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As healthcare landscape changes, so does chaplaincy

By David Lichter
Executive Director

So, how equipped do you judge yourself to be for the work you are doing? The theme of this issue of *Vision* is "CPE and Beyond: Professional competencies in a changing environment." When the NACC Editorial Advisory Panel chose this theme, discussion ensued about the changing chaplaincy landscape. It's real and evolving every day.

In fall 2011 and spring 2012, the NACC Board of Directors in consultation with you, our members, named the first goal of the 2012-2017 strategic plan "To educate and support association members for the future of chaplaincy." The first objective of this goal stated, "Provide formation and resources for chaplains to be effective ministers and leaders, especially in emerging settings and healthcare systems (both Catholic and other) and across the continuum of care."

You know, better than I, the drivers in healthcare that are changing the way service is provided and reimbursed — and our own role has been changing significantly. With indebtedness to Julie Jones, executive director of mission and ministry at Mercy Health, and her colleagues, we can name these changes as new focus, new priorities, new identify, and new roles. These slides provide a visual:

These shifts often require not on-the-job training, but on-the-spot testing of new skills, proposing new services, and finding new language to speak about the outcomes and benefits of what we do.

We have tried over the past three-plus years to plan educational resources, particularly our NACC webinars, and to collaborate with Trinity Health in its Spiritual Care Champion Series to provide you with knowledge and training. For instance, the NACC 2012 audio conferences included a four-part leadership series. 2013 topics included Wendy Cadge's research on chaplaincy, communicating the value of chaplaincy, and chaplains and patient satisfaction. Our 2014 webinar series covered discerning leadership, charting for interdisciplinary effectiveness, and two sessions on training and utilizing volunteers. In 2015 we are including spiritual screening and effectiveness, weighing spiritual care and other priorities, a dialogue with a chief executive, and future trends of chaplaincy.

The Trinity Health Spiritual Care Champions Series has also devoted itself over the past three years to similar topics that have provided a context for and samples of system initiatives in spiritual care to address the changing environment. The 2014-2015 series used the "New Roles" referred to above as the topics of each webinar. These are challenging roles, and often the presenters were more suggestive than prescriptive or practical in their presentations, as these roles are just taking form with you, our members.

I hope the articles in this issue might spur you to your own ongoing professional development so we all can provide the highest quality spiritual care.

Working in low-income rural clinic demands new skills

By Cathi Ruiz

I live in a small community in Tuolumne County, CA. Being nestled in the foothills of the Sierra Nevada Mountains has kept our community beautiful and free from progress and growth. Yet the demands of a chaplain to provide spiritual care services within our population — rural, poor, homeless, addicted, isolated, with a high suicide rate and mental health problems — helped me to reestablish and recreate my marketable skills. (Yes, the "M" word.) It has been a worthwhile challenge of self-reflection and action.

I have been working as a chaplain counselor at a local Native American clinic for the past 15 months. I assumed that the skills I learned over the last 10 years would be sufficient in providing spiritual care and counseling to my patients. But not surprisingly, the patients needed to go deeper. My task is to weed through a menagerie of traumatic events of addiction, sexual assault, domestic violence, depression, anxieties, mental health, and co-morbidities of complex health issues to help identify their spiritual pain. Their feelings of guilt and shame arose quickly as their willingness to resolve their pain came to the surface in discussion.

In a hospital setting, I often referred the patient to a social worker or the palliative care team for more resources. In a rural clinic, our resources are somewhat limited. I found that the patients at the clinic are educated about their wellness or lack of it. They expect the chaplain and the entire clinical staff to have a basic knowledge of trauma. If I engage in conversation, providing additional knowledge of the subject, in return they will share their specific traumatic event. This begins our dialogue of spiritual pain.

I began my new education by better understanding the population of Tuolumne County, and participating with other organizations that serve my patients: mental health, action agencies, hospital, faith community, hospice, drug dependency court, local attorneys, child welfare department, Salvation Army, local jail and domestic violence agency. I immersed myself into knowing a little about each agency and who to call.

During these months, my continuing education consisted of webinars, seminars and conferences about trauma-informed care and self-care techniques. Trauma-informed care is heard continuously in Tuolumne County by the agencies that participate in my patients' world. This approach aims to "engage people with histories of trauma, recognize the presence of trauma symptoms, and acknowledge the role that trauma has played in their lives."

The local domestic violence agency told me about an ACE (adverse childhood experience) study that classified 10 types of childhood trauma. Five are personal and five relate to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment.

I use the ACE 10-item questionnaire during my first session with patients from the clinic. Their answers show the fundamental elements of their trauma during discussion. This is the link that helps to bridge their situation with my skills as a chaplain to begin the healing process.

In addition, the self-care classes I attended provided techniques I could share with my patients. These techniques reduce stress and deliver a different focus to prayer life that engages all senses in connecting to God's grace. I discovered that yoga is one way to assist with post-traumatic stress disorder. It can also help with addiction and anxiety disorders. Adding prayer and meditation enhances breathing, relaxation and a focus on a peace-filled environment.

My spiritual care education consists of the skills, abilities and knowledge I began acquiring in CPE. My continuing education is focused specifically on the needs of the patient at the clinic. My patients are over 50 and live with chronic pain due to trauma as a child. They are now open to spiritual counseling because their health issues are becoming a roadblock to everyday activities. Spiritual counseling has helped them to identify the guilt/shame they perceive as their fault in the traumatic experience.

A chaplain can provide enormous value to a patient in a clinic: reducing their flight-or-fight mentality, reducing depression, providing techniques for self-reflection and self-care, reducing physician visits, and reducing stress that may affect health issues such as diabetes, headaches, and chronic pain. A chaplain can provide positive alternatives to violent relationships, and establish a plan for those who are suffering from self-doubt. It is a choice of all chaplains to continue their education and learn more about the challenges that face the population in which we serve. Is it not the choice we made when called to become a chaplain?

While recreating my skills through continuing education, I also intend to voice a strategy to help healthcare professionals re-think the value we as chaplains can provide in our community. I continue to learn and grow and serve our patients in Tuolumne County with integrity and respect. I will continue to market the many arenas where chaplains can establish a presence as a valued member of any team.

Cathi Ruiz, BCC, is the chaplain counselor at Mathiesen Memorial Health Clinic in Jamestown, CA.

Chaplains need to know church's Ethical and Religious Directives

By Sandra Lucas

When I was in CPE, I never learned about the Ethical and Religious Directives of Catholic Health Care Services, but it became an important resource after I got a job at a Catholic facility.

Now, when others arrive at Mercy Health in Youngstown, OH, in the same situation, Deacon Paul Lisko is the one who teaches them. Paul has worked in the spiritual care department for 16 years and is currently the site supervisor at St. Elizabeth Boardman Hospital. Before this position, he was the director of nuclear medicine in the same healthcare network. When Paul was in his diaconate training, he made a decision to change professions and he became a chaplain.

I chose to interview Paul about the Ethical and Religious Directives because he teaches the subject to CPE students, medical residents, and other hospital staff at Mercy Health as well as to the deacons of the Roman Catholic Diocese of Youngstown.

Q. Can you identify some areas in your ministry as a chaplain that you had to learn on the job?

A. There are two areas where I had a big learning curve. The first area was organ donation. The second was medical ethics. I had no training in either area in CPE. Fortunately, I was able to attend a 13-week course through the Ohio organ donor organization which prepared me for the role that spiritual care has on the transplant team. For my ethics training, the mission director at that time made arrangements with an ethics professor at Youngstown State University to present extensive classes in medical ethics to better prepare the chaplains in our role of coordinating ethics conversations and consults.

Q. What was your familiarity with the ERDs during CPE?

A. As a new chaplain, I had little familiarity with the Ethical and Religious Directives, and it was not something I learned in CPE. And I didn't receive instruction in the ERDs in my diaconate training, although I now teach the ERDs to new and current deacons.

Q. What aspects are the most critical in our understanding of the role and mission of a Catholic healthcare facility?

A. Part One on social responsibility is critical in shaping the foundation and practices of Catholic healthcare. That section names the principles that inform the Church's healing ministry, which include a commitment to human dignity, the biblical mandate to care for the poor, and our responsibility to contribute to the common good and to exercise responsible stewardship. *(pages 7-8)*

The purpose of the ERDs is to provide a moral compass for those of us working in Catholic healthcare, including administrators, physicians, chaplains, sponsors, trustees and all healthcare personnel. When I teach the medical residents about the ERDs, I tell them, "You don't have to believe it or accept it, but working in a Catholic healthcare facility, you have to abide by it." Once they become more familiar with its principles and see that everything is based on the dignity of the human person and the sanctity of all human life, their understanding and acceptance grows.

Q. If you were to pick one or two chapters of the ERDs that would be mandatory reading for all chaplains, which would they be? And why?

A. I'm not sure I would make any of it mandatory. However, I think all chaplains in Catholic healthcare should have a working familiarity with the whole booklet, especially Parts Two and Five.

Part Two, "The Pastoral and Spiritual Responsibility of Catholic Health Care," clearly states that medical care for a patient is incomplete without including the spiritual dimension of a person. It points out that pastoral care within a Catholic institution needs to encompass "the full range of spiritual services, including a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God's will with greater joy and peace." *(p. 11)* That's the part that should be mandatory for chaplains — to be a listening presence, yes, but also to have the skills and training to recognize, and minister effectively, in areas of spiritual distress and spiritual pain.

It's also important to be familiar with Part Five: "Issues in Care for the Seriously Ill and Dying," especially when working with physicians and families in conflict around end-of-life medical care. Often the chaplain is the facilitator of communication and understanding about patient choice, patient rights, and what constitutes extraordinary means.

Q. What are your expectations for chaplains who are not Catholic to have of the ERDs?

A. My expectation is that all chaplains know the ERDs well. We work with patients and families from diverse religious backgrounds. And families often look to the chaplain to provide guidance in making decisions about end-of-life care.

Q. What role do the ERDs play in your pastoral encounters with patients and families? Can you give an example?

A. Recently a Catholic family member expressed gratitude to me because I was with her loved one when a decision needed to be made about withdrawing life support. When the family understood that it was OK to withdraw life support, it lifted a huge burden. Even though it was still hard to say goodbye, they were able to do so in peace knowing they were supported in their decision by their church.

Q. There has been controversy about Directive 58 and its revision. What is your understanding?

A. Some wording changed in the fifth edition of the ERDs, but the bottom line is still the same. The patient can forgo or withdraw medically assisted nutrition and hydration when it becomes "excessively burdensome for the patient or would cause significant physical discomfort" *(p. 27)*, in other words when the burdens outweigh the benefits.

The Church reminds us in Part Five that "God has created each person for eternal life" and that "We are not the owners of our lives and, hence, do not have absolute power over our life." *(p. 25)* In our ministry as chaplains, we encounter patients, families, physicians, and healthcare providers who think that life is to be extended, at all costs, through the assistance of medical technology. The ERDs help us come to the understanding that we ultimately serve God as we serve the well-being of our fellow human beings.

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All excerpts are from the "Ethical and Religious Directives for Catholic Health Care Services" Fifth Edition, United States Conference of Catholic Bishops, 2009.

CPE curriculum focuses on pastoral formation

By Sr. Barbara Brumleve

How do we do CPE for today's world? I come to CPE supervision as a systems thinker with a belief that "everything is curriculum." Early on, I ask all interns and residents to consider the basics of system-thinking: that every system or theory is based in human experience; foregrounds some concepts, backgrounds other, and ignores still others; and develops by re-framing or re-arranging what had been foregrounded, backgrounded, ignored.

Here my focus is the CPE residency, and specifically the theological development and pastoral formation of the residency. At St. Vincent the residency is a twelve-month, four-unit program with a prior unit of CPE as a prerequisite. We have five stipended positions but we started the 2014-15 program with seven persons, the two additional being a military chaplain and a lay woman who needed their third and fourth units for certification. (They finished in February, but in summer another person joined to get his fourth unit.) These eight people were diverse: two women, five men; some recent theology graduates, others further from their formal graduate education. They were from eight Christian backgrounds: Baptist, Church of Christ, Church of God (Anderson), Disciples of Christ, non-denominational, Presbyterian USA, Roman Catholic, and Seventh-day Adventist. They were millenials and baby boomers, military and civilian, born in three different countries.

From the beginning of the residency, the group did diversity work by reporting on major holy days of various faith traditions as they occurred. After each report the residents discussed the implications for pastoral care and the underlying theology. The residents also had copies, distributed at orientation, of Handbook: Patients' Spiritual and Cultural Values for Health Care Professionals, edited by Susan K. Wintz and George Handzo. This outstanding resource, available from HealthCare Chaplaincy Network, addresses 20 religious and 23 cultural traditions, listing basic beliefs and practices — particularly around birth and death — as well as communication, decision-making, family structure, and time orientation.

Intentional theological/pastoral development occurred in a variety of ways. In the fall, Carrie Doehring's "The Practice of Pastoral Care: a Postmodern Approach" gave the group a common language and broadened their horizons, while at the same time becoming part of the "storming" phase of their group development. In December, each one wrote and presented a two- to three-page paper to explain their understanding and practice of spiritual assessment, and their peers provided feedback after the presentation. The residents also wrote and presented their theory of pastoral care as it applied to their current clinical context and as it would probably be modified in their second clinical placement. One resident, who was in her fourth unit, chose to present the competency essay that she intended to present for NACC certification. Seeing the distance they had to go was a challenge for her peers, but it motivated them.

Having completed these papers, the residents were better able to articulate and integrate their personal theology and pastoral practice when they met a committee in February to move to Level II CPE. After that transition, they were ready to broaden their theological and pastoral perspectives further. "Theological Reflection: Methods" by Elaine Graham, Heather Walton, and Frances Ward provided seven perspectives from which to "do" theology, although all from a Christian foundation. For each, the authors provided an overview, examples, evaluation (strengths, weaknesses), and questions. (Interestingly, the first of the seven perspectives, "Theology by Heart," included Anton Boisen as one of the examples.)

During the summer the residents expanded their theological thought and pastoral practice still more. Several publications from Hartford Institute for Religion provided key learning materials. A six-page Congregational Observational Guide assessed theology's expression in congregational ecology, culture, resources, and dynamics of authority. This document helped all the residents think systemically about their own churches and community, but it was particularly helpful to four who planned to return to, or move into, congregational ministry after the residency. Research studies on independent and nondenominational churches and on "nones" further broadened pastoral perspectives. In a complementary way, it was helpful and challenging to reflect on questions of religious, gender, racial, and LGBT diversity as well as white privilege.

Discussions, sometimes heated but always respectful, continued into the next phase of the residents' theological development and pastoral formation when the curriculum broadened to other faith traditions. "Spiritus Loci: A Theological Method for Contemporary Church Architecture" by Bert Daelmans, SJ, provided a theoretical base for this exploration. Daelmans presents sacred space not as a *container* but as a *relational event* which is perceived, conceived, and lived in. Sacred space provides an atmosphere, a signpost, and a stage for the human-divine (or in the case of Buddhism human-enlightened) encounter in the spirit. With those underlying concepts, the residents visited an Islamic center and an Orthodox church, Hindu and Buddhist temples, a Conservative Reconstructionist Jewish congregation, and the Menno-Hof to learn about the Anabaptist tradition (Mennonite and Amish) and the newly built Latter-day Saints temple. At each site, a representative explained the belief and practice of the group and implications for pastoral care.

Do I take this same approach to theological development in every residency? No, but with this group of residents, I found this was the best way to focus on theological development in the context of ACPE standards and the residents' future ministry goals. At the end of the CPE residency, along with pastoral competence, a credential file, a resume, interview skills, and knowledge of today's healthcare world, these residents took with them a deep affirmation of their own theological tradition coupled with a pastoral agility in caring for persons of diverse traditions. They are ministers for today.

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Joint efforts with cognate groups will enhance CPE

By David Lichter
NACC Executive Director

How does the professional education and training of chaplains keep up with the field? The primary answer is, "We do it together through strategic and persistent collaboration."

The Forum section of Reflective Practice, Volume 35 (http://journals.sfu.ca/rpfs/index.php/rpfs/article/view/390), continues the discussion started in Volume 34 on how best to prepare chaplains for the profession. The core article (http://journals.sfu.ca/rpfs/index.php/rpfs/article/view/391/382) was by Alexander Tartaglia, DMin, senior associate dean of the School of Allied Health Professions at Virginia Commonwealth University, titled, "Reflection on the Development and Future of Chaplaincy Education." It was an engaging, insightful, and forward-thinking article that offered the reader both a glimpse into the reform-minded foundations of CPE and some suggestions on improving the CPE model by attending to the changing healthcare environment.

After a thoughtful analysis of CPE's historical, theoretical, clinical, and educational tenets, Dr. Tartaglia identified "some key areas needing attention that might promote further development of healthcare chaplaincy as a clinical profession." These included a need for:

1. A consensus on professional standard definitions, particularly that of the role of the chaplain, and definitions of spiritual care and spirituality.
2. Commonly accepted components/content/metrics for a spiritual assessment, if it is a core standard of practice.
3. An "established criteria for prioritizing patient visitation or for determining which patients should be seen by a professional chaplain."
4. Some outcome-driven spiritual pathways for caring for specific patient populations that have been exposed to ongoing evaluation.
5. Moving away from what chaplains do to "what healthcare organizations do and how the chaplain's role can serve that mission."
6. An ongoing examination of the standards of professional practice to ensure that they parallel the improvement in healthcare delivery.
7. Becoming ever more a research-informed profession supported by evidence-based practice.

I was invited to write a response (http://journals.sfu.ca/rpfs/index.php/rpfs/issue/view/54) to Dr. Tartaglia's paper, along with David Johnson, president of ACPE; Judith Ragsdale, ACPE supervisor and director of education and research, Department of Pastoral Care, at Cincinnati Children's Hospital Medical Center; and Joseph Perez, APC chaplain and vice president for pastoral services at the Valley Baptist Healthy System in Harlingen, TX. Each of us took a little different perspective, but what was clear was the common call to improve the training through greater collaboration among the professional associations.

In fact the "strategic and persistent collaboration" among our cognate partners has been going on. First of all, ACPE, APC, and NACC leaders have four task forces examining: 1. Consistency in teaching to and assessing the common standards; 2. The parallel processes for certification of ACPE supervisors and board-certified chaplains; 3. The demographic trends for future clinical pastoral educators and board-certified chaplains; and 4. The increased competition among CPE and chaplain certification groups. These are very important topics for the future of chaplaincy, and it is vital we discuss these together.

Secondly, a collaborative initiative involves five of the six cognate groups (ACPE, APC, CASC, NAJC, and NACC) who developed, affirmed, and implemented the Common Standards for Professional Chaplains and the Common Code of Ethics to review/revise these two foundational documents. The sixth original association, American Association of Pastoral Counsellors, affirmed and supported the work we will do, but chose not to participate since its pastoral counselor members do not use these standards.

Thirdly, NACC, ACPE, NAJC, and APC are collaborating with George Fitchett, PhD, and Wendy Cadge, PhD, on a four-year project to advance research literacy among us health care chaplains, will results in education and training for our members. The project, funded by a $4.5 million grant from the John Templeton Foundation, recently launched its website www.researchliteratechaplaincy.org. Catarina Mako, BCC, is our NACC liaison on the Project Advisory Committee.

Finally, the Joint Research Council, initiated by APC, is a collaborative effort to transform chaplaincy in ways related to

research. It seeks to enhance communication among professional colleagues around research; advocate for research efforts and literacy; and provide a central place for information about opportunities for chaplain-related research. This Joint Research Council is really a global initiative, as it includes the major chaplaincy associations of North America, Europe, and Australia. Along with our cognate associations, participants include the National Association of Veterans Affairs Chaplains, Spiritual Care Australia, Scottish Association of Chaplains in Healthcare, and Healthcare Chaplaincy Network. Katherine (Kate) Piderman, PhD, BCC, is our NACC representative on the council.

The NACC is grateful for these strategic partnerships to advance the chaplaincy profession.

Healthcare changes require students and certified chaplains to be flexible

By Sr. Julie Houser, CSJ

Just today I was asked for a reference for a CPE student from 15 years ago. I remembered her as highly pastoral, very much a part of the group and sensitive in her visitation. I enthusiastically supported her application for her first chaplaincy position.

However, not long afterward, I considered the 15-year gap since her CPE training. Extensive changes have occurred during our center's history, and the CPE curriculum has also advanced greatly. Queens Hospital Center has always been culturally, ethnically, and religiously diverse. We are also challenged to provide quality healthcare to the most indigent and sometimes sickest people in the country. The CPE program has needed to meet this challenge in its flexibility and its highly diverse mix of students.

Consequently, many of the changes in clinical pastoral education have followed changes in healthcare organization and delivery. This is the current challenge for life-sustaining identity. Hospital systems are challenged to create holistic treatment plans and partnerships in providing care from birth to death. Intense competition for patients has become the design and basis of a more holistic system of health and wellness care. Critical to this reorientation is the level of patient satisfaction, as measured by Press-Ganey evaluations.

Since spiritual care consistently improves patient satisfaction, the need for chaplains in all areas, even beyond the inpatient model, is rising. Knowing the design of healthcare organizations and the ability to meet patients' spiritual needs is currently a very strong factor in funding pastoral care. The institution's need for positive patient outcomes has skyrocketed the chaplains into a very effective and critical position. Furthermore, care is gradually moving from sickness to well care, spanning the generations. Chaplains must develop this flexibility of ministry from birth to death, from sickness to wellness. Good health practices are gaining ground in all city hospitals; we now have fresh vegetables and fruit sold from farm stands at each facility. Reaching out into the community, chaplains also need to relate to the hospital's community advisory boards, thereby connecting with clergy of the area. For our chaplains, active involvement with the students in the mortuary, on site in each borough, raises awareness of the poor and unidentified bodies. Wake services and bereavement support are integral to the role of the chaplain.

Cultural, ethnic, and religious diversity necessities training and wholehearted efforts to meet the needs of patients and staff. Chaplains function on interdisciplinary teams and electronically chart on patients' files, giving and responding to requests from the treatment team. Chaplains need not only familiarity with the Ethical and Religious Directives in Catholic healthcare, but also the knowledge of working through ethical decision-making with the ethics committee and prominent members of the treatment team. Changes in curriculum have enabled chaplains to meet the challenging new NACC competencies.

Curriculum for CPE must necessarily keep the students in sync with these changes and priorities. The contrast with the past CPE priorities and the present is amazing, and generally more and more inclusive of the chaplains into the main patient care model. System-dictated changes have included updates in technology, such as electronic charting, and many types of computer video communication and electronic meetings are available and common. Webinars and different forms of telecommunications are common and available. The CPE systems are also changed by hospital mergers, re-formation of systems, an expanded understanding of patients' rights, and phone-based translators located at the end of the double telephone extension by each bed. Sensitivity and awareness of sexuality includes new terminology and options for acknowledging gender issues and sexual preference. Knowledge and sensitivity to religious beliefs and practices are more carefully delineated and needs met. Greater exposure to medical epidemics, greater knowledge and sensitivity to isolation-needed protocols and others are ever in flux.

And meanwhile, what about my former student? Like so many other certified chaplains who need to stay current, her pastoral skills and awareness could easily make the transition. As a very bright and highly pastoral professional, she would do well in bridging her CPE background and her professional practice to meet the current world of institutional pastoral care. She is the same gifted, unique, and creative person as she was in CPE. I would highly expect her to correctly evaluate her comfort and her skills and make the necessary changes. So will the rest of us.

I'm interested in the outcome of her employment interview.

Sr. Julie Houser, CSJ, is director and supervisor of the ACPE program in Queens Hospital Center, Jamaica, NY.

Internal family systems: Understanding the self using parts theory

By Marika Hanushevsky Hull

How does a person disengage from the noise of living and get to the real self? Richard C. Schwartz answers this question with the internal family systems model, looking at the "family of parts living within us."

This new and popular approach in the counseling field, also known as IFS or parts theory, is being widely appropriated into CPE programs and provides an intriguing view of human personality. Schwartz describes it in the 2001 book "Introduction to the Internal Family Systems Model." The brief, easy-to-read introduction is worth adding to your reading list.

Schwartz views our thinking processes as an internal dialogue with different parts of us. The goal of his method is to change the way we look at and interact with our thoughts and emotions. The model encourages us to become curious about the various internal dialogues that represent parts of us and to listen more carefully. By listening to the internal dialogue, the IFS method leads to compassion for emotions and thoughts, which then leads to attempts to help the parts. The real self can then emerge, and healing can take place.

Schwartz names the terms that most characterize the IFS method as Exiles, Managers, and Firefighters. Exiles are the vulnerable parts of us that we try to lock up or leave frozen, "the parts of us that feel like losers and think we are worthless."

Managers are "the protective parts that are responsible for our day-to-day safety," Schwartz writes. "For many of us, they are the voices we hear most often, to the point where we come to think of ourselves as those voices or thoughts." Managers are the parts that want to control everything, to prevent humiliation, abandonment, or rejection.

When the Managers fail to protect us, our Exiles are triggered. Then the Firefighters "do whatever it takes to deliver us out of the red alert condition." It can be socially acceptable binges (overwork, overeating, excessive exercise or shopping) or more drastic methods (illegal drugs, alcohol, suicidal thoughts, compulsive sexual activity). The difference between Managers and Firefighters is that Managers anticipate and Firefighters react.

Schwartz's IFS model can be very helpful in chaplain training and fulfill some of the standards for professional chaplaincy. The Common Standards for Professional Chaplaincy (TCP3) require that chaplains "incorporate a working knowledge of psychological and sociological disciplines and religious beliefs and practices in the provision of pastoral care." The ACPE Standards and manuals (309.6) require that students develop the "ability to make effective use of their religious/spiritual heritage, theological understanding, and knowledge of the behavioral sciences in their pastoral care of persons and groups." One of the ACPE outcomes (312.4) states that the chaplain must be able to "assess the strengths and needs of those served grounded in theology and using an understanding of the behavioral sciences."

The IFS model can provide insight to both the chaplain and the patient. If we assume there are many parts in dialogue with one another, and that some of these parts are in conflict with one another, or hiding the self, then Schwartz says the goal is to change how we interact with our thoughts and emotions. His method is to listen to what the parts are saying. He maintains that this "curiosity" leads to "compassion for … emotions and thoughts" and that this focused listening produces real healing. By discussing the feelings and using the phrase "part of me feels" rather than "I feel," Schwartz helps his clients to better understand their inner dialogue and in this way to begin to liberate the "good parts from the bad roles."

IFS finds its place in the stream of psychotherapeutic as well as spiritual methods that look at the self and how to access it. For all its merits, this book comes up short in two areas: It lacks rigor because of the lack of academic references, and it lacks the anecdotal, energetic flavor of the self-help genre. Schwartz offers a framework for thinking that can help the chaplain and the patient to move away from pathologizing or catastrophizing behavior, and to a place of recognizing "the possibility of goodness."

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NAJC's Jerusalem conference offers new perspectives

By John Stangle

Upon seeing that Neshama: Association of Jewish Chaplains was going to hold its 25th annual conference in Jerusalem and that the theme was "Interfaith Spirituality," I got the clear idea that this was something worth doing. Don't all of us chaplains want to visit the Holy Land sometime? There's nothing wrong with being merely a tourist or better, a pilgrim, but it seemed that this conference might be exceptionally educational — and it was.

My wife Krisztina had years ago taken some Hebrew when working on her MA (I took Greek), and could recognize letters. I didn't even remember that Hebrew is written right to left when she mentioned it. We had much to learn! We also didn't know how much of the conference would be in English, as Hebrew is the official language in Israel. In the end, both English and Hebrew were used with major addresses and many workshops utilizing very professional translators with participants wearing earphones like in the UN.

The NAJC conference itself was two days, with tours to pastoral care sites, mainly hospitals, before and after the main conference. The workshops were varied and interesting and the major addresses were well done and excellent. Rev. Eric Hall of Healthcare Chaplaincy gave the keynote address in which he condensed the solid research that is available for presentation to hospital boards and administrators vis-à-vis the value of pastoral care and chaplains. Maybe the reason he was chosen to present this subject is that the Israeli healthcare system is lacking chaplains. There are apparently plenty of rabbis, but their emphasis is more on rites and liturgy and determinations of lawfulness, rather than personal encounters and presence and spiritual care as one would find in taking CPE.

Therefore, many of the workshops were designed to expand knowledge of pastoral care and techniques for the many Israeli attendees. That there is much interest in pastoral care in Israel was also attested by a ceremony to certify and recognize the first large group of 20 or so chaplains. Their training has been ongoing for the last four years by U.S.-certified supervisor trainers with classes taught in Israel in Hebrew. A great effort was made to do this considering the travel and cost involved.

At the first tour the day before the conference, we visited the 125-year-old St. Louis French Hospital, a huge and beautiful stone structure just outside the stone walls surrounding the old city of Jerusalem. A German sister, Monika Dullmann, is the administrator and she has highly supported the Kashouvot organization of women to do hospice and pastoral care work. Its members have taken CPE, and some were certified at the hospital in a ceremony while we were there. The hospital itself is being renovated at great expense so as to be integrated into the Israeli healthcare system. It was built for the poor and indigent and for those who have no place to go, and it still has this mission of caring for all irrespective of race, nationality, or religion. Both Kashouvot and St. Louis French Hospital would be thankful for any support.

Another very interesting hospital that we visited was Laniado Hospital in the town of the same name on the Mediterranean Sea. It was founded by a rabbi who survived the Holocaust but lost his entire family and relatives numbering 150 people. He alone survived, and with a vision of fulfilling the Torah's commandment to care and love for all, he laid the cornerstone in 1958 when he had not a penny to his name! His vision is now a complete medical health center that has never been threatened by closure or labor strikes as apparently some hospitals have experienced.

An interesting fact — every rabbi I talked to had either lived or trained extensively in Israel. One poor young guy from the U.S. had even had to leave his fiancée for a whole year to complete his studies in Israel. Which brings up the question: Why don't more Christian pastors, priests, teachers, etc. spend time in the place that they talk so much about? The NAJC is exploring an interfaith pastoral care tour to take place in November or December. Check the NAJC website or contact Cecille Asekoff at execvp@najc.org for more information.

One last thing — even the food was educational. There was an abundance of delicious fruits (my favorite was fresh-squeezed pomegranate juice) and wonderful cheeses and breads and pastries at the buffets for breakfast. For lunch there was always hummus and tahini and often crispy falafel. It seemed like we were eating a very nutritious and healthy vegetarian diet although fish and meat were available. All, of course, was kosher.

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

Honoring diverse traditions helps build relationships

By Linda Arnold

I used to work at a hospital in an exceptionally diverse area, a diversity that was mirrored in the patient population, the nursing and support staff, and the medical staff. It included significant numbers of Hispanics, Africans, African-Americans and Orthodox Jews.

One of the leaders of the local Orthodox Jewish community, a rabbi who was a frequent visitor to the hospital to see his own congregants, had a massive stroke and was brought to the ER. He was put on a ventilator, but his condition was grave. According to one stream of the Orthodox Jewish tradition, once life support is initiated, it cannot be withdrawn. The critical care doctor (a woman who had been raised as an Orthodox Jew) and I (a Catholic chaplain with good knowledge of that tradition) met with the patient's wife and other family members. It was understood that nothing would be withdrawn, but neither would anything be added.

The crucifix in the room could not be removed because it was glued to the wall, but I arranged for it to be covered. We offered a conference room to the family where they could eat the hospital's kosher food or their own. I commented to one of the nurses that modesty was an extremely important value, and without being asked, the nurse made certain that the patient was appropriately covered under his gown. After about 48 hours, I requested and the hospital arranged for the house officer to sign the death certificate so that, should the patient die during the night, his body could be removed immediately. On the whiteboard in the patient's room, in the space for "What do you want to be called?" a nurse had written "RABBI."

The patient died early in the morning on the fourth day. His funeral was held in the community at noon. He was on his way to the airport shortly thereafter and was buried in Jerusalem by sundown the next day.

When I went to give my condolences to the rabbi's wife, she shared that writing "RABBI" on the whiteboard summed up the respectful way we had treated him and his family. Indeed, everyone involved had done their utmost to respect the family's traditions and needs.

At the same time that the important rabbi was dying on the unit, another patient was also dying — an elderly gentleman who had come here from China many years before, never learned to speak English or to drive while he worked in a Chinese restaurant, brought his entire family to the United States, and raised his children here. His daughter, the family spokesperson, was a research scientist. The patient was not an important person in the community, but he was important and beloved to his family, and their tradition of filial piety demanded that they do everything possible for as long as possible.

The critical care staff, the palliative care team, and I met several times with the family. They came along slowly, but when I suggested we would welcome a visit from the Buddhist monks at the wife's temple, something special seemed to happen.

The monks came and chanted, with the door to the ICU bay closed to avoid disturbing other patients. The patient was moved from the bed to a gurney so as not to disturb his body until eight hours after death, to honor the family's Buddhist belief about not causing pain. After he died, in the presence of monks and family, no tubes were removed, nor was the regular postmortem care done. After two hours in the room, the patient's body was covered with a yellow and red ceremonial cloth and processed, with monks, chimes, family, friends, and hospital security, to the viewing room in the morgue (at the opposite end of the hospital). They stayed there to complete the required eight hours. At 9 that night, the critical care unit sent a nurse to the morgue to remove the tubes and catheters and prepare the body. The family was tremendously grateful that their traditions and needs had been honored.

Spiritual care had prepared the way with extensive education on cultural and religious diversity, and in creating an atmosphere where diversity was not just tolerated or respected but valued and celebrated. The very different traditions and socio-economic situations of the two families mattered not at all to the way in which they were respected and cared for.

Linda Arnold, BCC, retired as director of spiritual care at Holy Cross Hospital in Silver Spring, MD.

Congratulate our newly certified chaplains

Our newly certified chaplains were interviewed in May and received their certification from the NACC Certification Commission at the July meeting in Milwaukee. We are excited to welcome these 36 newly certified chaplains. In addition, four board-certified chaplains achieved the palliative care and hospice specialty certification from interviews in March and July. We celebrate with them. Please join in congratulating them.

Deacon James J Byrne
Greenlawn, NY

Ms. Julie M Campbell
Cleveland Heights, OH

Mrs. Ellen L. Clark
Norfolk, MA

Deacon Peter R Cote
Fall River, MA

Ms. Rosemary Cotter
Portage, MI

Mr. Robert L Crecelius
Farmington, MO

Mrs. Shyla A Davis
Metairie, LA

Ms. Suzanne M Doran
Olympia, WA

Ms. Cythia M Dwyer
Windsor, ON

Deacon Richard J Feltes
Oak Lawn, IL

Mrs. Victoria A Frericks
St. Louis, MO

Ms. Nancy M Fusillo
St. Petersburg, FL

Ms. Cynthia G Harmeyer
Kenner, LA

Ms. Abigail Hodge
Seattle, WA

Mr. Jacob W Hurst
Spokane, WA

Rev Francis Ibanga MSP
Chippewa Falls, WI

Ms. Kathleen A Kelleher
Quincy, MA

Sr. Mary L Kieffer
Las Vegas, NV

Ms. Janice M Lautier
Southington, CT

Mrs. Barbara Manning
Orland Hills, IL

Mr. John McCullough
Chicago, IL

Mr. Daniel J McGill
Santa Maria, CA

Ms. Kristen R Muller
New Orleans, LA

Rev. Vincent Musaby'Imana
San Francisco, CA

Sr. Dorothy V Nkuba STH
Chicago, IL

Rev. Anthony N. Nwudah
Austin, TX

Ms. Mary Pappalardo
Port Jefferson, NY

Mr. Petros A Savva
Eugene, OR

Rev. Fr. Henry S Sequeira O Praem
Dyer, IN

Ms. Noelani M Sheckler-Smith
Sonoma, CA

Mr. Ronald L Stilwell
Richmond, VA

Mrs. Kathleen T Ullmann
New York, NY

Deacon Albert E Vacek, Jr.
Houston, TX

Rev. Randy S Valenton
Palo Alto, CA

Rev. Joy P Varkey
Levittown, NY

Mrs. Susan M Ward
Arlington, VA

Rev. Anthony C Williams
Overland Park, KS

Palliative Care and Hospice Specialty Certification:

Sr. Romona Nowak OP, BCC
St. Clair Shores, MI

Mr. Frederico G. Borche-Gianelli BCC
Los Angeles, CA

Mrs. Margaret Y. Jones BCC
Garden Ridge, TX

Rev. Calin L. Tamiian BCC
Ventura, CA

Conference 2016: Making All Things New

By Rod Accardi

Then I saw a new heaven and a new earth … and the one who was seated on the throne said, "See, I am making all things new." (Revelation 21: 1 & 5)

This past spring the NACC celebrated its jubilee year, and we came together with gratitude-filed hearts as we honored the many gifts and blessings we have received. Gathering as a community of chaplains next year in Chicago, we will hear the words of sacred scripture proclaim, "Behold, I make all things new!"

Co-Creation: May our hearts be inflamed by the words of St. Francis and Pope Francis, "Praise to you, my Lord!" as we recognize that we are co-creators, responsible passionate partners in the care of our common home and future.

Transformation: Evidence-based spiritual care outcomes are transforming healthcare chaplaincy. As we wade into the waters of research literacy, may our eyes be opened to better understand, summarize, and explain research studies in light of our pastoral practice.

Resilience: Every day, chaplains enter the world of personal and social crises. May we breathe with the breath of God as we explore modes of spiritual well-being that enhance resilience for ourselves as well as those we serve.

Hope: Our ministry takes place at the intersection of the secular and the sacred, the medical and the moral. May we deepen our theological understanding of what it means to be people of hope, engaging ethical questions and supporting dignified choices in the midst of vulnerability, suffering and affliction.

The NACC is blessed to have an outstanding National Conference Planning Task Force working on the 2016 conference. Beth Lenegan serves as the plenary speaker chair, Lori Kaufmann as the workshop chair, Fr. Rich Bartoszek as the liturgy chair, Jim Manzardo and Kathy Ponce as the local arrangements co-chairs, and Jane Mather as the board liaison. David Lichter, along with Jeanine Annunziato and Andris Kursietis, are providing input from the national office.

I am honored to serve as your task force chair and look forward to seeing many of you next April in Chicago. We meet nearly every week to pray, plan, prepare, and provide for the needs of those who will be attending the Chicago conference and those who will be with us in spirit. In the coming months, members of the task force will publish articles in Vision offering further information about the plenary speakers and workshops, the retreat, and local attractions, as well as liturgical presiders and prayer opportunities.

Our graphic artist provided us with a logo that incorporates the symbols that depict this year's theme: our hearts inflamed as passionate co-creators, the breath of God that sustains our resilience, the living waters that lead to transformation, and the hope that is rooted in Creation and the Creator -- all held in partnership with the hand of God.

Join us in Chicago with your colleagues as we engage in Making All Things New!

SOURCE: *Vision*, September/October 2015

Visit www.nacc.org/vision to read or subscribe.

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