face of such adversity. It's not unlike what I experience every day as a trauma chaplain. I'm proud to work alongside others who offer care compassion and hope to others in some of the darkest days of their lives.

Working in trauma and seeing first-hand the result of horrendous abuse and pain inflicted by people on one another has also had a profound impact on my own spirituality. I have become more comfortable living in a world that holds in tension good and evil. I now can embrace a world of grayness, and world of ambiguity, in which I no longer feel the need to make sense of everything I encounter. In most traumatic situations, especially man-made ones, such as Sandy Hook (another event where Disaster Spiritual Care was deployed), people will continue to struggle to try to make sense of it. It is through this desperation you encounter meaningless and unhelpful platitudes such as, "God will not give you more than you can handle." These platitudes will always continue to disappoint those in pain.

*Logan Rutherford, BCC, is adult trauma chaplain at the Texas Trauma Institute at Memorial Hermann Hospital in the Texas Medical Center.*

## CPR, dignity, and choices at the end of life

By Joe Cull

When I was a firefighter, if a victim's heart was not beating, we would perform CPR, as long as they were not decapitated or in rigor mortis. But sometimes performing CPR felt like a violation of a person's dignity. Pumping on the chest of a frail 90-year-old, it was not uncommon for ribs, sternum or even the spine to fracture due to compressions. The patient was often stabbed multiple times with an IV needle until a viable vein could be accessed. Inserting the plastic tube down the victim's throat risked dislodging or breaking teeth. It always disheartened me to hear the bones snap or see teeth break, but it was easy to rationalize the discomfort away. Bones can heal and teeth can be replaced, but when a human life was at stake, such injuries were incidental to a greater cause: saving a life. However, there were times I wondered, primarily for patients near end of life – if they or their family had known the intrusiveness of our actions, would they have approved our efforts?

I will never forget the time I was administering oxygen to a petite elderly woman suffering from shortness of breath. Her eyes were full of fear, but in an instant, her gaze turned peaceful. Entranced, I assisted her onto the stretcher where she willingly lay down. I was so fixated on her unexpected aura of tranquility, I almost missed that she was no longer breathing. Her heart had stopped. Immediately we began CPR. Paramedics intubated her and began IVs as we maintained compressions. In minutes oxygen was flowing into her lungs and fluids into her veins. Our response was fast and professional. With sirens blaring, we whisked her to the hospital – where doctors would pronounce her dead in the ER.

The moment of her death was one of the most profound events I have ever experienced. Looking back, 25 years later, it is ironic – we did everything in our power to aggressively stop that peaceful transition. A full tug-of-war ensued in our efforts to reverse the dying process. Six strange men hovered over her as family tearfully watched nearby.

Fast forward 15 years. A small, elderly man returns to the home where he was born and raised, months after being displaced by Hurricane Katrina. His only family consisted of caring neighbors who knew his daily routine. One neighbor contacted EMS when that routine was not followed and his efforts to check on him yielded no response. EMS found him in bed with a weak pulse and shallow breathing. Death was imminent. However, when paramedics attempted to transfer him to a stretcher, he struggled and feebly pleaded "No," and "Leave me alone." Paramedics explained it was crucial he be transported for his own well-being. (Paramedics were also legally liable to transport.) It took three people to place and restrain him on the stretcher. He struggled to remove himself and even attempted to cling to the door frame as he was wheeled through. His fight continued until he was placed into the back of the ambulance, at which time his fighting ended, as did his heartbeat and breathing.

Sometimes performing CPR felt like a violation of a person's dignity. If patients near the end of life had known of the intrusiveness of our actions, would they have approved our efforts?

Of course, CPR, with chest compressions, intubation and IVs began immediately. His neighbor expressed remorse for having called EMS, realizing his friend simply wanted to die alone at home, in his own bed, not in the back of an ambulance on a stretcher with strangers. He was pronounced dead a short time later in the hospital ER.

When I became a chaplain in a hospital, I learned how common it was for a patient's advance directives to be overridden by family members. Even as our mother lay dying with cancer, at age 80, her children, including two hospital RNs and myself, a hospital chaplain, questioned whether we should authorize more aggressive treatment. Leaning on each other for support and encouragement, we remained faithful to the advance directives of our mother. Not doing anything turned out to be the hardest thing we could have done, especially since she was conscious and talking up to the time of her death. Doing "nothing" per se (aside from comfort measures) was much harder than having her aggressively treated and transferred into the ICU. None of us regret respecting her wishes, but it was not easy, especially when we were all still hoping for a miracle. And who wants to say goodbye to Mom?

Nine years later, we remained faithful to our father's advance directives. Like our mother, he embraced his death courageously and naturally. However, it was still hard for his adult children to accept the finality of his illness, especially since he was one of the most resilient people we had ever known. Over the years, when death seemed merely days or even hours away, he always rallied and made it back home to enjoy his coffee and watching the birds at the feeder. Maybe, just maybe,

he would rally again? Of course that rally never came, just as it will eventually never come for all of us.

I remember vividly the death of the elderly woman whose anxiety was transformed to an all-encompassing sense of peace and tranquility. Her death helped catapult me into a new realm of understanding—that death is inevitable and no human intervention can indefinitely alter our mortality. But, more importantly, there will come a time when we will meet our maker, and that meeting will transcend any human presence or effort to interfere or intercede.

CPR is undeniably an invaluable life-saving tool well worth learning. Unfortunately, its implementation often entails intrusive procedures and risks additional injury to an already dying person. However, with advance directives, such procedures and risks need not be a concern to those who desire a different option, especially people facing end-of-life care who have the support of loved ones.

*Joe Cull, BCC, is employed by the McFarland Institute as a chaplain with the New Orleans Police Department.*

---

## Spirit of St. Louis: Reflections of a Conference Task Force Member

By Peg McGonigal

It was Friday, the 13th of December, and Winter Storm Alfred was predicted. Members of the Planning Task Force would meet in person for the first time – if they all arrived safely from the East Coast and Upper Midwest. After meeting via conference call for five months, it was great to finally meet each other in person.

A passionate bunch from various backgrounds, we were eager to experience St. Louis first-hand. The enthusiasm for all things St. Louis expressed by Angie Vorholt-Wilsey, local arrangements chair, was contagious. It became obvious – early in our task – that the Gateway Arch should be a part of the title for the conference. A symbol of all the best a pioneer spirit has to offer, the Arch seemed to be a fitting symbol for the new opportunities for chaplaincy employing strategies of compassionate leadership.

Months before the on-site visit, the task force completed several key tasks under the gentle guidance of NACC Executive Director David Lichter and Jeanine Annunziato, administrative specialist extraordinaire. The idea for the main theme of compassionate leadership came from conference chair Bob Barnes. He suggested that in these unpredictable times, it would serve us well to examine our role in compassionate leadership and its mission in the diverse settings of our ministry.

Once the over-arching theme (sorry, I couldn't resist) was established, the task force identified four pillars of compassionate leadership to be considered: from a renewed spirit, in new settings, with diverse partners, through innovative services. For you see, the task force hopes that this theme proves to be as inspiring as it is practical.

A passionate bunch from various backgrounds, we were eager to experience St. Louis first-hand.

The enthusiasm continued as nationally recognized compassionate leaders were identified, contacted, and confirmed. As plenary speaker chair, I am thrilled with the caliber of our speakers. While we were disappointed that author Wendy Cadge had to withdraw, we are pleased that Tracy Balboni, M.D., will be able to join us. Dr. Balboni, a contemporary of Dr. Christina Puchalski, has a special interest in how spirituality plays out in serious illness and end of life.

Next, the workshops. A record response to our call for presentations yielded a bounty of well-qualified presenters with timely topics for today's chaplain. Jack Crabb, workshops chair and veteran task force member, led the quest to review and select the workshops for the conference. At the same time, Wilson Villamar, liturgy chair, was considering the shape, setting, and content of the liturgies and prayer life throughout the conference. Angie deftly sought out places and presenters for the pre-conference retreat. In addition, she became our ambassador to St. Louis as she guided us to consider certain charities, field trips, sponsors – you name it, she knows it.

This phase of our work concluded with a visit to the conference hotel – the historic St. Louis Union Station mere blocks from the arch that serves as the framework for our conference. It didn't take long before the innovative, friendly, pioneer spirit of St. Louis swathed us like a comfortable blanket. So this is what Angie has been talking about!

The dreary winter weather melted away as we sampled the food to be served at various conference meals. There we learned fun facts about St. Louis: the 1904 World's Fair made famous the hot dog, iced tea, the ice cream cone and Dr Pepper. We became familiar with St. Louis favorites like toasted ravioli, gooey butter cake and Ted Drewes frozen custard. We learned that yes, the famous Budweiser Clydesdale horses are a part of the Budweiser brewery tour and occasionally St. Louis Cardinals baseball games. And let's not forget the American Kennel Club's Museum of the Dog! (Check out [explorestlouis.com](http://explorestlouis.com) for a sample of the fun things to do in and around the city.)

Lest you think that all we did was eat, we did explore the hotel and all of its offerings. Under the capable direction of Jeanine, some checked the logistics of the conference rooms, the hotel rooms, and vendor spaces. Wilson and I focused on the meditation space and how we could enhance it by moving this bench there, that lamp over there and this plant here. You see, while we each have our primary responsibilities, we extend the spirit of St. Louis to one another as task force members. We hope you will experience the same spirit through an enriching conference experience.

*Peg McGonigal, BCC, is a staff chaplain at Aurora Health Care in Milwaukee, WI, and the plenary speaker chair for the NACC 2014 National Conference Task Force.*

## We announce a new 2014 Conference speaker, Tracy Balboni

For personal reasons, Wendy Cadge ([www.wendycadge.com](http://www.wendycadge.com)) will not be able to be our 2014 Conference plenary speaker on Monday, May 19. We will miss her wisdom and insights. However, we are honored and excited that Tracy Balboni, M.D., M.P.H ([www.dfhcc.harvard.edu/membership/profile/member/1611/0/](http://www.dfhcc.harvard.edu/membership/profile/member/1611/0/)), has agreed to be our plenary speaker.

Dr. Balboni currently serves as an associate professor of radiation oncology at Harvard Medical School and director of the supportive palliative radiation oncology service at Dana-Faber/Brigham and Women's Cancer Center in Boston – a service dedicated to the palliative radiation therapy needs of cancer patients. With degrees from Stanford University, Harvard Medical School and the Harvard School of Public Health, Dr. Balboni is also a researcher with the Dana-Farber Department of Psychosocial Oncology and Palliative Care. Her primary research interests are located at the intersection of oncology, palliative care, and the role of religion and spirituality in the experience of serious illness. Her research endeavors have included examining religion and spirituality in the experience of advanced cancer as part of the ongoing NIH-funded *Coping with Cancer* study. Dr. Balboni's research work has received awards from the American Society of Clinical Oncology, the National Palliative Care Research Center, and the Agency for Healthcare Research and Quality. Her work also includes forging improved dialogue between academic theology, religious communities, and the field of medicine.

To learn more about Dr. Balboni's work, please view this interview with Selma Schimmel on The Group Room to discuss her research on *Relating To Patients On a Humanistic Or Spiritual Level: How Physicians Can Make a Difference*: <http://www.youtube.com/watch?v=R2HshSkgRqw>. The interview was filmed at the American Society of Clinical Oncology annual meeting in Chicago in 2013. Recent research by Dr. Balboni on cancer patients who received religious/spiritual support reveals important findings about the effects of this support on end-of life treatments. For a summary of the research findings and a link to its abstract in JAMA, see [www.healthleadersmedia.com/content/QUA-292016/Spirituality-Presents-a-Paradox-in-EndofLife-Care%20archinte.jamanetwork.com/article.aspx?articleid=1685898](http://www.healthleadersmedia.com/content/QUA-292016/Spirituality-Presents-a-Paradox-in-EndofLife-Care%20archinte.jamanetwork.com/article.aspx?articleid=1685898).

Also, the NACC's Austine Duru has prepared summaries of three of Dr. Balboni's recent studies. To read them in this issue of *Vision*, please go to [www.nacc.org/vision/2014-Mar-Apr/Conference-speaker-Balboni-has-published-significant-research-on-spirituality-illness-By-Austine-Duru.aspx](http://www.nacc.org/vision/2014-Mar-Apr/Conference-speaker-Balboni-has-published-significant-research-on-spirituality-illness-By-Austine-Duru.aspx).

### Night Out in St. Louis - Monday, May 19, 2014

While you are in the beautiful city of St. Louis, we hope you will take time to experience a bit of what the city has to offer. The conference task force has planned two special opportunities for conference participants.

Select one and get a "**taste**" of St. Louis.

- 1. Anheuser-Busch Brewery Tour** ~ Join fellow conference participants on a tour of the Anheuser-Busch Brewery in the city where the company got its start in 1852.
- 2. St. Louis Trolley Tour** ~ Join fellow conference participants on an evening tour of the city of St. Louis from the comfort of a trolley provided by the St. Louis Fun Trolley Tours. This guided driving tour will offer an informed and entertaining look at major St. Louis sites.

For more information on each of the special events and for a registration form, go to [www.nacc.org/conference/default.aspx#local](http://www.nacc.org/conference/default.aspx#local).

## Conference speaker Balboni has published significant research on spirituality, illness

By Austine Duru

Dr. Tracy Balboni, associate professor of radiation oncology at Harvard Medical School and director of the supportive palliative radiation oncology service at Dana-Faber/Brigham and Women's Cancer Center in Boston, has been chosen as a plenary speaker for the 2014 NACC National Conference. To help introduce her to our members and readership, we would like to highlight some of her research work.

Her primary research interests include the intersection of oncology, palliative care, and the role of religion and spirituality in the experience of serious illness. Below is a brief presentation of three of her works (in collaboration with other investigators) that seek to forge new partnerships and improved dialogue between academic theology, religious communities, and the field of medicine. Open access links are provided for further reading.

Balboni, T., Balboni, M., Paulk, M. E., Phelps, A., Wright, A., Peteet, J., ... & Prigerson, H. (2011). **Support of cancer patients' spiritual needs and associations with medical care costs at the end of life.** *Cancer*, 117(23), 5383-5391. We featured this article in the last edition of Vision Research Abstract on palliative care, but it is worth repeating here with new insight into the authors' body of work on this topic and the rationale for the research. The cost of health care is known to skyrocket towards the end of life, due in part to aggressive treatment and use of the intensive care facilities. In this prospective, multisite study, Tracy Balboni and her colleagues investigate whether the infrequency of spiritual care at the EOL affects the cost of medical care. The study followed 339 advanced cancer patients from an outpatient center between 2002 and 2007. Spiritual care was measured by patients' reports on how well the healthcare team met their spiritual needs. The results suggest, "Cancer patients reporting that their spiritual needs are not well supported by the healthcare team have higher EOL costs, particularly among minorities and higher religious coping patients." The authors leave the readers with the following questions: Is the lack of spiritual care by the healthcare team associated with medical care costs at EOL? And given higher rates of aggressive EOL care among racial/ethnic minorities and high religious coping patients, is insufficient attention to spiritual needs associated with greater EOL costs among these at-risk patient groups? Given these statistics, the authors "hypothesized that patients whose spiritual needs are not well supported by the healthcare team would have increased EOL medical care costs, and that cost implications would be greatest among racial/ethnic minorities and high religious coping patients." To read more visit <http://onlinelibrary.wiley.com/doi/10.1002/cncr.26221/full>.

Vallurupalli, M., Lauderdale, K., Balboni, M. J., Phelps, A. C., Block, S. D., Ng, A. K., ... & Balboni, T. A. (2012). **The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy.** *The journal of supportive oncology*, 10(2), 81-87.

Research in religion, spirituality and science has long established the importance of religion/spirituality in the trajectory of illness and disease process and how individuals harness this resource to cope with their illness or new diagnosis. In palliative oncology, however, it appears that the relevance of religion and/or spirituality of the patient as a significant resource for coping is not yet fully appreciated. This study by Tracy Balboni and colleagues looks at three variables of religiousness, spirituality, and religious coping to see how these affect the quality-of-life outcomes, and assesses how patients perceive spiritual care in the oncology setting. This cross-sectional study surveyed 69 advanced cancer patients who were receiving palliative radiation therapy across multiple sites. Multivariable models assessed the relationship of spirituality and R/S coping to patient's QOL. The authors conclude, in spite of the limitations, that "Patients receiving palliative RT rely on R/S beliefs to cope with advanced cancer. Furthermore, spirituality and religious coping are contributors to better QOL." These findings underscore the relevance of spirituality in oncology care. It also has significant implications for the training of physicians and nurses on how to provide appropriate spiritual care interventions. To read more visit <http://pubmedcentralcanada.ca/pmcc/articles/PMC3391969/>.

Balboni, T. A., Balboni, M., Enzinger, A. C., Gallivan, K., Paulk, M. E., Wright, A., Steinhauser, K., VanderWeele, T. J. and Prigerson, H. G. (2013). **Provision of spiritual support to patients with advanced cancer by religious communities and associations with medical care at the end of life.** *JAMA Internal Medicine*, 173(12), 1109-1117.

This research article has generated significant media attention since its publication. However, as always, some of the media spin does not do justice to the broader view and significance of this research work. Tracy Balboni and her team of investigators wanted to look at the influence of clergy and religious communities and "to determine where spiritual support from religious communities influences terminally ill patients' medical care and quality of life near death." The findings were astonishing, and the results were intriguing, with significant implications for the training of chaplains, medical students, nursing students and other clinical staff members. It also has important significance for community clergy, associations and for-profit healthcare facilities where spiritual care may not be high on the list of their patients' needs. John Ehman, ACPE Research Network convener, presents a robust and elaborate summary of Balboni's article in the May 2013 Article of the Month for the ACPE Research Network. To read the summary, go to <http://www.acperesearch.net/may13.html>. To read the entire article, visit <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3791610/>.

For a list of the significant research work done by Tracy A. Balboni and Michael Balboni in collaboration with other researchers see: [http://www.ups.upenn.edu/pastoral/events/Balboni\\_Bibliography.pdf](http://www.ups.upenn.edu/pastoral/events/Balboni_Bibliography.pdf).

*Austine Duru, BCC, is director of mission and pastoral care at St. Elizabeth Regional Medical Center and Nebraska Heart Health in Lincoln, NE.*

---

## Seeking, Finding: Ministering to same-sex couples in healthcare settings

By Elaine Chan, BCC

Right after New Year's, I was called to the bedside of an elderly patient who had been unconscious the entire time he was hospitalized. I had prayed at his side and arranged for the Sacrament of the Anointing of the Sick, but I had not met the family or friends. I was informed that the family was coming to visit in the afternoon. When I got to the room that day, I met his lifelong partner, as well as his niece and nephew. I prayed with them, and shortly thereafter the patient passed.

A month or so earlier, I had been in the same unit for another patient whose same-sex partner of more than 40 years requested the Sacrament of the Anointing of the Sick for him. Shortly after receiving the sacrament, he passed. In both cases I felt the loving bond between the partners as I watched them by the bedside. Also, I witnessed the profound loss and grief of the living partner. I felt privileged to minister to both of these patients. Their loved ones were most appreciative of my help in arranging for the Sacrament of the Sick and my prayers with them.

Across from one of these patients was another elderly patient who had been in and out of the hospital, with her partner of many years. When the partner saw me, she asked me to say a prayer.

Reflecting on these three pastoral visits, I have to ask: What are the pastoral needs of this population? How can chaplains respond to the patients, their partners, families and others, some of whom may not accept their sexual orientation?

What are the pastoral needs of this population? How can chaplains respond to the patients, their partners, families and others, some of whom may not accept their sexual orientation?

The pastoral needs of the patient who is homosexual are similar to those of a heterosexual patient. They struggle with coping with illness and hospitalization. They seek support, including spiritual and religious support. They may especially need support if family and/or friends have not accepted their sexual orientation. Chaplains can respond by providing one-on-one pastoral care, as well as by facilitating spirituality and bereavement groups specifically for patients and/or their same sex partners.

Often I do not know if a patient is gay or lesbian unless he or she tells me. In these three cases, the partner told me. I feel it takes a great deal of trust for someone to come out to me. It is very personal, and they may be concerned about how I, a religious person, will respond. Some patients may feel estranged from the church because of their sexual orientation and may not initially want my

services. If an opportunity arises to visit them again, I follow up to see how they are doing. Others may use pastoral care services but not tell me their sexual orientation. I do not need to know, but if someone confides in me, I want to be mindful of how I respond. In these and all pastoral encounters, I say a prayer and ask God to guide me in my words and actions.

All human beings have a deep desire to be accepted and loved for who they are. I am aware of cases in which people have been rejected and marginalized by families, friends, religious and institutions. Years ago I heard about a dying patient whose family had not accepted his sexual orientation. This patient's partner was unable to visit him or have any say in his care. This was heartbreaking for both the patient and the partner. If I were the chaplain for this patient, I would have tried to persuade the family to let the partner visit and participate.

A fellow chaplain told me a story about how the family of a dying patient was concerned that his partner was visiting him. When the chaplain got to the room, the patient's partner was reading the Bible to him. The chaplain asked him if he was at peace. He said "yes." She said she felt there was nothing more for her to say or do, since he was at peace.

Pope Francis is often quoted as saying: "If a homosexual person is of good will and is in search of God, I am no one to judge." My role is not to discuss church teachings or judge the patient's sexual orientation. I am mindful of not only the individual, partner and family but also how I speak and act when disparaging remarks are made about homosexuality. As a Roman Catholic as well as a chaplain, I am a role model to others. I need to courageously speak up for the human dignity of all. I am to welcome and include those who may not always feel welcomed in the Catholic community. In my research, I found church documents on the subject including a November 14, 2006, statement by the United States Conference of Catholic Bishops on Ministry to Persons with Homosexual Inclinations. The document is a way of beginning a conversation. We need also to include people who are homosexual in the conversation.

As we enter the holy season of Lent, may we learn to fast from judging and feast on acceptance. May we give ourselves fully to all in need, especially those who may feel marginalized and rejected. May we know God's love for us and all beings. May the Holy Spirit guide us in all things. God bless you and your ministry!

*This article is dedicated to Fr. James Nieckarz, M.M., who died Nov. 4, 2013. In the late 1980s, Father visited people with AIDS in New York hospitals and at their homes. Some of these patients had been abandoned by their partners, families and friends. Father was their only visitor. He conducted many funerals and memorials for them and also facilitated a bereavement group for survivors. He also was involved with two different prayer groups, as well as serving on an institutional review board that created protocols monitoring experimental drugs for people with AIDS.*

*Elaine Chan, BCC, is a staff chaplain at New York Hospital in Queens, N. Y. and Healthcare Chaplaincy Network.*

---

## Featured Volunteer: Kay Gorka

**Name:** Kay Gorka

**Work:** Manager of Spiritual Care at Providence Sacred Heart Medical Center and Providence Holy Family Hospital

**Member since:** 2006

**Volunteer service:** Washington state liaison

**Book on your nightstand:** *Field of Compassion* by Judy Cannato

**Book you recommend most often:** *Joan of Arc* by Mark Twain

**Favorite fun self-care activity:** Roller skating with my 5-year-old

**Favorite movie:** Gravity

**Favorite retreat spot:** My family ranch in Montana

**Personal mentor or role model:** My grandfather

**Famous/historic mentor or role model:** Sr. Joan Chittister

**Why did you become a chaplain?** I worked as a nursing assistant at 15 years old, and I noticed some of the suffering people experienced in the hospital was noticed, but not addressed.

**What do you get from NACC?** A supportive community and trusted colleagues.

**Why do you volunteer?** To serve and work at finding opportunities to support other chaplains in order to advance chaplaincy as a profession.

**What have you learned from volunteering?** There is always an opportunity to advance chaplaincy.

---

## Featured Volunteer: Matthew Kammer

**Name:** Matthew Kammer

**Work:** Director of Chaplaincy Services at Avera McKennan Hospital in Sioux Falls, SD

**Member since:** 2003

**Volunteer service:** Ethics Commission and South Dakota State Liaison

**Book on your nightstand:** *The Rule of Benedict: A Spirituality for the 21st Century* by Joan Chittister, OSB

**Favorite fun self-care activity:** Running, pushups, pull-ups, dips, sit-ups

**Favorite movie:** City Slickers

**Favorite retreat spot:** Any place or activity on the family farm

**Personal mentor or role model:** Grandpa Helmut

**Famous/historic mentor or role model:** Paul Harvey

**Why did you become a chaplain?** In my junior year of college, my professor asked me how I saw myself helping people. I told her I wanted to meet people where they are at, hear their unique stories and never have to judge or place a human-made value on them. She said, "You sound like a chaplain," and helped me enroll in my first unit of CPE my senior year. The rest was history!

**What do you get from NACC?** Connection, guidance and support from a community of caring individuals who believe in the sacredness and the professionalism of an amazing healing Ministry.

**Why do you volunteer?** I grew up in small Midwestern farm community that taught that volunteering is the heart of growth and sustainability in any community so that no needs go unmet.

**What have you learned from volunteering?** Humility

---

## Book review: Establishing and exploring the field of ‘neurotheology’

By John Gillman, Ph.D, BCC

Andrew B. Newberg, *Principles of Neurotheology*. Ashgate Science and Religion Series. Burlington, VT: Surrey, England: Ashgate Publishing, 2010, 276 pages. Softcover, \$29.95.

An associate professor of radiology and psychiatry at the University of Pennsylvania, Andrew Newberg has dedicated much of his research to exploring religious experience from a neuroscientific framework. In this volume he sets forth 54 principles for “neurotheology,” which he defines as the field of study linking the neurosciences with religion and theology.

He asserts categorically that “all religious beliefs and all religious systems can be considered from a neurotheological hermeneutic.” Since the brain is necessarily involved in assent to religious beliefs, religiously motivated behavior and the processing of religious experience, this principle, while offering a relatively new approach for theology, merits serious consideration.

Newberg challenges readers, from the materialists to the idealists, to question their assumptions in light of new data, particularly from the study of brain processes. At the same time, he acknowledges that the brain by itself cannot definitively determine truth about the world or truth claims made by theology.

Also a lecturer in religious studies, Newberg is well versed in the views of major theologians and religious thinkers. He also occasionally cites the catechism of the Catholic Church. In chapter nine he specifically offers reflections on major topics in theology.

Since one of the standards for the certification of chaplains is the ability to “incorporate a working knowledge of psychological ... disciplines” (302.2), those in our profession would be well served to be aware of the research being conducted on brain activity as it relates to religious experience and beliefs.

It would have been helpful had the author applied Occam’s razor (“plurality should not be posited without necessity”), which he discusses, to the proliferation of principles, thus yielding a reduced number with a more focused content specific to neurotheology. Also, I found it curious that the majority of the principles are formulated as duties or obligations (“should” or “must”) rather than as fundamental truths or propositions. Finally, although the study is well footnoted, it lacks a bibliography.

This volume presents a new approach toward the relationship between religion and science that has significant implications for chaplains who would like to broaden their understanding of the neurological component of spiritual experiences.

*John Gillman is an NACC and ACPE supervisor at VITAS Innovative Hospice Care in San Diego, CA.*

## Book review: A practical theology of dementia

By John Gillman

John Swinton, *Dementia. Living in the Memories of God*. Grand Rapids, MI: Eerdmans, 2012. Softcover. 298 pages. \$25.00.

One of the most feared diseases today, dementia affects over a quarter of the population in their 80s and 90s. This increasingly prevalent affliction is an ongoing challenge medically and theologically. In this volume, John Swinton, professor of practical theology and pastoral care at the University of Aberdeen, Scotland, articulates a practical theology of dementia that serves as a solid foundation for dialogue among chaplains, the faith community, and beyond that, the medical community.

With thorough research and persuasive argument, Swinton addresses the question: Who am I when I've forgotten who I am? He rejects the notion that loss of memory means loss of self-identity.

Drawing upon Buber's perspective, Swinton maintains that those with dementia are indeed persons by reason of their being in an "I-Thou" relationship with God. He adds: "Even if human beings do not or cannot respond, they remain persons as God the absolute Person continues to relate with them." The value and identity of human beings is assured ultimately by God who created them and sustains them through the power of the Holy Spirit.

The invitation for pastoral-care givers is to approach those with dementia with the intention of engaging in an "I-Thou" relationship and thus to bear witness to the Divine who may be experienced in "the between." This implies that any tendency to objectify, analyze or conceptualize the other – thus limiting this to an "I-It" interaction – is put aside, so that there is the possibility of a real meeting of one human being with another, both of whom have been created in the image of God.

Swinton affirms that it is not a person's memory that assures one's identity; rather it is the memory of God. In suggesting that God remembers those with, for instance, advanced dementia, the author asserts "that God is with and for them and that God *is acting* with and for them in the present as they move toward God's future" (p. 217, emphasis in original). Speaking collectively, he concludes that since we are held in the memory of God, then dementia does not destroy us.

The church has a special role as well, which is to be an attentive community of memory and hope for those suffering with dementia. By including them in community worship, prayer and ritual, the church attests to their meaningfulness and dignity as full members of the People of God.

Swinton's contribution to the theology of dementia merits careful attention and ongoing reflection. In particular, I believe that more consideration needs be given to the meaning and implications of the assertion that those with dementia are in an "I-Thou" relationship with God. Also, what are some meaningful ways for chaplains and the community of believers to hold the memory of those who no longer recall their own identity?

*John Gillman is an NACC and ACPE supervisor at VITAS Innovative Hospice Care in San Diego, CA.*

---

SOURCE: *Vision*, March/April 2014

Visit [www.nacc.org/vision](http://www.nacc.org/vision) to read or subscribe.

Vision is a serial publication of the National Association of Catholic Chaplains.