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Mental illness affects everyone

By David A. Lichter
Executive Director

This issue of *Vision* features several articles on mental health issues. The graphic is the head of an individual depicted as a puzzle with many parts that need to fit together. Perhaps you and I feel that way at times, when our own mental health is challenged by loss, depression, stress, or fatigue. I know for myself in these times, words such as *lost*, *drifting*, *flat*, *confused*, and *bewildered* come to mind.

The National Alliance on Mental Illness (www.nami.org) notes that one in five Americans will be affected by a mental health condition in their lifetime. They also state the obvious: that every American is affected by family and friends who experience mental health challenges. In my own extended family, people have committed suicide or needed diverse mental health services. But their situations were not always addressed openly and persistently. Some family members suffer the debilitating residual effects of losing a loved one to suicide or have their own mental health issues. How painful it is, and often how helpless one feels, in the face of their ongoing struggles. I don't think our family is unique in this.

Given the prevalence of mental health challenges, it's good that we devote a *Vision* issue to this topic. Did you know that among our 2,100-plus NACC members, only 11 identify themselves as associated with a mental health institution? That seems so few. However, I suspect that category might be too narrow for members to self-identify with it. When we think about all the diverse places where mental health services can be received, they can include hospital inpatient settings, general medical or surgical hospitals (with psychiatric or inpatient drug/alcohol rehabilitation services), residential mental health treatment, psychiatric hospitals, intensive outpatient programs, or partial hospitalization programs. I am sure you can add other settings where you work with individuals challenged with mental health issues, such as PTSD.

I recommend a July 2016 study by NAMI, titled "Engagement: A New Standard for Mental Health Care" (www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/Engagement-A-New-Standard-for-Mental-Health-Care/NAMI_Engagement_Web.pdf). This document was the result of a two-day

listening session and subsequent interviews with experts around the topic. It begins with the dismal data that 70 percent of those who seek mental health care drop out after their first or second visit. The study provides examples and cases of how that first engagement between those needing help and their service providers sets — or fails to set — the tone for a healthy, long-term helping relationship of trust and respect.

The study helps me appreciate even more the gifts of chaplaincy, and how so many of you engage people with mental health challenges with the trust, respect, and dignity that help them face their challenges and avoid further traumas. The study points out, “When the door is shut on engagement, too many people leave school, lose jobs, get arrested, become homeless, or attempt suicide.”

I am grateful for your spiritual care profession and the many ways your ministry supports providers of mental health services, as well as those needing care. We have tried a few times to create a network of our members whose ministry addresses mental health challenges. Perhaps these articles might stir interest among some of you to see the value of such networking. If so, please let me know.

Blessings,
David A. Lichter, D.Min.

Toxic religion: The unhealthy relationship of “bad theology” to mental illness

By Donna Dickerson

When I was hired as a staff chaplain at a state mental hospital, I did not know how best to minister to the spiritual needs of our patients. My prior experience was largely end-of-life and crisis ministry at acute care hospitals and in hospice settings. But as a mental health chaplain, I found that my clients were suffering, but for the most part not from physical pain. I saw that they were frequently in acute spiritual distress, and that their spiritual needs were often closely linked with their mental illness.

The hospital where I work has an average patient census just short of 300, and it serves a vast area encompassing most of south and southwest Texas. Nearly half are forensic patients, either “NGRI” (not guilty by reason of insanity) or coming from jail to gain mental competency to stand trial for their offences. Their crimes may range from simple trespassing to homicide. Other patients are short-term or longer-term acute, geriatric, or residential patients from the community at large. About 10 percent are adolescents. I am the sole chaplain for the facility.

The National Institute of Mental Health estimates that 1 out of every 4 adults will experience some form of mental illness in their lifetime; likewise approximately 10 percent of children and adolescents. Stigma and shame often prevent persons from seeking treatment or asking for help. This can be especially true for those who consider themselves deeply religious.

Many of our patients return again and again (often within months or even days after discharge) largely due to inadequate support in the community. Often they are homeless with no family support system and few friends; some struggle with substance abuse in addition to their mental illness. For them, the hospital has become a “safe place” where they can reconnect with people they trust and have known for years. It is both home and sanctuary.

In south Texas, a majority of the population is Catholic, primarily Hispanic. A sizable minority comes from fundamentalist/evangelical Protestant backgrounds. Almost all are inactive in their church or faith group, although frequently they grew up in devout families. Many read Scripture regularly, however, and tend to interpret it quite literally, sometimes becoming fixated on certain problematic themes, which can become psychologically unhealthy. I call this “toxic religion” or “bad theology” (and

yes, I realize this must come across as a value judgment). Much of my work here is gently coaxing these patients back to a more positive religious perspective, by offering “spiritual wellness” groups and individual pastoral counseling.

Some patients may present as hyper-religious, with religious delusions dominating their entire world view. Sometimes problematic religious themes feed into their mental illness and vice versa. Individuals with major depression or bipolar illness sometimes exhibit an overwhelming concern with sinfulness and guilt. They can even feel that they deserve to die for past offenses or bad choices, leading to suicidal ideation. They may believe that God (or the devil) is punishing them, or that everything is predestined and therefore hopeless. Sometimes they will refuse medications because they are convinced God will heal them if their faith is strong enough — or conversely that God’s will is for them to suffer, and therefore taking medication is a rebellion against God.

Psychotic and delusional patients with schizophrenia seem to be especially fascinated by prophetic scriptures concerning the end of days, especially Revelation, but also Isaiah, Daniel, and Jeremiah. For many, the end times are imminent. Some believe they are Satan, the Antichrist, or “666” himself; others, one of the archangels, Jesus Christ returned, or the Prophet Mohammed. They may insist on seeing a priest for an exorcism, or ask for a curandero (traditional healer) to do a ritual cleansing of their room to remove demonic powers or evil spirits.

Some have auditory or visual hallucinations in which they are convinced that evil spirits or demons have cast spells or cursed them or are commanding them to do evil things. They may believe that others, especially family members, are demon-possessed. Some have acted upon these delusions and committed various offenses, even murder. They may have chosen to embrace their delusions to avoid taking personal responsibility, but I try not to psychoanalyze them. It is important that a chaplain respect their present state of mind and needs, including their religious delusions, neither confronting nor validating them. I do pass on relevant information that might be helpful to their treatment team, without violating pastoral confidentiality. Sometimes this can be a delicate ethical tightrope to tread.

Meeting the person “where they are” is particularly important when working with the mentally ill. It is essential to recognize that for a person with mental illness, this is their reality. I always try to see the person, not the diagnosis, and remember that they may have mental illness but they are not stupid. Many are incredibly intelligent and perceptive, and bristle at words or tones of voice that come across as patronizing or

condescending. To avoid being unduly influenced by a person's specific diagnosis or legal circumstances, I tend to review other practitioners' chart notes after visiting the patient rather than before.

It is not helpful to try to talk a person with mental illness out of a particular delusion by using logic, reason, or theology, and in my opinion it could even violate the chaplain's role. A non-judgmental presence and active listening can establish a much better pastoral relationship than talk ministry. For this reason I try to focus on spirituality rather than religion per se, to "walk with" that person as they seek their own path to spiritual wholeness and healing. My personal conviction that a given religious belief is "toxic" or "bad" theology does not give me the right to evangelize against it. As a person moves beyond crisis to wellness, they often discover for themselves how certain deeply held religious beliefs are working against their recovery, and they realize a deeper and more positive spirituality. Our job as mental health chaplains is to reflect God's unconditional love and to support the patient's spiritual journey, no matter how troubled, as companion and gentle guide.

Donna Dickerson, BCC, is a chaplain at San Antonio State Hospital in San Antonio, TX.

For further reading

These observations are largely subjective, based on five years of personal experience. I encourage others to research these observations in hopes of furthering our understanding of the complex inter-relationship of mental illness and unhelpful religious belief systems.

Some existing publications of interest include:

Significance of the Chaplain within The Mental Health Care Team, *Psychiatric Bulletin* 2002.
(<http://pb.rcpsych.org/content/26/5/190>)

Confidentiality and Mental Health/Chaplaincy Collaboration, University of Nebraska Public Policy Center, 2014.
(<http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1130&context=publicpolicypublications>)

The Chaplain as a Voice and Bridge for Mental Health Patients, *PlainViews*, 2014.
(<https://csupalliativecare.org/mentalarticle1/>)

Repeat mental patients strain staff's compassion

By Daniel Waters

The church was warm on a beautiful Sunday morning in July when I saw Sam seated in the section next to ours. I had visited Sam more times than I can count over the past five or more years as a patient in our dual-diagnosis behavioral unit at the hospital, but on this morning he seemed comfortable in the pews of the diverse inner-city parish. I did not approach him, but he came over to greet me and I introduced my wife.

Less than two weeks later, I saw Sam as a patient again. I felt sadness and heartbreak more than anything else. I was filling in for our chaplain, who does weekly spirituality groups in the Behavioral Health Institute, and Sam had been admitted just hours before. A nurse and a recreation therapist rolled their eyes and made comments about Sam being “back again!” and “who knows what he will do for now.” About two-thirds of the way through the spirituality group Sam came to the room. He struggled to keep his eyes open. When the group ended, he told me he was happy to see me but ashamed that I was seeing him like this again. It was tough for him to even make a clear sentence. He did ask for prayer and we asked for God’s light, peace, and forgiveness; Sam was soon heading back to his room to sleep.

I learned later that Sam had been found passed out on the street in the early morning hours. The squad had taken him to the closest hospital, and from there he came back to our BHI unit. It had been more than six months since Sam’s last admission, and he had left us with promise and high hopes. He had a good place to live and he was beginning a new job. Finding work is not easy for someone with Sam’s psychiatric history. We had transitioned Sam to our outpatient program for ongoing support in the hopes of avoiding yet another downward spiral.

I made time to visit Sam over the next several days. The ongoing frustration of some of our staff was very evident. I found myself providing a listening presence to our staff members as much as spending time with Sam. Active listening is an important intervention for staff. Other spiritual care interventions with staff could include exploring healthy coping resources, critical incident debriefing, discussion

of meaning and purpose, exploring their definition of hope, exploring their thoughts and emotions, or exploring their relationship with God/the transcendent.

Their frustration around Sam was born out of a genuine concern for him. The social worker had worked hard to line up job interviews and find an apartment complex where he would be accepted. Recreation therapists had worked on healthy coping practices. Nurses had gone forward and backward over the need to stay with his prescribed medications. Now they felt that all of this had been for no reason. As I listened, I could feel their frustration and hopelessness. Sam is not the only one on this treadmill, and it is not hard to see why some staff members become cynical. Compassion fatigue and moral distress can manifest in different ways in a behavioral unit compared to a medical unit, but in either setting, they can be just as real and debilitating. Intentional use of some of the interventions mentioned above can help staff work through fatigue or distress.

When I reflect on my own hopelessness and sadness, I must be honest about whether some of this is my ego. Is this about my ability to change Sam's life and looking like a hero? Or am I willing to keep Sam's well-being as the focus and surrender enough and remain open, seventy times seven? The process of allowing the staff a sacred place to vent and talk through their frustration has helped them come to a place of willingness to work yet again with Sam. Perhaps one of the most powerful things chaplains can do is allow the staff to take the initiative of letting go of frustration or cynicism themselves. Only when I can look at a patient and know in my heart "there but for the grace of God go I" can I surrender my emotions to the One who chose to become broken and move forward myself. In Sam's case, worshiping with him earlier made me aware of my own failings. There was no way I could feel more whole or well than Sam during our time of prayer together.

As the staff and I journeyed through our own frustration, sadness, and hopelessness, we continued to work with and minister to Sam on his journey. He spent about two weeks with us inpatient and then made the transition once again to outpatient support. As frustrating as Sam's case has been, the one trend he has this year is overall fewer inpatient admissions.

I would be naïve to think I would never see Sam as an inpatient again. The dark emotions that he struggles with can take a different form but can weigh down staff as well. Staff members have their own struggles such as mental illness of their own family or friends, financial issues at home, or staffing shortages, to name just a few. The journey toward the healing peace of our loving God continues for all of us.

Daniel Waters, BCC, is Spiritual Care Coordinator at Mercy Health in Oregon, OH.

Plot lines: Allegories of recovery help adolescents

By Anne M. Windholz

During my chaplain residency at a large Midwestern hospital, I worked with adolescents in behavioral health, both one-on-one and as leader of a weekly, one-hour values discussion group.¹ Some patients were grappling with eating or personality disorders; some were cutting themselves or fighting addiction. By far the greatest number suffered from severe depression, even attempting suicide. Few looked forward in hope.

Having been an English professor and teacher of children's literature, I sought to create an intervention that would encourage patients to see themselves as the protagonist — the main character — of their life story and to identify a positive goal for themselves; to name the obstacles (antagonists or antagonistic forces) blocking their way; and to brainstorm about values that might help them overcome and succeed. Though their ages varied from 10 to 18 and they came from diverse racial and economic backgrounds, I found that all could connect with the power of story and begin thinking about shaping their own life narrative instead of allowing others — or their disease — to determine it for them.

Patient turnover from week to week was substantial. We started each session largely from scratch, identifying who we were and how we stood in relation to each other. My title was a puzzle to them: neither teacher nor counselor nor therapist. Those few for whom "chaplain" had any meaning at all ventured (with a question mark in their voice) that it had "to do with church." This led to a discussion of beliefs, of spirituality as distinct from religion, and ultimately of what it means to value something or someone. Borrowing from Willard Ashley, I described a chaplain's job as "to listen, learn, love, and liberate." Often perceiving themselves as judged or dismissed, not heard, and not loveable, these kids were able to connect with those four L-words as values that could be measured by concrete actions.

Juveniles with mental illness, these patients could control little in their lives. How could I free them to tell their own story? Raised on movies and computer games if not books, they knew the plots of Harry Potter and the Hunger Games. They needed a storyline they could plug into: one less well known with less distinctive

heroes, one less cluttered by the paraphernalia of Hollywood and current popular culture. One that could, as a relatively blank slate, free their imaginations.

They needed allegory.

Early in my teaching career I taught John Bunyan's *Pilgrim's Progress*. A 17th century best-seller and enduring classic, it relates the adventures of an allegorical everyman named Christian who leaves home (the City of Destruction) to seek salvation in the Celestial City. He faces monsters, troubles, and temptations along the way that threaten his survival. He also finds friends and tools that foster what we would call resilience. Filled with adventure and misadventure, horror, and hope, Bunyan's plot offers touchstones upon which patients could loosely chart their own journeys.

I briefly summarized *Pilgrim's Progress*, acknowledging its basis in a European, Christian world view while reassuring patients that neither need be part of their story. Seated around a large table, they each received a pencil and a time line with cartoon drawings inspired by Bunyan's plot:

- The City of Destruction;
- The pilgrim's Burden;
- The Slough of Despond;
- The friends Helpful and Goodwill;
- The distractions of Vanity Fair;
- The Valley of Humiliation, the Shadow of Death, and the Giant Despair who imprisons the pilgrim in Doubting Castle;
- The liberating Key of Promise and the Celestial City.

After explaining any parts that confused patients, I asked them to ponder what their own Celestial City, their own Slough of Despond, etc., might be. They were free to reconfigure the plot, to skip parts they found irrelevant or too disturbing. Working quietly, they took control of the story. Involved in the solemn work of naming fears and articulating hopes, they laid down boundaries between friend and foe, safety and danger, being sick and becoming well.

When we came back together, patients who felt comfortable were invited to share the allegorical names they gave themselves, how they labeled their best helper on the journey, and what they hoped to find in their celestial city.² Their

chosen names were poignant: Regretful. Thoughtful. Vocal. Compassionate. Selfish. Lonely. As Selfish named himself, he hung his head. Brash outwardly, he was in fact carrying — and hiding — a heavy burden of self-condemnation. Group members were uneasy about the negative label, but his willingness to be vulnerable gave everyone a chance to explore the power of self-naming, the danger of being named by others, and the liberation of re-naming. Selfish, who called his helper Beauty, quietly revealed that he was seeking Respect, Love, and Trust. Others in the group opened up: Lonely sought Optimism, Thoughtful was trying to find Motivation, and Regretful longed for Self-Compassion.

I did not ask patients to reveal their burdens or monsters. Group time was too limited, and exploring fears struck me as a task for one-on-one visits. Nor was I concerned with the “objective” truth of their stories; my role was not to treat their illnesses or fix their views of reality. My work was to help patients discover how deeply their stories matter because they, themselves, are valued.

The bedrock of chaplaincy is story. Belief in story’s sacredness is part of what makes our listening holy and allows us to honor the entirety of the persons we serve, not just focus on the illness that puts one in the hospital or the crime that gets one incarcerated.³ Dramatic enough to hold interest and general enough to support many personal stories, *Pilgrim’s Progress* provides one example of an allegorical scaffold upon which young patients can build meaning. To be sure, allegory’s tendency to label good and evil without nuance risks oversimplification. But it gave my patients the chance to name their monsters, to acknowledge their helpers, and to pin down their goals. It engaged their imaginations and offered them space in which to dream about what recovery might look like. And it reminded them that, like Christian, they need not walk their darkest nightmares alone. Being a pilgrim in supportive company can itself be salvation.

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¹ See Levi Gangi on the distinction between leader and facilitator in “A Lifetime of Recovery: Spirituality Groups on an Acute Inpatient Psychiatric Unit,” *Journal of Pastoral Care and Counseling* 68.2 (June 2014), p. 7. My own

understanding of the difference between spirituality and therapy groups was enriched by the *Training Manual for Spirituality Discussion Groups for Mental Health with Focus on Cultural Competency* compiled by the Center for Spirituality and Healthcare at New York University's Langone Medical Center and the Nathan Kline Institute for Psychiatric Research, pp 6-9.

² No uniquely identifying patient information is disclosed in this essay.

³ Michele Guest Lowery notes the tendency of "people with mental disorders [to] over-identify with their illness and thus struggle to see themselves in a fuller context." In "Behavioral Health," *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*. Ed. Stephen B. Roberts. Woodstock, VT: Skylight, 2012. p. 269.

Prison worship helps cope with mental illness

By Peg Newman

I work in a psychiatric prison hospital, and, like most chaplains, I love my work. The prison features stand out dramatically — the barbed wire, the officers, the prison food, and everything else. That’s not the part I love.

On a typical day, if there is such a thing, I might facilitate a group on forgiveness, do rounds in a segregation unit, lead a Bible study, and see two or three patients for 30-minute pastoral counseling sessions. On a less typical day, the building that houses the chapel might be locked down because patients have been fighting, and the officers who normally oversee the building would be taking a patient to the emergency room. These are the times I catch up on emails, phone calls, and paperwork.

Many men are imprisoned more by their mental illnesses than by the barbed wire. (The modern medications with near-miraculous results do not help everyone.) Those are among the men I come to know well. Often they are the ones who most appreciate the safety and comfort of the chapel community. Some are lectors, Eucharistic ministers, and gift bearers. They hold the memory of the many priests who have volunteered over the years to come in for Mass and confessions. They are joyous when the cardinal comes and we arrange for a large Mass in the gym. Almost as exciting are the annual visits by the bishop for confirmations and occasionally baptisms. Religion feeds their strong faith and anchors their lives.

Several years ago, a prison official, a mental health clinician and I began what we named “The Companion Program.” Inmate workers who transfer to the hospital to work on maintenance, grounds, kitchen, etc., were invited to become companions to some of the patients who needed the most help, most often because of cognitive challenges or behavior difficulties. We developed an eight-week training program involving staff from all the disciplines. Many applied, but only 10 were selected. Assigned to a patient much like a buddy or big brother, they spend at least four hours a week together, and the bonds form quickly. The program is helpful for the patients and transformative for the inmates. The

weekly supervision group always begins with an inmate sharing a spiritual reflection. As the years pass, the depth of these reflections continue to impress me.

I was blessed to do three of my extended units of CPE in prison settings, where I discovered that chaplaincy in prison gave me a strong and consistent awareness that I was a vehicle for God. My third unit brought me to the State Hospital. Though it was 16 years ago, I remember clearly driving home in the evening with a strong sense of God's presence. I don't feel God's presence in the same way anymore, but I cherish the memory and I know that God is right there with me. When I am feeling depleted or frustrated by the work, I am sustained by that memory.

Men in prison, patients and inmates alike, are stripped of pretense. In our conversations, I find I have to be honest. There is no place for those religious phrases that have great meaning for some but have never spoken to me. I don't say, "God never gives us more than we can handle" or "God doesn't give us what we want, God gives us what we need." Clearly these things do not appear to be true for the men I work with.

A man kills someone he loves dearly. How can God allow this to happen? There is no answer. But I am present when the man, with the help of medication and the passage of time, stabilizes and has to find a way to live with his actions. A jury may tell him he is not responsible for his actions, but more deeply healing is experience of God's mercy offered through the sacrament of reconciliation. Learning to live with an agony that never goes away, a man needs to experience that mercy again and again. His faith and the support of the chapel community form the foundation of his survival. God's presence is not subtle, not an abstract idea. Jesus walks with this man.

Another man hears voices. He explains that the medication that reduces the chaos of the voices also makes him feel sleepy, drugged, unable to function. His daily life is misery. He comes to my office wanting to know why God doesn't answer his prayers. I tell him I don't know, and I ask him if there is anything he knows for sure about God. He speaks of God's love.

Reluctantly, the psychiatrist reduces his medication. Now he comes to my office explaining that he has been taken over by Satan. Just as his therapist does, I

explain to him that the voices are a symptom of his illness and that he has most definitely not been taken over by Satan. He doesn't believe me, but he accepts my offer to pray with him. I ask God to provide healing and strength and ever-deepening faith. He leaves my office a little calmer, a bit more hopeful. He keeps coming back to talk with me and to pray. He goes to church on Sunday, even when the voices object. I see God acting in his life even when he can't. Slowly he comes to believe that Jesus will help him get through this painful time.

Group worship on the assisted living unit is the place I can most reliably feel God's presence. It is there that I find my certainty that Jesus walks with me, just as he walks with the men I serve. I look around the room, and I see men as faith-filled as any I have ever met. Some arrive in wheelchairs while others shuffle in slowly. The walls are unadorned hospital green cinder blocks. The tables are caked with food not yet wiped up from lunch. I try to breathe through my mouth to minimize the unpleasant odor. Two inmate workers set up an altar, pass out the music booklets and plug in the CD player. Officers can sometimes be indifferent or even unkind about religious activities, but on this unit I am often told how important our weekly services are and how on Sundays the men keep asking if it is almost time for church. The singing is loud and full of enthusiasm. Voices are strong and earnest as we pray the Lord's Prayer.

Silent retreats by the ocean feed my soul. The Easter vigil often awes me with beauty and hope. But it is in the worship service with the elderly, mentally ill men in their day room that God speaks to me the loudest.

Peg Newman, BCC, is a chaplain with the Department of Corrections in Massachusetts.

Dementia: The testimony of silence

By Matt Moser

“Death is hot.”

This comment, made in passing by the presenter of a talk I recently attended, while questionable in taste, is true. Death and dying are hot topics receiving much attention these days in popular media. Atul Gawande’s *Being Mortal* is quickly becoming the manifesto for a movement to change end-of-life care. Many other authors have written books on dying well, which they typically define in terms of living well, especially one’s last days. But the person with advanced dementia, whose death holds no possibility of being the conclusion of a self-chosen narrative, challenges the concept of dying well that is predominant in our culture.

The number of Americans living with Alzheimer’s disease is rapidly growing. As of 2016, it was an estimated at 5.4 million, according to the Alzheimer’s Association. Of these, 5.2 million are age 65 and older. By 2050, the number will nearly triple to 13.8 million, with some estimates as high as 16 million. For family, the emotional and physical toll of caregiving is great, with nearly 60 percent of caregivers rating the emotional stress of caregiving as high or very high and about 40 percent suffering from depression. Among caregivers, almost 75 percent report that they are concerned about maintaining their own health since becoming a caregiver. Ever greater numbers of chaplains will be needed to provide spiritual care for this vulnerable and often voiceless population and their families.

Bioethicist Howard Brody names aging and dementia as one of three topics that bioethics should pursue in the coming decades. The necessity of this ethical pursuit, which is also a spiritual pursuit, is captured in his book *The Future of Bioethics*.

“A narrative conception of dementia, in particular, seems on one hand absolutely essential to ethical understanding, and on the other hand extremely elusive. A first-person narrative of dementia, to the extent that it is coherent, invariably signals that the author is only in the very earliest stages of the condition, and so is unable to reflect for us what deepening dementia consists of. Narratives of advanced dementia, by contrast, are almost always the

narratives of the caregivers, not of the patient. Those caregiver narratives can in themselves be extremely significant, but they do not answer the deepest ethical questions.”

For Brody, bioethics must stand on the side of the most vulnerable and act to protect them. As resources for dignified care for persons in the end of life diminish, the population of persons with advanced dementia, whose end of life can be lengthy, will become ever more vulnerable.

In *The Wounded Storyteller*, sociologist Arthur Frank provides insight for comprehending the reality of advanced dementia, with its absence of a first-person narrative. For Frank, “Ill people’s storytelling is informed by a sense of responsibility to the common-sense world and represents one way of living for the other. People tell stories not just to work out their own changing identities, but also to guide others who will follow them.” The most common story people tell and are told is the restitution narrative — a person suffers an affliction that interrupts normal life, a medical intervention removes her affliction, and she returns to normal life. While having its proper sphere, the restitution narrative cannot function when a person’s illness is chronic or a person is dying.

However, he writes, “Quest stories meet suffering head on; they accept illness and seek to *use* it.” The “communicative body” is the name Frank gives to the person, or “body-self,” who tells quest stories. For Frank, “The body itself is the message; humans commune through their bodies,” even when the body-self loses its ability to verbalize. The person with advanced dementia tells a story, necessarily beyond their will, of meeting suffering and accepting illness. The person with advanced dementia testifies, silently, to a fundamental human reality — humanity is vulnerability; our beginning and our ending is marked by total vulnerability.

When I was a Jesuit seminarian, I once found myself deeply disturbed by an elder Jesuit who was no longer able to recognize the body of Christ, that for which he gave his life. The presider repeatedly offered the host, “Bill, the body of Christ. The Body of Christ. The Body of Christ, Bill.” I later spoke with my superior, who suggested, “Maybe he had become the host.” Yes, he had in fact become like the host — emptied but for God, on whom he was utterly dependent. As Frank suggests, the ill body-self’s dependence on God is the realization of existing for the other. The person with

advanced dementia exists for us, providing silent testimony to our vulnerability and calling us to respond. Our response will depend on how we hear this vulnerability.

Like other mental illnesses, dementia takes away the remembered person from their family. “That is not Dad,” or “Mom has been gone for a long time,” some families say. Many patients with advanced dementia are alone because their families cannot face the pain of their remembered parent being gone. But knowing that caregivers visit throughout the week is comforting for families who can find relief from the sense of obligation to see their loved one. For most families, knowing that they are not alone in bearing the long grief of dementia is consoling.

“‘Stay with us, because it is almost evening and the day is now nearly over.’ So he went in to stay with them.” These words from the Gospel of Luke continually inspire me in my care of dementia patients. Spiritual care for advanced dementia patients is reduced to the core of chaplaincy — *being with* them and assuring them through gentle touch and loving words of their eternal worth. I like to think that in these moments I help them to remember a little who they are in God. And if there is no remembering, I think they do feel loved. Some will not remember that you were with them five minutes later, but when you are with them they can feel loved, safe, and less alone in the world.

Dying well, when defined as living well one’s life and especially one’s last days, means living as autonomously as possible for as long as possible. This dying well can be a very meaningful experience for dying persons and their loved ones, but it cannot be the experience of the person with advanced dementia. In her silence, her dependency, her vulnerability, she tells a story about our human predicament, about being finite and about accepting definiteness, which is to say, accepting that the ultimate shape of our life and the line of our story are beyond our authorship. According to the predominant conception of dying well, the dying of persons with dementia appears devoid of meaning. As chaplains, we hear a counter-story. In deed and word we tell the story of God who bends low and is ever more present the lower God bends. In our telling, the person with advanced dementia, whose end of life is marked by total vulnerability, is cause for awe, wonder, humility, and reverence.

Matt Moser, BCC, is a chaplain with Fairview Home Care and Hospice in Minneapolis.

Mental patients' families seek peace in the storm

By Anne Millington

The families of behavioral health patients can often feel like people at sea, doing their best to navigate the challenges of their loved one's illness. Behavioral health issues are often difficult to diagnose, challenging to manage, and resistant to cure, and families often find themselves struggling to manage their loved one's ever-changing and complicated symptoms. As challenges continue, behavioral health families experience tempests of feeling, including denial, anger, shame, regret, hope, love, frustration, burnout, and all kinds of shoulda-woulda-couldas. I recall the look of disbelief and denial on the face of a father confronted by his teenage son's diagnosis of schizophrenia. I also recall the anguish of a son at the time of his father's death, defeated that he was never able to find a cure for his father's psychosis.

To navigate a loved one's behavioral health issues, families require a lot of support and guidance. Proper medical attention is needed to diagnose illnesses as accurately as possible and manage symptoms. Behavioral health counselors and social workers are needed to help manage family dynamics and locate supportive resources. Support from extended family, friends, and community is also critical.

Where there are physical and emotional injuries, there are also spiritual injuries, and as pastoral caregivers we are called to minister to these sensitive and often painful places. Behavioral health families are certainly not alone in experiencing stormy weather. Indeed, in the Gospels we find Jesus' disciples at sea during a storm so furious they feared they would perish. Scared and overwhelmed, they were astonished that Jesus, also aboard, remained soundly asleep, exhibiting that "peace of God that passeth all understanding" (Philippians 4:7). As Jesus demonstrates, peace is possible for us, regardless of weather, and I believe this peace is available to every human being of every faith background and belief. As ministers, we can help families heal by guiding them to locate this peace and claim it for themselves.

We can begin by "building the boat," forming, through our listening presence and support, a container to hold them and keep them afloat during whatever they are

navigating. Unlike so many in our fast-paced, understaffed, insurance-company-driven world of health care, we can approach those we serve with no goal beyond listening. Our skills at active listening give families the time, space, and support to tell their stories, to speak their truth, to share their deepest feelings about what they are experiencing. Often they have been holding it all in for quite some time, in their focus on caring for their family members' needs.

Early on in my pastoral ministry, I recall listening to a woman in the throes of managing her child's mental illness. Once she began talking she talked and talked and talked, one word tumbling out after another. Initially, I felt compelled to say something clever or to reassure her in some way, but after a few minutes I gave up, relaxed, and just let her words flow, supporting her nonverbally by nodding my head and by gazing at her with empathy and concern. Finally, she told me she felt better than she had felt in a long time, and that she felt a marked sense of relief and renewal. By having as much time as she needed to express herself, she was able to achieve a catharsis formerly inhibited by the time and agenda constraints of caring for her son.

Once families have the space and safety to pour out their hearts, we then facilitate peace by helping them name and explore the depths of their feelings. I remember speaking with a mother furious that her daughter had been diagnosed with paranoid schizophrenia. In sitting with her fury, she noted her own struggle with mild schizophrenic symptoms, and together we explored how her anger was masking the sadness and guilt she felt over the notion that her daughter may have inherited this illness from her. When we bring to the surface and name all troubling feelings, these feelings begin to lose their power over us, and a space opens in the soul where increased peace may enter.

Once deep feelings have been recognized and named, possible avenues toward peace naturally emerge. Unmet needs can be identified and remedied; God's calling can be discerned. A woman I know has felt angry and defeated by her husband's unwillingness to get help for his depression, but she has managed to find solace in playing competitive tennis. One couple found peace around their adult daughter's bipolar condition by mentally moving on with their lives, continuing to support her, and yet also making some time for travel and other interests. Families may need to grieve their broken dreams, put firm boundaries in place, or perhaps rekindle old friendships and interests. Although families may

not be able to fix their loved one's illness, peace takes root in their hearts as they access God's ways of fulfillment, deep meaning, and even joy in life amid dealing with behavioral health illness.

Regardless of what issues a family currently faces, we know all too well that life is an ongoing series of challenges. If we live for the day that a certain problem or challenge is resolved, we find only that another has taken its place. But I believe that God provides in each difficulty some sort of opportunity for growth, and, most important, God makes it possible for us to live peaceful, fulfilling lives amid our ever-changing challenges. Our continual task is to locate and cultivate God's way of peace in our hearts, in every kind of weather. The families of behavioral health patients, in their profound struggles, have profound opportunities to grow in this way.

Anne Millington is director of pastoral care at Beth Israel Deaconess Milton Hospital in Milton, MA.

Young offenders rebuild relationships in group therapy

By Matt Jacobson

Walking across the parking lot toward the behavioral and mental health center, I noticed the windmills set upon the mountain ridgeline separating West Virginia from Maryland in the distance. I smelled the crisp autumn air as overwhelming colors crawled over the hills surrounding me. I was in an amazing backdrop of beauty and life for healing and ministry. It was Wednesday, and I was about to facilitate an hour-long spirituality session of group time with young adolescent boys who were court ordered to this residential facility for detention and rehabilitation.

I rotated between two groups every week. One group included drug and substance abuse offenders; the other was boys charged with sexual offenses. Every day in the main hospital, I did typical chaplain duties: serving families of patients withdrawing life support in intensive care; facilitating grief with palliative care; baptizing babies and holding the ones who died; facilitating goals of care discussions, and so on. But during this one hour each week, I was with a group of young men who were barely one step away from incarceration. They voluntarily spent their free time with me to discuss spirituality. And what does “spirituality” mean for adolescents who are struggling with behavioral and mental issues, who have acted out on the world, others, and themselves? It meant community, trust building, remembering, sharing stories, being vulnerable, being honest, and hopefully it meant reconciling their life-threatening choices with their life-giving hopes. I wondered if any of my clinical work in the hospital could translate over to this population.

When I picked up the assignment to facilitate the spirituality groups, I met with my predecessor to hear the wonderful things she did with them: beach ball ice-breakers, creative emotional exercises for coping, charismatic prayer, Bible studies, and more. I was nervous about what I could do for them, as I didn’t believe I was all that creative. But relying upon my experiences of Ignatian spiritual direction, I began by asking them the question of the resurrected Jesus to Mary Magdalene: “Who are you looking for?” I went further and asked, “What does spirituality mean to you? When was a time you felt spiritual?” These were

not really clever or creative questions. I simply wanted to gauge their spiritual needs. But what emerged was breathtaking.

One by one, every boy told his story of remembering that at some point in his life, he had felt connected to something or someone greater than himself. They pointed to their churches, their families, nature, even mystical experiences of prayer and closeness with God. And they said they would like to share their stories. We would begin each group with a short reflective piece, one person would share his story without interruption, and then the group could provide reflective feedback of identification, inspiration, or insight. We would close with the presenter's choice of a song, poem, or quote.

Many boys spoke of growing up in the wild, wonderful West Virginia wilderness, finding God sitting with grandparents on the porch, discovering their own talents of academics, music, and more. They also shared a consistent theme of grief and loss: lost identity, lost hope, lost purpose, lost family members, lost innocence. They expressed the gamut of emotions that colored their memories: joy, gratitude, anger, fear, sadness, shame, guilt, and for some, hopefulness.

Harrison spoke of witnessing his father getting shot. Wayne told us of asking God to be his parent when he was abandoned by his parents as a boy. Marshall admitted his substance abuse began as a way to connect with his grandmother, whom he longed to know better. Braxton wrote and played for us a song about his hope to grow up to be a defender of children instead of an abuser. Ritchie shared poems of his journey through darkness and disbelief. Taylor described his desire to go to college and be an educator in a jail for other offending youth. Preston simply expressed that being able to share his story allowed him to feel connected to the other residents, which allowed him to believe that maybe God is unconditional love. Grant said he couldn't reconcile his shame and admitted he'd like to seek more intensive counseling for healing.

And Tucker described his insatiable curiosity about other religions. On Ash Wednesday he asked if I would provide him ashes, so I did. Immediately behind him formed a line consisting of the entire roomful of boys. We discussed Lent as a time to name our brokenness and our need for healing, and to make sacrifices in order to feel the emptiness of our needs. The boys said they wanted to participate, and we agreed that each week we would check in on how we were

doing on our Lenten sacrifices. The week before Easter, Tucker said he had called his estranged parents to reconnect again and ask for forgiveness. He described tearfully, while also smiling and looking down at his feet, how it felt when they granted him forgiveness. He said he understood what it felt like to be blessed. He lost his sense of shame and his wariness of his future. But, he said, he had dropped the ball on giving up orange drink: "You have to forgive me, Chaplain Matt ... don't forget, I'm an addict!" You are forgiven Tucker; enjoy the freedom.

Although I now work over 500 miles away, in a big city with big buildings, big shoulders, and big pizza, those West Virginia boys remain a cherished part of my journey in ministry and accompaniment. I treasure being with them in their needs, encouraging them to name their hopes and fears, to put the pieces of their broken lives back together through storytelling and reconciliation, and creating spaces of trust and solidarity. Those are some of the many gifts they gave me that I rely upon in patient encounters today. I still hope for their continued healing and freedom. *Montani Semper Liberi*. Mountaineers are always free.

Matthew Jacobson, BCC, is a palliative care chaplain at Northwestern Medicine in Chicago, IL.

Spiritual care and mental health: What the research tells us

By Austine Duru

Mental illness is often misunderstood, and in some circumstances ignored or treated as taboo. It is not uncommon for chaplains to be asked for assistance in addressing mental illness. In fact, early research and major surveys in this area (Regier, et al., 1984; Hohmann & Larson, 1993; Wang, Berglund, & Kessler, 2003) show that many people in the general population tend to seek help from clergy, pastoral counselors, and chaplains rather than from mental health professionals. As mental health institutions grapple with patients' unmet religious and spiritual needs, professional chaplains can be an important ally in providing religious and spiritual interventions for mental health patients.

To evaluate the impact of religious and spiritual interventions on individuals with diagnosed mental health problems, J.P.B. Goncalves et al undertook a systematic review and meta-analysis of randomized controlled clinical trials in seven different scientific and academic databases. The study, which was published in *Psychological Medicine* (2015), yielded interesting results that might help chaplains (see <https://www.cambridge.org/core/journals/psychological-medicine/article/religious-and-spiritual-interventions-in-mental-health-care-a-systematic-review-and-meta-analysis-of-randomized-controlled-clinical-trials/B26314DC89133A3FA4CC4220B6A5FBCF>). The findings show that RSI provided additional benefits to mental health patients, especially in levels of anxiety and other clinical symptoms. The study further identified opportunities for studying the impact of RSI on mental illness and other health conditions, such as neurodegenerative diseases.

In older adults, spirituality has been shown to play a significant role in the well-being of individuals who suffer from dementia and other mental health problems (Puchalski, 2001). Mental illness cuts across age brackets, but when it manifests in older individuals, it poses unique challenges for families, healthcare providers and geriatric patients. This was the subject of a study published by Anita M. Y. Goh et al, in *Asia-Pacific Psychiatry* (2012) titled "Pastoral Care in Old Age Psychiatry: Addressing the Spiritual Need of Patients in an Acute Aged Mental Health Unit" (https://www.researchgate.net/publication/249648458_Pastoral_care_in_old_ag

e_psychiatry_Addressing_the_spiritual_needs_of_inpatients_in_an_acute_aged_mental_health_unit) The findings show that the clinical care of patients is optimized by developing a comprehensive understanding of their spiritual needs and providing more holistic services. This is the unique role of the spiritual care provider working as part of the multidisciplinary healthcare team. This study has implications for specialized training and skills development for chaplains who work in mental health facilities.

Psychiatric patients often have unmet spiritual needs, in spite of the increasing body of literature that associates religious beliefs and spirituality with positive health outcomes on mental health symptoms such as depression and suicide, and higher levels of well-being (Van Ness P., et al, 2002). This is especially true when one considers the unmet spiritual needs of underserved populations with mental health problems. In his recent work titled *The Imam and the Mental Health of Muslims: Learning from the Research with Other Clergy* (<http://quod.lib.umich.edu/j/jmmh/10381607.0010.106/--imam-and-the-mental-health-of-muslims-learning-from-research?rgn=main;view=fulltext>), Dr. Osman M. Ali takes a closer look at the mental health needs of Muslims. While this is not a formal research work, it relied heavily on available research literature to explore some of the challenges and gaps in meeting the spiritual needs of Muslim individuals dealing with mental illness. The author acknowledges a 2011 survey by Abu-Ras and Laird, which found a chronic lack of trained and certified professional chaplains in the United States and more importantly, that the needs of Muslim patients may not readily be met by using the interfaith chaplaincy model.

An interesting study by Virginia Ross et al. (2016) explores how the ongoing role of suicide prevention among clients affects mental health professionals (https://www.researchgate.net/publication/299395490_Mental_Health_Workers'_Views_About_Their_Suicide_Prevention_Role). It also tried to identify some of the thoughts and feelings associated with this role. This research may be meaningful for chaplains, especially those who work in mental health facilities. The authors of this work suggest that the renewed focus on preventing suicide adds additional burden on mental health workers. It is not clear whether chaplains were surveyed for this study, but it shows that mental health workers experience elevated stress and anxiety because of suicide prevention. The authors conclude that self-care strategies are needed for those workers.

Apart from mental health workers, friends and family members often constitute important support systems for both mental health patients and other patient populations. Family caregivers are often referred to as “hidden patients” (Kristjanson L. et al, 2011) because of the adverse effects of the burden of caregiving. Two recent research studies explore the mental health needs of caregivers. The first, “Spiritual Care Training for Mothers of Children with Cancer: Effects on Quality of Care and Mental Health of Caregivers,” by Somaieh Borjalilu et al, (2016) explores the effectiveness of spiritual care interventions for the mental health well-being of mothers who care for children with cancer (http://apepressco.com/apjcp/apjcp_file/issue_abs/Volume17_No2/545-552%208.21%20Somaieh%20Borjalilu.pdf). This quasi-experimental study comes out of Teheran. The study found that spiritual care intervention for mothers of children with cancer produced positive outcomes such as decreased anxiety and reduced spiritual challenges. This study supports training caregivers to recognize and address spiritual and emotional pain.

Another substantive research work on the mental health needs of caregivers by Peter Hudson et al., (2015) is titled, “Reducing the Psychological Distress of Family Caregivers of Home Based Palliative Care Patients: Longer-Term Effects from a Randomized Controlled Trial” (<http://onlinelibrary.wiley.com/doi/10.1002/pon.3610/abstract;jsessionid=9DC5BEC1A73156BC475834D663500472.f03t02>). The study explores the effects of one-on-one psychoeducational intervention aimed at mitigating stress for caregivers of cancer patients receiving home-based palliative care. The finding shows that even small psychoeducational interventions can yield greater mental health benefits for family caregivers. This finding supports existing evidence and may help chaplains in palliative care or hospice settings get additional resources.

Access to mental health services is certainly one of the greatest challenges facing modern healthcare. One possible solution is using the growing field of telemedicine for mental health services. Leslie A. Morland et al, (2015) investigates in “Telemedicine Versus In-Person Delivery of Cognitive processing Therapy for Women with Post Traumatic Stress Disorder: A Randomized Noninferiority Trial” (<http://onlinelibrary.wiley.com/doi/10.1002/da.22397/abstract>). The researchers studied a sample of veterans and civilian women who were given cognitive behavioral therapy for their PTSD through both videoteleconference and in-person treatment. The authors conclude that providing a trauma-focused

cognitive therapy using VTC produced outcomes that were not different from in-person treatments. This finding has implications for the broader expansion of mental health services to remote and rural locations, or in areas with huge gaps in access to trained mental health providers. It also has significant implications for addressing the spiritual needs of mental health patients and staff. Of note is the potential implications this study might have for understanding and mitigating moral injury in mental health patient populations.

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Doubt: A meaningful part of Mother Teresa's story

By Charles W. Sidoti

One of the most important revelations about Saint Mother Teresa (1910-1997) was made after her death. It came in a collection of personal letters to her spiritual advisers published in 2007. The book, *Mother Teresa: Come Be My Light*, revealed that she was plagued by serious doubts about her faith. The news headline read: "Letters Reveal Mother Teresa's Secret: Book of Iconic Nun's Letters Show She Was Tormented by Doubts in Her Faith." The article stated in part, "In a rare interview in 1986, Mother Teresa told CBS News she had a calling, based on unquestioned faith. ... But now, it has emerged that Mother Teresa was so doubtful of her own faith that she feared being a hypocrite."

At first my heart sank upon hearing this news, but as I thought more, I found myself saying, "Thank God! Finally, something I can relate to about Mother Teresa!"

As I was growing up, I remember the images of her on television news. Articles and books about Mother Teresa's dedication to the "poorest of the poor," and how she saw the face of God in the outcast and destitute of Kolkata, India, were very popular. Pictures of Mother Teresa in her familiar blue-and-white habit, looking saint-like, were also common. Many times she would be holding in her arms one of the poor children she served. Seeing these images, I recall admiring her, but I also remember feeling that I simply could not relate to the saint-like behavior or the *unquestioning faith* that she professed. The iconic figure in the news just did not resonate with my faith experience, which has always contained some measure of doubt.

Our perception of religious figures, whether in Scripture or in contemporary society, may endow them with superhuman qualities. They can seem to be larger than life, having an inside track to God that you and I do not have. This can cause us to falsely believe that they did not (or do not) have the same human limitations and struggles that you and I must contend with.

But the religious people that we look up to are first and foremost human. If they were not, then they really would have little to offer us, for they would not have walked the path of life in the same way that we must walk it. If Mother Teresa were more than human, then we could never hope to have her level of faith, any

more than we could hope to fly like Superman. But thankfully, that isn't the case, and that is very good news.

The revelations about Mother Teresa's doubts do not alter my belief in God or my admiration of her virtuous, God-centered life. They confirm it. The simple truth is that faith must co-exist with doubt, or it cannot be called faith. Faith without doubt or at least the possibility for doubt, is something else — fanaticism or extremism possibly, but not faith. The God that Mother Teresa professed belief in is not an otherworldly pie-in-the-sky god but rather a God whose presence transcends and envelops, who comes to us from within creation yet can seem hidden and very difficult to perceive. This is the basis of our need for faith — real, doubt-containing faith.

Do you suppose that Abraham had serious doubts? How about Moses? Gandhi? Martin Luther King Jr.? If so, should we think less or *more* of them for having persevered in their life's work, despite their doubts? Could it not be said that the greater the personal doubt, the more virtuous the life that struggles to see the presence of God in a world that can seem so cruel, random, and chaotic, yet on the other hand can be filled with kindness, beauty, order, and wisdom? Allowing our heroes to be human — in fact, being thankful for their humanness — can be an important first step for those who hope to follow in their footsteps. Allowing them to be human helps us to allow ourselves to be human as well, and accept our own limitations. When we do this, we will more readily see the spark of the divine that exists not only in our heroes, but also within ourselves and within all of creation.

Charles W. Sidoti, BCC, is coordinator of spiritual care at South Pointe Hospital, Cleveland Clinic Health System in Ohio. He is the author of two books, including "Simple Contemplative Spirituality," published in 2016.

Common Qualifications and Competencies are ready to go

By David A. Lichter
Executive Director

As many of you might remember, on Nov. 7, 2004, in Portland, ME, six pastoral care organizations met, affirmed, and committed to four foundational documents:

- Common Standards for Professional Chaplaincy
- Common Standards for Pastoral Educators/Supervisors
- Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students
- Principles for Processing Ethical Complaints

A link to these documents can be found on the NACC website at www.nacc.org/certification/professional-standards-and-procedures/common-standards.

Collectively, these documents established a unified voice for the six organizations that affirmed and committed to them: Association for Clinical Pastoral Education (ACPE), Association of Professional Chaplains (APC), Canadian Association of Spiritual Care (CASC, then CAPPE/ACPEP), National Association of Catholic Chaplains (NACC), Neshama: Association of Jewish Chaplains (NAJC, then National Association of Jewish Chaplains) and American Association of Pastoral Counselors (AAPC). These cognate groups represented over 10,000 members who serve as chaplains, pastoral counselors, and clinical pastoral educators in specialized settings as varied as healthcare, counseling centers, prisons, and the military.

It has been a long and winding path, but after a decade of use, we are ready to begin putting a revised version of the chaplaincy standards into practice. Below is a summary of how we got here.

2005-2007: NACC adopts Common Standards and adds NACC-specific Standards

After NACC affirmed those Common Standards in 2005, we adopted the Qualifications of the Common Standards, including a requirement of a graduate-level degree in theology (301.3). The NACC Standards Commission went to work

immediately to add to these Common Standards to our Catholic standards. The NACC Board of Directors approved this document in July 2007 and submitted it that fall to the USCCB/CCA, which approved it in November 2007. These have served our members well.

2014: NACC reviews/revises/submits for USCCB approval Certification Standards

As you might recall, these NACC 2007 Standards were up for review and re-approval by the USCCB in 2014. For that renewal process, we needed to show how the NACC Standards aligned with the new USCCB National Certification Standards (www.usccb.org/beliefs-and-teachings/how-we-teach/catholic-education/certification/index.cfm) that were published in 2012 by the USCCB Subcommittee on the Certification of Ecclesial Ministry and Service (see www.usccb.org/beliefs-and-teachings/how-we-teach/catholic-education/certification/upload/2016-Directory-6.pdf). These new NCS were based on the four formation principles of *Co-Workers in the Vineyard of the Lord* (<http://www.usccb.org/upload/co-workers-vineyard-lay-ecclesial-ministry-2005.pdf>).

The NACC Standards Commission developed a very helpful crosswalk between those NCS and the NACC Standards, and added certain standards found in the NCS that had not been in the NACC Standards. In July 2014, the NACC Board of Directors approved these revised standards and submitted them to the SCEMS for re-approval, which we received in September 2014, effective for 2015-2021. The January-February 2015 *Vision* provides many articles on the process and content for these revisions (www.nacc.org/vision/2015-Jan-Feb). These revisions only *added to* and did not replace any of the 2004 Common Standards.

2015: Cognate partners review/revise 2004 Common Standards for Certification

In August of 2015, five of the six founding organizations that developed and adopted the 2004 documents established a Common Standards Task Force to review and revise one document, Common Standards for Professional Chaplaincy. They were ACPE, APC, CASC, NACC, NAJC. (The other founding cognate partner, AAPC, elected not to participate.) Therefore, the NACC Certification Commission decided it was best to wait on educating and implementing the new USCCB-

approved NACC-specific standards until this work of the Common Standards Task Force was completed.

2016: Cognate partners affirm revised Certification Qualifications and Competencies

That work ended in December 2015, and by July 2016, the five associations had reviewed and affirmed the recommended revisions. This revised document is now being published for implementation.

We highlight here several features of this new document:

- 1. It has a new title.** It is now called Certification for Professional Spiritual Care: Common Qualifications and Competencies (CQCs) to emphasize:
 - a. The core elements of the document: qualification required to apply and competencies needed to be evidenced, and
 - b. Spiritual care versus chaplain, as the Canadian context uses different terminology.

Also, this title distinguishes this document from the Standards of Practice.

- 2. It reaffirms qualifications.**
 - a. Endorsement of faith group: The Cognate Partners remain convinced of the essential link between spiritual care and being rooted in one's faith/spiritual tradition, whatever it may be. The spiritual care provider respects and fosters respect for every faith expression, while his or her professional role is rooted in the authority or commissioning of one's own tradition.
 - b. Academic preparation from nationally accredited schools: In the highly professional peer environment within which these spiritual care providers work, possessing a graduate-level degree from nationally accredited academic institutions remains of paramount importance.
 - c. Four units of CPE from CASC or ACPE centers: In the United States, APC, NACC, and NAJC remain committed to the requirement that spiritual care professionals receive clinical pastoral education in professional clinical settings that are recognized and accredited by the U.S. Department of Education.

- 3. It adds competencies.** It adds competencies based on the development and demands of the profession related to research literacy (ITP6), understanding organizational cultural and business principles and practices (OL3), a more expanded requirement to formulate and utilize, along with spiritual assessments, interventions, outcomes, and care plans that are all professional chaplain expectations for effective care (PPS10), greater self-examination (PIC1), and expanded group facilitation skills (PPS9).
- 4. It provides greater content consistency and clarity of language.** Several adjustments were made to the document for greater consistency and clarity, including terms used so that competencies can be utilized in diverse settings, with diverse care recipients and diverse faith groups.

2016: NACC adopts CQCs and incorporates NACC-specific competencies

The NACC Standards Commission, with the review and recommendations of the NACC Certification Commission, decided to keep the Common Qualification and Competencies letters/numbers under its 300 section (ITP, PIC, PPS, OL) format for inserting the NACC competencies for certification. This allows the cognate partners to work together to educate members, create common narrative guides, and provide CPE supervisors a common teaching guide for all our members. All the NACC-specific competencies again are found as sub-points of the CQCs.

Moving forward together

While the implementation of the NACC-specific competencies has taken longer than expected, it was important that we move forward together with our cognate partners. Also, it was affirming to find that the cognate partners included as part of the revised CQCs three of what would have been new NACC-specific competencies (demonstrate the ability to be self-reflective - PIC1, group dynamics - ITP5, and research - ITP6). The collaboration points to the benefits and strengths of our common partnership to advance the profession of chaplaincy.

We look forward to more communication with you as we implement these revised qualifications and competencies.

2017 Conference Speakers

By **Beth Lenegan**

2017 Conference Planning Task Force Chair

In April, chaplains from across the country will gather in New Mexico with the desire for renewal. Each year we are inspired, we feel connected, we learn about ourselves as ministers, and we come to understand the current needs of those we minister to. This gathering happens in the framework of prayer, hospitality, and fun.

The 2017 conference planning task force identified four underlying topics that our plenary speakers will explore: living tradition, sacred stories, God always with us, and continually transformed. And all of our four plenary speakers — Dr. Dianne Bergant, CSA, Dr. Megan McKenna, Dr. Emmanuel Lartey, and Dr. Raymond F. Reyes — will address some aspect of those topics in their own fashion.

Dr. Dianne Bergant, CSA, will begin our conference exploring the living traditions of our church that lay the foundation of our Christian faith. Stories from Scripture and of contemporary fellow travelers will be examined in order for us to see the journey God has set forth for each of us. Sr. Dianne is the Carroll Stuhmueller, CP, Distinguished Professor Emerita of Old Testament Studies at Catholic Theological Union in Chicago. She was president of the Catholic Biblical Association of America and has been an active member of the Chicago Catholic/Jewish Scholars Dialogue for the past 30 years. For more than 25 years she has been the Old Testament book reviewer of *The Bible Today*. Sr. Dianne will inspire us to revisit the stories of our past in order to carry the work and ministry of our Church into the future.

At our second plenary session, we will learn “The Art of Storytelling and Story Listening” with **Dr. Megan McKenna**. The stories of the past will be interwoven with our present stories as well as the stories of those to whom we minister. Dr. McKenna will explore how we continually develop our own story on the road we travel, while we engage in the stories of those we minister to as well as a global story. She is a native of New York City and has lived in and visited North and South America, Europe, and Asia. She works with indigenous groups, in base Christian communities, and with justice and peace groups as well as parishes, dioceses, and

religious communities. Dr. McKenna is an internationally known author, theologian, storyteller, and lecturer. She is a lover of words: the Scriptures, stories and tales, poetry, images, and phrases spoken aloud, written down, and spun to make meaning and how these both convert and transform us and bring meaning and hope to the world.

On Sunday, **Dr. Emmanuel Y. Lartey** will take us on a journey reminding us that we do not minister in isolation and that God is always with us — ahead of us and beside us. Dr. Lartey comes from Ghana, West Africa. He holds degrees in psychology and statistics from the University of Ghana and a Ph.D. from the University of Birmingham (U.K.) in pastoral theology, religion, and health. He is currently the L. Bevel Jones III Professor of Pastoral Theology, Care and Counseling at Chandler School of Theology, Emory University in Atlanta. In addition to 24 chapters in edited volumes and over 16 articles in peer-reviewed journals, Dr. Lartey has authored among others *Pastoral Theology in an Intercultural World* (2006) and *Postcolonializing God: An African Practical Theology* (2013).

Our final plenary speaker, **Dr. Raymond F. Reyes**, will share how, with the presence of God and burning hearts, we continually grow and are transformed along our own road to Emmaus. Dr. Reyes currently serves as the associate academic vice president and chief diversity officer for Gonzaga University in Spokane, WA. He has 33 years of experience in Indian education and professional development training, and has delivered workshops and seminars addressing multicultural education; emotional intelligence; diversity and organizational change; cultural competency in counseling psychology; the principles and practices of “sacred hospitality”; and team building using laughter, humor, and play.

Each of these plenary speakers will challenge the community of chaplains gathered in New Mexico to go forth and travel their own Emmaus journey, companionship others on the way until we meet again.

Beth Lenegan, BCC, is director of pastoral care at Roswell Park Cancer Institute in Buffalo, NY.

Conference offers diverse array of workshops

By Alex Chamtcheu

2017 Conference Workshops Chair

“Were not our hearts burning within us while he talked with us on the road and opened the Scriptures to us?” (Luke 24.32)

Our conference theme in 2017 is “Hearts on Fire: Our Own Emmaus Journey.” As we began selecting pre-conferences and workshops for the conference, we realized that our journey to Emmaus had already begun.

Our rich pre-conference offerings will explore the competencies for spiritual care leadership; renew our interest in research projects by exploring care conferences; explore the art of storytelling through various forms of arts; and, finally, rediscover how we can use the treasure of our Catholic social justice tradition to minister to patients, families, and our institutions.

The workshop submissions show the excitement of NACC members, non-members, and chaplains from other faith traditions to share their ministry, expertise, and creative skills with all. We have been blessed to receive many submissions, covering most aspects of our ministry and capturing the vibrancy of our profession: Prayer and spirituality; research; leadership; palliative care. Our presenters will also discuss new trends in chaplaincy and beyond hospital; workplace spirituality; creative chaplain skills; end of life issues; self-care; and much more. I am confident that with the wide range of workshops offered, everyone who attends the conference will find a way to revive their interest in a particular topic or to spark a whole new area of learning.

It has been a delight to realize that some of our upcoming workshops have been featured in local news because of their creativity and inspiration, and some are hits on YouTube because they offer creative ways enhance spiritual healing and wellness.

The conference is always an occasion of making connection, building new relationships, allowing self-discovery, widening horizons, building community, gaining new learning, and much more. Even though our Emmaus journey goes through New Mexico, our destination is really the journey, and we hope to feel our hearts burning inside. Come ready to have your heart set on fire for discipleship.

Alex Chamtcheu, BCC, is a chaplain at Wheaton Franciscan Healthcare in Milwaukee, WI.

Essays use the voice of women to seek justice for all

Elizabeth Johnson, *Abounding in Kindness*. Maryknoll, NY: Orbis, 2015. 240 pp.
\$24

By Maria Rego-Herrera

In *Abounding in Kindness*, Elizabeth Johnson writes on a variety of topics addressed to a general audience, “the people of God.” These thought-provoking essays on the Christian faith are an invitation to engage in theological reflection. The format, however, accommodates a single reader or a reader in a group. The common thread is “the compassion of God engaged with the struggles and suffering of the world.” (p. vii)

Johnson’s commitment to a life of faith, while not diminishing the value of Christian tradition, is captured by her motto “passing on the faith.” Her essays call attention to the voice of women to seek truth and justice for all. Examining and reflecting on familiar biblical texts and prayers, Johnson features feminine images and names for God. Her intent is never to exclude the masculine images and names for God, but rather, to expand to include the feminine aspect of God. Her strong words inspire and empower us to consider a more inclusive insight to the Scriptures: The word of God for the people of God.

According to Johnson, in the chapter titled “Sacred Ground at the Bedside,” the ministry of word and deed is both a profession and a vocation. This marvelous reflection captures the heart of compassion of the caregivers who tend to the dying patient with dignity. The caregiver experience reflects the powerful compassion and love of God who is already present in their encounter. Patients and their caregivers together are on holy ground: “In doing so, they embody in a beautiful and real sense the mystery of divine compassion.”(p. 154)

Johnson takes a strong stance for ecological responsibility and justice. She addresses current issues of our time: a just earth, reverence and respect for the human dignity of all persons, the struggles of the poor, and violence against women. The reader is invited to experience transformation, coupled with responsibility and a call to action not only for human beings, but for all of creation. “Our attention widens beyond humanity ... to the whole community of

life.” (p. 115) When we are transformed by our life experiences, we are no longer the same. There is a need for a deeper awareness and “ecological conversion” so that this earth can continue to exist for generations to come and be loved and enjoyed by all.

I found *Abounding in Kindness* to be an inspiration for my own personal life journey and as a chaplain, a professional caregiver. I recommend this book to all who wish to stretch their theological views and to read through the lens of a feminist perspective.

Maria Rego-Herrera, BCC, is a chaplain at Mercy Medical Center in Chicago, IL.