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Spiritual Wellness and Prevention

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Let's think more broadly about spirituality of wellness

By David A. Lichter

In this *Vision* issue, NACC member Marilyn Williams expresses clearly how wellness programs, for some time, were not as inclusive of the spiritual dimension, and now there is a more concerted effort to make spiritual wellness one of the dimensions of wellness (www.nacc.org/vision/2015-Nov-Dec/After-drifting-away-from-spirit-wellness-needs-to-come-back-By-Marilyn-Williams.aspx). Marilyn offers a very helpful way of examining "spiritual health." She also reminds us of the challenge of one of our Conference 2014 plenary speaker, Chris Lowney, that we develop a deeper spirituality of wellness. I appreciate the challenge. Let me just use a couple website samples to make some observations on our theme.

The day I did a Google search on spirituality, I received 112 million results! Spiritual health received 50 million results. Searching "spirituality of wellness," I got 12.6 million results! Spiritual wellness received "only" 5.7 million results! Of course, these results include all sites that include both of these terms, so the might not tell us much. However, we can learn from reflecting on a spirituality of wellness.

The Psychological Health Program website of the National Guard Bureau (www.jointservicesupport.org/PHP/Spiritual.aspx) names spiritual wellness as one of its *five* wellness pillars, along with physical, emotional, social, and family. This spiritual wellness was described in a three-dimensional way: contemplating one's purpose in life and achieving greater mindfulness of one's impact on the rest of the world; achieving harmony with one's surroundings and balancing one's personal needs with the needs of others; and having personal values and beliefs and acting compassionately in accordance with those values.

Its website even offers a description of spirituality as "expressed in many forms, whether tied to a religion, a moral philosophy, or an inherent sense of connectedness with something greater than oneself. In any form, spirituality is always personal." Specifically describing spiritual wellness, it says that the need "is often downplayed as less important than emotional, physical, or social wellness, but vital to the overall wellness of every Service Member in the National Guard is a sense of hope and belonging – of purpose."

The University of New Hampshire Health Services website at www.unh.edu/health-services/ohep/spiritual-wellness offers *eight* dimensions of wellness: emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual. And it suggests, "Spiritual wellness may not be something that you think much of, yet its impact on your life is unavoidable."

It offers its own description of spirituality as "discovering a sense of meaningfulness in your life and coming to know that you have a purpose to fulfill." It further adds, "Many factors play a part in defining spirituality — religious faith, beliefs, values, ethics, principles and morals. Some gain spirituality by growing in their personal relationships with others, or through being at peace with nature." Spirituality, it says, "allows us to find the inner calm and peace needed to get through whatever life brings, no matter what one's beliefs are or where they may be on your spiritual journey." Then it adds, "If we take care of our spirit, we will be able to experience a sense of peace and purpose even when life deals us a severe blow. A strong spirit helps us to survive and thrive with grace, even in the face of difficulty."

Let me make two observations about a spirituality of wellness. First, it would be helpful to use the definition of spirituality offered in the *Clinical Practice Guidelines for Quality Palliative Care 3rd Edition*, "Spirituality is that aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience connectedness to the moment, self, others, nature, and/or to the significant or sacred." This definition can be helpful as it offers a two-dimensional understanding of spirituality: meaning/purpose and connectedness. This goes beyond most definitions that simply focus on meaning/purpose, or ones that only connect one to some religion, philosophy, or transcendent connection. This broader definition would allow an approach to a spirituality of wellness that includes all the dimensions of wellness.

This leads to my second point. A spirituality of wellness should look not only at spiritual and emotional wellness but the totality of wellness. It seems many approaches examine only spiritual wellness. However, if we use the definition of spirituality above, then the second half of the definition allows us to connect all the dimensions of wellness together within a spirituality of wellness. Whether it is the five pillars of the National Guard or the eight dimensions of the University of New Hampshire, a spirituality of wellness would help us emphasize the holistic nature of wellness.

I appreciate the challenge to us to develop a deeper spirituality of wellness. What are your thoughts?

Blessings to you,

David A. Lichter, DMin.
Executive Director

After drifting away from spirit, “wellness” needs to come back

By Marilyn Williams

The Affordable Care Act has renewed attention on prevention, wellness, and the continuum of care throughout the life cycle. This discussion also indirectly appeals for healthcare to be holistic, encompassing the whole person — mind, body, and spirit. To date the healthcare chaplain’s voice and leadership has mostly been absent in this dialogue, and in the research underlying wellness and holistic approaches to care. I would suggest that chaplains need to enter into this arena by asking and answering the question, “What is spiritual health?”

Over a half century ago, the World Health Organization defined health “as a complete state of physical, mental, and social being and not merely the absence of disease or infirmity.” However, in the 1970s and 1980s, most people, including health professionals, still thought of health only in terms of the body’s anatomy, physiology, and pathology or the absence of disease or infirmity. In response, some developed a model of total well-being they called “wellness,” while others used “holistic health.” In addition, by the 1990s many became interested in medicine developed outside of the West’s bio-medical model, as well as in specific modalities that became known as alternative, complementary, or more recently as integrative therapies. Some of these modalities would be referred to as mind-body interventions, as research started showing the interconnection between the mind and body. This body of research is sometimes referred to as psychoneuroimmunology. Much of this research would provide fertile ground for the integration of the spiritual dimension into wellness programming. Moreover, these years saw more research regarding the impact of religion and/or spirituality on physical and mental health. Most recently, some health professionals and researchers talk about the bio-psychosocial or bio-psychosocial-spiritual model of healthcare.

The earliest proponents of “wellness,” such as Dr. John W. Travis and his co-author of “The Wellness Workbook,” Regina Sara Ryan, spoke of it as a choice, a way of life, and a process that is never static and has no endpoint. Wellness to them encompassed all dimensions of life including those related to spirituality such as relationships with self, others, and the transcendent and finding meaning. “No matter what is your current state of health,” Travis and Ryan stated in the introduction to their book, “you can begin to appreciate yourself as a growing, changing person and allow yourself to move toward a happier life and positive health.”

In writing this article, I was surprised to discover that many of the wellness principles and mind/body interventions I use with support groups, with stress management programs for patients and staff, and with one-on-one pastoral care, are from publications and conferences of 20 or 30 years ago! However, a quick Internet review leads me to believe that the original work regarding wellness and spiritual care has as much value today as when it first appeared (and may be more useful than some more recent work).

An unfortunate trend of wellness programs is to focus primarily on the physical: exercise, nutrition, weight management, smoking cessation, etc., despite the more expansive vision of the earlier proponents of wellness. While some programs do address stress management and emotional health, and may even include questions addressing spiritual health, the earlier push to integrate all dimensions appears to be mostly lacking.

Should we call this concept of spiritual well-being “spiritual health” or “spiritual wellness”? I have chosen “spiritual health” because the concept of health as encompassing the spiritual dimension is clearly articulated in the Catholic tradition of healthcare as well as implied in the WHO definition. The Ethical and Religious Directives assert: “Since a Catholic health care institution is a community of healing and compassion, the (health) care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social and spiritual dimensions of the human person.” Also, the use of “health” seems to be more consistent for looking at the state of spiritual well-being at any given time if “wellness” is regarded as a journey toward wholeness or complete health.

My guess is that most healthcare chaplains would say they know “spiritual health” when they encounter it, even if they might have trouble describing it. The starting place, thus, may be to identify the signs or indicators of spiritual health. Based on my ministry experience; on a list by Elizabeth Tsang, BCC used in a 2007 presentation; and on wellness literature, especially “Seeking Your Healthy Balance” by Donald A. and Nancy Loving Tubesing, I would propose the following indicators for discussion and research:

- Knowledge and acceptance of oneself
- Acceptance of one's current reality
- Resiliency in coping with life's challenges
- Acceptance of life's limitations and the ultimate reality of death
- Optimistic and hopeful / has dreams and goals
- Forgiveness of self and others
- Care and concern for others
- Trust
- Ability to receive love and care from others
- Feeling that life has meaning/purpose or has a commitment to something
- A sense that one's actions are consistent with personal values/beliefs
- Appreciation and gratitude for something
- Playfulness or the ability to celebrate and experience joy
- Reverence and awe for the mystery of life or awareness of the transcendent

It should be noted that these indicators could apply to those who do not practice any organized religion or even profess any religious or spiritual beliefs.

Finally, we should develop a deeper and explicit spirituality of wellness, as we were challenged to do by Chris Lowney, one of our plenary speakers at the 2014 NACC conference. A spirituality of wellness could challenge us to wake up and pay attention to how we care for our bodies and minds as well as spirits. And thus help us to begin and progress on the journey of wellness, finding better health and more happiness along the way.

Marilyn Williams, BCC, is director of spiritual care at St. Mary's Health Care System (Trinity Health) in Athens, GA.

Chaplains promote spiritual wellness as foundation

By Julianne Dickelman

Providence Health and Services has recently launched a well-being initiative aimed at employees. This initiative from our human resources department encourages us to take advantage of benefits at our disposal to nourish five dimensions of well-being — emotional/spiritual, community, career, financial, and physical. The initiative envisions “well-being champions” who are “committed to building a resilient, inspired and vibrant workplace; encouraging healthy behaviors ... and supporting those around them.”

But haven't chaplains always been well-being champions? Haven't we always supported fellow staff, believing in the trickle-down theory that if the care provider is cared for, then the patient and family receive better care? (We may not always be as good at taking care of ourselves — but I see great improvement on that front.)

Chaplains in other ministries likely do what we do here at Providence Health Care in eastern Washington: serve as critical incident debriefers, lead prayer and memorial services for staff, offer hand-blessings and other rituals, build relationships, become trusted team members, listen compassionately as colleagues share their stories both personal and professional, participate in Schwartz Center rounds, and help create — and advocate for — sacred space in our clinical real estate. There are numerous examples of activities and interventions in which chaplains lead and participate.

But perhaps more essentially, I see great progress in our ability to clearly identify and articulate *indicators* of spiritual health, such as the ability to articulate meaning in the face of change/loss/grief or to name and describe utilization of support systems. We have also made progress with indicators of spiritual distress; e.g., despair that manifests as noncompliance or anger; physical pain as an indicator of spiritual pain rooted in specific or aggregate loss; an inability to forgive or to receive forgiveness; indicators of alienation from family/God/faith. We had to find better vocabulary in order to improve our assessments and charting. Now a rippling effect infuses all the dimensions of our work, and hopefully in our beings as well. That chaplains can help *name* these issues is fundamental to an individual's or organization's ability to design “plans of care” that enhance the positive and support the challenges.

What is the difference between spiritual and emotional health? What expertise do we bring to that specific aspect of whole-person fitness? I am biased that spiritual health is not one of several dimensions, but the ground from which all the others grow. When our HR departments lump this in with the other dimensions, conflate it with emotional health, I think it our responsibility to illuminate the unique role of spiritual health to overall resilience.

Without splitting semantic hairs, we may discover that spiritual resilience differs from the emotional when we commit to digging more deeply — and helping others dig — beneath coping resources to uncover profound issues of meaning, from simply surviving to transcendence, beyond flexibility in handling change to finding purpose that's not dependent on status quo, beyond positive thinking to profound joy. How do you do this? It's a worthy conversation.

To paraphrase Peter Maurin, co-founder of the Catholic Worker Movement, who said “We need to create a society in which it is easier for people to be good,” let us celebrate the ministries of chaplains and those who walk with us in humble, authentic, compassionate service, creating environments where it is easier for others to be spiritually well. Let us continue to give voice to that, to intentionally integrate, in all aspects of our work and our beings, a fluency in the language of spiritual health.

Julianne Dickelman is a chaplain educator at Providence Health Care in Spokane, WA.

Chaplains must model self-care for other staffers

By Jane Mather

Western medicine has increasingly given lip service to the concept of holistic health, employing practitioners of mind and spirit to accompany the technical work of doctors and nurses in the care of patients and the support of their families. Chaplains have been employed to support the spirit, and social workers, psychologists and psychiatrists to render emotional and psychological nurture. Given the emphasis on evidence, we can assume that these roles exist because they have proven effective, not just at the end of life when all medical means have failed, but throughout the healing trajectory.

While chaplains were originally engaged as support for patients and their families, care for the whole person, body, mind and spirit, has evolved to include the caregiving staff as well. A healthy staff — one that is physically well, emotionally steady and spiritually balanced — creates an environment conducive to healing. The fact that such an environment also improves patient satisfaction, reduces absenteeism, employee turnover and worker dissatisfaction has also been duly noted by those keenly interested in how such factors impact the bottom line.

Chaplains attending to the sick and the dying know well the interplay between mind, body and spirit, and how care for any of those dimensions will be good for all of them. However, it has become increasingly popular to pay special attention to the human spirit in the interest of holistic health. We have learned that the mind and the spirit can provide critical help to those suffering from bodily sickness or injury, especially when we engage the mind and spirit on behalf of healing. The work of chaplains in healthcare is the intentional support of each person's spiritual health.

Once relegated to discussions between clerics and their parishioners, today spiritual well-being has become front-page material for *Time* magazine and highlighted in *Forbes* and the *Harvard Business Review*. Increased public awareness of the importance of personal spiritual health (not to be confused with specific religious teachings) has helped employers of all types to encourage their employees to care for all dimensions of their health. Growing numbers of businesses have included workout and exercise rooms, counseling, and places (both physical and time) for quiet meditation.

A business may see such measures as a means to a financial end; but chaplains see spiritual wellbeing as an end in itself. Attending to the whole self allows individuals to become their best, regardless of their occupation, physical status or religious connection (or lack thereof), and although the chaplain has historically been involved in care for patients who are sick or near death, we are becoming more aware that the same skills we have used to support and restore health can also be used to prevent sickness! Care for and attention to mind, body and spirit in balance and with intention — these are the building blocks of health!

Healthcare administrators are slowly realizing that supporting caregivers' health also improves the care that their patients feel they have gotten from those same workers; thus, programs are developing at even the busiest hospitals and clinics to engage staff in holistic self-care. Because the busiest, most hectic places, such as ICUs and emergency departments, seem to impose the most intense stress on the doctors and nurses who work in them, they are most in need of developing practices that restore and inspire health.

The phrase "Physician, heal thyself" nudges us to avoid hypocrisy by walking our talk. Healthcare chaplains must be prepared to model healthy self-care behaviors and lead and inspire others to take literally the admonition to be healthy from the inside out. It is not just to maintain a viable workforce, but because we are called to honor health (root word "whole") as a gift of creation, for ourselves, for the patients and families we encounter and for the colleagues with whom we work. Teaching our colleagues about healthy self-care practices, and advocating for time and space in our workplaces to practice them, will change the environment of care almost as much as our time at the bedside of patients.

Chaplain time dedicated to staff care expands the concepts of self-care exponentially, because every doctor or nurse then touches multiple patients, hopefully with less stress and more compassion. If we can teach about critical incident stress management, second-victim support, spirituality and the workplace, resiliency and coping skills, or offer support groups and Bible study groups for staff, then a holistically healthy medical staff is likely to be attentive to the basic spiritual needs of patients and families. This frees chaplains to attend to the most spiritually distressed patients — who are more likely to be identified and referred by spiritually attuned caregivers! Such an integrated model of care fulfills both the medical and the spiritual mission for healthcare — especially Catholic healthcare — and is likely to shape the future for healthcare and for chaplains. Let's be equipped to teach, model and lead past the bedside and in cooperation with colleagues equally dedicated to mind, body and spirit wholeness.

Jane Mather, BCC, retired as the director of the Center for Health and Wellbeing at Providence Health Care.

Schwartz Center rounds help alleviate moral distress

By Karen Pugliese

In 2010, our palliative team began Schwartz Center Rounds at Central DuPage Hospital. Guided by co-facilitators (myself and a social worker), each month a panel of caregivers from diverse disciplines briefly describe their patient experiences, not from the medical model perspective, but from an emotional, human, reflective, and “feeling” perspective. Within a confidential, safe environment, panel members and participants focus on their patient-caregiver relationships. The format comes from the Kenneth B. Schwartz Center, which was founded “to support and advance health care in which caregivers, patients and their families relate to one another in a way that provides hope to the patient, support to caregivers, and sustenance to the healing process.” Clinical staff from every area of the hospital and outpatient settings explore our own personal responses, perceptions and prejudices in order to promote compassion toward patients and their families’ needs, as well as toward one another.

As increasingly challenging and complex situations surfaced during these meetings, we began to look into the rich resources in nursing literature highlighting continually shifting patient conditions such as acuity, life-and-death issues, technology, complex staffing models, caregiver-to-patient ratios, and workforce shortages. These issues, as well as appropriate and ethical care delivery, present sometimes overwhelming concerns for chaplains and other disciplines, as well as for nurses. Much research and many learning programs had been created to raise awareness and coping skills for syndromes such as burnout and compassion fatigue. Clinicians traditionally have had a difficult time talking about these skills because there hasn’t been a common language for understanding, quantifying, assessing and developing those competencies.

As far back as 1984, moral distress was seen as a key factor negatively affecting healthcare providers. Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints. In 1993, nursing literature identified the stress caused by providers feeling tremendous sense of responsibility, but little authority. In 1995, research indicated that nurses and other providers who felt caught between the needs of the patient and the demands of hospitals experienced a strong tension between power and powerlessness. The consequences are far-reaching. Demonstrated long-term effects include decrease in self-worth, estrangement in personal and professional relationships, behavior changes and distressful physical symptoms. The effects do not diminish; each new experience leaves a new coating of psychic residue on the layers of distress already embedded. Although studies have focused on quantifying moral distress, there has been almost no research on what type of interventions are effective in reducing it.

As chaplains, we are not immune to these effects in ourselves and in the staff with whom we work. At CDH, one of our associate chief nursing officers, along with me and my social worker colleague, wondered if staff exposed to supportive interventions would exhibit greater resilience in coping with moral distress. We created a 24-month action plan featuring a three-pronged intervention process. A key component was our monthly Schwartz Center rounds, with additional opportunities for individual and group consultation and counseling, as well as cognitive learning sessions and using the Ethics Committee. Our findings indicated an overall decrease in moral distress scores between pre-intervention and post-intervention groups, and a significant difference in decline between control and experimental groups. Moral distress scores were significantly higher for those who were considering leaving their position.

And so we more purposefully integrated Schwartz Center rounds into our intervention plan. We intentionally related moral distress to the cases presented each month. We used one of the sessions to present a Schwartz Center webinar on moral distress. Every other week I would post eye-catching fliers in report rooms and locker rooms, reminding staff of signs and symptoms of moral distress, as well as available resources for coping. We instituted a moral distress hotline on each of our phones.

Schwartz Center rounds promote empathy and compassion toward patients and families, and foster openness to giving and receiving support *from colleagues* — something healthcare providers, including chaplains, often find difficult. Those who participated reported enhanced personal connections and improved insights into their own experiences, as well as increased appreciation of others’ roles and contributions.

Some of the evaluative comments we received include:

"I have had flashbacks and panic attacks upon coming back to work before. I never fully understood what was happening. Now I have a supportive community of co-workers."

"The conversation from the panel and participants helped to normalize my own reactions."

"I learned how to recognize the physical symptoms that resulted from what I was experiencing, and give it a name."

It has been said that we teach what we need to learn. For me and my chaplain colleagues, Schwartz Center rounds inspired and encouraged us not only to address stressful, ethical and challenging situations with one another, but also with our clinical colleagues. We are more intentional about noticing signs and symptoms within ourselves and our coworkers, and more likely to seek "in the moment" support. We work with a heightened awareness of the importance of respecting self and staff determination in self-care. Last year, our Spiritual Care Resources Department provided nine days of reflection for employees focusing on personal, professional and spiritual resilience. We have committed ourselves to learn more about integrating emotional intelligence theory and somatic regulation interventions along with resilience theory in our ministry. And we come aside for a day of reflection ourselves each year to explore our inner space, and share with one another something of that sacred region deep within and far beyond ourselves where we discover ever-new meaning in our ministry.

Karen Pugliese, BCC, is an advanced practice chaplain at Central DuPage Hospital in Winfield, IL.

Eucharistic ministers need chance to absorb spiritual hospitality

By Beringia Zen

Some time ago, I came upon one of our department's Catholic volunteer Eucharistic ministers who was visibly upset. She told me about a patient who not only needed the Eucharist but also a caring, listening presence. On this particular day, she happened to be that needed presence. "I was in tears after I left the room," she told me. I asked her how she might take care of herself after such an encounter. She responded, "I will just add her to my prayer list. What else can I do?"

Communion ministers, just like chaplains, are spiritual witnesses to suffering, sickness, dysfunctional family dynamics, death, anxiety, and fear. Even though they are volunteers assigned the task of giving the Eucharist, they are also at risk for compassion fatigue and vicarious trauma. Coordinators of volunteer Eucharistic ministry programs should know the challenges and possibilities for integrating practices of self-care.

These volunteers are often in a liminal position; they are not chaplains, but neither do they only serve the Eucharist. During June, July and August of this year, our 29 Eucharistic ministers made contact with 3,210 patients and family members. Out of these contacts, 49% involved communion. So Eucharistic ministers spend over half of their volunteer hours engaging with patients and families outside their primary task of serving the Eucharist. Our volunteers are trained to refer patients to departmental chaplains when additional emotional or spiritual support is needed. However, they often find themselves in situations where they are the primary givers of spiritual care.

One day, after being out on the hospital floors, a Communion minister reflected, "I made some hospitality calls today." He was referring to those visits that stay on surface topics such as the weather, Kansas City sports teams, or national news. As we talked further about the concept of hospitality, he proposed that perhaps his ministry could be understood as spiritual hospitality — an important insight. Eucharistic ministers enter a hospital room entrusted with the authority to give patients and families the body of Christ. As a result of this authority, however, they also bring their unique spiritual wisdom to which Catholic patients and families are often attuned. Eucharistic ministry in a hospital setting is a vocation of hospitality that intertwines the giving of both Eucharist and spiritual presence.

Abba James, one of the Desert Fathers from the fourth or fifth century, is thought to have said, "It is better to receive hospitality than to give it." I have shared this piece of desert wisdom with our Eucharistic ministers to reflect on the importance of self-care. Those who give hospitality also need to receive hospitality; in fact, it is in the balance of giving and receiving that emotional and spiritual equanimity is found. I have stressed to our Communion ministers that a crucial aspect of Eucharistic ministry is developing a spiritual practice of self-care — a practice of giving oneself spiritual hospitality.

For our volunteers, this can be a counterintuitive idea. The foundation of Eucharistic ministry is to give the Eucharist; this is not a ministry based in the symbolic giving of oneself but a concrete sharing of a tangible sign of God's grace. Additionally, self-care cannot be learned in a single training session, but develops slowly over time as spiritual caregivers are formed in their vocation. Such ongoing formation of Communion ministers can often be hindered by the challenges of staff workloads and the often fluctuating schedules of volunteers.

Despite these challenges, ongoing formation can be informally interwoven into encounters between departmental staff and Communion ministers. Volunteers need to be informed of the signs of compassion fatigue and vicarious trauma through emails, educational pamphlets, or direct conversation. This education can validate an existing self-awareness of Eucharistic ministers that their hospitality extends beyond the rituals of giving Communion. Such education normalizes the emotional and spiritual difficulties that they feel, and leads to opportunities for emotional processing with departmental staff and for introducing a variety of tools for self-care. I have found that just the suggestion of journaling or developing a simple ritual around hand-washing can help Communion ministers to explore the delicate and necessary balance of giving and receiving spiritual hospitality.

Also, staff chaplains must model self-care. When volunteers witness staff chaplains caring for not only others, but themselves, self-care becomes part of the lived, shared experience of departmental best practices. I collage for self-care, and I often leave one of my collages in progress on my desk. Doing so allows me to share my processing with our volunteers and demonstrates one way of practicing self-hospitality. Also, as much as I can while still maintaining the boundaries of HIPPA, I share with our volunteers my own struggles with emotionally and spiritually challenging hospital encounters. The modeling of self-care creates an environment of vulnerable collegiality rather than one of guarded demarcation between chaplain and volunteer. As Eucharistic ministers learn ways of caring for themselves, they not only learn important skills, they begin to integrate the spiritual value of self-care into their ministry.

Beringia Zen, CSJA, PhD, is a chaplain and Catholic coordinator at St. Luke's Hospital in Kansas City, MO.

Teaching gratitude and forgiveness improves patients' lives

By Matt Kronberg

In faith-based healthcare, we value caring for the body, mind, and spirit. But how do we operationalize this value? What does it mean to care for patients and their families in a holistic way? While there are not simple answers, one possibility is to teach people — patients, families, and staff — to embrace practices in forgiveness, compassion, and gratitude. Such practices can foster hope and resilience.

The practice or habit of being grateful, for instance, is one thing that can help lead to greater health outcomes. When we are conscious of the gifts and good things in life, we feel most alive. Realizing the blessings in life both leads to and enhances a healthy and vibrant life. This has been scientifically verified, and much research has been done in this area ([See Emmons, 2003](#)). Being grateful can help not only patients; it can help anyone. Life is not about survival; it isn't about getting discharged from the hospital, making it to retirement, or making it to the next day. It is about embracing the fullness and goodness of life and all that it has to offer.

I recently participated in a conference that highlighted not only gratitude research but evidence-based research on altruism, mindfulness, and forgiveness. A physician at the conference shared how for years he prescribed his HIV and hepatitis C patients daily walks, daily gratitude journaling, and weekly volunteering. All of these practices, he knew, had evidence-based research showing that they improve health outcomes. His 30-plus years of personal experience confirmed the research. He stated emphatically, "I could always tell who was going to be successful in their treatment. Those patients who complied with the daily walks, gratitude journal, and volunteering were almost all successful. Those who didn't; well, almost every single one didn't have a good outcome." The efficacy of these practices is true and verifiable. See, for example, the work being done at UC Berkeley (ggia.berkeley.edu).

Physician and author Ira Byock explains in his book "The Four Things That Matter Most" that our focus should be on living out the following statements:

- Please forgive me.
- I forgive you.
- Thank you.
- I love you.

Forgiveness, compassion, gratitude and hope are not only important at the end of life; they are the most important things in life. Consider another story. A few months ago a staff chaplain met with a woman caught in a complex web of abuse who had out-of-control anxiety. After the chaplain met her and established rapport, the woman said that she didn't feel safe with anyone in her life — not a family member, not a friend, not God.

The chaplain proceeded to ask if there was anything or any place that gave her comfort. She responded, "Well, I really do love my dog." And at the mention of her dog, the woman's constant rocking stopped and her breathing became more even. "Yes, I do love my dog," she exhaled.

This opened the door to the chaplain leading the woman in a guided meditation where she envisioned the safety and love and comfort of her dog — no matter her external circumstances. This intervention created a sanctuary of sorts — a place of comfort and safety — for this woman.

This story highlights a spiritual practice that spiritual care can promote. While the patient felt great spiritual and emotional distress, the key to moving toward a positive outcome — towards gratitude and compassion and hope — was to focus on her strengths and give her a tool, a spiritual practice, to take with her. In this case, what gave her strength was thinking about her beloved pet — her dog. Far from being trivial, this may have been the most important intervention of this woman's hospitalization.

With shorter and shorter hospital stays, it may seem that a chaplain's opportunity to make a difference in patients' lives is dwindling. Our time with patients — especially with those able to talk and open to some level of spiritual direction — is greatly diminished. Perhaps it is time for chaplains to focus more on the long-term goal of engaging and teaching patients about practices that foster spiritual health?

There is not a simple answer to the challenge of focusing on prevention and wellness. But opportunities are all around us. As healthcare shifts to focus more on improving the health of populations as a whole, spiritual care can make a corresponding shift. We will need to become experts in the spiritual practices and experts in collaborating with other healthcare professionals doing science-based research on practices that encourage a more meaningful and vibrant life.

Rev. Matt Kronberg, BCC, is director of spiritual care for the Dignity Health Central Coast Service Area in Santa Barbara County, CA.

Breath prayer brings God into the body

By Kathy Quinn Anderson and Susan Flynn Boruff

“Breathe God in, breathe God out; breathe God in, breathe God out.” Chances are if you ever attend one of our retreats, you will hear these words and put them into practice. We have been teaching the power of the breath prayer for many years. Our ministry, *Take Twelve Today*, encourages all Christians to stop, breathe and listen for at least 12 minutes a day. Why? To take time for God, to take time for silence and to take time to listen for God’s direction in your life. It has been said that “silence is God’s first language.” The breath prayer is an essential practice for spiritual wellness as it cultivates silence and brings our focus on God. According to the Desert Fathers and Mothers, the breath prayer is the foundation for all other spiritual practices. In our experience it is the one practice that makes the most difference for the people who attend our retreats. Not only does it bring the sense of peace and stillness that we are all seeking, it also teaches us how to focus on God. It is a way to pray without ceasing. It is spiritual nourishment. With every breath, we can breathe God in and breathe God out. Prayer is our relationship with God, and when we adopt the breath prayer as a spiritual discipline, our relationship with God can deepen. As we draw nearer to God daily, our spiritual wellness improves.

God has designed our brains to become like what we focus on. When we focus on our anxieties, worries, and fears, we become fearful and anxious. According to Deepak Chopra in his book “*Super Brain*,” our brain is always eavesdropping on our thoughts. We are our own movie production company with little or no direction. Our movies are full of action, drama, tragedy, comedy and romance. Unfortunately we tend to keep replaying the dramas and tragedies in our lives over and over, and this contributes to our suffering. St. Augustine put it this way: “All the time I wanted to stand and listen. To listen to Your voice. But I could not, because another voice, the voice of my ego, dragged me away.”

Cut! This is where *Take Twelve* comes in. We are invited to become the “director” of our movies. We can become aware of our tendency to rerun the negative tapes, we can edit our tapes and we can practice letting go. This is what we learn in the breath prayer. Recent science has shown that as little as 12 minutes a day of meditation is enough to rewire our brains for more love, compassion, tolerance, and acceptance. By focusing on a loving God in meditation, we can develop the mind of Christ who set his “mind on things above, not on earthly things.” (Colossians 3:2).

God wants us to use the wisdom of our body, not let our bodies use us. The breath prayer teaches us how to slow down our body. As we breathe slowly and deeply, our heart rates slow down and the body stops releasing anxiety-producing harmful chemicals. Deep breathing deactivates the limbic system in our brain where fear, anger, anxiety and other negative emotions are generated. It helps us become less reactive and more receptive. Many of us have heard the term “monkey brain” to describe how our minds tend to jump from thought to thought just as a monkey jumps from limb to limb. We need a method to slow down and let go of these thoughts. The breath prayer trains us to focus on one thing, our breath, as we breathe in and out a scripture, “For God alone, my soul waits in silence.”

The more we practice, the more it brings us out of our suffering and into a loving awareness of God’s presence. We become less reactive and more receptive and open to receive all that God has for us. This spiritual training allows us to follow St. Paul’s invitation in Philippians 4:8-9: “Finally, beloved, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy — think about such things. Whatever you have learned or received or heard from me, or seen in me — put it into practice. And the God of peace will be with you.”

The following are some examples of people who have put it into practice. They have learned to quiet the world of inner chatter and open their listening hearts.

- Janet, who is going through a difficult divorce and uses the breath prayer to keep her emotions in check and lessen her anxiety,
- Ginger, who has a devoted meditation practice and notices that she feels more peaceful and calm and is able to live more in the moment,
- Emily, who has been suffering from insomnia and after learning and practicing the breath prayer, has been sleeping through the night for the first time in months,
- Kallie, who as a mental health clinician uses breathing meditation to help her patients through panic attacks,
- And John, who suffers from PTSD, and has learned through scuba diving the power of silence and deep breathing for his healing.

All of these people understand the power of a regular practice of meditation. And it all starts with the breath prayer; a life practice that is: free and always available and works almost immediately. Just like God.

Kathy Flynn Anderson and Susan Boruff are retreat leaders in northern Virginia who led the NACC’s pre-conference retreat earlier this year. For more information, visit their website, www.taketwelvetoday.com.

Investigating Spiritual Well-Being: Insights from Research

By Austine Duru

The concept of spiritual well-being is not new to health literature and research. In fact, this concept has shown remarkable resilience and has resurfaced in research literature as well as in popular culture, but not without lingering problems related to its complexity and measurement limitations.

David Moberg, a sociologist, was perhaps one of the earliest individuals to attempt to measure spiritual well-being as a subject of sociological study. His "Spiritual Well-Being: Background and Issues" in 1971 introduced a 96-item questionnaire for evaluating spiritual well-being and opened the door for further research. However, it was not until 1982 that Raymond F. Paloutzian and Craig W. Ellison developed a more refined and streamlined 20-item spiritual well-being scale to explore both the subjective and objective aspects of the quality of life (Paloutzian & Ellison, 1991 - see www.lifeadvance.com).

In 2002, the Functional Assessment of Chronic Illness Therapy Spiritual Well-being (FACIT-Sp) was introduced to the research community by Amy Peterman et al. This 12-item instrument is perhaps the best-known tool for measuring spiritual well-being from a broader perspective with a more inclusive set of criteria and language. It has been validated and tested in 15 languages and used in several studies that investigate the correlation of spiritual well-being, health and illness. The FACIT-Sp instrument measures two subscales: a measure of the sense of meaning and peace, and a measure of the role of faith in illness. The initial study, "Measuring Spiritual Well-being in People with Cancer: The Functional Assessment of Chronic Illness Therapy-Spiritual Well-being Scale" tested this instrument and was published in 2002. (The article is available in the *Annals of Behavioral Medicine*, for a fee, at link.springer.com/article/10.1207/S15324796ABM2401_06).

Another article that helped test and validate the FACIT-Sp instrument soon after it was published was Michael J. Fisch et al (2003), "Assessment of Quality of Life in Outpatients with Advanced Cancer: The Accuracy of Clinician Estimations and the Relevance of Spiritual Well-Being – A Hoosier Oncology Group Study." This study explored the correlation between quality-of-life impairments and spiritual well-being among patients. For a fairly thorough review of both articles by Peterman et al. and Fisch et al. please see the ACPE Research Network by John Ehman at www.acperesearch.net/feb04.html.

Peterman, et al, also developed "The expanded version of the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale (see www.facit.org): Initial report of the psychometric properties." This expanded instrument included 11 additional items that explore questions about forgiveness, appreciation, and connectedness.

These earlier investigations and measurement tools laid the groundwork to explore spiritual well-being in the context of illness and disease. This field has grown to include various disciplines, such as healthcare, entertainment, education, social work, human resources, economics and management studies, leadership studies, agriculture, fashion, television, major businesses, politics, political policy and citizenship. The more researchers learn about the connection between spirituality and overall wellness, the more interest it generates among the general public and within the academic community. Certainly this is driving integrative medicine, which is gaining significant traction in the medical community; so also is psychoneuroimmunology or immunopsychiatry, a concept with deep roots in spirituality, psychology, bioscience and neuroscience.

One recent creative application of well-being measure by a chaplain was the team well-being measure developed by chaplain Nancy Cook. Although this is not an investigative research work, Cook lays out a unique four-step process for raising employee well-being within a healthcare organization. Cook draws from the human and development models and the writings of Bernard Lonergan. The protocol is best suited for teams, but can also be adapted for individual use. To read more about Cook's work, go to bit.ly/20x8rSE.

Subsequent scholarship has continued to build on the robust background of research in spiritual well-being and wellness. A key movement in this area, as evidenced by available literature, is a push toward community health, or healthier communities. Inspired by new regulations and incentive structures, organizations are looking at ways to impact the health of the broader community, not just individual members of the community. This has significant impact for healthcare organization, chaplains, communities, policy development and advocacy. Below, we offer

abstracts of a few relevant and more recent investigations.

Austine Duru, BCC, is regional director of mission, ethics, and pastoral care at SSM Wisconsin.

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Abstract: Mindfulness-based interventions are reported as being efficacious treatments for a variety of psychological and somatic conditions. However, concerns have arisen relating to how mindfulness is operationalized in mindfulness-based interventions and whether its 'spiritual essence' and full potential treatment efficacy have remained intact. This qualitative study used interpretative phenomenological analysis to examine participant experiences regarding the acceptability and effectiveness of a newly designed secularized intervention called meditation awareness training (MAT) that follows a more traditional Buddhist approach to meditation. Participants (with issues of stress and low mood) reported experiencing improvements in psychological well-being due to receiving MAT. The wider implications are discussed. This article can be accessed in full for a small fee: link.springer.com/article/10.1007/s10943-013-9679-0 .

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Abstract: This study offers a conceptual framework which relates the influence of spiritual leadership on employees spiritual well-being and job satisfaction. Spiritual leadership is a relatively new concept in leadership literature. It aims to intrinsically motivate the leaders and the followers for their spiritual well-being. Job satisfaction is a critical concept with various antecedents and consequences. The situational and dispositional factors or the combination of both factors determine the level of satisfaction of the employees toward their job. How the leaders spiritual leadership influences employees' spiritual well-being; and its relationship with the employees' job satisfaction are discussed. The framework suggests that spiritual leadership is directly influences employees spiritual well-being and job satisfaction. It is also hypothesized that spiritual well-being is also directly influences job satisfaction and mediates the influence of spiritual leadership on job satisfaction. A full version of this article is publicly available at no cost: www.irnbrjournal.com/papers/1418117947.pdf

Lamis, D. A., Wilson, C. K., Tarantino, N., Lansford, J. E., & Kaslow, N. J. (2014). Neighborhood disorder, spiritual well-being, and parenting stress in African American women. *Journal of Family Psychology, 28*(6), 769.

Abstract: Using a culturally informed risk-protective framework, the purpose of this study was to examine spiritual well-being (existential, religious) as a moderator (protective factor) in the relation between neighborhood disorder (risk factor) and parenting stress in a high-risk sample of low-socioeconomic status (SES) African American women (N = 144). These women, who were primary caregivers of children between 8 and 12 years old, reported on disorder in their existential and religious well-being, neighborhoods, and 3 types of parenting stress. Women who perceived more disorder in their neighborhood had more parenting stress, and women who reported more existential and religious well-being had less parenting stress. Existential (characterized by a sense of purpose in life), but not religious (characterized by a sense of life in relation with God) well-being moderated the relation between neighborhood disorder and all types of parenting stress, such that women with medium or high levels of existential well-being had low levels of parenting stress at low levels of neighborhood disorder, but higher levels of parenting stress at higher levels of neighborhood disorder. No moderation effects were found at low levels of existential well-being. Results are framed in a context that emphasizes their relevance to incorporating family interventions that bolster culturally relevant resilience factors, such as spirituality, pertinent to low-SES African American families. The full text of this article is available for a fee: psycnet.apa.org/journals/fam/28/6/769/

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Abstract: Self-transcendence is considered a developmental process of personal maturity and a vital resource of

well-being in later adulthood. Measurement of the associations between self-transcendence and spiritual well-being in cognitively intact nursing home patients has not been previously published. The aim of this study was to identify the relationships between self-transcendence and spiritual well-being in cognitively intact nursing home patients. A cross-sectional design using the self-transcendence scale and the FACIT-Sp spiritual well-being questionnaire was adopted. A sample of 202 cognitively intact nursing home patients in mid-Norway was selected to respond to the questionnaires in 2008 and 2009. Statistical analyses were conducted using lisrel 8.8 (Scientific Software International, Chicago, IL, USA) and structural equation modelling. A hypothesised structural equation model comprising a two-factor construct of self-transcendence and a three-factor construct of spiritual well-being demonstrated significant direct relationships between self-transcendence and spiritual well-being and total effects of self-transcendence on spiritual well-being. *Implications for practice:* Facilitating patients' self-transcendence, both interpersonally and intrapersonally, might increase spiritual well-being among cognitively intact nursing home patients, which is seen to be of great importance to nursing home patients' overall satisfaction and satisfaction with staff. The two-factor construct of self-transcendence and the three-factor construct of FACIT-Sp allow a more complex examination of the associations between the constructs and prove more specific guidelines for nursing interventions promoting well-being in nursing home patients. A full text of this article can be rented or purchased: onlinelibrary.wiley.com/doi/10.1111/opn.12018/full

West, Colin P., et al. Intervention to promote physician well-being, job satisfaction, and professionalism: a randomized clinical trial. *JAMA internal medicine* 174.4 (2014): 527-533.

Abstract: Objective: To test the hypothesis that an intervention involving a facilitated physician small-group curriculum would result in improvement in well-being. Design, Setting, and Participants: Randomized clinical trial of 74 practicing physicians in the Department of Medicine at the Mayo Clinic in Rochester, Minnesota, conducted between September 2010 and June 2012. Additional data were collected on 350 nontrial participants responding to annual surveys timed to coincide with the trial surveys... Results: Empowerment and engagement at work increased by 5.3 points in the intervention arm vs a 0.5-point decline in the control arm by 3 months after the study ($P = .04$), an improvement sustained at 12 months (+5.5 vs +1.3 points; $P = .03$). Rates of high depersonalization at 3 months had decreased by 15.5% in the intervention arm vs a 0.8% increase in the control arm ($P = .004$). This difference was also sustained at 12 months (9.6% vs 1.5% decrease; $P = .02$). No statistically significant differences in stress, symptoms of depression, overall quality of life, or job satisfaction were seen. In additional comparisons including the nontrial physician cohort, the proportion of participants strongly agreeing that their work was meaningful increased 6.3% in the study intervention arm but decreased 6.3% in the study control arm and 13.4% in the nonstudy cohort ($P = .04$). Rates of depersonalization, emotional exhaustion, and overall burnout decreased substantially in the trial intervention arm, decreased slightly in the trial control arm, and increased in the nontrial cohort ($P = .03$, $.007$, and $.002$ for each outcome, respectively). Conclusions and Relevance: An intervention for physicians based on a facilitated small-group curriculum improved meaning and engagement in work and reduced depersonalization, with sustained results at 12 months after the study. A full text of this articles is available for free in the JAMA Network, registration is required: archinte.jamanetwork.com/article.aspx?articleid=1828744

Merriam, S. B., & Kee, Y. (2014). Promoting community wellbeing: The case for lifelong learning for older adults. *Adult Education Quarterly*, 64(2), 128-144.

Abstract: Community wellbeing is a function of many factors working in concert to promote an optimal quality of life for all members of a community. It is argued here that the promotion of lifelong learning among older adults can significantly contribute to community wellbeing. The aging society is a worldwide phenomenon presenting both opportunities and challenges to community wellbeing. Research suggests that the more active, healthier, and educated older adults are, the less drain they are on family and community resources and services. At the same time, active and healthy elders contribute to community wellbeing through their accumulated life experience, expertise, and service. The relationship between lifelong learning and community wellbeing is argued from a social capital perspective. This framework contends that formal, nonformal, and informal learning activities of older adults promote an active and engaged lifestyle that helps create and preserve community. Issues of access and opportunity are also addressed. This article is available in full for a fee: aeq.sagepub.com/content/64/2/128.short

Learn your limits to avoid burnout

By John Stangle

I love the idea of spiritual wellness, but I must confess that often I get it mixed up with psychological wellness or even physical wellness. Why? Because they are all related but can be distinguished. As chaplains, hearing the terms “self-help” and “wellness” make a flag pop up called “burnout.” Why burnout? Because chaplains, like nurses and doctors and priests and those in so many helping professions, tend to overdo and overextend. We are givers and doers, and we sometimes find it hard to stop. That is, until burnout happens.

When it comes, we are usually at the end of our ropes. We’ve given and given, spent long hours on call or on duty, have tried to fill every need or get that need filled by others. We can feel beat, tired, irritated, demanding, flummoxed, and just plain worn out. We can actually feel sick, like having the flu, or a cold, or some unnamed viral something. Does this mean we are spiritually unwell? No, it doesn’t, but it can put us into a position to fall into spiritual unwellness.

Spiritual wellness is ultimately rightness with God. As chaplains, we should be able to remain in this state. But like anyone who suddenly experiences turmoil, we can be thrown into doubt and temptation. When things don’t go right, and we are dragging our feet or feel dragged down, we can react in ways that are selfish, self-centered, not generous, and unfeeling. Actually, for our own survival we do need those qualities to some extent. To take care of ourselves, to deny others’ requests, and to give ourselves healing situations is what we need to do. These, on a physical and psychological level, are basically just what we need. What we don’t need is selfishness that leads to sinfulness.

So we must learn our limits. Often that process means overdoing things and making mistakes as we hone in on what those limits are. Sure, I want to take a double shift and night call too, but you know what — last time I did it, I was just two inches away from lashing out at a coworker. So I have to decline to be helpful, as much as I would like to be liked by being so generous and willing.

What puts us on the edge, or over the edge, psychologically, physically, and spiritually? After all, we are working in an environment where many people are on edge! Just think of the doctors with their complex cases and long hours, the overworked nurses, the students who are sometimes stumbling, and especially the patients we focus upon, probably unwilling participants in the whole process!

Many patients are like the chaplains — well before God, if we can use the term “spiritual wellness.” Yet they suddenly face changed situations and lives, with accompanying doubts. And then there are those who hardly considered spirituality, who could care less, they thought, about God or God stuff. Some still feel this way; some want to reconsider, seeing that they have a new awareness of life, of fragility, of dependence, of just plain thinking about what it all means. To deal with these patients effectively means to have dealt with your own life effectively — as the physicians’ oath says, “first, do no harm.” That seemingly low bottom line requires a high line of spiritual wellness, and certainly psychological stability and physical wellness for a chaplain.

Oftentimes it is hard to distinguish between spiritual, physical and psychological wellness, but distinguishing is a chaplain’s skill. But, for a chaplain, being needed doesn’t mean that you are a necessity and that no one else can fill your shoes! And it doesn’t mean that you need to meet all demands. God grants certain graces to all of us to serve; a big mistake is to try to grant these graces to ourselves! To think more of ourselves than what we are given leads to burnout — whether it be spiritual, psychological, or physical. When we are physically worn out and psychologically beat, we are then on the edge to be spiritually unwell. Being aware of these dynamics can re-call us to a more level way, a more peaceful place of service to others — and to ourselves!

John Stangle, BCC, is a chaplain emeritus who retired from Sells Indian Hospital in Sells, AZ.

Plenary speakers to address themes of conference

By Beth Lenegan

Next April, chaplains from across the country will gather in Chicago in the knowledge that we cannot do our ministry alone. Each year as we gather we are inspired, feel connected, learn about ourselves as ministers and come to understand the current needs of those we minister to as well as discover new research and resources available to us. This gathering happens in the framework of prayer, hospitality, and fun. This year's main theme is "Making All Things New," with four underlying topics that will be explored by our plenary speakers: co-creation, resilience, transformation and hope.

On Friday, April 22, Dr. C. Vanessa White will begin our conference exploring our role as co-creators.

We will be reminded that we are not passive participants of life, but rather responsible and passionate partners in the ministry of chaplaincy. Dr. White is assistant professor of spirituality and ministry, director of the certificate in pastoral studies, and director of the Augustus Tolton Pastoral Ministry Program at Catholic Theological Union in Chicago. The Tolton Program is a theological and spiritual/ministry formation program for black Catholics who are pursuing graduate study in preparation for ministerial leadership. She is also member of the faculty for Xavier University's summer Institute for Black Catholic Studies in New Orleans, as well as adjunct faculty for the African American Ministries Certificate program at Loyola Marymount in Los Angeles. Dr. White is not a stranger to NACC, and she will inspire us to create ripples of life to all those we touch.

On Saturday, April 23, we will learn the art of resilience with our second plenary speaker, Br. Loughlan Sofield, S.T.

We are called to self-awareness and self-care. Each of us searches for our meaning and purpose in life; to be able to accept ourselves and show hope not only to others but in our own lives. Br. Sofield, a Missionary Servant of the Most Holy Trinity, is currently the director of the community's Senior Ministry house. He has served as director of the Missionary Servant Center for Collaborative Ministry; director of the Washington Archdiocesan Consultation and Counseling Center; and assistant director of the Center for Religion and Psychiatry in Washington. Brother Loughlan has worked in almost 300 dioceses in six continents. He will lead us to discover that our spiritual well-being can lead us to a sense of resilience.

Dr. George Fitchett will take us on a journey of transformation on Sunday, April 24, as he explores current research in chaplaincy, spirituality and healthcare.

Chaplaincy is transformative, and as we grow in our faith, we grow in our knowledge and in our ministry. Dr. Fitchett is director of research in the Department of Religion, Health, and Human Values at Rush University Medical Center in Chicago. He also holds an appointment in Rush's Department of Preventive Medicine. He has been a certified APC chaplain and ACPE supervisor for over 35 years. Dr. Fitchett will take us on a transformational journey which will help us to see what has changed in chaplaincy, what is changing, and how we as chaplains move through this transformation.

As we prepare to go home and continue to send ripples throughout our places of ministry and in our personal spaces, we are sent forth in hope. People now have more say in how they want to live and how they want to die which has presented us with some challenging ethical questions. On Monday, April 25, Carol Taylor, PhD, RN, will share with us the latest ethical discussions and challenges facing chaplains on life and death. Carol is a senior clinical scholar in the Kennedy Institute of Ethics at Georgetown University and a professor of medicine and nursing. Experienced in caring for patients who are chronically and critically ill and their families, Carol chose doctoral work in philosophy with a concentration in bioethics because of a passion to "make health care work."

Each of these plenary speakers will send a ripple throughout the community of chaplains gathered in Chicago and in their own unique way challenge us to make all things new until we meet again.

Beth Lenegan, BCC, is the plenary speaker chair of the 2016 National Conference Task Force.

Conference can fill your soul with laughter, praise and wisdom

By Lori Kaufmann

Sometimes I spend all day trying to count the leaves on a single tree. To do this I have to climb branch by branch and write down the numbers in a little book. So I suppose, from their point of view, it's reasonable that my friends say: what foolishness! She's got her head in the clouds again. But it's not. Of course I have to give up, but by then I'm half-crazy with the wonder of it — the abundance of leaves, the quietness of the branches, the hopelessness of my effort. And I am in that delicious and important place, roaring with laughter, full of earth-praise.

Jane Oliver

As we plan the 2016 conference "Making All Things New — Co-creation, Transformation, Resilience and Hope," I invite you to join us in foolishness.

For isn't it foolish to think that we can learn all we need to know by attending a conference and hearing this speaker and that speaker, this idea and that idea? We can find ourselves approaching the workshops and plenary sessions climbing branch by branch trying to gather all the information. What are the latest and greatest ideas? What are the important issues of our profession? What are the things I should know as a board-certified chaplain? The information that we can try to attain can be like trying to count all the leaves on a single tree.

Learning can also fill us with wonder at the abundance of ideas, the quietness of the wisdom that is shared and the awareness that as ministers we don't do what we do by our efforts alone. Between the pre-conference workshops and the 75-minute workshops, we received a forest of proposals. We were half-crazy and giddy with the abundance.

Reviewing the topics and discussing the needs and interests of chaplains, we focused our forest, chose our trees and began counting leaves ... actually, five pre-conference workshops and 24 conference workshops. They represent leaves of current topics such as adverse childhood experiences and ministry in outpatient settings. There are branches of workshops that offer practical topics such as narrative charting and spiritual assessments. There are whole trees of interest for those who do long-term care, CPE supervision, advance care planning, and leadership. As the workshop chair, I am touched that so many people are willing to share their wisdom and experience.

So please plan to join us in Chicago and experience a delicious and important conference that will fill our hearts and souls with laughter, praise and the wisdom of colleagues who share in our journey making all things new.

Lori Kaufmann, BCC, is an ACPE supervisor and workshop chair of the conference task force.

Take a moment to reflect and bless your cell phone

By Bridget Deegan-Krause

For the busy healthcare leader, the cell phone is as important a tool as any piece of complex diagnostic equipment. For some it serves as a distraction or even an obsession. But for most of us it is a tool for connection.

Covered with fingerprints, our cell phone is something we touch more than we touch our loved ones. The stuff of our lives is there. Our work. Things that inspire us. Images and words exchange with people we love. For many of us, some of the most significant moments of our lives have been held in this small device.

As you hold it tenderly, consider what it holds for you. A text from a grieving friend. Work plans. An important medical update. A grocery list. An image of a beloved.

Consider what this device allows you as a leader to accomplish each day. Managing people. Staying on track. Filtering out what really needs your attention.

Consider as well how it allows work to infuse every nook and cranny of our lives, if we let it. Thus from time to time, it needs to be put in its place.

In some communities, a traditional Labor Day “blessing of tools” has included tool boxes, drafting supplies, a vacuum cleaner, a firefighter’s coat — all coupled with a prayerful call to remember those who use these tools for their work. Honoring the busy healthcare leaders of today, the Mission: Day by Day team offers this reflection and blessing of one of your most important tools.

For Individual or Team Reflection

- Each day in our work in Catholic healthcare we are invited to find the sacred in all things. How does this tool remind you of something sacred in your work?
- Now consider the phone, or mobile device, of the person with whom you work each day. Notice it in their hands. What comes their way? What responsibilities do they have? What do they have to hold on to?
- Finally, consider too the phone of someone who is struggling. What do they await? What would they rather not see?

Cell Phone Blessing

Loving God,
I hold in my hands
a tool for connection.

Today it will bring me
the information I need
to serve those
entrusted to my care.

As I use this tool,
direct my gaze
to all that deserves
my best attention.

If today
it serves as a distraction,
help me to put it
in its proper place.

And if today
it burdens me,

help me to work through
the pressing responsibilities,
the hurts and hopes,
and place them in your hands
where they belong.

You have blessed me with good work
and the tools to do it.
Bless this tool,
and all that it holds for me.

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Bridget Deegan-Krause, BCC, is a managing partner of Leadership Formation Partners, the creators of Mission: Day by Day, a ministry formation program for leaders in Catholic healthcare. Learn more at lfpnow.com.

History and mission of the NACC inspires gratitude

By Fr. Richard Leliaert

What Abraham Lincoln beautifully called “the mystic chords of memory” come to mind as I share personal memories of the NACC. However my aging memory is not all that it used to be. So I ask your pardon if I unintentionally omit or err as I share my gratitude for all that the NACC has meant to me.

Shortly after getting my doctorate in 1974, I wanted to balance my head with my heart. As a priest, I needed to be a pastor as well as an academic. So I took a unit of CPE at the Indiana-Purdue University Medical Center in Indianapolis. This experience sowed the seeds of my interest in chaplaincy as I grew to understand my strengths and weaknesses as a minister to people dealing with illness, suffering, life and death. While teaching at Nazareth College in Kalamazoo, MI (1977-87), I did part-time chaplaincy at Borgess Hospital while developing a course called Issues in Life and Death. This course began in response to the needs of student nurses who were struggling with dying patients: How do I work with grieving families? How do I cope with the ethical issues in medicine?

Once I left teaching, I was hired as a chaplain at St. Joseph Mercy Hospital in the Detroit area. My colleagues suggested I join a professional chaplains group. The NACC was the obvious choice, but then I learned I needed to be certified. How well I remember struggling in that certification interview. But I made it. My commitment to the NACC helped me to appreciate the importance of being a certified *professional* chaplain while *professing* a strong faith, hope and love in sharing in Jesus’ ministry of healing.

In the mid-1990s, my involvement with the NACC took off. While working at Oakwood Hospital in Dearborn, MI, I began to get involved with the then-Region VI of NACC, Michigan and Ohio. I recall the enthusiasm of the regional meetings and some great speakers like Sr. Jose Hobday. Local meetings enabled us to get more involved with issues such as certification. I did spend a lot of time with certification, as an interviewer and counselor. These interviews helped us surface more eventual national leaders such as Bridget Deegan-Krause. My involvement with certification solidified when I became representative of the regional directors to the national certification team, whose work I grew to respect and to admire.

Then in the late 1990s, my name surfaced as a candidate for president of the NACC. I accepted the nomination and I was elected. But these were times of transition from the regional model to a board model, so I had to run again for chair of the newly formed Board of Directors. I had the unusual honor of being both the last elected president and the first chair of the board of the NACC. I remember our first board meeting in Milwaukee as we all realized that the NACC was indeed entering into a whole new era in its history. The regional model had many strengths, but there were way too many committees, and it proved difficult to streamline needed reforms in financial matters and infrastructure.

The most memorable event of my three-year term as chair was the special convention in Toronto in 2003, when the five cognate groups (NACC, APC, AAPC, NAJC, CAPPE) voted to work together as a unified body to enhance the dignity and mission of chaplaincy. The executive directors of the cognate groups were very instrumental in this process, and I was thankful for the leadership of Fr. Joe Driscoll, then and throughout my years in the NACC.

One project meant a lot to me personally while enhancing the reputation of the NACC — our membership in the National Coalition for Health Professional Education in Genetics. My experiences on ethics committees got me thinking about the Human Genome Project and the impact that genetics issues might raise for our NACC members. The NACC leadership supported the idea, and I became our representative at the national annual meetings of NCHPEG in Washington. I and another APC chaplain, Vincent Guss, moderated a panel during the 2004 meeting. It was very well-received and garnered the respect of many NCHPEG people for both the religious/ethical issues affecting genetics and for the role of chaplains on medical ethics committees.

After I left the board in 2004, the NACC underwent some difficult times. Karen Pugliese described a lot of the transitions of those years in her [Vision article of January-February 2015](#). There was a lot of personal transition going on in my own life as well, as I left my religious order, the Crosiers, to be incardinated as a priest of the Archdiocese of Detroit in 2004. I stayed on at Oakwood Hospital until 2006 when I became pastor of St. Robert Bellarmine Parish in Redford, MI. In my busy years as pastor, I’ve been unable to keep as close to the NACC as I would like, but I’m still a member and a chaplain emeritus.

There are so many NACC people whom I haven’t mentioned, but you are all in my heart and mind and prayer, and a special hug to two special friends in leadership, Mary Lou O’Gorman and David Lichter. I wish I had been able to attend the wonderful 50th anniversary celebration last April (especially since a dear friend, Bev Beltramo, was a key organizer), but it did my heart good to learn that the NACC keeps sharpening its vision for the future. Ad multos annos, NACC, and God bless us all.

Fr. Richard Leliaert is pastor of St. Robert Bellarmine Parish in Redford, MI.

Community finally accepts woman's wish for natural death

By Ilse Wefers

When I encounter families and patients facing end-of-life issues due to the final stages of illness, accident, or advanced age, I am profoundly aware that they are already in the midst of the grieving process.

Lauren, age 30, is experiencing this grief. Her mother Marge, 64, has been on life support for three years. They belong to a very conservative evangelical community. Marge and her first husband were missionaries in Africa, where Lauren was born. Marge is now at home, bedridden on life support, unable to move, and Lauren and her stepfather, Mike, share her daily care. The costs are not covered by minimal insurance. It is a loving, supportive family, under extreme duress.

However, Lauren and the community are concerned for the soul of her mother. Marge wants to stop the pain medication and terminate her life support. Lauren believes that doing so will condemn her mother to hell. Earlier, Lauren told me that she and her congregation understand Marge's present condition as punishment by God for possible sins. However, Lauren, after talking with me, indicates that she would like to offer other perspectives to everyone. She suggests I visit with her mother and members of the community.

As I arrive at the house, a man greets me politely, serious and a bit uneasy: Pastor Dan. Mike, Lauren and another older couple are present. Marge is a gentle, beautiful woman, and in spite of the illness or perhaps because of it, she radiates peace and kindness. Her eyes rest on you, and you are aware you are in the presence of a holy woman. Her mind is clear and is able to communicate without restriction of any kind. I start the conversation by placing us all — Marge, the family, the congregation and the pastor — in the presence of the divine.

I invite Marge to share with us her missionary work and what it has meant to her. She shares a life of joyful, loving dedication, generosity, abnegation, prayer, song, and faith based on Jesus Christ and the Holy Scriptures. She finds that aside from some failures, for which she has asked for forgiveness, provided proper restitution, and felt forgiven, she has truly tried to live up to the high standards that she set for herself at her born-again conversion. The others in the room share their own perception of her loving, joyful, fruitful and grace-filled life.

Marge then says, "My medications keep alive a body that is not functioning anymore." Her prescriptions are degrading her capacity to die in full control of her mind. "I want myself, even in pain, to die surrounded by my loved ones," she says, "and the blessings of my community, and in the presence of Jesus Christ." Why, she asks, would God punish her desire to forego a senseless, incapacitated, temporary artificial life, without the blessings of the dignity owed to her as a human being? Why can't she enjoy the blessing of dying when her body is unable to function any longer as intended by God?

"How will Jesus Christ look at Marge's life, when she is called to his presence?" I ask. The others share their own perception of her fruitful and grace-filled life as a missionary and as a member of the community. "We know that her missionary work was wonderful between her home, the school, and the clinic." "She is prayerful." "She provides good guidance to the Marriage Support Group." "She is always ready to help." "She is a good sister-friend to me." "Yes, she has fulfilled her mission."

Then I ask if Marge will be sent to hell for letting nature take over the function of her body. After some silent consideration and group sharing, the older man says, "Marge does not need to fear death. She can encounter Jesus Christ and hope and trust in his mercy." Furthermore, Marge discerns that perhaps it is even a sin to allow technology to interfere with her obligation to a natural life and death experience as intended by God.

After this encounter, Lauren continued to attend grief sessions. She also shared with her own congregation and Pastor Dan her journey, and they came to recognize that there was no sense in blaming her mother's painful condition on punishment for possible sins.

Marge died in peace, a natural death, in the presence and the blessing of Pastor Dan and members of her congregation, and she was surrounded by her husband, her children and grandchildren.

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Talking to true friend offers hint of divine presence

By Maggie Jones

Walking about the house on Christmas morning, I attempted to name whatever it was I was feeling — the ghosts of Christmas past, the loneliness of Christmas present, or a himmering* that there is a bigger picture and more to life than what is inherently present. I brought light into the darkness by turning on the Christmas tree lights, lighting a candle and starting a fire in the fireplace. Settling in with my dog and the day's first cup of coffee, I let the feelings cover me like the handmade blanket that warmed us. Thoughts continued to blink in my brain, and feelings poured into and out of my heart. Advent had been meaningful, Christmas Eve unique, and now Christmas Day was here. Now what? The coffee was too good to drink alone, and the feelings too overwhelming. It was clearly time for a phone call.

We don't always see each other on all of the "high holidays." In fact, we usually don't get together on the expected days. We have become extremely countercultural and feel absolutely no musts in our friendship. For many years we did exchange gifts. In fact, I was wearing the still-bright-red robe she had given me one Christmas more than 20 years ago. But our conversation was as warm and delicious as the fire and coffee. We journeyed to the usual subjects, checking on where all the children were and the time spent with them, traveling on to our extended families, a little about ourselves and finally the usual destination — the presence of God and learned experiences of the bigger picture. I told her of the cool wind that had moved across my cheek when I went to light the candle earlier and asked if she thought it might be a form of presence of a ghost.

"I've heard that a kiss from Mother Mary can feel like a cool wind on your face," she told me. I looked up at the candle burning on the mantle and saw the light himmering* on my statue of Mary like sunlight on a field of snow. My heart smiled and I knew what I was feeling this Christmas: the nearness of God. It was the same feeling I had experienced throughout Advent. God in all places, in my feelings, in the light of my home, God in relationships, and God in the hope and possibility of what my friend was offering me. The possibility that Mother Mary had kissed my cheek was a bright and beautiful gift, and I smiled at the inward knowing. I realized also, as I have many times in the last 40 years in knowing her, a true friend is a gift from God. When the phone conversation ended, and with a heart so full, I could do nothing less than to offer the two gifts back to God wrapped in prayer. With gratitude, I thanked God for the gentle love and companionship of our Mother Mary. Then I sent a time-traveling prayer 400 miles northward and thanked God for the himmering* gold in my friend.

*New word created by my friend and me. Meaning from hint and glimmer; meaning a subtle sparkle. You will recognize a himmering when you see it.

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