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Others offer valuable resources for moral distress

By David Lichter
Executive Director

This issue of *Vision* is dedicated to the theme of moral distress and spiritual care. If we have been around healthcare for some decades, we might recall that the term moral distress was named such in 1984 by Andrew Jameton in *Nursing Practice, Ethical Issues* (www.amazon.com/Nursing-Practice-Prentice-Hall-philosophy-medicine/dp/013627448X), where he identified moral distress occurring “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.” (p. 6). Over the past three decades, research has continued to refine the term and the methods to study it.

The best presentation I have heard on moral distress was given by Cynda Rushton, Ph.D., RN, an ethics professor at Johns Hopkins University. At the Supportive Care Coalition’s 2013 Congress, she spoke on “Transforming Moral Distress into Healing and Resilience.” Much of that presentation was published later in 2013 in an article she co-authored with Alfred W. Kaszniak, Ph.D., and Joan S. Halifax, Ph.D., in the *Journal of Palliative Medicine* (www.upaya.org/wp-content/uploads/2013/12/JPM-application-of-framework-for-MD.pdf). She also cites the work of Webster and Bayliss in defining moral residue as “that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised.” (www.amazon.com/Margin-Error-Mistakes-Practice-Medicine/dp/1555720536/ref=sr_1_1?s=books&ie=UTF8&qid=1455640485&sr=1-1&keywords=Margin+of+error%3A+The+ethics+of+mistakes+in+the+practice+of+medicine)

I appreciated her exploration of moral distress and moral residue as types of suffering a clinician can experience in her or his work setting. She explains that suffering for and with those we care for (whether one is a physician, nurse, social worker, or chaplain) is an integral part of our profession as we attend to the needs of that other person. However, she notes the danger of suffering that impinges on and wounds our sense of well-being.

She offered the helpful distinction between healthy empathy, which stays focused on the well-being of another, and personal distress, which can become a self-focused emotion that one wants to alleviate because of the discomfort it causes. The healthy motivator of empathic emotional arousal can reach such heightened levels that it can become a negative emotion that we want to distance ourselves from.

Over time, our conscience and sense of moral responsibility advance. We come to recognize and make decisions about daily situations of our profession, and thereafter we carry the weight of those decisions. When they go against our identity and integrity, moral distress follows.

I found valuable her further suggestions for developing resiliency by tending thoughtfully and intentionally to one’s own basic physical, emotional, social, spiritual, and intellectual needs. Most of us might say, “Yes, I work at staying attuned to those needs and incorporating practices to tend to them.” However, Dr. Rushton spent further time on the importance of cultivating mindfulness. She noted the value of distinguishing between oneself and the one we are caring for, being alert to what triggers personal distress, and recognizing when our empathy is pushed to limits that become
personally draining. We should cultivate personal capacities “that are conducive to compassion,” she said.

She concluded that moral distress is “an inevitable dimension of clinical practice,” but how we respond to it is part of our control. We need to cultivate the capacity to be present to suffering without being overwhelmed by it, transforming personal and moral distress that can leave us feeling powerless and tempting us to despair, and offer us an invitation to reclaim our identity, integrity, and compassion.

This was a brief summary of her presentation, but I invite you to read the article for yourself (www.upaya.org/wp-content/uploads/2013/12/JPM-application-of-framework-for-MD.pdf). The lines that provide me good food for thought this Lenten season are cultivating personal capacities that are conducive to compassion and being present to suffering but not overwhelmed by it. I think about our Christian heritage, the call to stand by the cross with other believers, the invitation to reflect on the sufferings of Christ in the many forms and people we encounter every day, and the verse from Luke’s Gospel 22:28: “It is you who have stood by me in my trials.” Does this Lenten journey help me, as a Christian believer, to cultivate our personal capacities that are conducive to compassion? I hope so.

I conclude with two quotes from Etty Hillesum’s An Interrupted Life (p. 225) that hold in tension both the desire to be with others in their suffering and the practice of not being overwhelmed by suffering. Perhaps she provides here a model for us as well.

“One day, I would love to travel through all the world, oh God; I feel drawn right across all frontiers and feel a bond with all Your warring creatures. And I would like to proclaim that bond in a small, still voice but also compellingly and without pause. But first I must be present on every battle-front and at the center of all human sufferings.”

“I believe that I know and share the many sorrows and sad circumstances that a human being can experience, but I do not cling to them, I do not prolong such moments of agony. They pass through me, like life itself, as a broad, eternal stream, they become part of that great stream, and life continues. And as a result all my strength is preserved, does not become tagged on a futile sorrow or rebelliousness.”

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What is moral distress? An overview

By Fr. Bryan Lamberson

Although the earliest discussion about moral distress in medical literature dates back to the early 20th century, philosopher Andrew Jameton is widely regarded as the first to offer a thorough treatment of the phenomenon in the modern era. In his 1984 book *Nursing Practice: The Ethical Issues*, Jameton described moral distress as psychological disequilibrium, painful feelings that result from recognizing an ethically appropriate action but failing to take that action. This inability to act can be the result of either internal (personal) or external (institutional) constraints on taking the “right” action (Fig. 1). Stated simply, moral distress occurs when one knows the ethically correct action to take but feels powerless to take that action.

A precise understanding of what constitutes moral distress is necessary, as the terminology can be confusing. For example, bioethics has long placed greater emphasis on *ethical dilemmas* than on *moral distress*. They are not the same thing. Ethical dilemmas speak to the ethical justifications when considering alternative courses of action (clinical, legal and spiritual components), whereas moral distress begins after the fact, and involves the social and organizational issues at play, along with a consideration of personal feelings and explorations of accountability and responsibility.

Moreover, *moral distress* is qualitatively different from *emotional distress*. Emotional distress is more common; it can be found in stressful work environments but not have an ethical element, which can be the source of an individual’s moral distress. Thus a moral element, not characteristic of emotional distress, is present. This moral element differentiates emotional distress from moral distress.

Long-term exposure to events causing moral distress can result in *moral residue*. Powerfully integrated into one’s thoughts and views of the self, it is this aspect of moral distress — the residue that remains — that can damage the self and one’s career, particularly when morally distressing episodes are repeated over time.

Among the most frequently cited causes of moral distress in the clinical realm are those identified as follows (Fig. 2).

Moral distress involves a threat to one’s *moral integrity* — that sense of wholeness and self-worth that comes from having clearly defined values that are congruent with one’s perceptions and actions.
Moral distress is clearly not just a nursing issue, but one that influences all healthcare professionals. It can be one of the key issues affecting the workplace environment. Moral distress causes existential suffering such as a sense of isolation, feeling unheard and devalued. It leads to compassion fatigue and may result in resignation if left unresolved. Groups of people who work together in situations that cause distress may experience poor communication, lack of trust, high turnover rates, defensiveness and a lack of collaboration across clinical disciplines.

Most research and literature on the topic has focused on identifying the signs, inherent dynamics, and effects of moral distress. Methods focusing on how to alleviate it are less abundant. The following list (Fig. 3) incorporates a variety of agreed-upon strategies from the literature on how to achieve healthy resolutions.

### Fig. 3: Strategies to Address Moral Distress

- **Speak up**: recognize and name moral distress, dialogue with other parties involved
- **Build support networks**: that empower speaking with one voice
- **Focus on desired changes**: that preserve moral integrity
- **Address causes in institutional culture**: that perpetuate distress and hinder collaboration among team members
- **Develop policies**: that permit any provider to initiate ethics consultations

For a report on a promising pilot program addressing the issue, see “Schwartz Center Rounds Help Alleviate Moral Distress” by our colleague Karen Pugliese in the November-December 2015 issue of *Vision*.

Addressing moral distress and its causes should be part of any organization’s initiatives to create a healthy workplace environment. The benefits related to staff satisfaction, retention and productivity alone make support for such initiatives critically important to an organization’s leadership. If organizations are to remain true to stated core values such as compassion, respect, excellence, and integrity, finding solutions to moral distress is an ethical imperative. For chaplains and spiritual care providers, familiarity with and sensitivity to the signs of moral distress will provide opportunities to be of greater service to our colleagues.

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Family meeting resolves son’s moral dilemma

By Charles W. Sidoti

I recently participated in a goals-of-care family meeting regarding a 73-year-old female patient in the ICU. The patient’s son had been told that his mother had a poor prognosis for any meaningful recovery from her coma due to anoxic brain injury, without evidence for improvement. The patient also suffered from other serious and advanced co-morbidities. One option would include the removal of artificial life support in favor of a comfort-focused plan of care. The other option would require a tracheostomy to continue artificial life support on a breathing machine and a tube for nutrition.

The palliative care physician, who would be leading the family meeting, felt that my presence might be helpful, because for religious reasons, the patient’s son considered that removing life supports was equivalent to causing the patient’s death. However, a tracheostomy and placement in a long-term care facility for artificial life support to continue was something that the son knew that the patient “would never want.”

The patient’s son was experiencing moral dilemma between making a decision that he knew his mother would not want (continuing artificial life support) versus his religious beliefs. His understanding was that by agreeing to remove artificial support, he would be “killing my mother.”

This type of moral dilemma is not the same as moral distress, but its implications reached beyond the patient and her family. If we could not agree on a medically appropriate plan of care, the result could be moral distress involving the medical staff. When a comfort-focused plan of care is indicated for a patient approaching the end of life, but the legal decision-makers insist on aggressive curative treatment that only prolongs the suffering of the patient, the medical staff must perform treatments and procedures that have little or no chance of achieving their intended benefit. Moral distress contributes to nurses and other medical professionals feeling a loss of integrity, and often causes nurses to leave the work setting and profession. And conferences such as the one I had been called to often end badly, from the staff’s point of view.

I arrived a few minutes early and noticed the son was in the patient’s room. I introduced myself as the hospital chaplain, and he warmly welcomed me. He was holding a Bible in his hand. The son shared with me that his mother had been a very prayerful woman her whole life and a minister in her church. He also said he was a minister in his Pentecostal church. Shortly afterward, the palliative medicine doctor arrived and the three of us went to the conference room.

My impression of the patient’s son, who appeared to be in his late 40s or early 50s, was that of a sincerely religious and friendly person. I perceived that he had strong religious convictions, but I did not sense that he was going into the family meeting with his guard up.

I suggested that we begin with a prayer. The patient’s son responded, “Yes! Let’s begin with a prayer. I think this is great.” We all joined hands and I led a Christian prayer asking for God’s guidance and wisdom in our discussion and blessing upon the patient and her family.

The physician then very compassionately began to review the patient’s current neurological and medical status, as well as estimating her prognosis for meaningful recovery and survival. The son was not surprised to
learn that it was extremely unlikely for his mother to regain any significant neurologic function. He spoke about his religious beliefs for several minutes, concluding with his belief that if he agreed to discontinue artificial life support, “I will be killing my mother. I can’t do that. I believe that we have to do everything.”

I asked, “Did you and your mother ever discuss what she would want if she was ever in this type of condition?” He replied, “Yes, I did, we have talked about it. She said that she would never want to be kept alive by machines. But I can’t kill her. I wish she would just die in her sleep and there would be no decision to make. Oh (laughing nervously) I don’t mean that … can I say that? And if someone else were to make the decision to kill her, I would not want to know about it.”

I gently interrupted, saying, “You need to unburden yourself. You need to understand that in choosing to withdraw artificial life support, no one is killing your mother — not you, and not the medical staff. That would be called euthanasia. It is illegal in this state, and it has nothing to do with the decision you are being asked to make. Death is a natural part of life, and everyone is going to die at some time. Today we have wonderful life-saving technology, but it is important to understand that we have a responsibility to use it wisely, for situations where there is a reasonable hope of meaningful recovery — and also with humility, acknowledging that we are not God. The decision to be made today is whether to artificially extend the dying process, or to acknowledge that the dying process, already taking place with your mother, is irreversible, that it is a part of life, and choose to let it be.”

I asked him what he thought his mother would want if she could choose for herself. He replied, “She would want us to let it be. She would never want this.” We all laughed because we realized that we had quoted the Beatles song “Let It Be.”

The son asked what would be involved in removing artificial life support. The physician explained in detail the compassionate weaning process, explaining how the patient’s comfort becomes the primary focus of care. The patient’s son asked if the removal of life support could take place on Sunday at noon, to allow for family and church members to be present. The physician agreed.

It was clear that the meeting was over, and the physician suggested that we conclude with a prayer. The patient’s son offered to lead the prayer. We all joined hands and the son gave thanks for the life of his mother and for the medical staff. After the patient’s son had left, the physician asked me to stay in the room to debrief.

The physician and I looked at each other and said, “What just happened?” After a goals-of-care meeting when the patient is clearly approaching the end of life, it is not unusual that a surrogate decision maker chooses a comfort-focused plan of care. We both acknowledged, however, that it is unusual that a surrogate decision maker who cites religious beliefs would change his mind in favor of allowing the natural process of death to occur.

While the physician and I did a very good job in the meeting, I did not say anything that I do not ordinarily say to patients and families in this type of situation. I attribute the son’s change of heart to a quality of openness that helped him to evolve in his thinking with regard to his religious beliefs and EOL options.

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Support group gives nurses a chance to process feelings

By Lisa A. O’Connell

When our Med Surge ICU nurses encountered two difficult cases of medical futility, the managers of the unit thought a support group, or debriefing, would offer some self-care to the nursing staff. They didn’t name it, but their staff was feeling the effects of moral distress and its attendant sense of powerlessness. When they approached me, I recognized that creating a group format specifically to counter the effects of this distress would be helpful for our hospital.

I gathered with the two managers and listened to their thoughts. I shared information about moral distress, compassion fatigue, and burnout. “What are your goals for the group?” I asked. The nurse manager said that first, she wanted a space for her staff to vent — a “consequence-free zone” to relieve the burdens felt when facing extreme situations. Second, she thought learning some tools to handle this stress would be beneficial. Third, by offering comfort food and paying the nurses for attending, the managers hoped to show support for the staff. And the last, overarching goal was to avoid compassion fatigue and burnout, and thereby keep staff on the unit.

The managers wanted this group to be elective. We decided on a location near the unit and the time; the group would run from 7:45 to 9:00, both in the morning and evening. The assistant nurse manager announced the group and its purpose at rounds, and reminded and encouraged the staff several times in the weeks beforehand to attend.

I created a format that included six parts: introductions, decompression exercise, brief education about moral distress, rules for the group, conversation (the “consequence-free zone”), and wrap-up.

The introductions began with the nurse manager speaking to the participants about why the group was being offered. I, and later the chaplain who ran the evening group, took time to introduce ourselves and explain why we were qualified to run the group, and that as pastoral caregivers we were there to support staff. At this point, the managers left so staff could speak freely.

Next we did a brief decompression exercise. I chose to do a breathing exercise; the evening chaplain offered guided imagery. After the exercise we gave brief education about moral distress. We covered how moral distress is defined, the difference between moral distress and moral dilemma, the “residue” and stress that accompanies moral distress, and how moral distress can turn into compassion fatigue, burnout, and higher job turnover.

In going over the rules, we let the staff know that “what’s said in the group stays in the group!” Also we noted that one person would speak at a time, everyone’s feelings would be respected, and we would try to discuss one case at a time.

During the next 30 to 40 minutes, as chaplains, we led the conversation about cases that had recently caused the staff moral distress. We decided to discuss specific cases, with names, illnesses, treatment decisions, family members, etc. We were allowing the staff to lay it all on the table. If the discussion was slow to start, the chaplain would bring up a specific case, patient, or situation, and
set the scene — giving details of the case, and asking staff, “What was so distressing about this case?”

As group leaders, we had in front of us reminder lists of how to facilitate. The first was “The Value of Debriefing,” which included items such as reminders to normalize feelings, assess the units’ strengths and weaknesses, re-establish perceptions of being in control, and to allow storytelling. Second was “Our Role,” which reminded us to set the tone, and to encourage discussion with questions such as “Did anyone else feel that way?” Reminders to be comfortable with silence and to enforce ground rules were also part of our role. And lastly we were to “Be There!” even if no one showed up for the group.

During the 10-minute wrap-up, the chaplain reiterated what was heard and asked if there was anything that the group wanted to bring to the manager, over and above just venting. We also offered tools to help the staff, including taking a break, deep breathing, and literature on stress. We had a brief discussion on what folks were using for relief. We talked about healthy crutches, such as exercise or meditation, and unhealthy crutches like drinking.

We ran the group four times and had 26 people attend over the course of a week. The members participated in all discussions, respected the rules, and were able to talk about specific cases, patients, and their feelings. Some portions were very emotional. They did ask us to take two items back to the management, and other conversations stayed within the group. The staff reported over the next few weeks that the group was very helpful. In the future, we plan to run the group quarterly, or whenever tensions run high due to specific cases.

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Moral Distress: Are There Solutions?

By Georgia Gojmerac-Leiner

Much research has been done on moral distress and its effects on those who experience it. Epstein and Delgado credit Andrew Jameton for defining moral distress in 1984 “as a phenomenon in which one knows the right action to take, but is constrained from taking it.” Moral distress has become prevalent in our medical settings to such a degree that we yearn to find some solutions to the dilemmas of caregivers. It can be experienced by a variety of caregivers and in a variety of circumstances. As a chaplain, I experienced some moral distress directly and some vicariously through nurses, aides, therapists, and physicians.

For instance, a case came to an ethics rounds with a question: “Should an ICU patient have CPR?” The particular case was of an 87-year-old woman who was a DNR resident at a long-term care facility. But the DNR order did not come with her to the hospital. The ICU attending physician wrote to have her resuscitated should she code. The nurse assigned to care for the patient became conflicted about calling code blue for the patient should it be necessary. Her moral distress arose from her belief that the resuscitation would harm the frail patient; her ribs would be broken in the process.

The members of the ethics rounds discussed the case in depth and provided emotional support to the nurse. The consensus was that the patient should not have CPR if she coded. But the physician was not present at the discussion, and the ethics team could do no more than make a recommendation. The case was complicated by the fact that the woman had no family, only a legal guardian who was not very involved in her care. Although the nurse felt supported by the ethics team she still faced having to follow doctor’s orders against her principle if the patient coded. The only other recourse would have been for the nurse to engage the physician in a discussion, along with the help of nursing administration and the hospital administration if needed.

Moral distress is an ethical concern, but some researchers have found that “traditional ethics education that focuses on ethical dilemmas and underlying principles is inadequate to address situations involving moral distress.” Thus nursing professionals have proposed other means to help nurses deal with their moral distress.

While solving or eliminating moral distress may not be a realistic goal, some protocols and strategies can potentially ease it. A senior director of the American Association of Critical-Care Nurses, Ramon Lavandero, declared that “Our challenge isn’t to eliminate moral distress; it is becoming part of our new normal and not going away, so our new goals have become learning how to recognize and address it effectively.”

1 Epstein, Elizabeth G. and Sarah Delgado, Understanding and Addressing Moral Distress,” The Online Journal of Issues in Nursing, September 10, 2010, pg. 1
2 Ibid, pg. 3
Lavandero and his colleagues offer the following 10 best practices for addressing ethical issues and moral distress. They say that organizations should:

1. Support the nursing code of ethics  
2. Offer ongoing education  
3. Create an environment where nurses can speak up  
4. Bring different disciplines together  
5. Provide ethics experts  
6. Add unit-based ethics mentors  
7. Hold a family conference  
8. Sponsor ethics journal or book clubs  
9. Reach out to professional associations  
10. Offer employee counseling services.

Additionally, the Ethics Work Group of the AACN has developed a practical tool called “The 4A’s to Rise Above Moral Distress.” The four steps are Ask, Affirm, Assess, Act. This reflective document offers succinct definitions and can easily be adapted for professionals other than nurses, such as chaplains. The resource begins by answering questions, such as:

- What is moral distress?  
- What are the sources of moral distress?  
- What does moral distress feel like?  
- What are the barriers to taking action?

The 4A’s guidelines begin with the person, asking her to self-reflect. The guidelines then lead the person through the process of self-affirming and self-assessing, and making the commitment to act. First, though, they need to “Contemplate (their) readiness to act.”

The resource usefully categorizes the common responses to suffering into four types: physical, emotional, behavioral, and spiritual. Under each of these categories are lists of examples of how suffering manifests itself in a person experiencing moral distress. The lists show how the experience of moral distress can be personally devastating and professionally detrimental. The 4A’s is an entirely practical resource for taking action, along with the 10 best practices discussed above.

In the case of “Should an ICU patent have CPR?” mentioned at the beginning of this article, the nurse would have benefited from reading the portion of 4A’s that deals with the 4R’s: Relevance, Risk, Rewards, Roadblocks. For a copy of the 4A’s brochure, go to: www.aacn.org/WD/Practice/Docs/4As_to_Rise_Above_Moral_Distress.pdf.

These are some of the best practices found in the literature addressing moral distress. The next step for research might be to study the effectiveness of these practices.

Georgia Gojmerac-Leiner, D. Min., BCC, is a former chaplain at Emerson Hospital in Concord, MA.
Moral distress, up close and personal

By Fr. Bryan Lamberson

I have both witnessed and experienced moral distress many times as a chaplain. An example of the first was the patient who had deteriorated after open-heart surgery and developed gangrene. Doctors agreed there was no hope for his survival but his spouse wanted to “do everything.” Making a difficult situation infinitely worse and the source of moral distress, the patient’s spouse refused to allow him to receive adequate pain medication since it made him sleepy and she wanted to talk with him!

Although the threat of legal action is never a first response, this situation was ultimately resolved when the wife was informed she would be taken to court to permit appropriate palliative treatment, which would allow the poor man to die peacefully. She relented, eventually, and her husband ultimately died as comfortably as was possible.

Another memorable case involved a patient whose injuries resulted in a deficit of brain activity. The sources of moral distress for most of the clinical team were twofold: The patient’s family held out hope that God would grant them a miracle of recovery, and the attending physician would not speak frankly with the family.

The physician had an increasingly difficult time facing the combined weight of the family’s wishes, while specialists offered false hope (slight improvements in renal and hepatic function in a brain-dead patient are meaningless). There was more than enough moral distress to go around in this case, but it was especially evident in the nursing staff, who felt untold stress over a period of many days. Just when it appeared that all were locked in an endless struggle of wills, the patient coded and died. Sometimes God answers prayers in ways we don’t anticipate.

My own all-too-frequent source of moral distress has been the inadequate substantive treatment options for alcoholic and addicted patients. I have ministered in hospitals where the community resources available for these patients’ needs were woefully inadequate or even nonexistent.

Typically, such patients present with the symptoms of their addictive disease, but meaningful discussion by caregivers about the causes of and pathways out of active addiction are largely absent. I have seen the same patient admitted to an ICU seven times in one calendar year for the symptomatic effects of his alcoholism, without clinicians candidly addressing the root cause — interventions that might have interrupted the destructive cycle. Most addicted people’s denial is indeed powerful and the seeming hopelessness of some cases is truly daunting, but these never justify forgoing the ethical obligation to offer solutions to the sufferer.

This I have tried to do, wearing the dual hats of chaplain and recovering person. When the census shows the admitting diagnosis is connected to addiction, I have reached out in solidarity to the patients and offered them a way out of their spiral. I think of Moses’ blunt proposal to the Israelites: “See, I set before you today life and prosperity, death and destruction ... Now choose life, so that you and your children may live.” (Deuteronomy 30:15, 19b) Sadly, many are so enslaved by their addiction that such interventions fall on deaf ears, and death will, directly or indirectly, sooner or later, be the result of their disease.

When I have addressed this clinical and ethical void with other members of the care team (physicians, nurses, social workers, and care managers), their responses have seemed to me short-sighted, inadequate, and morally mystifying. Acute-care facilities, I have been told, are not reimbursed for
interventions to get at the roots of addiction. It’s rather like saying, “We only get paid for applying Band-Aids, so that’s what we do.” As a recovering person and minister, I experienced this line of reasoning as a clear violation of my moral integrity, and hence, the source of my moral distress.

I initially attempted to soothe my distress with self-talk — the likes of “There but for the grace of God go I.” This worked in the moment, but somewhat shopworn bromides did little to ease the cumulative effect of my internal discord. I found myself identifying with the nursing staff when confronted with my personal powerlessness in the face of moral distress. Had the institution assuaged its conscience enough to accept at a minimum indifference, perhaps even clinical nonfeasance? Like many nurses who have contemplated leaving their jobs or the field entirely as a way to preserve their personal integrity, I considered my options. “I’m a priest; there aren’t that many of us around anymore,” I reasoned. “If speaking up gets me canned, I won’t be without a job for long.”

On reflection, however, this line of thinking struck me as self-centered, and an easy way out. I have rarely thought of myself as a “prophetic voice,” but I am a chaplain because I think the Church must do a better job of taking care of its sick members. Reminding myself of those truths, I decided to do something. I hoped to improve our care of addicted patients, push that care more in line with institutional values, and perhaps even begin to resolve my distress.

I drafted a proposal to approach the addicted differently and submitted it to institutional leadership. The plan would establish a set of clinical “flags” that indicated clues about patients’ substance abuse and identified those whose admissions were related to their active addiction. A multidisciplinary team would then offer assessments, frank talk about their addiction and appropriate referrals.

Just the act of giving voice to my concerns alleviated a good deal of my personal moral distress. I hoped my proposal would be well-received, but my diminished distress did not depend on a positive institutional response or successful implementation. Happily (for addicted patients, especially), they listened. And acted. And — I’m still a chaplain.

_Bryan Lamberson, BCC, is priest/chaplain at Sts. Mary & Elizabeth Hospital in Louisville, KY._
Conditions in pediatric hospital ripe for moral distress

By Jim Manzardo

An ICU bedside nurse caring for an intubated post-stem cell transplant child whose swollen and discolored body was painful to see: “We’re torturing her. When will her parents let her go and die in peace?”

A CNA, after listening to a mom whose son was dying of a terminal brain tumor: “It’s so hard to listen to the mom as she struggles with her decision to stop nutrition seeing that after three weeks he is still alive. I, too, am wondering if we’re doing the right thing.”

A physician reflecting on a patient whose test confirmed brain death, yet whose parents wished to continue full support: “What are we doing? Why do we have to keep going? We’re treating a dead child. It makes no sense and goes against everything that medicine is supposed to be.”

These thoughts, feelings, and questions, which have kept my colleagues awake at night, are some examples of the moral distress I have heard as a pediatric chaplain in an intensive care unit. Being one of the top-ranked specialized pediatric hospitals in the country, having some of the best physicians, and utilizing the most advanced medical treatments are both a blessing and a curse. Highly critical and near-death patients, whom other hospitals have determined they cannot help, are often sent to us. Parents’ expectations of cure, or at least of avoiding death, are high. In fact, in the past 30 years, death in pediatric intensive care units has decreased due in large part to technological advances.

But with the saving of lives has come an increase in children with profound deficits requiring tremendous lifelong advanced medical intervention. With pediatric healthcare for the most part no longer being paternalistic, parents are the ones making treatment decisions for conditions which in the past were fatal but now with ventilator assistance, other therapies, and 24/7 nursing allow a child to survive and be cared for at home. The majority of children who do not survive in pediatric ICUs die as a result of a decision to stop life-sustaining treatment.

In this context, my colleagues are practicing their craft, witnessing incredible suffering both of children and parents, and wondering if they are doing more harm than good. Their moral distress is the emotional, mental, and spiritual struggle stemming from choices they have made that they perceive to be contrary to what for them is the right thing to do; witnessing or participating in directly or indirectly an event which they feel in some way violates their conscience and values; or deciding what the right action is, but, because of constraints, not being able to make it happen.

Each of my colleagues experienced moral distress to differing degrees on emotional, mental, and spiritual levels. Emotionally, some felt guilt for what they did or did not do or simply for their complicity, for being upset with the parents and their choices or lack of decision. In some cases, they felt some frustration and anger with parents’ decisions, with colleagues over communication breakdowns or disagreements about goals of care, or with the institution for not backing them. Some verbalized powerlessness and helplessness to influence the outcome. All felt sad for the parents witnessing the depths of their grief.
Mentally, they second-guessed themselves. They wondered if they made the right treatment decisions. They questioned their own judgment.

Spiritually, they struggled with a loss of control and finding meaning, experienced some crisis of their own faith and of their vocation, and felt some disconnection from colleagues, family members and friends.

Fortunately, the leadership of the intensive care unit in which I work recognizes how stressful this place of intense caring can be for staff. We know that moral distress is a given and a sign that we are conscientious caregivers practicing in very complex circumstances. We know too that the awareness, naming, validation, and acceptance of this very real stress, and the range of accompanying feelings and questions, as well as forums for expressing and discussing it, are vital for staff wellness.

At our institution, chaplains provide one-on-one check-ins with staff, facilitate debriefings, meet regularly with leaders at all levels throughout the hospital, and participate in other gatherings where open and honest communication is encouraged. With our well-developed listening and facilitation skills, our nonjudgmental perspective and willingness to ask the hard questions, chaplains play an integral role in addressing moral distress.

*Jim Manzardo, BCC, is a chaplain at Lurie Children’s Hospital of Chicago.*
Relationships built in long-term care may lead to moral distress

By Ellen Williams-Masson

She opened her eyes and nodded when I spoke her name, her skin tissue-soft as I clasped her hand to pray. Adeline (not her real name) was an 87-year-old resident of the long-term care facility who had suffered a third major stroke 15 days before. She no longer had control of the right side of her body and was terminally ill and close to death. Adeline’s advance directive clearly spelled out her wishes should such an event occur: no feeding tubes, no IVs, and no extraordinary measures to keep her alive. Her grown children agreed, so Adeline was placed on “comfort care” and given only those medications and treatments needed to keep her comfortable and out of pain. Our staff provided compassionate care and her family gathered around her bedside. Adeline peacefully passed away 20 days after the final stroke.

However, as a new chaplain, I struggled with Adeline’s lack of hydration and nutrition, even though I knew it was what the patient and family wanted. Was she dying from the effects of the stroke, or from starvation and dehydration? Was an extended fast within our ethics as a Catholic organization? After all, didn’t Jesus call us to feed the hungry and care for the needs of others? On the other hand, Adeline could neither eat nor drink naturally; she couldn’t swallow. She had clearly stated in writing she did not want IVs or feeding tubes, and a loss of appetite is a natural part of the dying process. Our staff provided the best of care, and Adeline had a peaceful natural death surrounded by her family. Would I really want to change that outcome?

Moral distress like I was feeling is inherent in healthcare and occurs when professionals cannot do what they believe to be right due to forces outside their control. Although most prevalent in nursing, moral distress can be felt by any staff member and occurs when personal integrity and values clash with course of action, and the conflict cannot be readily resolved (reviewed in Guthrie, 2014). Studies have shown that moral distress correlates with low job satisfaction, attrition, burnout, poor collaboration between physicians and nurses, lack of ethical support and climate, low psychological empowerment, and low autonomy (reviewed in Lamiani et al, 2015).

Many studies on moral distress have focused on hospital settings, but long-term care is also rife with opportunities for distress. According to research, understaffed nursing homes employing underpaid staff often struggle to balance quality care with the bottom line. Staff form relationships with the residents and advocate for their care, squeezed between limited resources and the needs of multiple residents. Residents of long-term facilities are an increasingly vulnerable population who may have difficulty speaking up for themselves. Lack of managerial and administrative support, when coupled with a lack of nurse-physician collaboration, also distresses nurses who may feel powerless when their professional integrity is challenged (Pijl-Zieber et al, 2008). There is also moral distress for administrators and physicians because of decisions they have made, no matter how reluctantly.
Many nursing homes have taken steps to address these concerns; for example, the facility where I minister fosters an atmosphere of open communication, and residents receive compassionate and loving care. Even in the best of circumstances, however, moral distress may arise in nursing homes among family members and spread to staff. A classic example is “the son or daughter from the coast” who flies in and disrupts family harmony over care for a loved one. The local family members have witnessed the slow and gradual decline in Grandpa’s health and are prepared for his imminent death, but the relative coming from a distance is shocked at Grandpa’s wan appearance and wants a battery of tests “just in case.” This creates moral distress for the family, which now has internal conflict; the staff, who were settled on a care plan; the physician, who feels pressured to begin more aggressive and unnecessary treatment; and even the patient, who gets caught in the middle and in consequence may have a less than peaceful death.

The typically longer length of stay in long-term care facilities allows relationships to develop among staff, family, and residents that might not have time to ripen in hospital settings. These relationships are key to how a chaplain can intervene and alleviate moral distress. Long-term care chaplains can serve as a buffer between arguing family members and advocate as needed for residents, family, staff, and administrators. Chaplains can educate facility employees about mitigating moral distress and guide them in exploring their values and personal ethical beliefs. They also serve as a confidential safety valve when emotions run high. Caring for employees can reduce “moral residue,” the reactive distress that accumulates following moral distress-causing events (Epstein and Hamric, 2009).

Long-term care facilities, which use less aggressive treatments than hospitals, may cause less moral distress from medical futility. Caring for patients with little chance of recovery is emotionally taxing for nursing staff, but the burden is relieved if patients are allowed to die a “good” death without excessive medical intervention.

Such was the case with Adeline, the stroke patient mentioned above, whose IV was disconnected and aggressive medications stopped. Although I knew everyone involved only wanted what was best, and kindest, for Adeline, I remained conflicted about the manner of her death. Alleviating my personal moral distress involved talking to medical staff and ultimately taking the case to our Medical Ethics Committee, where the case was discussed in detail.

Promoting an ethical workplace allows chaplains to foster a healthier environment for everyone, as does creating a safe place for staff to process their experiences and give voice to the distress they are feeling. Administrators can help by creating structures that allow these conversations to occur. Administrators and leaders across the healthcare spectrum have an obligation to address moral distress, which is increasingly recognized as a major cause of nursing staff burnout and attrition.

Ultimately, moral distress is a symptom of an empathetic, caring staff. For the Adelines of the world, that may be just what Jesus ordered.

Ellen Williams-Masson is a staff chaplain at St. Clare Hospital in Baraboo, WI.
Bibliography


Behavioral health staffers face unique issues of moral distress

By Richard Rudolph

It is a calling to serve patients who suffer with behavioral health issues. The staff who work in this field understand the special issues of these patients and the most helpful interventions for this population. But oftentimes, constraints within the healthcare system make it hard to achieve what is most helpful for patients.

To gain a deeper appreciation for this topic, I interviewed 10 staff members at Mercy Health Clermont Hospital’s Behavioral Health Institute about the moral distress that they experience. This is a state-of-the-art facility offering both inpatient and outpatient care using a recovery-based model at a regional hospital in southwest Ohio. The group interviewed included psychiatrists, therapists, nurses, technicians, and managers who represent the staff on this unit. As a chaplain, I work closely with this group of caregivers to provide support to their patients.

These staff members were asked to describe situations in which they or their co-workers experienced moral distress. Our working definition of moral distress was a distressing situation for a care provider caused by the internal conflict of wanting to do the appropriate, ethical action, but being prevented from doing what they believed was in the best interest of the patient.

A problem for many of those interviewed is treating newly admitted patients who have both acute medical and psychiatric illnesses. These cases present a real challenge in the hospital. In triaging the patient, it is often unclear if the best initial placement is on a medical unit or the behavioral health unit. The behavioral health unit does not offer the advanced medical technologies, and the staff does not have the same comfort level in addressing complex medical needs. However, the behavior of these patients may be so aggressive that it is unsafe for them to be treated on a medical unit. The behavioral health staff experiences moral distress when they believe the patients’ medical needs are not being adequately addressed in the behavioral health unit.

Another cause of moral distress is when it is clear a patient ready for discharge probably will not receive quality ongoing mental health care. The overburdened community systems have backlogs that may extend for months before patients can be treated. Also, some patients lack basic independent living skills, financial resources, and support systems, which may render them homeless. All too often, a crisis occurs in which the individual becomes a danger to themselves or others. So they are readmitted to the hospital via the emergency department. Clinicians feel frustrated and helpless that the system perpetuates this revolving-door cycle and there is little that they can do.

Some patients could take care of themselves in the community but are not committed to making the necessary changes in their lives to stay healthy. Because they are noncompliant with medications and follow-up treatment, they regress and frequently are readmitted. It is a challenge to treat these patients with compassion when they are not committed to their own recovery. Staffers question how they can stretch themselves to care for those with the highest acuity and still maintain compassion for the noncompliant “frequent flyers.”
Another situation that causes moral distress is when patients are admitted with significant eating disorders and other addictions. A general behavioral health unit like ours is not equipped to offer the specific treatment programs required to treat these patients with the best possible outcomes. Our unit engages in multistate searches for placement, often to no avail. So the clinicians do their best to treat the patient while knowing they would be better served elsewhere.

Several months ago, an outpatient took his life at home over a weekend. This caused great distress among the clinicians who had just seen him the previous Friday. When a suicide occurs, clinicians are troubled and ask themselves, “Is there something that I missed that might have prevented this?” and “What more could I have done?” Shock, guilt, anger, fear, and other feelings were present. The staff requested my support for themselves and for the outpatients who had bonded with this patient. Though it is always heart-wrenching, the clinicians who have experienced this before are often better able to put this into perspective. One psychiatrist said, “Severe depression may be a terminal illness.” Even with the best treatments for depression, some patients will take their lives.

The staff was asked what they find helpful in managing their stresses. Several people mentioned sharing one’s feelings with supportive colleagues. “Having even one person I can trust” appears to be key. Some staff members see a professional counselor or therapist. For some, nurturing their spirituality through prayer and other means helps them to find a higher purpose and meaning in their work. This helps to provide peace and sustained motivation. Everyone has his or her own unique ways of recharging and refreshing. Whatever the approach, good self-care (i.e., sleep, nutrition, exercise, family and social life, spirituality) should be a priority.

As a chaplain, I found that exploring the moral distresses of these staff members has given me a greater awareness of the stressors they experience and the importance of providing them spiritual and emotional support. I am grateful to each for their openness to share about the challenges they face and the impact on them and their colleagues.

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What does the literature tell us about moral distress?

By Marilyn Williams

Moral distress was first defined by Andrew Jameton in 1984 as a phenomenon that occurs when nurses believe they cannot act in ethically appropriate ways due to institutional constraints. Later researchers extended constraints to include internal constraints, including a sense of powerlessness and a lack of knowledge or understanding. (Jameton, 1984) Moral distress is characterized by psychological disequilibrium or painful feelings. (Kelly, 1998) Psychological characteristics of moral distress include frustration, anger, guilt, anxiety, depression, withdrawal, self-blame, and reduced self-worth. Furthermore, research has shown that nurses experiencing moral distress reported physical symptoms of headaches, back pain, and stomach pain. (Schluter et al, 2008)

Jameton theorized there are two components of moral distress: an initial distress of an acute nature that occurs as a situation evolves, and a reactive distress or moral residue that remains later when the initial distress is not addressed. Based on later research, Webster and Bayliss (2000) defined moral residue as “that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised.” Moreover, Epstein and Hamric proposed in a 2009 research article a model they called the crescendo effect to describe the interrelationship between moral distress and moral residue based on an empirical study of NICU nurses and physicians. (Epstein and Hamric, 2009) Thus, when chaplains encounter initial moral distress, it is vital that they address it effectively in order to cope with future ethical situations.

Pastoral Response to Moral Distress

The research regarding moral distress is dominated by nursing; one of the few articles from a healthcare chaplain’s perspective is a 2014 article by Michael Guthrie, a chaplain at the Denver children’s hospital. (Guthrie, 2014) Although not based on quantitative or qualitative research, this article provides a nice review of the literature from a chaplain’s perspective as well as “food for thought and reflection” regarding the pastoral response to moral distress. Guthrie presents a theoretical case study involving a critical care nurse experiencing moral distress and her encounter with the chaplain. Building on the premise of Lutzen and Kuist (2012) that moral distress could actually strengthen an individual’s exercise of moral agency, Guthrie suggested that the chaplain can help facilitate the growth of character as well as healing of the one experiencing moral distress.

As such, he asserts that calling for an ethics consultation in the case presented would be a negative vs. a pastoral response. Instead, he says the initial goal should be encouraging the safe sharing of her story and emotional response. Then he outlines a pastoral response.

This article might be helpful to other chaplains in reflecting on their own pastoral practice when they encounter moral distress. Furthermore, it could help in formulating a model of pastoral intervention for a research study that would look at whether such an approach helps ameliorate moral distress in nurses or other healthcare professionals.
Nursing Research on Moral Distress

Reviewing the nursing research can help pastoral practice regarding moral distress. One of the earliest and foremost nursing researchers is Mary Corley; her first study of 111 members of the Association of Critical Care Nurses appeared in 1995. This study concluded that the three factors most associated with moral distress were aggressive care (unnecessary tests and treatments) at the end of life, lack of honesty with patients/families, and inadequate/incompetent treatment by physicians. This study also indicated that 12% had left a position due to moral distress. (Corley, 1995)

Then in 2001, Corley and her co-investigators published their landmark study of their moral distress scale, which is still being used with little modification. This instrument, initially 32 items and revised later to include 38, utilizes a 7-point Likert format — the higher the score, the higher the degree of moral distress. The scale has shown to be reliable and valid in measuring moral distress; mean scores of 3.9 to 5.5 indicate moderately high levels of moral distress. This scale has also been used with other healthcare professionals besides nursing.

Much of the nursing research has focused on the correlations between work constraints (e.g., policies and procedures, staffing level, leadership style and support, communication issues, lack of empowerment, ethical climate) and the degree or intensity of moral distress. Of course, correlation does not mean these factors cause moral distress. For example, Pauly et al (2009) showed an inverse correlation between ethical climate and moral distress.

Likewise, a 2012 Netherlands study of 365 nurses employed in different settings indicated that those with less job satisfaction also had higher moral distress scores. This same study showed that most moral distress occurred when nurses perceived a discrepancy between wishes of the patient and of the family, physician-nursing disagreement, and perceived unsafe staffing levels. (de Veer, et al, 2012) Interestingly, the Netherlands study also showed a higher level of moral distress for nursing home nurses than those in acute-care hospitals.

In other studies, however, especially in the U.S., the only subjects have been critical care nurses. There are significant differences in end-of-life care among countries that may impact the frequency and intensity of moral distress. Exploring this could make for worthwhile research. Of interest is a research protocol regarding moral distress in EOL care in the ICU published in 2013 for a study currently taking place in the United Kingdom. The results of the study could be thought-provoking to chaplains, since it uses a qualitative methodology of narrative inquiry for three categories of EOL situations occurring in intensive care and will look at moral distress in nurses, physicians, and relatives. (St. Ledger, et al, 2012)

Conclusion

Being familiar with the research on moral distress provides the chaplain with an additional context of how the work environment might contribute to moral distress beyond the specific situation, which could lead to more effective pastoral care. Future research could benefit from including
chaplains on research teams. Research regarding the use and effectiveness of pastoral interventions could especially be helpful to those hurt by moral distress, as well as the institutions and ultimately the patients they serve. In addition, there appears to be no research yet regarding moral distress that chaplains may experience.

Works Cited


Other References


Out of chaotic hospital scene, love and hope emerge

By Camille Buckley

One Sunday morning I was called to the emergency department. I learned that the patient had posted a suicide note on Facebook that morning and a close friend saw it. She notified his mother, who found him unresponsive and pulseless. Emergency responders were able to revive him to the extent that he had a heartbeat and blood pressure. Now he was on life support.

Eventually his mom arrived, very distraught. Her appearance revealed a life fraught with physical and perhaps psychological and emotional challenges. As the morning wore on, she shared her story about her own very poor health, death of her siblings from cancer, suicide of her husband at a young age, prior incarceration of this son while her other son was currently in prison, and more.

The mother of the patient’s son arrived. By coincidence, she had been at work here at the hospital, heard the Code 10 called, and felt immediately she knew who it was for. Their 6-year-old son was at home with family. She had a quiet strength. Although very tearful and emotional, she was realistic in her expectations.

The neuro-intensivist and nurse practitioner performed many tests to evaluate the patient’s brain function, while the family and I remained in the room.

The patient’s mom shared that her other son was currently incarcerated locally, and she wanted him to come in to see his brother before he died. This began a LONG series of phone calls trying to get a human rather than a recording. Frustration set in with multiple options — “push 1 for ..., push 2 for ...” — all on a Sunday morning when much of the working world had a day off. When I finally got a live voice, the news was not good. There had to be permission from a higher authority and transportation arrangements, which could not be done on a Sunday, but the patient could be dead in hours.

The patient’s mom also requested a visit from her Orthodox priests, but when they did arrive the patient was being transferred to ICU. This is generally a lengthy process, and the priests did not stay. When my shift ended, it seemed that all did not go as hoped.

The patient was in ICU on Monday morning. I spoke with the mother of his son, and she told me how she brought the child to the ICU to see his dad. She felt it was particularly important, as the patient had promised the night before to see his son that day and now would not be there. She told me the plans she made to help him though this time.

The priests were called again, and this time two of them came to be with the patient’s mom and to pray the Orthodox prayers over the patient. By afternoon, word came that the brother would arrive. He did, in his orange uniform and shackles on both wrists and ankles, escorted by two correctional officers. He was walked slowly to the bedside, where he said his farewell and cried inconsolably. He asked me about heaven, told me some of his story and concerns. I answered, supported, and suggested he might talk with the correctional facility’s chaplain. Having been a volunteer in several prisons over the past 10 years, I was acutely aware of repeated stories about prisoners who could not be at the bedside of a dying relative. They have shared their suffering because of this. This motivated me to make sure this did not happen in this instance.
The next morning the patient’s room was empty as the body was in the operating room for the harvest of organs. “Harvest” in the usual sense of the word is gathering the fruits of our labor to provide nourishment to our bodies. Perhaps this word was intentionally used as this body, although it had experienced many droughts, was still able to provide new life to others.

This is a sacred story because of the humanness and goodness of all who were present. For me it shows hope.

It was about the mother who, though suffering her own illnesses and addictions, wanted her incarcerated son to be with his brother as he lay dying.

It was about the incarcerated brother who, though imprisoned for his crimes, still poured out his grief by his brother with his shackled arms and legs, his humanity very evident.

It was about his human dignity and being invited to touch his dying brother’s hand, to reconnect skin to skin, give him a kiss. It was about being offered tissues to dry his so-human tears.

It was about the man who had lived with the patient’s mom for 26 years and left her for another woman, who came to the hospital and was at her side to support her despite their past.

It was about the new ICU nurse who broke down into compassionate tears of deep connection and understanding as she watched the brother’s anguish as he said “Goodbye” and “I love you.”

It was about the nurse manager who calmly attended to organizing and overseeing the patient’s, family’s, and staff’s needs.

It was about the nursing staff who respectfully tended to this patient, carrying out all the procedures necessary to enable his body to bring life to many even in this tragedy.

It was about the caring, compassionate, nonjudgmental attitude of all within the midst of the messiness of broken lives and death.

It was about goodness and hope and life in the midst of dysfunction, addiction, crime, and broken relationships.

It is a sacred story.

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Study of resilience can benefit chaplains and patients

*The Virtue of Resilience*
by James D. Whitehead and Evelyn Eaton Whitehead
Paperback: 148 pages
Orbis Books (2016)

By Martin Folan

Co-authors James and Evelyn Eaton Whitehead’s *The Virtue of Resilience* offers readers both an instruction booklet and a toolkit to mine the resource of resilience hidden in every individual. Packed with a balance of case studies, stories, resources, instructions, and generous doses of humor, *Resilience* explores the meaning and power of the virtue in the context of biblical history, natural disasters, national tragedies, and civil life. From stories of soldiers whose lives remain shackled by post-traumatic stress disorder to a gunman’s attack on Arizona congresswoman Gabrielle Giffords; and from the civic resilience of Bostonians who rushed toward the Boston Marathon bombing site to save victims, to the community members who united to rebuild New Orleans after Hurricane Katrina, resilience is a power of survival.

Described as “a resource both obvious and mysterious,” resilience’s three R factors — recruit, reframe, and resolve — by themselves are enough to provide individuals, or chaplains, the needed leverage to restore one’s soul to wholeness. Here, the Whiteheads are not long on words, but provide clear-cut definitions, examples of how each R achieves positive outcomes, and back their explanations with stories.

The Whiteheads impart very little of their own wisdom to readers, but instead rely on the expertise of renowned psychologists Carl Rogers and Erik Erikson; civil rights activist Nelson Mandela; and Dutch Catholic priest, writer, and theologian Henri Nouwen, among others.

Two of the more practical chapters are how-to sections: “Developing Resilience — Mindfulness and Humor” and “Practicing Resilience — Hope and Gratitude.” Although this book explores a most serious topic, these chapters will have you laughing as well. “Laughter is aerobic exercise,” the authors state. As exercise helps maintain physical health, laughter exercises the brain and keeps people healthy.

James Whitehead, a historian of religion, and Evelyn Eaton Whitehead, a developmental psychologist, understand human beings in mind, body, and spirit. They understand the need for hope and its power to deliver individuals from a mindset of today’s pain and suffering. They understand the power of appreciating life and expressing gratitude for all of its gifts. And they understand the effects of growing old, as show in the chapter “Resilience in Aging — Supporting Lifelong Resilience.”

Co-authors of more than a dozen books, the Whiteheads’ freshest dose of soul medication is a must-read for those eager to achieve greater spiritual empowerment personally and as professional chaplains.

*Martin Folan, BCC, is director of mission and spirituality at Mercy Hospital and Medical Center in Chicago.*
Case studies may shake chaplains out of their routine

*Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy*
Edited by George Fitchett and Steve Nolan
Paperback: 320 pages
Publisher: Jessica Kingsley Publishers (2015)
ISBN-10: 1849059764

By Juli Dickelman

How do we chaplains articulate the layers of knowledge we carry with us? How do we describe our depth of understanding into the complexity of the human being and the spirit that animates her? How do we value and communicate our unique expertise on the interdisciplinary team? If you would like to be both inspired and challenged, I recommend *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy.*

Nine case studies from pediatrics, psychiatry, and palliative care demonstrate the importance of spiritual issues in clinical care; analyze what the chaplain does in identifying and addressing spiritual issues; and demonstrate the value in detailed self-reflection and dialogue with peers and other specialists. The editors — George Fitchett, well-known as a leader in spiritual care research, and Steve Nolan, a palliative care chaplain and educator in England — challenge us to be leaders, to develop theories specific to our field, to do research, and to actively involve ourselves in quality improvements.

Fitchett, who will be among the plenary speakers at the NACC conference in Chicago in April, argues in his introduction that ours needs to be a research-informed profession. Case studies such as these provide a foundation for research. They also can help train new chaplains and educate our interdisciplinary colleagues.

Each case study is followed by responses from an experienced chaplain and another professional from a field related to the case. The respondents often highlight theoretical frameworks that the chaplain may not have even recognized.

I entered into a dialogue with the chaplain while reading a case and often found myself challenged and surprised as I listened to the respondents. Professionals who are very good at what we do and who have been in the field for a long time may be at risk for being able to do our work with our eyes closed. Engaging with case studies provides an opportunity to be shaken out of rote or habitual methods.

I was very impressed with the citing of research, developmental theories, theology, and cross-references to other disciplines. Like the metaphorical iceberg, the bulk of a chaplain’s expertise is often hidden beneath the surface, unseen by others and perhaps even concealed from ourselves. Although I know we chaplains are academically well-prepared, capable of honest self-reflection, well-trained, and deeply experienced, I do wonder if we declare our fluency nearly enough — on our interdisciplinary teams, through our charting, in journals and other writing.

This book demonstrates that case studies can assist chaplains as we continue to evolve as a professional discipline and continue to argue for funding and places at the table.

*Juli Dickelman is a chaplain educator at Providence Healthcare in Spokane, W.A.*
Movie Review

Healing from the *Inside Out*

By Daniel J. McGill

Why should we seek God’s will instead of our own? Paradoxically, why are we given our own will if, as many say, following it leads to disaster?

These are religious questions, but religion is suspect in our age. So perhaps no surprise that one of the most spiritually insightful films of 2015, now available on DVD, has nothing obviously spiritual or religious about it.

Pixar’s *Inside Out* on the surface appears to be an excellent animated family film. Its simple plot is insightful and wise. Five emotions — Joy, Fear, Anger, Disgust, and Sadness — are portrayed as individual characters working in a control room inside the head of an 11-year-old girl, trying to navigate her through the transitional crisis of her family’s cross-country move. Led by Joy, these emotions draw upon the girl’s childhood memories, each one represented by a colorful ball, to help her make the transition happily.

But one emotion seems like a disaster waiting to happen. Every positive memory that Sadness touches turns gray and hopeless. Despite Sadness’ efforts to stay out of the way, and the other emotions’ valiant efforts to rescue the girl from her grief, an inevitable crisis reveals at the climax that Sadness isn’t the danger, but the solution. The release of the girl’s tears allows her to pass through the death of her past memories in the face of new realities. Then, and only then, can healing and new life begin.

Chaplains often encounter this scenario, where sadness is turned to only as a last resort, much as in religious terms people turn to God’s will only when disaster overwhelms them. Much of a chaplain’s work consists in helping people to mourn their losses, or in religious terms, to accept God’s will. Thus both sadness and God’s will appear costly and perilous. *Inside Out* gently helps its audience not only to accept grief but to recognize that grief leads not to inner poverty but rather to new riches. So too then the acceptance of God’s will?

At the movie’s end, the audience realizes that the little girl is growing into a larger, adolescent self. Does this help answer the initial questions above? Julian of Norwich observed that “it is quicker for us and easier to come to the knowledge of God than it is to know our own soul.” This is because our larger selves lie hidden in God. Dying to our smaller selves and accepting God’s will makes possible the discovery of our larger selves. *Inside Out* provides a child-safe demonstration. But it also cautions chaplains: Life’s deepest wounds are seldom child-safe, especially when they happen in childhood. Chaplains can confuse child-safe with God’s will and recoil from the initially terrifying and often disguised faces of grief represented by Fear, Anger, and Disgust. A chaplain’s capacity to face these troubled faces of grief is critical to the art of healing from the inside out.

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