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Enter the sacred core of the long-term care resident through symbols

By Jennifer Paquette, MAPS, BCC

The experience of symbol

Reality is never present to us except in a mediated way, which is to say constructed out of the symbolic network of the culture which fashions us.¹

Our world is pervasively symbolic. So integrated is symbolism into our everyday life that we do not distinguish the symbols separately from the reality they present. Yet we experience the reality in ways unique to each of us. One of the most culturally powerful symbols is the American flag. Yet the meaning it evokes for a new citizen may be very different than the meaning for a veteran. If we experience symbols uniquely, they must have the capacity of multiple meanings.

Experienced symbols permeate the whole of our lives. Symbols include words, language, metaphors, and myths. Indeed, symbols precede language. Symbols can also include gestures, people and objects. The discussion here will focus specifically on objects which reveal "who" we are imbedded in the symbol.

In the course of our lives, we take on many symbols while shedding others. For example, children are usually eager to shed the training wheels on their bicycles. Some symbols prevail throughout our lives; others prevail but their meaning will change. Among all of the symbolic objects which enter or exit our lives, there is a remainder that should be of keen interest to every chaplain ministering to an older adult. Typically, today's older citizens have downsized their lives from houses to successively smaller residences until the day comes that frailty gives them no choice but a long-term care residence. Diminishing space necessitates shedding many symbolic treasures. Yet, they choose to retain and take with them some very personally meaningful belongings. Sometimes, age and frailty lead a parent to relinquish deeply felt objects when urged to do so by the children "helping" with the move. The search then is for the most special objects that the resident of long-term care has chosen to be a part of life to the very end.

This is the crux of the search for precious objects. Among the symbols that do move in with the resident, which ones reveal who this person really is? Which symbols reveal how this resident would want to be known? Very often we collect from the new resident information about what the person has been (a mother, a nurse, a skier). Or we gather data about how the person is (frail with dementia). By contrast, symbolic objects allow us to reach deep into the essence of who the person is. Symbolic objects have the potential to be the doorway into the sacred essence of the person.

Toward an understanding of symbolism

We should distinguish "signs" and "symbols" as these words are often used interchangeably, yet they have distinct differences. "Signs" generally have a one-to-one relationship with what they signify. For example, an "exit" sign can be counted on to point to the way out of a room but nothing more.

"Symbols," by contrast, have many qualities: 1) They have multiple meanings. Water, for example, can contain inherent frightening qualities for the flood victim while being symbolic of our baptismal life in Christ. 2) Symbols arouse feelings. We enter into symbols emotionally, although words may be lacking to describe the symbolic significance. 3) The most significant quality is the ability of the symbol to enter into the reality that it signifies. Whereas the sign points to something apart from itself, "the symbol introduces

us to a reality of which it belongs.”² The symbol makes present the reality which it “re-presents.”³ (This should sound like the quality we know of sacraments.) Thus, symbolic objects have the potential to lead the chaplain into the mystery of the older adult in a powerfully distinct way. 4) Last, the more committed the individual becomes to a symbol and the more psychic energy that the person invests in the symbol, the more likely it is that the symbol will be a powerful re-presentation of the reality of who the person is.

How does “symbol” function for the older adult?

Symbols can lead the individual to self-discovery. Over the years, I have known residents drawn to specific items in ways they couldn’t fully articulate. When asked why an item had remained with the owner, the answer most often went something like this, “Well, you know, I don’t know why I’ve kept that thing. I’ve had it so many years. I just like it.” The owner will probably concede to an emotional response to the item. Among many possible choices, this object was chosen to continue on in the life of the resident. The object merits further discovery.

Symbolic objects open us to deeper realities that we might not otherwise come to know or experience. The symbol has the potential to provide fuller understanding when we are open to what it can say to us, yet the symbolic is likely not fully knowable. “Faith is the name for that attitude which determines just how much we are going to see.”⁴ This is a faith that the mystery of another’s life has much to reveal to us if we are attentive.

The older adult resident in a long-term care setting will likely have a limited number of personal possessions. Nonetheless, one or two will rise above the rest in personal significance. “The possessions one selects to endow with special meaning out of the total environment of artifacts are both models of the self as well as templates for further development.”⁵ This is a key point in the discovery of the individual. We must not forget that the older adult, like all of God’s creation, is still being created.

Finally, we should not overlook hidden symbols, those tucked away in a drawer or box. Some of the most “special” objects for the older adult may very well be out of sight, hidden like the self and awaiting discovery by the chaplain.

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References

¹Chauvet, L. M. (1995). *Symbol and sacrament: a sacramental reinterpretation of Christian existence*. Trans. Patrick Madigan, S.J., and Madeleine Beaumont. Collegeville, MN: The Liturgical Press, 64.

²Chauvet, 113.

³Schneiders, S. M. (1999). *Written that you may believe: Encountering Jesus in the fourth gospel*. New York: The Crossroad Publishing Company, 66.

⁴Guzie, T. (1981). *The Book of Sacramental Basics*. New York: Paulist Press, 129.

⁵Csikszentmihalyi, M. & Rochberg-Halton, E. (1981). *The Meaning of Things: Domestic Symbols and the Self*. Cambridge: Cambridge University Press, 189.

Communal, systemic dimensions of work call for new CPE strategies

By Barbara J. Fleischer, PhD

When Anton Boisen, the acknowledged originator of clinical pastoral education (Dystra, 2005, p. 1), first brought seminary students into a hospital setting, he exhorted his students to learn about human nature first-hand by reading "living human documents," i.e., the patients they were about to meet (Boisen, 2005, p. 29). The key work that he set before his students was to listen deeply and hear the spiritual questions and struggles embedded in their patients' stories. Their work was also to assist the patient in making meaning of their suffering and situation in life. Today the Association for Clinical Pastoral Education highlights Boisen's key metaphor in describing contemporary clinical pastoral education, "The textbooks for CPE include in-depth study of 'the living human documents.' By 'living human documents,' we mean both the people who receive care as well as a study of ourselves, the givers of care" (2011).

The structure of CPE thus focuses upon and prepares prospective chaplains for in-depth conversations with patients and family members and the pastoral visits they will conduct in hospitals, psychiatric settings, prisons, and long-term care facilities for elders. What I want to suggest here, however, is that this preparation for one-on-one visits, as vital as it is, needs to be augmented for chaplains in long-term care facilities to include other important dimensions of their pastoral care work. Specifically, *communal* and *systemic* dimensions play a major part of pastoral care in long-term care facilities, and these aspects go beyond the boundaries of interpersonal dynamics alone.

One of the key contextual differences between a hospital setting and a facility such as a nursing home or assisted living residence is the length of stay. Hospital stays in non-federal hospitals average 4.8 days (Center for Disease Control and Prevention, 2011), while the average length of stay in skilled nursing facilities is 2.4 years (National Care Planning Council, 2011). Residents in long-term facilities are often dealing with a sense of loss of home and their previous relational networks; loneliness is a major issue. In short-term hospitals, community building and group activities where residents can connect with one another are usually not possible nor, in most cases, desirable. In long-term facilities, these activities become major intervention strategies for helping residents share their stories and connect with one another in a prayerful setting. For example, group prayer circles with simple hymns for residents with Alzheimer's and other forms of dementia have been introduced in a number of long-term care facilities. With higher functioning residents, Bible study and other types of prayer groups may be attractive to residents, and they provide vehicles through which residents may share and review their life stories and concerns in light of the wisdom traditions they are exploring. One chaplain whom I recently interviewed described her work in this way:

It's very different than hospital chaplaincy. Relationships can be developed and deepened. A lot of what I do is community building. I try to create frameworks so that community can happen. For example, we have an interfaith discussion group. It is very inclusive and any of the residents can come. We studied Abraham together and then I invited an Episcopal priest, a Jewish rabbi, and an Islamic imam to come and speak to the group. If I find out that someone in assisted living loves to speak French and I know that someone in independent living also loves to speak French, I try to introduce them to one another. I do pastoral care visits, but there is so much more to pastoral care in a setting such as this.

These important communal aspects of chaplaincy work call for a skill set that builds upon but also goes beyond the interpersonal competence needed for pastoral visitations. Facilitation skills and the ability to guide group dynamics are essential. Moreover, these group skills may be especially important when working with residents who lack or have lost some of their sensibilities for listening well and relating to others in community.

In addition to the substantial work of building community, there are systemic aspects to pastoral care work in long-term care facilities. Most Catholic hospitals currently have administrators and staff dedicated to fostering the institution's mission and religious identity. In long-term care facilities, the onus for fostering a Christian environment and culture in the facility often falls to the pastoral care staff.

Because long-term care facilities are residential, the healthcare staff members, particularly the CNAs, regularly see the residents and form relationships with them. They, along with all of the direct care staff, implement the institution's mission of Christian caring. As one chaplain in a Catholic nursing home put it, "The challenge now is to get the word out to everybody in the facility to have more patience in dealing with aging. Everyone has a pastoral care role in this facility. I want everyone to see that." In meeting this challenge, the field of organizational development offers many insights into how transformation occurs in organizational cultures. The systemic work of pastoral care would be enhanced through greater interdisciplinary work that would draw from this growing body of organizational science.

An LPN at a long-term facility told me recently, "I wish I knew that the administration would allow staff, if they so chose, to pray with the residents. I need to hear from administration that it's OK to have a prayer with a patient." While an administrative "yes" might seem like a simple answer to this query, a larger issue looms. Do all staff members who want to pray with patients know how to approach the resident with such an offer? How might staff be educated to appropriate ways of entering into prayer with a resident? What kind of training and orientation might be needed? These are systemic questions that call for some reflection and overall planning. The systemic issue of how the institution itself is caring for staff, while going beyond the boundaries of pastoral care, also affects the quality of caring overall that is fostered throughout the facility. Pastoral care staff may contribute to a caring atmosphere for staff by providing opportunities for blessing the staff and celebrating their contributions.

In summary, the residential nature of long-term care facilities offers exciting opportunities for chaplains to engage in the *communal* and *systemic* aspects of their work. A large part of their work with residents will involve community-building and small group as well as larger public worship events. Drawing other staff into a vision of caring to create an overall culture of compassion involves systemic thinking and action. Both of these dimensions call for skills that go beyond the interpersonal depth that CPE offers. Hopefully, the resources, networks, and ongoing education that organizations, such as the NACC, offer will help to equip chaplains for these vital aspects of pastoral care work in long-term care facilities.

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References

Association of Clinical Pastoral Education (2011). Who we are. Retrieved from <http://acpe.edu/index.html>

Boisen, A. (2005). The living human document (1936). In R. C. Dystra (Ed.), *Images of Pastoral Care: Classical Readings* (pp. 22-29). St. Louis, MO: Chalice Press.

Center for Disease Control and Prevention (2011). Faststats. Retrieved from www.cdc.gov/nchs/fastats/hospital.htm

National Care Planning Council (2011). About Nursing Homes. Retrieved from www.longtermcarelink.net/eldercare/nursing_home.htm

SOURCE: *Vision*, November/December 2011

Life circumstances vary, but universal themes remain

By Margot Hover, DMin

A core belief for me is a variation on the truism, "The more things change, the more they stay the same." My version of that focuses on large, universal themes that are given shape and color by our individual lives. Safety, control, limitation, hope, connection, identity, desire to "make a difference," vulnerability, change, loss, grief, forgiveness, loneliness, wealth, beauty, shame, virtue, strength, responsibility, love, loyalty, truthfulness, possessions, attachment, dependency, trust – these are a few of those universal themes. They may look different from person to person, from situation to situation, and from stage to stage in an individual's life. Safety for an infant means nurturing, food, being held securely. Safety for a coronary bypass patient in an acute care setting may involve a pre-surgery prayer or a visit from her home pastor. And safety in the long-term care context may involve familiar faces, a regular schedule, and predictable placement of a walker.

After many years supervising students in major urban medical centers, I directed a CPE program for pastors and community leaders in rural Midwestern states, going to my students on their schedules, and meeting with their constituencies in congregations, hospices and other pastoral situations. Then, a year ago, I moved to Pilgrim Place, located outside of Los Angeles, CA. It is a Continuing Care Retirement Center (CCRC) "intentional community" specifically for retired clergy and lay professional religious organization and nonprofit personnel, comprised of both independent and assisted living arrangements as well as a skilled nursing, rehabilitation and hospice center. Residents and administration have worked hard to generate resources to transform the assisted living and nursing home areas into "households." Concurrently, the entire community is enrolling in "Person First," an experiential program aimed at helping all residents to learn how to integrate dementia patients into the full fabric of the community.

After years with my rural students and their townspeople and institutions, I agreed to supervise one unit back in a large urban teaching hospital. Although my rural students were always busy, usually at the hub of county activity of all kinds, I was struck by the starkly contrasting hurry and flash of the hospital. Hurry and flash are rare in the steady reliability of long-term care facility activities of daily living and rehabilitation. Some details are unique to each setting. For example, while a nursing home chaplain might not be allowed to enter chart notes, hospital chaplains' observations were a tiny, tightly structured part of massive computerized records, many of which might not be read by treatment teams. Particularly in today's climate that discourages long hospital stays, acute care facilities address critical issues of the moment; long-term care issues tend to be chronic. Chaplains in a nursing home might respond to a resident's hunger for solid ground in the midst of dementia by singing an old popular song together; "leisure" for spiritual care like that is a rare commodity in a medical center.

Beyond those obvious differences, however, it might be illuminating to explore how spiritual issues in both settings are similar. The running joke at Pilgrim Place is that residents don't make a lot of long-range plans. But given the acuity level of hospital patients, one can assume that the nature of mortality and the meaning of hopefulness, faith and prayer are very much in those beds as well as they would be for long-term care stroke or dementia patients. Television ads for erectile dysfunction cures in otherwise active men parallel in a number of ways the growing awareness of elders' sensitivity to and hunger for touch and issues around personal boundaries, body image and powerlessness, regardless of medical condition.

Suffering is present both in hospitals and nursing homes, and we should assume that both populations struggle to find meaning, to integrate their experiences of pain, limitation and alteration. No one enters a hospital or care facility, even to visit, without encountering to some degree a challenge to his or her belief system.

Compassion implies shared sensitivity with another's experience. Spiritual care, whether in medical center or in short-and long-term nursing centers, is inevitably enriched by looking honestly and carefully at the universal human needs present across the whole spectrum of fragile human life, regardless of setting, age, and medical condition.

*Margot Hover is ACPE/NACC emeritus supervisor, and the author of *The Sacred Spiral: Spirituality and Aging*, in "Perspectives on Spiritual Well-being and Aging," edited by James A. Thorson (Charles C. Thomas, publisher, 2000).*

SOURCE: *Vision*, November/December 2011

Recognizing ‘sacredness of work’ causes huge ripple effect

By Sister Frances Baker, CSJ, BCC

In June, I made a retreat entitled, “Finding God in a Hi-speed, Hi-tech, Hi-pressure world.” This title aptly describes the acute care setting. It also described where I was emotionally after being downsized with 50 others and moving to Los Angeles after 14 years in a mid-sized town in Arkansas. The known and comfortable gave way to the unknown and at times unwanted. I was a stranger in a foreign land. Feeling this way, I found it easy to identify with many residents I had met in long-term facilities.

How best to contrast long-term and acute care? Both have benefits and challenges. People will always be the variable factor in ministry; mystery and grace will still abound. Should I take the minister’s perspective, or see matters from a patient’s viewpoint, or perhaps look at the broad national range?

Long-term care

While I enjoy ministry in both settings, as I age, I have become more aware of the increasing spiritual needs of the elderly as they live the words of Psalm 73. “My flesh and my heart fail, but God is the strength of my soul and my portion forever.” As we know, spiritual care of senior adults becomes more important and affects both mental and physical well-being. Growing dependence and a sense of loneliness and isolation can deepen with age. Chronic illness and pain nibble at faith and undermine trust. Depression, grief and suicide appear to have a greater influence on the elderly and frail. Statistics tell us that at age 70, 15% are depressed, but only 10% receive treatment. Military persons who enter long-term facilities may suffer from Post Traumatic Stress Disorders. Rehabilitation units need to be aware and sensitive to their special and sometimes hidden needs.

Anxiety and fear for some become daily companions. Issues of physical safety, a history of assault, robbery, or recent moves of self or loved ones, disability, dependence on others bring many elderly persons to a fearful place in their lives. For those over 70, 6% develop an anxiety disorder requiring psychiatric treatment. Panic and anxiety replace previous resilience and steadfast trust in God and their own abilities to cope. Family may not be able to visit, or do not choose to see the elderly member of the family. Therefore, staff assume yet another role in care giving.

My experience with long-term residents is that they welcome an opportunity to talk about God, and what it means “to go home to God.” Today, as the population of aging persons increases with “baby boomers” entering the retired and long-term ranks, it will become more important for chaplains and pastors to know how best to reach and support those who experience life changes and stressors to their faith life and purpose in living. The best that theology and spirituality can offer should be available.

In summary, I have learned a great deal from patients in both settings who have the courage to face loss, change, and diminishment as yet another opportunity to trust in a gracious and loving God. Challenges remain to offer proper staffing, salaries are lower than acute care, long-term facilities face more regulations than hospitals, and staff members must assume many roles, especially when families do not visit.

Acute care ministry

As the retreat title suggested, we attempt "To find God in a Hi-speed, Hi-tech, Hi-pressure world." Both settings offer the opportunity to find and to minister literally to the body of Christ on earth. And what if we looked beyond the usual problems of acute care: inadequate staffing, regulations and inspections, new and newer technology, orienting staff over and over to mission and purpose, meeting family needs with compassion and empathy, ethical concerns, conflict management, multiple meetings, mandatory education, recent healthcare reform, and an over-priced, under-regulated, difficult to access and navigate healthcare system, especially for those "at risk."

Demands could be met by accepting the invitation to simply work more lovingly, more gratefully, more consciously and more focused on the individual's sacredness. It does not necessarily mean working harder, faster, longer or more efficiently, as Fr. Louis Savary notes.

Perhaps this focus might bring renewed spiritual energy. What would it look like to spend a day focused on God's healing power and presence in the workplace? What would it feel like to focus on the sacredness of work? Really, there need be no distinction between sacred and secular. When we recognize the sacredness of work, in whatever setting, the ripple effect can be enormous. Loving and generous staff can bring a new mindset, a new way of thinking of oneself as interdependent, part of a greater whole, and all of us working side by side for the healing of those we respectfully and gratefully serve.

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SOURCE: *Vision*, November/December 2011

Residents share coping strategies, after naming and grieving ‘hidden losses’

By Sandra Lucas, MDiv, BCC

At Mount St. Joseph, a long-term care facility in Waterville, ME, where I worked for 10 years, the Pastoral Care Department offered an annual memorial service for families of residents who had died during the year. We also held a brief remembrance service on the unit for every resident who died. The remembrance service offered a way for residents and staff to acknowledge the loss of that person who was part of our daily lives. In addition, chaplains offered bereavement support to residents experiencing the death of a family member or friend.

We were good in addressing significant losses in the lives of the residents. But how did we fare in acknowledging other kinds of loss?

Social Worker Marilee Caldwell and I attended a workshop called “Grief Through the Life Cycle” presented by Kenneth Doka, professor of gerontology and author of numerous books on bereavement and loss. We learned about “disenfranchised grief” – losses that are not recognized or validated by others.

Mr. Doka distinguishes between “tangible” and “intangible” losses. Tangible losses are the significant, culturally recognized losses such as the deaths of spouses, friends, siblings, and parents. Intangible losses are the not-so-obvious things, the hidden losses, such as the loss of one’s mobility, autonomy, or abilities – things that seem “little” compared to tangible losses but are significant nonetheless, and need to be acknowledged and grieved.

After the workshop, Marilee and I decided to look at “hidden losses and coping strategies” for our residents. We invited 10 residents to a discussion. The participants ranged in age from 72 to 89 and had resided in the facility from four months to five years. All were cognitively alert and understood the purpose of the group.

We opened the discussion by acknowledging that everyone present had experienced significant losses, particularly the death of loved ones. (Everyone was a widow or widower; one person had recently experienced the death of her son.) We explained that the purpose of this group was to identify other losses in their lives. We invited them to name the losses and difficulties they experienced in giving up their homes and coming to live at Mount St. Joseph.

We wrote their responses on a flip chart. The following list is presented in the order it was created.

Question 1: “What losses did you experience when you came here to live?” “What do you miss not having or being able to do?”

Responses: “I miss my daily routine.” “I miss my own bed.” “Getting my own mail.” “My independence.” “Having my own sheets and towels.” “I miss my dog.” “I miss getting in my car and going places.” “I miss having my own teeth!” “Going to church.” “I miss my mother.” “Working in the garden.” “Traveling.” “Planning ahead.” “My kitchen things and cooking what I liked.” “Controlling my own money.” “Going to sports and games.” “Friends who have died or have moved away.” “I miss not being able to do what I used to do.”

Question 2: "What helps you in coping, adjusting, or making peace with these losses?"

Responses: "Learning to live with it." "Prayer." "Staying active and involved." "Be able to accept advice and not just give it." "Talking to someone." "Don't plan too far in advance." "Live one day at a time." "Share memories." "Remember our blessings." "Resident Council Meetings – make changes here." "Have a sense of humor." "Don't keep fighting your situation." "Everyone has something that's hard." "Try to help someone else." "Be nice to the staff; ask them how they're doing. It makes you feel better."

Question 3: "What do you find isn't helpful in adjusting to your changes and losses?"

Responses: "Staff who don't listen." "Family too busy to visit." "Feeling like a bother to family and staff." "Feeling lonely." "Not being needed." "Hating to ask for things." "Saying harmful or hurtful things." "People who don't look you in the eye." "Visitors who stay too long." "Staff not following through." "Complaining!"

At the end, we solicited their feedback about the group. Did they find it helpful? Would they like to meet again?

The residents responded that it was good to name their losses and learn that others felt the way they did. "It lifts your spirits to talk about it," one resident said. Also, it was helpful to see all the items listed, noting that no one could have thought of the list individually. The consensus was that one meeting was sufficient; they did not see a need to meet again.

Marilee and I concluded that it was a one-time group but could be offered to new residents. We noted issues of concern and loss for follow-up visits. We were pleased that everyone participated and expressed support for one another. We then presented the results of our study to the Administrative Team (department managers, directors, and the executive team.)

The Administrative Team offered good feedback, including the insight that "There's more wisdom and information here than in a stack of textbooks." One person noted that residents on the Alzheimer's unit are unable to identify their losses or coping strategies and it's essential for us to understand their needs as well. Another person pointed out that residents have lost their community connections and former support systems, as well as their social roles. "It's not the same, coming to the nursing home to visit Grandma, instead of going to her home." Someone else noted that there was something missing from the list: "the loss of privacy."

I was intrigued by the observation that privacy was not named. After the meeting, I asked one of the residents in the group for her insight on that topic.

The resident said that when she accepted the fact that she needed help with the activities of daily living – bathing, dressing, etc. – the privacy issue was settled as well. Initially, it was easier to accept care from strangers than from the people she once cared for. Now she accepts care – with its requisite lack of privacy – from all, grateful for the things she can still do. "I never think of my own privacy," she said. "It's not an issue." That's why it didn't make the list, at least for her.

How did the resident survey change the focus of our spiritual care? It made us more cognizant of the huge array of losses experienced by residents before and during their time with us. It pointed out the importance of engaging residents to name their losses, in our spiritual assessment and pastoral visits. It reminded us to validate feelings of grief and explore coping strategies with residents and family members. It challenged us to help residents find purpose, joy, community, and quality of life in their new environment.

In the Gospels, Jesus says, "I was thirsty and you gave me something to drink." In long-term care, many of us have had the humbling experience of giving a resident a sip of water or soothing parched lips with a sponge swab. I interpret the passage to mean I am asked to help others in need, especially their basic needs.

I forget sometimes that Jesus is the receiver in that Scripture passage, not the giver. One day, I will be in need of a helping person to quench my thirst. Will I be a Christ-image to those who bring me water and food and clothing? Will I be able to receive, with dignity and grace, that which I cannot supply or do on my own?

This is the lesson I learned from the residents of Mount St. Joseph.

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Reference

Doka, K. J., ed. (2002). *Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice*. Champaign, IL: Research Press.

Related resources

About Kenneth J. Doka, PhD
www.drkendoka.com

How Elderly Nursing Home Residents Transcend Losses of Later Life
journals.lww.com/hnpjournal/Abstract/2003/05000/How_Elderly_Nursing_Home_Residents_Transcend.7.aspx
(source: *Holistic Nursing Practice*, May/June 2003 - Volume 17 - Issue 3 - p 159-165)

(If you wish to read the whole article after reading the abstract above, you may want to find out if your institution has a subscription to this journal.)

SOURCE: *Vision*, November/December 2011

How I came to love elder care ministry

By James J. Castello MBA, MA, BCC

I have spent most of my chaplaincy career working in hospitals and I really treasure the experience. The Lord is a God of surprises as I was led to this ministry through the death of my first son-in-law, who died at the age of 30 from a brain tumor. Up until that time, I had very little exposure to death but something really touched me as we set up a hospice for Mark Lamb, a U.S. Army captain. This event led me into the CPE experience and into a ministry that led me to encounter more than 1,000 deaths in an eight-year period.

I completed three of my four CPE units at Hackensack University Medical Center, a 600-bed acute care trauma center in northern New Jersey. On my evening shift I had to cover the entire hospital but my favorite units were PICU and NICU because of the children whom I dearly loved. I also loved the Psych unit and came to like the ER once I got used to its frantic pace. I covered geriatrics when needed, but it was definitely not my favorite unit.

When my mother and father were in St. Anne's Long-Term Care facility in Lancaster, PA, I would look in wonder at a diminutive Roman Catholic priest from Ohio who displayed so much enthusiasm when working with the elderly. He would get so excited over Bingo or a game of cards or reading the paper, and his enthusiasm ignited the spirits of the residents who seemed to really enjoy whatever activity they were doing. I remember thinking to myself, "I could never do what he is doing." I have since learned the lesson to "never say never" because you never know what God has in store for you. I know I didn't.

Two years ago, my wife and I moved from Bergen County, NJ, to Kennett Square, PA, to be in the center of our rather large family of five daughters, five sons-in-law and 16 grandchildren. I volunteered as a chaplain at A.I. DuPont Hospital for children and covered the PICU and NICU for four hours one day a week and I enjoyed it because of the children. But the pastor of our church suggested I talk to the chaplain at Franciscan Care Center in Hockessin, DE, to see if they could use me.

Turns out they were delighted to have me come in on Fridays and run the Communion service for the Catholic residents. I soon found out that giving Holy Communion to 85-year-old dementia residents who are hearing and sight challenged was a formidable task. Only one can walk on his own; the others are in wheelchairs or walking chairs. I eventually learned who was able to receive the whole host and who could only swallow a small piece. I also learned that you have to watch them consume the host because once in a while it comes back up.

As I began to get to know each of these lovely people, I was able to relax and enjoy the whole process. I also learned they can be very funny. For example, a lovely Polish lady of 84 was wheeled to a Stations of the Cross service I was asked to lead. I knew she was fairly deaf but I didn't know she had forgotten to put in her hearing aids. As soon as I started the sign of the cross, she said rather loudly, "I CAN'T HEAR YOU!!!!" So I cranked up the volume for the balance of the service. At the end she told me, "I DIDN'T HEAR A WORD YOU SAID!" Exasperated, I said in a normal speaking voice the only Polish I know, "Yak Shamash? (Phonetic spelling). She instantly replied, "Dobja!" I guess she can hear a lot better in Polish than in English.

When I looked at the other side of the group, I saw a lady with a wonderful Irish face – undeniably Irish.

Whenever I see such a beautiful face, I cannot resist the temptation to ask the person if they are Irish (I have never failed until this time). I said, Helen, "Are you Irish?" She replied, "NO, but my parents are!" You cannot make this up. Just today the sharpest resident we have who remembers everything he is told (retired police officer) said to me at lunch, "How do they do these sweet and sour meatballs? – Is one meatball sweet and the other sour?"

I really enjoy leading the Communion service and being able to reach the residents in the songs, responses and the reflections. They have vastly improved their level of participation in the Mass – particularly in loudly proclaiming "Alleluia" and singing "Amazing Grace" and "You Are My Sunshine." I have told them several times how much I have come to love them as I have gotten to know them. I now love them as much as the children. One of the beauties of long-term care ministry is that the residents are usually there for a much longer time than patients who are in hospitals an average of only three to four days, thus giving you time to get to know them, their gifts and idiosyncrasies. I shared with them my feelings one day and told them I really like them, and that when I looked in the bathroom mirror that morning and observed all the wrinkles in my face, it hit me that I was one of them. Praise God!

James J. Castello, of Kennett Square, PA, worked 35 years in executive marketing positions for two global manufacturers before becoming a chaplain in 1998. As a chaplain, he ministered eight years at Hackensack University Medical Center and then worked as director of pastoral care at St. Vincent Medical Center in Jacksonville, FL, and Bon Secours Community Hospital, Port Jervis, NY. He is a consultant for NACC on marketing communication projects.

SOURCE: *Vision*, November/December 2011

‘Keeper of stories’ in long-term care took on role of ‘connector’ in hospital

by By Pat Hartsel Dennison, MA

For more than four years, I was blessed with the opportunity to serve both as a director of pastoral care in a long-term care facility and also as an associate chaplain in a local hospital. Not surprisingly, my ministry in the two settings overlapped considerably. The skills and gifts that I brought to the hospital setting were pretty much the same ones I exercised in long-term care: a compassionate presence, reflective listening, good analytical skills, and a deep respect for the patients, residents, families and staff to whom I ministered. But there were definite differences between the two settings – some subtle, some pretty obvious.

One obvious difference was the length of the relationships. In the long-term care facility (called Heritage House, or just Heritage for short), our permanent residents ranged from very independent to acute care. Patients in our rehab unit were typically with us for four to six weeks. Our ministry offered to residents a continuum of care that allowed them to stay where they were, and still get the care they needed as their needs became more acute. As a one-person pastoral care department, I walked with all residents on their journeys, regardless of length of stay. Since we were a residential facility, family members also became a regular part of my “territory,” especially as the end of life neared. And my ministry would sometimes extend to staff members grieving the loss of a resident with whom they had become close.

With time to spend with residents and families, I could develop some very deep relationships. As you would suspect, some people needed a lot of spiritual support, and others had the spiritual support they needed from family and friends. So my daily interactions with residents and families ranged from casual conversations in the hall to one-on-one, heart-to-heart talks. Our prayer together ranged from public and liturgical to private and intensely personal. And sometimes we would sing (in both settings!).

Some long-term residents were Alzheimer’s/dementia patients. These were not the most serious cases – Heritage was not set up for that level of care – but we had our share of difficult behaviors to cope with. There were also some wonderfully profound moments when God’s face shone through. There was a resident (described as “pleasantly demented”) who numerous times a day recited the litany of her brothers and sisters in order of birth, before proudly announcing: “and then I came!” She would regularly forget where she was and how she got there, but her family was always with her.

In part, my role became “keeper of the stories” for residents, families, and staff. Even though we worked very hard at making Heritage a home, it could still be very lonely for the residents and the short-time rehab patients. At some point, even the regular family visitors had to go home, and the resident was left alone. Sharing and listening to stories kept residents connected to what was most important to them at that stage in their lives: their families and their God.

Hospital relationships, in contrast, were usually short and very intense. It still surprises me how willing patients and family members are to get to their deepest needs in such a short time. There really is no time for the social niceties, especially in crisis situations. While there was a population of “frequent guests” that I got to know over the four years at the hospital, most of my interactions were for a single-patient stay, or even a single shift. These interactions called for a much higher level of energy. No two

interactions were exactly the same. In one visit, the patient may be in good spirits, only needing a short visit and a simple prayer. In the next room, a patient might be in great spiritual distress and need all I have to offer.

And then, of course, there are the crises. My hospital experience was full of them. Our hospital was a Level II trauma center, the heart surgery specialist in the area, featuring two IC units, located in a small city an hour outside of Chicago. Activity levels in the ER were not nearly what you might see in the "big city," but we had our share of trauma – accidental deaths, traffic or farm accidents, and sudden deaths due to catastrophic health issues. We had our share of medical miracle workers on staff, but even they could only do so much for the body. And through it all was the swirl of emotions among families in spiritual and emotional crisis of their own. And the staff could present their own spiritual needs, such as ER staff shaken by the traumatic death of a child.

In part, my role in the hospital was as "connector." Heritage allowed time to share stories, but the hospital mostly presented a "now" that must be dealt with, whether it was a crisis or not. I would pray with those who asked, pray for those who couldn't pray, give words to those who didn't have them, and pray intensely with those who needed "God with skin on." While the patient was always the focus, I found that families came more to the forefront in the hospital, especially in the IC units and in ER.

Death was experienced differently at Heritage than in the hospital. At Heritage, death was a process of life: in some cases longed for, in some cases quick, in some cases agonizingly slow in coming. But always it was an accepted and expected part of life. After all, people came to Heritage knowing that this would be the last place they would live. Our goal was to make their last days ones of dignity. At the hospital, death was the foe to be fought at all costs (in some cases, quite literally). The medical staff (especially certain doctors) refused adamantly, sometimes almost unreasonably, to let death win. But theirs was only a physical battle. I complemented that fight with a spiritual dimension, which many patients and families (and even many staff) found meaningful and ultimately more important. At this nexus, much of my most rewarding ministry took place, in both settings. When I look back at those years, I am most grateful for the opportunity to serve God's people in two such different and yet similar places.

Pat Hartsel Dennison currently is liturgy coordinator for four parishes in Green Bay, WI: Annunciation, St. Joseph, St. Jude and St. Patrick. In addition she is a PRN chaplain for St. Mary's Hospital, Green Bay, WI.

SOURCE: *Vision*, November/December 2011

Ohio residents, staff issue dramatic salute to America

The summer's patriotic holidays were recognized in a "grand old way" at three long-term facilities in the Humility of Mary Health Partners network in Ohio. Mary Tatman, BCC, spiritual care coordinator at Laurel Lake Retirement Community and Sandra Lucas, BCC, regional director of spiritual care, wrote the script for "Salute to America: A Patriotic Performance," featuring patriotic stories and songs.

Residents, staff, and family members were cast in the roles of the pilgrims, George Washington, Betsy Ross, Thomas Jefferson, Abraham Lincoln, the Statue of Liberty, Uncle Sam, Yankee Doodle Sweetheart, and President Barack Obama. Several patriotic songs were included and a medley of military anthems offered tribute to all those who have served our country.

Independence and freedom were celebrated as well as the founding principles of "life, liberty, and the pursuit of happiness." Thomas Jefferson read from the Declaration of Independence. Abraham Lincoln read from the Gettysburg Address and The Statue of Liberty read from her famous words welcoming immigrants, the poor, and all those "yearning to breathe free."

In the grand finale, Uncle Sam and his girlfriend, Yankee Doodle Sweetheart, made an appearance as well as President Barack Obama. They asked that God's blessing be given to our country and that "we always act in justice and work to bring peace into the world." The play closed with waving flags and a rousing rendition of "God Bless America."

(Reprinted from Partners, Sept. 5, 2011)

SOURCE: *Vision*, November/December 2011

Bible stories offer children new sense of hope, faith, meaning

By Lorraine Gardner

Back in December, when I began my first unit of ministry in pediatrics, I went into the unit with the idea that I was simply a child of God. In the Gospel of Mark, Jesus reminds the disciples that the Kingdom of God is destined for those who come to God, with the grace and humility of a small child. He said, "Let the little children come to me; do not stop them; for it is to such as these, that the Kingdom of God belongs." With the time that I have spent on the pediatric unit now, I still find myself following in the steps of the children there. It is their insight, it is their resiliency, it is their humble simple way of looking at God in their lives, that keep my feet going back there everyday.

Pastoral care in pediatrics is challenging, heartbreaking, dynamic and rewarding. In the span of just a few hours, the life of a child can change due to trauma or a critical diagnosis. Pediatric ministry, coupled with interactions between family members, can be one of the most powerful experiences that a chaplain can have. In my ministry to children and families, I like to engage the children through the reading and telling of stories. In the New Testament we find some of the most refreshing gifts Jesus left us – his parable teachings.

Our Lord was a masterful storyteller, and like many children, he knew the power of understanding that stories create in the hearts and minds of people everywhere. As children grow into adults they often lose the powerful imagination they had when they were young. The ability to imagine and create stories for themselves gives them a sense of faith, hope and meaning. Stories often give children a sense of inspiration along with new insights. By reading children's Bible stories, we are able to give children a new vehicle of understanding, especially in time of crisis. Bible stories give children the opportunity to think about and articulate to others the difficulties they have experienced. I believe that by reading these stories to them, I can contribute to their lifelong spiritual pilgrimage in a positive way.

By way of example, one of the stories I love to read to children is the story of Jesus with the disciples in the middle of a storm. Using a children's book of Bible stories with school age children who are old enough to understand this passage, I find this story to be one that most kids like to discuss. Many children have experienced being out in a rain or thunderstorm with their parents, so in a very simple way they are able to understand the fear that a storm can bring. The disciples were afraid of the storm, thinking that they were going to die. Jesus calmed the waves of the storm, which in turn calmed down the fearful men, but more importantly, he asked the disciples, "Why are you afraid?" This is a great question to ask children facing difficult situations. Other questions, such as, "When were you afraid before?" "What does it mean to you to be brave?" give children a chance to talk about their fears. With this story, I like to relate the idea of the disciples' bravery with their faith in Jesus. There are many other good examples of biblical stories that give children the opportunity to talk about other trials in their lives, such as grief, illness, loss and bad behavior. In my pastoral role with children, I try to keep them focused on the present time and on one particular subject or event. In my ministry with children, I like to use arts and crafts, puppets, and stuffed animals to engage them, because these toys can open conversations with children that are not threatening or uncomfortable for them.

Working here in pediatrics has given me the opportunity to meet and visit children from all over the world.

One of the greatest things the children have taught me is that God has a face in some traditions and a voice in other traditions. By way of example, I met a 13-year-old Jewish boy in June. He was preparing for his bar mitzvah, which had been delayed, due to his illness. I asked him about his bar mitzvah, his studies of Hebrew, and his preparation for the celebration. I asked him to tell me how he saw and understood God, while he was so sick. He told me that God spoke to him and therefore, he could hear the voice of God, but God had not come to him. As a follower of the Jewish faith, and taught by his father who is an orthodox Jew, this boy told me that the Messiah had not come and therefore, we do not know his face. He did not see the face of God, as many Christian children do in the drawings and pictures of Jesus; he only heard God's voice in prayers.

Finally, for me it has been interesting to learn how children understand God and what it means to them to be a patient in the hospital. They say some of the funniest things much of the time, but there are those times when they say something that really gets your attention. Last week an 11-year-old child asked me, "Why does God take some kids away from their Mom and Dad, and leave other kids with parents that don't treat them very good?" The only answer I could give this child that day was that we do not know why God does some of the things that he does, but that praying to God sometimes makes us feel a little better. These kinds of questions really make me work hard in this ministry. Ministry in pediatrics is so different from ministry with adults. It is a new challenge each day, from one child to the next, from one parent to the next, with a new vision of God shining through each time.

Lorraine Gardner is a Catholic laywoman, who recently finished her CPE residency at the Mayo Clinic in Rochester, MN, and is seeking work as a chaplain. She attended Mt. Angel Seminary, in Mt. Angel, OR, where she received a master's degree in theology with a minor in Sacred Scripture.

SOURCE: *Vision*, November/December 2011

Join in dialogue on long-term care standards

This issue of Vision is dedicated to long-term care ministry. We are grateful to all who contributed articles to this issue.

While the NACC database indicates that we have only 186 members (7.5% of membership) who identify themselves as working in long-term care (nursing/retirement homes is the designation in our database), this ministry will only continue to grow as our boomer population ages. Thank you to all our members working in this ministry.

The NACC continues to seek ways to support our members who serve in long-term care settings. In spring 2009 we communicated with those members and invited them to network with one another through the use of a listserv (an automatic mailing list server that broadcasts to everyone on an e-mail list when messages are posted that only individuals on the e-mail list can access) so that they could communicate with one another on questions and resources. This approach did not prove to be an effective means for member communication/networking.

In spring 2010 we invited our NACC members working in long-term care to participate in quarterly conference calls. We have nearly 50 members who are on the e-mail list that is used to alert them of these quarterly calls. Those who participate have found the calls to be supportive, educational, and good for networking with other members in order to share ministry experiences, invite feedback from others on approaches to ministry, and exchange reading and training resources and ministry tools. A variety of important topics has been discussed, such as: spiritual assessments; chaplains in care plan conferences and developing care plans; end-of-life DNR directives; clinical, residential and neighborhood models; training and use of volunteers; forms of prayer and prayer services; Alzheimer's and dementia ministry; help for those who are beginning to experience diminishment; life-reviews; and memorial services. If you are not on this mailing list, please let us know if you want to join these conference calls by contacting Cindy Bridges (cbridges@nacc.org).

You might also know that the Association of Professional Chaplains (APC) has published Standards of Practice for Professional Chaplains in Long-Term Care (SOP-LTC). (www.professionalchaplains.org/index.aspx?id=1210#Long_term_care) The APC is using a process to refine, finalize and seek affirmation from other associations for the SOP-LTC, similar to the one they used for the Standards of Practice for Professional Chaplains in Acute Care Settings (SOP-AC). For the SOP-AC, APC initially brought together in 2008 leaders in healthcare chaplaincy that included members of ACPE and NACC to prepare a first draft of the SOP-AC. These were posted on the PlainViews website with the invitation to all professional chaplains to comment. We alerted NACC members to this draft through NACC Now, and invited our members to review and comment on the SOP-AC. Based on feedback, the SOP-AC second draft was published. After more feedback, the final draft of the SOP-AC was prepared and the 13 SOP-AC standards were presented to the Spiritual Care Collaborative in fall 2009 for affirmation and acceptance. Professional chaplains were encouraged to engage the SOP-AC's and develop more examples that could test out the SOP-AC's. These SOP-AC's can be accessed ([here](#))

What you read now is the second draft of the SOP-LTC. You will notice in the introduction that the SOP-LTC work group included ties to ACPE and NAJC. NACC offered a list of NACC members to participate, but since the work group had already begun, our NACC members were not engaged on the work group that prepared the first draft nor refined the second draft. However, Jon Overvold (JOvervold@NSHS.edu), chair of the APC Commission on Quality in Pastoral Services, seeks feedback and comments from our NACC

members on this second draft before a final draft of the 13 standards is prepared and sent to the various cognate boards for affirmation or endorsement.

These SOP-LTC are worthy of review and comment. We all know the importance of having common agreement and endorsement on what long-term settings are, how we define terms, what distinguishes this care from acute care, and what essential standards include. If this is your ministry field, please access the SOP-LTC and join the professional dialogue on their usefulness. Let me highlight three features of the SOP-LTC.

First of all, the introduction to these SOP-LTC refer to long-term care settings as: skilled nursing facilities, adult day care centers, assisted living facilities, independent living facilities, sub-acute care, dementia care, and continuing care retirement communities (CCRC). This defining is always helpful.

Second, they highlight, among many distinguishing factors, three characteristics that affect spiritual care. As a residential model, long-term care invites diverse spiritual care services and programs depending on lifestyle preferences, including types of worship services. Also, many facilities are not based on a medical model, so care planning, record keeping, and the chaplain's roles and responsibilities will look different, depending on state licensing and federal requirements. Finally, chaplaincy care with a resident and family often covers weeks and months allowing for more depth and understanding of the resident, and how to help that resident address life and death issues.

Third, they offer 13 succinct standards sub-divided into three sections: with residents and families, for staff and organizations, and maintaining good chaplaincy care. When you place these 13 SOP-LTC alongside of the 13 SOP-AC, you will notice identical divisions, standard headings, and text. The only differences are:

- using "resident" instead of "patient," "service record" along with "medical record," and "resident-centered" instead of "patient-centered care";
- adding the adverbs "actively and clearly" before the verb "collaborates" in standard four, and "actively" before the verbs "models and collaborates" in standard seven;
- and changes "in accordance with federal and state laws, regulations, and rules" in the SOP-AC to "and abides by all applicable laws and regulations" in the SOP-LTC.

As with the SOP-AC, the SOP-LTC standards with residents and families encompass: assessment, delivery of care, documentation of care, teamwork and collaboration, ethical practice, confidentiality, and respect for diversity. The standards for staff and organization include: care for staff, care for the organization, and the chaplain as leader. Maintaining good chaplaincy standards are: continuous quality improvement, research, and knowledge and continuing education.

The fact that these 13 standards are identical in both the SOP-AC and the SOP-LTC highlights these are "minimal but essential standards of practice" and core standards for board certified chaplains. How they are implemented in each of these settings will vary. It will be important for the profession that our members serving in long-term care provide feedback on how well these standards "hold up" in each unique service setting.

We hope this issue of long-term care will both bring to light the vital ministry of chaplaincy in these settings and help to point the way to advancing and further improving our ministry to this precious population.

Your thoughts and observations are most welcome.

[David A. Lichter, DMin](#)
Executive Director

Q&A with Dorothy Hulsey, nursing home resident

By Edco Bailey, DMin, BCC

Edco Bailey I am glad to see you today, Dorothy. Thank you for agreeing to review some of your thoughts of our time together. I first saw you when I worked in the hospital. Do you remember when that was, and what was going on at that time?

Dorothy Hulsey Yes, it was around 2006. I was in the Intensive Care Unit. They said I was a “failure to thrive” case. Actually, I did not wish to live further. You came several times and talked and prayed with me. It perked me up a bit. And I decided to get better and live. But I still want to die.

EB I know. If I remember correctly, one of your return visits to the hospital occurred as a rescue effort from an attempt to exit from this world.

DH I did try once. But it must not have been my time.

EB I remember scolding you about this. I said I would be awfully disappointed if I should learn in heaven that you cheated your way out of this world.

DH That was a shocking statement. I have not tried to commit suicide again. But I hope they hurry up and take me home.

EB When I worked in the hospital, I did not see you much or regularly. It was quite a hit-or-miss type of relating. I might see you if someone alerted me, or if in checking the census list I spotted your name. But you learned to expect my visit. In fact, you joked that your attempted suicide was an effort to get back into the hospital to see me.

DH You were always so mindful and caring. You gave me back my will to live at least until I die. You did not criticize me. You listened. You prayed. You cared. And I liked that. But really, I did not attempt suicide to see you. I was trying to go to see the Lord! And it seemed that he was not ready for me up there.

EB You will agree that they have their own schedule for us -- for when we are to arrive there?

DH Yes, but I hope they don't keep me here as long as they are keeping your 106-year-old cousin!

EB When my cousin was some years younger but still quite beyond the years of most persons, she would sometimes say, “I don't know what I did that causes God to keep me here for so long!” She lived in her own home until she was about 100 years old.

DH I hope I don't have to stay here that long! I will be 84 on my next birthday.

EB When I first met you, you lived out on the farm near the horses. I believe your friend P called for us in pastoral care to see you. And your friend L was very supportive of you.

DH L is still very supportive. He comes in weekly now with washed clothing for me. P is busy with her life, especially since her mother died recently. She calls or I call her often.

EB I am glad that L and P keep up with you and support you as much as they do. Things have changed greatly for you in the past five years. I remember the big challenge of helping you to accept nursing home placement. I still do not know what it was that you dreaded so much about nursing homes.

DH The stories you hear about poor care.

EB Yes, that has been a part of the anxiety you experienced earlier here.

DH I see that my roommate calls sometimes for help, and nobody responds. That is frightening. It could be me any day! And sometimes it does take long for them to answer me. It is frightening. I could be having an emergency and there is too little staffing to respond. Or maybe they are sitting around talking and eating.

EB We talked through this sense of anxiety. I don't think you are as affected as you were earlier. In fact, I see a new faith, confidence and cheer in you. And we still have work to do on this.

DH Well, L comes regularly now. I know how to get hold of P when I need something or just want to talk.

EB And you know how to get hold of me!

DH I really appreciate your calls, your visits, and your prayers. It means so much to me.

EB The interesting thing is that it means so much to me, too. At first, I did not think that I wanted to commit to seeing you per your request, "once a week." It seemed to me that the more that I did for you, the more you looked to me to do. I helped you to reaffirm a will to live. Now you require me to support you spiritually in living. I encouraged you to accept the nursing home. Then you requested that I contact you here on a weekly basis. This, of course, is wonderful for me, for you have found someone for whom you have taken on prayer responsibility. My wife and I value highly your prayer for us!

DH If someone is regular and dependable...

EB I know that that is pretty important to you. I want to apologize for the times I have arrived late recently. I feel bad about that because I know you get dressed for my visit and you would much rather not clothe yourself in this hot room that is required by your roommate.

DH For an unemployed person, you get rather busy here of late. But I don't complain. I know I called you on being a little late one time. It is so much better when you can depend on the word that someone gives you. If you cannot come as you say, at least you can call and say that you can't come, or that you will have to reschedule.

EB You are gracious about that and I thank you.

DH Even if you are going out of town, I only ask that you let me know when you are leaving and when you are coming back.

EB We have been able to do much necessary work since we have accepted regular visitation commitments. You have grown in confidence toward me and my ministry. You feel that you can count on me to serve you, as you believe your spiritual needs require. In the irregular visitation that I did at the hospital, you never asked for Confession or Holy Communion. You never revealed the strength and depth and constancy of your desire to die. You did not let me know about the anxiety with which you were so debilitated. And quite honestly, I do not believe I ever saw you in good cheer at the hospital. We have come a long way together since you have entered the nursing home.

DH You haven't forgotten what I am asking you to pray for, have you?

EB No, Dorothy. I hope you will get your "promotion" soon and very soon! But I trust and hope that you will be patient as you await the way and work of the Lord on this one. I want "goodness and mercy to follow you all the days of your life!"

DH I always think of two cheerful little kids tagging along behind me whenever I think of that part of Psalm 23!

EB You always get a chuckle out of that thought! You know, you have taught me much about praying the 23rd Psalm.

DH It's my favorite psalm.

EB We pray it together much; and I want you to "dwell in the house of the Lord forever." But I want you to have much goodness and mercy while you dwell in the house of time and space here on earth!

DH We have been able to enjoy some laughter also since I have been in here.

EB It's the best medicine, so they say. "A merry heart doeth good like medicine." I will buy laughter anytime! We must laugh.

DH When you come back next week, I will have another humorous reading for you. The staff brings those to me.

EB I will expect that, thanks!

DH I can hear better! They worked on cleaning the hardened wax out of my ears. Now I can hear much better.

EB I am so glad for you!

DH In fact, people seem to talk too loud now!

EB We are making little improvements as we tag along toward heaven. I want you to have these comforts. Thank God for improved hearing! I hope the surgery on your eyes brings you improvement, also.

DH Well, that hasn't happened yet, but at least I have not lost any more vision.

EB We will keep hoping and praying, and together, we will see what the Lord will do!

Chaplain Edco Bailey was affiliated with Shady Grove Adventist Hospital in Rockville, MD, for over 21 years. He continues to serve Dorothy Hulseley, a former hospital patient, who moved into Collingswood Nursing Home care in Rockville. He is an NACC associate member and a board certified member in APC. He has worshipped in the Catholic tradition for 33 years.

SOURCE: *Vision*, November/December 2011

Tech alert: Handwritten records no longer accepted

By Sheila Hammond, RSCJ, BCC

At the hospital where I am in ministry we are preparing for the move to an electronic record. Among the comments about this development are: "Well, finally we will be able to read doctors' orders; finally there will be fewer chances for medication errors because we will be able to read the prescriptions, etc." The gist of the message is, of course, that handwriting is difficult to decipher sometimes!



While the results of even the best penmanship do not have such drastic consequences in our field, it remains true that handwritten records do not communicate as clearly as those done through word processing or what some of us remember as typing! So the NACC and the certification commission, in order to better serve our membership, and to be able to preserve the sanity and eyesight of our staff, will require that all Education Report Forms and Peer

Reviews for renewal of certification be done via the computer. You will still submit hard copies of your records, but handwritten records will no longer be accepted in the process.

This makes sense. Our staff will be better able to assure that you receive credit for the continuing education you have completed. You will be able to organize your own records without killing as many trees. If you have access to a computer where you can save documentation, you will be able to save all of your continuing education hours in an accessible place. If you need to use another computer or one at the public library, for example, you still will have an easily readable record of your year's activity.

By the end of the year, the NACC is looking to develop a new form for our continuing education records. You will be alerted by NACC Now, by *Vision*, and by email that the new recording form is alive and well, available on the NACC website. There will be clear directions for how to make use of the form and it will be easily downloaded for your use. So as the new year begins, be aware that from then on ONLY Education Report Forms and Peer Reviews using word processing via the computer will be accepted as part of your renewal of certification material. Handwritten Education Report Forms and Peer Reviews will not be accepted. If this causes you anxiety, talk to a friend who uses the computer more than you do and make a deal for help. Or, as I sometimes do, consult a young relative! Teenagers are great at this. And always be assured that Phil Paradowski by email (pparadowski@nacc.org) or via telephone (414-483-4898) is at the ready to assist you. He, especially, is charged with assisting you to solve any technological problems, but all members of the NACC staff are helpful and generous in your service. Here's to everyone going forward with this initiative with serenity, good humor and the ability to hunt and peck on a keyboard!

Sheila Hammond is a member of the NACC Certification Commission.

SOURCE: *Vision*, November/December 2011

Toward improved health and hopefulness: Spirituality groups for elderly patients with depression

By Katherine M. Piderman, PhD, Gage R. Church, MDiv, Alexander S. Kindred, MDiv, Laura A. Lovejoy, MDiv, and Roger J. Ring, MDiv, MA

Abstract

As chaplains in a psychiatric hospital, we facilitate a weekly spirituality group for depressed elderly psychiatric inpatients. The groups focus on topics that are common sources of spiritual distress and spiritual well-being in this age group, including resentments and forgiveness, grief, suffering, spirituality, and hope. While these groups have not been studied empirically, our experience is that they are beneficial to our patients. Research could provide important information and insights for spiritual care.

According to the National Institutes of Health, approximately 20% of adults, 65 years of age and older, have depression (nihseniorhealth.gov). For some, the symptoms of depression are so severe that they require inpatient psychiatric hospitalization. Research confirms that depression is a complex illness with biological, psychological, social, and spiritual components, and multidisciplinary approaches to treatment are important (American Psychiatric Association, 2000; Blazer, 2006; Koenig, 2001; Lapid et al., 2011).

Our elderly psychiatric patients often report that depression interferes with long-established religious activity, including church attendance and private prayer. Many also report that they feel less comfort and guidance from their faith, and more spiritual distress (Piderman et al., 2011). These changes often result in the additional burdens of loss of social structure and support, and further isolation from peers and God (Steffens, 2007). All of this seems to disrupt a framework that facilitates meaning and purpose, and the ability to cope.

As chaplains in a psychiatric inpatient facility, we function as part of a multidisciplinary team. We participate in team rounds and meet with patients individually for spiritual assessment and spiritual care. We also facilitate a semi-structured group each week that lasts 30 to 45 minutes. The vast majority of our patients are affiliated with Lutheran and Catholic churches (Piderman et al., 2011), but the themes for our groups are not explicitly religious. Rather, they are related to some of the more general spiritual challenges of aging, e.g., grief, suffering, resentments, and spiritual distress (Chittister, 2008; Erikson, Erikson, & Knivnick, 1986; Valliant, 2002). (Table 1).

Erikson and his colleagues propose that coming to terms with the experiences of life, positive and negative, is the most important developmental task of the elderly. They stress the importance of foundational spiritual beliefs and practices in this process (Erikson, Erikson, & Knivnick, 1986). Our groups provide a structure for our elderly patients to discuss some of the issues that may contribute to their depression and to remember beliefs, practices, relationships and resources that can help them to build pathways to integrity and well-being. Our purpose in describing the details of how we conduct the spirituality groups is to provide a model that other chaplains may wish to consider for application in their clinical practice or in future research.

Table 1: Topics and Transitions in Spirituality Groups

Topics	Transitions
Spirituality and Hope	Invitation to move from, "What have been my spiritual resources?" to "How can I use my spirituality to make my life more abundant?"
Resentments and Forgiveness	Invitation to move from, "What am I angry about?" to "How can I can let go of what is burdening me?"
Suffering and Hope	Invitation to move from, "Why am I suffering?" to "What perspective on my life would be more helpful to me?"
Grief and Hope	Invitation to move from, "What have I lost?" to "What do I still have? What is possible for the future?"

The spirituality group is always listed in the patients' schedule, but the chaplain also takes the initiative to invite each patient to participate. Once the patients have gathered, the chaplain clarifies that the goal of the group is to provide information that will help them journey toward a more healthy and hopeful approach to life. Then, the chaplain invites the patients to introduce themselves by stating three things: 1) first name, 2) hometown, and 3) some other piece of open-ended information, such as favorite hobbies, movies, or foods. The responses provide the chaplain with a brief assessment of patients' functional level and their ability to engage in the group process. For example, some patients may be cognitively impaired and unable to remember the directions. Some may be reticent to speak because of the severity of their illness or distrust, while others may respond readily and at length.

After the introductions, the chaplain introduces the day's topic and begins to present a structured outline related to it. For example, for the topic "Resentments and Forgiveness" a definition of "resentment" is given and the process of acquiring resentments is described. Often, the metaphor of a heavy backpack or suitcase is used to represent the burden of resentments. The chaplain then asks the participants to offer their associations with the word "resentments." Typical responses might include experiences of anger, sadness, and bitterness, e.g., "Nobody understands me," "Even God is against me," or "Everyone who has ever loved me has left me and now they're moving me to a nursing home." The chaplain receives these comments with compassion, but also acknowledges that current emotions need not be the entirety of a person's experience.

When the discussion of the first part of the topic is complete, the chaplain directs the participants to the second half of the group, i.e., "forgiveness," defining the word "forgiveness" and offering suggestions about moving towards a willingness and choice to forgive. Again patients are asked for their associations and their experiences. While some do not see forgiveness as a possibility, most do. Affirmations, such as, "I'm working on letting go," "I'm ready to move on," and "If God can forgive, I can try," are common. The chaplain responds with encouragement and suggestions for commitment to realistic application of intentions. To conclude the group, the chaplain synthesizes the discussion, emphasizing the transition from resentment to forgiveness. Often this is done with a continuation of the opening metaphor, i.e., putting down a heavy backpack, or a story in which forgiveness brought peace and relief. While we have found it essential to have a structured outline for the group, the participants' comments throughout often take the discussion in a different and even richer direction than the chaplain had expected.

Our experience with the spirituality groups is that they are beneficial to our depressed elderly patients in several ways. First of all, the groups engage patients in a lively process with others that mitigates passivity and distancing. Secondly, they provide an opportunity for patients to share the wisdom they have accumulated over the years, to feel heard and understood, and to experience connection and

commonality with others. Most importantly, the groups offer patients an opportunity to reflect on and address areas of distress and challenge in ways that promote integrity, healing, and movement towards hope. While there is some evidence of the efficacy of psychotherapeutic groups for the elderly (Ingersoll-Dayton, Campbell, & Ha, 2009; Payne & Marcus, 2008), to our knowledge such evidence is not available for spirituality groups with depressed psychiatric elderly inpatients. Research exploring the outcomes of such groups could be instructive and provide important insights with clinical benefit.

Acknowledgement

We gratefully acknowledge Heidi Durland, BS, for her attention to the detailed preparation of this manuscript.

About the authors

At Mayo Clinic in Rochester, MN, all of the authors work in the Department of Chaplain Services. Katherine M. Piderman and Roger J. Ring are also affiliated with the Department of Psychiatry and Psychology at Mayo Clinic.

References

- American Psychiatric Association. (2000). *American Psychiatric Association practice guidelines for the treatment of psychiatric disorders*. Washington, DC: Author.
- Blazer, D.G. (2006). Spirituality, depression and the elderly. *Southern Medical Journal*, 99(10), 1178-1179.
- Chittister, J. (2008). *The Gift of Years: Growing Older Gracefully*. New York: Blue Bridge.
- Erikson, E. H., Erikson, J. M., & Kivnick, H. Q. (1986). *Vital involvement in old age*. New York: W.W. Norton.
- Koenig, H.G. (2001). Religion and Medicine II: Religion, Mental Health, and Related Behaviors. *International Journal of Psychiatry in Medicine*, 31(1), 97-109.
- Ingersoll-Dayton, B., Campbell, R., & Ha, J.H. (2009). Enhancing forgiveness: a group intervention for the elderly. *Journal of Gerontological Social Work*. 52(1):2-16.
- Lapid, M. I., Piderman, K. M., Ryan, S. M., Somers, K. J., Clark, M. M., & Rummans, T. A. (2011). Improvement of quality of life in the hospitalized depressed elderly. *International Psychogeriatrics*, 23 (3), 485-495.
- National Institute of Mental Health, *NIH Senior Health: About Depression*
nihseniorhealth.gov/depression/aboutdepression/04.html Retrieved August 12, 2010.
- Piderman, K. M., Lapid, M. I., Stevens, S. R., Ryan, S. M., Somers, K. J., Kronberg, M. T., et al. (2011). Spiritual well-being and spiritual practices in elderly depressed psychiatric inpatients. *Journal of Pastoral Care and Counseling*, 65(1), 3:1-11.
- Steffens, D. C. (2007). Spiritual considerations in suicide and depression among the elderly. *Southern Medical Journal*, 100(7), 748-749.
- Vaillant, G.E. (2002). *Aging Well*. Boston: Little, Brown, and Co.

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SOURCE: *Vision*, November/December 2011

Chaplaincy on wheels taught new lessons

By Sandra Lucas, MDiv, BCC

Several years ago, on a snowy Groundhog Day in Maine, I was hit head-on by a pick-up truck that slid into my lane of traffic. The car buckled like an accordion. The airbag deployed. When I regained consciousness, I sensed a circle of protection around me. I suffered a broken arm, shattered knees, and multiple contusions. In those first weeks of painkillers and physical therapy, I learned that I did not handle pain well. I also learned how difficult it is to rely on others for all my needs.

After being off from work for several weeks, I returned via cab to my position as a chaplain in a long-term care facility. I could walk with a cane, but only for short distances. Mount St. Joseph supplied an electric wheelchair, dubbed "The Cadillac." It was golden yellow, styled like a riding lawn mower, and came with a basket and horn.

I made pastoral visits in residents' rooms, maneuvering "The Cadillac" around beds and nightstands and wheelchairs. I zipped down hallways giving a warning toot on the horn. Jesse, the resident cat, scurried away when he heard me coming! I went to daily Mass and sat in the wheelchair section.

I visited residents whom I had visited many times before my accident. Now I was on their level – eye-level – without stooping or bending. Like them, I experienced what it was to have my physical body unable to do the things it once did.

Dorothy, a resident who had been an artist until arthritis, a stroke, and failing eyesight put an end to her creative endeavors, asked me, "Sandy, what are you going through?" And even though we learn as chaplains not to turn a pastoral visit back toward us, I understood that she needed to express her compassion and care.

I remembered a version of the Holy Grail legend. No one could partake of the contents of the chalice, a consecrated host with healing power, until the seeker asked the crippled king guarding the vessel, "What are you going through?" That question recognized the king's suffering and their shared humanity. It allowed entry to that protected, private, sacred place.

Dorothy and I had enjoyed many visits before the accident. Widowed three times, her last marriage had been to a nursing home resident when she was 82 years old. "You're never too old to fall in love!" she declared. We talked about her times of strong faith and her times of wavering faith. We read literature and poetry and Biography magazine. Now she wanted to hear my story.

I told her how frightened I had been and how grateful I was. It could have been much worse. I shared how humbling it was to visit residents in a wheelchair. I told her how I had this sense of a protective shield around me at the time of the accident.

"It's like that Psalm," Dorothy said, "the one where God hems you in." Together, we read Psalm 139.

I did not share my personal story with the other residents except to assure them I was OK. But those visits were different as well. People's hearts opened as they shared their losses, joys, hopes, and sorrows. They wanted the chaplain-in-the-wheelchair to hear their stories. They wanted the chaplain-in-the-

wheelchair to know what they were going through.

One day, I hobbled to my closet to put my red L. L. Bean coat in the trash. It had been a Christmas present and I was reluctant to part with it. But it was splattered with blood and had been slit down the arm by an EMT in order to administer fluids in the ambulance. I checked the pockets. Inside the right pocket was a gold pyx. Inside the pyx was one consecrated host.

Until that moment, I had not remembered that I stopped at the hospital on the morning of my accident to bring Holy Communion to a hospitalized resident. She was out of the room and I did not see her. I put the pyx in my pocket to bring back to the tabernacle at work, but in between I had the accident.

I shared my discovery with Dorothy. "You had Jesus in your pocket!" she exclaimed. "Yes," I said. "It was Jesus who protected me." "He hemmed you in," she said.

Eventually I could do rounds without a cane. I parked "The Cadillac." Then came the day I could drive again. The only thing I could not do was kneel. I protested to my orthopedist. "I'm Catholic," I said, "Catholics have to kneel!"

Each week at Mass, as I pray on the kneeler, I'm reminded of that snowy Groundhog Day in Maine. I was lucky. Unlike the movie "Groundhog Day," my day didn't repeat forever. I didn't have to spend my life in a wheelchair unable to move around freely, unable to get from one place to another without assistance or pain. Mine was a temporary sharing of the experience.

The needle-like pain in my knees reminds me of God's protection hemming me in. It reminds me of my friend, Dorothy, now gone to her eternal rest. It reminds me to open the door of my heart when fear, anger, hurt, or fatigue has closed it tight. It reminds me to ask, "What are you going through?" and then listen for the response.

Sandra Lucas is a member of the NACC Editorial Advisory Panel.

SOURCE: *Vision*, November/December 2011

Featured Volunteers: Colleen O'Neill and Meredith M. Young

Name: Colleen O'Neill

Work: Chaplain/bereavement coordinator, Pathways to Compassion Hospice, Omaha, NE

Member since: 2006

Volunteer service: State liaison for NACC, plus other various positions over the years

Book on your nightstand: "Sacred Dying: Creating Rituals for Embracing End of Life," by Megory Anderson. I have to admit that I am also drawn to an occasional copy of People magazine!

Books you recommend most often: "Spiritual Literacy: Reading the Sacred in Everyday Life," by Frederic and Mary Ann Brussat, and "Soul Weavings: A Gathering of Women's Prayers," edited by Lyn Klug

Favorite spiritual resource: A bookstore called "Soul Desires" in Omaha's Old Market.

Favorite fun activity: Hanging out with my wonderful nieces and nephews. There's nothing like a good game of "Simon Says" or cartoon tag to brighten a day!

Favorite movies: Most recently, "The Help"

Favorite retreat spot: In cyberspace, an online retreat site called "Sacred Space" at www.sacredspace.ie; otherwise, my mom's house in the small town of Sumner (pop. 200) where I grew up.

Personal mentor or role model: Definitely my parents. Dad died in 1990 and my mother is still living.

Famous/historic mentor or role model: Mother Teresa

Why did you become a chaplain? Well, after being in newspaper reporting and editing for about 15 years, I was ready for a change. I had always been drawn to chaplaincy. Being with folks at the most vulnerable and sacred time in their lives continues to be a gift.

What do you get from NACC? A host of educational opportunities and wonderful support from the NACC staff!

Why do you stay in the NACC? Because I get so much from it. I feel like I'm "in the loop" with the NACC. David Lichter, NACC executive director, stays on the cutting edge of chaplaincy and what is happening in other states. I love the camaraderie with fellow chaplains across the nation, and look forward to the monthly calls with other chaplains who work in palliative/hospice care.

Why do you volunteer? I am so blessed to have all that I have. It's the least I can do.

What volunteer activity has been most rewarding? I've enjoyed them all. I recently moved to Omaha and hope to do some volunteer work with those who are disabled.

What have you learned from volunteering? That giving of oneself is truly good for the soul!

Name: Meredith M. Young

Work: Chaplain responsible for two MICUs, and med-surg floor at St. Vincent's Hospital, Birmingham, AL

Member since: 2005

Volunteer service: Interviewer for certification, peer interviewer for renewal of certification, state liaison for Alabama, organizer of local area chaplains' Day of Reflection

Books on your nightstand: "Come Away My Beloved," by Frances J. Roberts. For 25 plus years, I have found comfort and spiritual nourishment from this book. Peace always results from time spent with it.

Book you recommend most often: "Battlefield of the Mind," by Joyce Meyer. Many patients and families are dealing with depression, anxiety and stress. This book helps them to invite Jesus into their struggles by surrendering their worries to him.

Favorite spiritual resource: The Bible: The Holy Spirit is always waiting to teach me what I need as I journey through life's difficulties.

Favorite fun self-care activity: Aerobic walking, either outside or inside with a 2-, 3-, or 4-mile DVD by

Leslie Sansone. I especially enjoy sharing outside walking with a friend.

Favorite movie: "Foul Play" – this movie is a great humorous escape from life. It never fails to lift my spirits!

Favorite retreat spot: I always seek out water – ocean, lake or river. The smell of salt air renews me, as does the sound of the surf or the babbling of running water. Nature always speaks to me of God's love for his world and his children.

Personal mentor or role model: Will Rogers: "I never met a man I didn't like." This quotation challenges me to find something to like about every person I meet.

Historic role model: St. Vincent DePaul. His dying words were "I should have done more." When a saint, who founded the Ladies of Charity, the Daughters of Charity and the Vincentian Priests, says this, it challenges me to reach out to the poor and do more.

Why did you become a chaplain? When my husband died, I had an unfortunate experience with the hospital chaplain, who only asked about donations and never said he was sorry my husband died. I originally applied to do CPE to straighten out the people who trained him. But I discovered two things: First, the CPE supervisors weren't the problem; Second, all the facets of my personality came together perfectly when I functioned as a chaplain.

What do you get from NACC? I appreciate the support that I receive from the NACC. The webinars enable me to grow as a chaplain and also accrue CEHs. I also appreciate the professionalism of the NACC. Recently I had to wait nine months for ecclesiastical endorsement from my diocese. The support I received from David Lichter and Cindy Bridges helped me remain patient and optimistic.

Why do you stay in the NACC? I'm proud to be a board certified chaplain. I feel that it's important for me to continue to give the best pastoral care possible. NACC helps me to grow so that I render better pastoral care to patients, families, and staff. Also I enjoy the collegiality of fellow NACC members.

Why do/did you volunteer? As a volunteer, I learn from those that I'm mentoring or working with. Their personal commitment to chaplaincy is contagious and touches me deeply. It reinforces my own call to chaplaincy.

What volunteer activity has been most rewarding? I enjoy doing the peer interview for renewal of certification. I enjoy learning about the chaplain's personal growth and ministry over the past five years. I also find it interesting to note how God has ordered their steps.

What have you learned from volunteering? I've gained a deeper appreciation of how different personalities take various approaches to rendering pastoral care. Many times an approach I wouldn't take challenges me to look at the outcome and reflect on the value of each approach – which is most helpful for the patient.

SOURCE: *Vision*, November/December 2011

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

Book addresses critical questions about afterlife from Christian perspective

By John Gillman, PhD, BCC

Death and Afterlife. A Theological Investigation. By Terence Nichols. Brazos Press, Grand Rapids, MI, 2010. Paperback, 220 pp. \$22.99.

In the earliest of his letters, Paul tells the church of the Thessalonians not to “grieve like the rest, who have no hope” because of their belief in the Resurrection of Christ. Paul reassures those whose faith has been shaken by unexpected deaths in their community that God will not abandon the dead, but rather will bring them forth so that they “shall always be with the Lord” (1 Thess 4:13,18). Taking up a similar challenge of those who struggle with the seeming finality of death, Terence Nichols, professor of theology at the University of St. Thomas in St. Paul, MN, offers a vigorous contemporary defense of the Christian belief in the Resurrection of the body and an afterlife with God.

First Nichols offers the readers a quick overview of death and afterlife in ancient Judaism, the New Testament, and Christian tradition. In discussing 1 Cor 15:42-53, he asserts that the “resurrected will be in a different state of materiality” and concludes that both states of the body, the perishable (earthly) body and the imperishable (resurrected) body, are “physical.” However, since Paul uses the term “spiritual (pneumatikon) body” (1 Cor 15:44) to name the resurrected body, Nichols does not adequately explain in what sense it can be understood as “physical.”

The precise meaning of Paul’s expression “spiritual body” remains a challenge. The context of v. 44 in 1 Cor 15 does imply that there will be a radical transformation of the body at the resurrection. But what precisely is transformed? Nichols is more cautionary toward the end of his study when he reflects: “I am wary of arguing that it must be the matter of this creation that is transformed” (Nichol’s emphasis, p. 140).

In synthesizing several New Testament passages on the afterlife, Nichols argues vigorously for an intermediate state, the condition of the soul that survives death without a body (“naked,” 2 Cor 5:3) between death and the general Resurrection at the end of time. He concludes that “it is the soul that carries the personal identity of the dying person beyond death to the Resurrection of the body in the last days” (p. 51). Again, Nichols is more reserved later in the book when he comments, appropriately, that there is “little on any intermediate state” in the New Testament (p. 173).

Nichols goes on to respond to four scientific challenges to an afterlife and then uses the testimony of near-death experiences as evidence that, in his view, confirms Christian beliefs about death and afterlife. In the later chapters he addresses thematically the soul, Resurrection, justification and judgment, heaven, purgatory and hell.

This study succeeds in addressing important questions about the afterlife from a Christian perspective. Nichols aptly names “two important helps” for those facing the trial of death: 1) the love of God and of Jesus Christ, which accompanies believers through the ordeal of dying, and 2) the hope and vision of heaven (p. 184). While not all will be completely convinced by the argumentation, this book can serve as

a beneficial resource for individual reflection and group discussion for chaplains, pastors, and priests.

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

SOURCE: *Vision*, November/December 2011

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