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Spiritual Care in the Emergency Department

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What traits make a good emergency chaplain?

By David Lichter
Executive Director

I am sure most of us have grown up on emergency room television shows. Probably most of us have spent time in emergency rooms and can readily recall the emotions that were part of that experience. Emergency departments have a certain feel about them.

Our NACC members and other chaplains who work in emergency departments not only have myriad stories to tell, they most likely also have certain personal and professional traits to work well in those settings.

I tried to research if anyone has identified those traits of chaplaincy, but I did not find any such study or article. Perhaps, after you have read the contributions to this *Vision* issue, we could create such a portrait!

However, several sites describe traits of nurses in EDs. Could we take a minute here to share some traits of an ED nurse and reflect on whether they are an appropriate way to describe a spiritual care provider as well? Perhaps the ministry of spiritual care in this environment might require other, or even opposite traits.

Let's take the five personality traits of ED nurses offered on this site: www.bestmasterofscienceinnursing.com/5-personality-traits-of-emergency-room-nurses. The first is "can accelerate the pace as needed." Both nurses and physicians have to think, process, diagnose, and decide quickly about individuals' health circumstances. But would it be fair to suggest that the chaplain might require the opposite trait? As the treatment process is moving rapidly, is it also the disposition of the chaplain to be providing a "slowing down" quality of presence? In the sports world, some athletes describe getting to the point where the "game slows down" even though the pace of the game does not, because one understands the inner logic of the game, and senses the human flow underlying the seemingly frenetic activity.

The second trait, "remain calm in the midst of chaos," seems like a shared trait with chaplains. The author describes this as being "cool-headed" and "collected"

to help the patient calm down. That sounds like the chaplain's quality of "centered" presence, being attentive to one's own inner peace, as well as sensing the spiritual and emotional distress in the room along with the sources of life and strength.

The third trait, ability to multitask, seems evident. We have all witnessed and admired the nurses' and physicians' abilities to balance the needs of several patients and families, often moving quickly from one to another. The gift of a spiritual care professional, too, is to exhibit and communicate attentiveness to each patient and family in way that they know they are the only ones who matter at that moment. Of course, nurses and physicians can do this, too, but this is a particularly important trait of the chaplain, the singular and sacred attentiveness to this patient in this moment.

I liked the next set of traits, which were identified through a 2014 survey at the University of Sydney — being "agreeable, extroverted, and open." These include being honest and direct, friendly and sociable, unbiased and objective, socially confident and adaptable. That does not seem like too much to ask, does it? I suspect each of us can identify an ED nurse or physician who fits this portrait. But we do all recognize that so many of us chaplains are introverts, not extroverts! Hopefully, we also are "honest and direct, friendly and sociable, unbiased and objective, socially confident and adaptable." However, how does our more common quiet side benefit the patient and family in these settings that can be loud and noise-filled?

The final trait noted in this link is "good coping skills." The author notes that nurses "cannot be emotional or linger over patient deaths ... cannot allow the death to have an impact on the care of other patients." I suspect this is a shared trait with chaplains. Then I wonder whether this "coping" has a type of contemplative quality as chaplains allow the experience of deaths, anguish, and anger to find a place within themselves, and allow a certain reception of that tragedy in their hearts in a way that binds them to that person's suffering and loss. This is not a psychological "lingering" as mentioned above, but a holy holding of the person's misery, not unlike the Mary of the *Pieta*.

So, what do you think? What would be the traits of an ED chaplain? What does one need to do this ministry? Your thoughts are welcome!

Conflict mediation is part of chaplain's job in ED

By Jayne Nachtrab

I was paged to the ED for a tragic situation: A 2-year-old girl had been shot in the head and had died. Unexpected death in an ED can raise all sorts of intense feelings in those who are personally involved and in the medical staff there to provide care. This situation was everyone's worst nightmare and presented some unique opportunities for me as a chaplain to do conflict mediation and crisis management.

My first step was protecting the father of the girl who died. Many family members and friends had gathered in the ED, and some were looking for someone to blame. The father became the target for the anger and outrage everyone was feeling.

At the time, we did not have all the details. We later learned that the girl's 6-year-old brother had accidentally fired the shot, but at the time, the father was saying that the girl must have done it herself. Upon hearing of the death of his girl, the father curled up in a ball in the corner, rocking and crying. This was when a family member exploded in anger; she wanted to blame someone, and the father was right there. The father never even acknowledged what was happening. The physical pain she was inflicting was nothing compared to the emotional pain he was experiencing.

I stepped forward and told the security officers that we were going to move the father away from the family. I took both parents into a private room, which I arranged with the nursing manager. A police officer was stationed outside the door. I then asked the parents which family members they wanted to see, and worked with the police to limit visitation to one person at a time.

The family calmed down once the parents were removed. Relatives kept gathering in the ED and were appropriate in their emotional response. They also were mutually supportive of each other and really were in shock. Before the parents left, the family encircled them and prayed over them.

Meanwhile, I learned that the trauma room where the little girl had been treated had become a crime scene. I alerted the staff, and we secured the room. I recognized my own limitations in supporting everyone involved in this situation: a grieving family, a grieving staff, and two police departments, due to jurisdictional issues. I called my manager and we arranged for extra spiritual support. The staff did a marvelous job;

they were compassionate and very professional. As the nurses began charting the medical crisis and death, it became a time for some to confront their own feelings. I made sure there was support staff in place to be a listening presence when this happened.

The biggest need of the girl's parents was to see their deceased daughter. They repeatedly asked permission to do so. Because of the ongoing criminal investigation into this girl's death, the parents would not be allowed to hold or touch their daughter — another loss for them to endure. The parents were in unconscionable and inconsolable grief. I felt it was extremely important to help them have some time with their daughter before she left the hospital. I talked to medical staff and the police about whether the parents could see their daughter, without touching her, and, to my relief, they were open to the possibility. Once I knew that, we all worked hard to come up with a plan. The girl's body was moved into another room in the ED that had a glass door from floor to ceiling. Police officers were placed throughout the hallway and near this room. I then escorted the parents up to this glass door and wept with them as they spoke to their daughter of their love, sadness, and regret.

The mother was in shock and didn't speak, except to sob and ask for her daughter. The father's strength showed through his tears, grief, and heartache. The only time I saw him lean on his wife was when we were walking down the hallway to view the girl, hand in hand. I remember thinking at the time, "I wonder if this is what it feels like to walk to an electric chair." The hallway was lined with police officers, and the tension and pain were palpable.

This is an event that will stay with me forever — things that touch us deeply always do. I believe that those who were present that day felt the presence of God in unexpected ways: the peacefulness of the girl's death as she was receiving loving care from the medical staff; the attending doctor's compassionate arms as he held the parents as they expressed their pain; the flexibility and understanding of the police officers who allowed the parents to see their daughter.

Before the father was escorted out of the hospital by the police, he asked permission to personally thank me for my presence and support. As he hugged me, I was very grateful that God used me to bring his light, peace, and presence into a terrible situation.

Jayne Nachtrab is a chaplain at Mercy St. Charles Hospital in Oregon, OH.

Chaplain on Code Blue team faces unique challenges

By Anne Millington

My day at the hospital is mapped out, and I have patients to see, a meeting to attend. Suddenly, my pager goes off: "Code Blue Team. ED." A patient is in cardiopulmonary arrest and requires immediate resuscitative efforts.

As the chaplain member of the Code Blue team, I immediately re-route myself to the Emergency Department, my day's priorities now shifted to providing spiritual support to the patient and possibly family in crisis. While Code Blues can occur anywhere in the hospital, the majority I have responded to have been in the ED, where often little is known about the newly arrived patient. They are true crisis situations, and, in my experience, the patient usually does not survive. While the medical team strives to resuscitate the patient, I focus on supporting any gathered family and friends, responding to their varying spiritual needs during a difficult and often surreal time.

During ED Code Blues, meeting people where they are generally involves meeting people who are in shock, mentally reeling, attempting to gain some sort of footing. I recall a Code Blue involving a former Marine, accompanied by a good friend who was also a former Marine. When I introduced myself, the friend said, "Is he dead? Is he dead? I do not want another Marine to die alone." When I responded, "I know the medical team is still working on him," he jumped up and began pacing, pausing occasionally to take deep breaths, beads of sweat on his brow. Clearly, this was not the time for any kind of in-depth conversation or meaning-making efforts, and I assessed that any spiritual support must begin with checking the patient's status. Unfortunately, the patient did not survive. After sitting for some time with his now-bereaved friend, I said, simply, "I'm so sorry for your loss." As silence enveloped us, I remembered his desire to be there at the end for another Marine, and so I added, "You were here today for your friend. You've done him a good service. One Marine to another."

I also try to help people in crisis stay focused on the present moment, not on the regrettable past or the terrifying future. Once I offered spiritual support to a woman whose husband had unexpectedly fallen down some stairs. Although the ED medical team had restored the husband's pulse, and his vital signs were

promising, his wife kept repeating, “Now he’s going to be brain dead ... now he’s going to be brain dead ... all the things we had planned, all the things we wanted to do together. And now he’s going to be brain dead.” Initially, I responded, “I can imagine how worried you must feel, how scared you must feel.” But at the same time I could see that she was torturing herself prematurely. After a bit of time, I gently said, “I know you are afraid your husband is brain dead, but no one has said that yet. There are still some unknowns and I know how scary this may be, and I know how much our human minds can jump to scary conclusions. For now, though, as far as we know, the worst has not happened, and maybe it won’t.” As it turned out, her husband did survive and proceeded to make a highly successful recovery, brain and all.

When patients do not survive, families and friends generally have strong feelings about whether or not to view their loved one’s body. Once a woman was found drowning and was brought in by her husband. She was pronounced dead very quickly, and her husband sobbed, “How could this have happened? How could this have happened?” As other family members arrived, new waves of grief washed over them all. After some time had passed, I quietly asked the husband, “Do you feel that you or any of your family here would like to view your wife?” His response was clear and resounding, “No. No. I don’t want anyone of us to remember her this way. She was a beautiful woman. Now ... she doesn’t look like herself at all.” I scanned the family’s faces, noticing only looks of agreement, of relief. “That’s fine,” I said. “If any of you decide you would like to see her, just let me know.” I spent some time praying with the family and, as they departed, the patient’s husband asked if I would go and pray over her body, which I did.

Other families, however, require permission and even encouragement to leave the deceased’s bedside. One patient was the matriarch of a large family, and their grief was intense. Her son and family spokesperson told me, “I want each family member to have a chance to pay his or her personal respects.” But as some family members were coming from distant places, it took almost two hours to gather the full group of 25 or 30, and staff was beginning to get concerned. The son told me they were planning a big funeral, so I replied, “I think it’s important to know that this is only goodbye for now. They will have another chance to pay their respects at the service you are planning.” He nodded, and yet everyone just seemed to linger. So I approached him again, and said, “We are going to need to care for her body soon, so shall we say a final prayer and then you all can leave her with us for

now?” Fortunately, he understood, and after a final prayer, the family was able to say goodbye-for-now and depart.

After a Code Blue, I look to focus immediately on the spiritual needs of the ED staff. They, too, have experienced the crisis, and yet they usually have to “keep calm and carry on” to meet the needs of other patients. I remember complimenting a nurse after a Code Blue about how she handled the patient’s family. She immediately teared up and said, “I just felt so bad for the patient. I heard he just lost his wife, and he had a tattoo that said ‘I love you forever.’ I bet he had had that done in honor of her when she was alive. I felt so sorry for him.” While this nurse had already moved on to the next patient, her feelings were still fresh and raw, and I was glad she was able to voice them.

To meet people in crisis where they are, I must be where I need to be, physically, emotionally, and certainly spiritually. To this end, I have sought to establish and maintain disciplines of prayer, spiritual direction, self-care, self-reflection, supervision, peer support and more. Jesus said, “The wind blows wherever it pleases. You hear its sound, but you cannot tell where it comes from or where it is going. So it is with everyone born of the Spirit.” (John 3:8) I seek both to hear and honor the wind of the Holy Spirit within the crisis, and I seek then to guide others into whatever relief, wisdom, and solace the Spirit may be offering. It is my prayer that the Holy Spirit, in partnership with my efforts and disciplines, will enable my service as a chaplain to be truly a ministry of presence — presence to the Spirit, presence to others, presence to myself.

Anne Millington is a chaplain at Beth Israel Deaconess Hospital in Milton, MA.

When a child dies: Transforming the sterile into sacred

By Lisa Hermann

The page from the Children's Emergency Department said, "Lisa, we need you down here. There is a patient in cardiac arrest coming in." As I entered the room I noticed a man in street clothes who seemed distraught. I cautiously assumed him to be the patient's father, but approached slowly to offer support. I placed my hand gently on his shoulder, and he turned with tears in his eyes and swallowed me in his embrace. It took me by surprise, but I held him, and he held me. When I got a good look at him, I realized it was Joe (not his real name), one of the RNs in our Adult Emergency Department across the hall. The patient lying lifeless on the table was Joe's infant son, whom he brought to the ED from home because he knew something wasn't right. "I intervene, daily, on behalf of hundreds of others, but today I couldn't save my own son." That was all Joe could say. His son died that afternoon in the ED.

The chaplain's role in the ED when a child dies, among other circumstances, is to transform a place that is sterile, frightening, and without feeling into a sacred and safe place for family and others gathered to receive unbearable news, share feelings, and begin grieving. Our role is to hold space and the others' stories, honoring the family's grief until they can begin holding it and carrying it for themselves. I believe there are four concrete ways to make this happen.

First, **don't just DO something, BE there**. Practice a ministry of presence by meeting the family where they are. I introduce myself, then use silence as a tool. Just being there as a less anxious presence says so much when many people have no idea what to say or do next. Many times they are not sure what you can do for them, but do not want you to leave. Instead of inserting myself into their painful situation, I let the family invite me into their space and experience. Even if their pastor or spiritual leader is there, I stay. The pastor knows the family, but I know the clinical environment, and collaboratively we can better guide the family in these beginning stages.

Second, **many feelings will be expressed — and suppressed**. Grief is as unique to the individual as a fingerprint. In an emergency department you never know what is going come through those doors, so rather than attempt to prepare for it all,

we work out of some basic understandings. That allows us to be present with the family of the deceased and to normalize their shock and disbelief, yet not discount their experience. We are able to say, “No, you are not abnormal, your child has just died, and your world has been ripped apart.” As chaplains we normalize the lamentation — lamentation as both sadness and a love song, honoring what was lost.

We acknowledge the search for meaning, the big question of “WHY!?” It is spoken by the bereaved as a question, but it is one that no one, including the chaplain, should attempt to answer. Many times the search for meaning that sounds like a question is actually a protest, a protest toward God and the natural order as they know it. This is not how life is supposed to be. No parent should ever have to bury a child. A family walked into the ED with a child, now they leave, arms empty. The family now reasons in terms not of milestones, but of never again, like Nicholas Wolterstorff in his book *Lament for a Son*. He writes, after his son’s death, that it is “the neverness that is so painful. Never again to be here with us — never to sit with us at the table. ... All the rest of our lives we must live without him. Only our death can stop the pain of his death.”

The chaplain’s role is to normalize family members’ varied feelings, make room for them to ask why and to protest. The chaplain needs to hear and acknowledge the pain, the anger, and the uncertainty in that protest, but again not to diminish the family’s painful experience. I have found that having all the right questions — and none of the answers — helps me to sit with a bereaved family and normalize their feelings. As people talk, they begin to process and express their feelings. Through this processing they generally find answers to their own questions.

Third, **work with nursing staff** so that the parents hold their child, if they want to. Invite them to participate in some of the last things like washing and preparing the deceased for movement, and memory-making that some facilities do with hand molds and footprints. One emergency department I worked in had a rocking chair as standard equipment. On many occasions those rocking chairs and stretchers became a shared mourning bench for children, where families searched for and found words to voice their grief and honor life. The idea of a mourning bench, which comes from Nicholas Wolterstorff’s book, I find profound and sacred. I envision it as a place we sit together in our grief, no matter what that mourning bench looks like.

Fourth, **use interdisciplinary resources**. Most of the deaths that I responded to in our Children's ED were both unexpected and lengthy, in terms of taking care of the family and visitors. I relied on the social worker, the RN, the physician, and the child life specialist to help this family navigate one of the most horrible events of their lives. No one was more important than the other. Often our roles of being present, offering reassurance, and allowing the family to be present with their child was a shared effort, and in the aftermath we could help one another.

On the wall at the seminary I attended in Louisville, KY, a bronze plaque bears the words of one of the former professors, Dr. George D. Carter: "It is not enough to say, 'Ain't it awful.' We have to get close enough to get hurt." Practicing a ministry of presence with a grieving family is to take a risk. The sterile becomes sacred when the chaplain goes where it hurts, risks the embrace, and reminds others that the Holy is already present and suffering. A chaplain's job is to be with the family, journey alongside them, carrying their story, as they take those first few steps out into a new normal.

Rev. Lisa Hermann, BCC, is a chaplain at Providence Health in Columbia, SC.

Caring for ED staff takes time and trust

By Elizabeth Schultz, John W. Ehman and Ray Lewis Jr.

It is remarkable to watch Trauma/Emergency staff respond to crises. Their calm confidence can seem like a medical variation on the pastoral theme of non-anxious presence. One patient is bleeding, another is in pain for unclear reasons, a third is angry and abusive while being treated. But physicians, nurses, and other staff just move through their jobs with great professionalism. It's easy for chaplains to overlook how much stress is buffeting providers and how much effort it takes to handle that. Chaplains are generally in a physical position to support staff, but it usually takes some intentional, relational positioning on our part to be most effective.

Every time a trauma team assembles at the Level 1 and Level 2 facilities within Penn Medicine, a chaplain is there. Over 2,600 trauma patients a year are brought to the Penn Presbyterian Medical Center in Philadelphia, and over 2,200 to Lancaster General Hospital in Lancaster, PA. Tens of thousands more are treated annually in the two emergency departments, where chaplains are involved as well. That's enough activity around patients and families to keep any chaplain busy, but our position allows us a special opportunity also to support the staff alongside us.

Consistency in pastoral care is extremely significant. Many emergency department staff often guard their own hearts, because of what their work shows them: the trauma and wrong that has been done to their patients. For this reason, chaplains must work intentionally on building relationships with staff. Watching chaplains care for patients and families on a consistent basis, day to day, helps to build trust in their eyes. Staff will watch as we listen to, care about, and connect with people. Then, slowly, those staffers give us the chance to care for them, and they begin to feel comfortable building relationships with us.

Four interrelated pathways can help support staff:

First, acknowledge their effort. Let them know that they are seen and appreciated. A quick and well-timed comment can send a message that celebrates the dedication of the provider and stands against any sense of being taken for granted. It is not the place of the chaplain to “validate” the provider, but we can help bring appreciation of the staff to voice.

Second, affirm their spirit. See beyond what they do to the very heart of why they do it, and lift up their motivation in treating such challenging patients and families. The sheer pressures of the healthcare environment can distance providers from the spark inside that first brought them into a caring profession. By affirming indications of the spirit that underlie caring actions — perhaps purely something like bedside manner — chaplains honor how care is much more than a medical service; it is an expression of truest self.

Third, hear them when they wish to process their experiences. This might occasionally happen in a private space during a break, but typically it will take place in brief moments between treatment and documentation. Yet active listening works even in short exchanges. If staff members know that they can be heard deeply without having to say much, they will probably feel less apprehensive in sharing vulnerabilities. Little experiences of feeling heard on the fly can lay the groundwork for more substantial interactions at planned times.

Fourth, hallow their work. Connect the staff's caring explicitly with what can be understood as sacred. Actions can range from an informal "Bless you" to a formal reflection or prayer. Inviting staff to be present for a prayer at a patient's bedside is one way, especially at a traumatic death. Communal occasions might take place through the year, like unit blessings or pastoral letters or staff memorial services. A growing number of hospitals seem to be conducting a Blessing of the Hands ritual once a year. Emergency administrators can be good partners in brainstorming about how to show reverence for the work life in their areas.

At Penn Presbyterian, one meaningful event every year is a service of remembrance for trauma patients who died from violence. With families in attendance, staff members read initials of the deceased (for confidentiality) while lighting memorial candles. This is often a profound — and for many a spiritual — event that some have linked to their sense of calling. Another supportive initiative is staff debriefing programs. A chaplain regularly leads a discussion in a Rounds series on the personal and interpersonal dynamics of being a caregiver. Out of that has grown a plan for debriefings after resuscitations, so staff may reflect on the emotional and spiritual significance of the events.

At Lancaster General Hospital we have adopted a post-code pause in the Emergency Department. When a death occurs after a code blue, a chaplain invites all responders to stay for a moment before they disperse. She or he reads a script that calls to mind the humanity of the patient and recognizes the heroic efforts of the team. Attendees are invited into 10 to 15 seconds of silence to use

in any way they feel comfortable. Then the chaplain checks in to see how individuals are doing, providing a chance to “read” the room, address acute distress, and notify management if further interventions may be warranted, such as a debriefing.

We also emphasize building and strengthening relationships between all emergency staff and the chaplains. Many times a nurse, aide, or unit secretary has said to a chaplain, “Thank God it’s you” or “I’m so glad you’re here.” When we ask why, they say, “I know you will do your job well and I can do mine with less stress,” or “I don’t have to worry about this grieving family because I know you will take good care of them.”

But how do we build this trust with CPE students rotating through the ER? First, we utilize our emergency staff chaplain as a bridge of trust with the ER staff. Change is difficult, and in a stressful environment where teamwork is so important, changes in the team can produce anxiety. But the staff chaplain helps the ER staff adapt to change. In addition, a trauma nurse who sits on our CPE advisory committee also helps orient new students to the department.

Lastly, we may ourselves model constructive coping. We are willing to talk about this, to name stressors and their effects, and to champion self-care. We are often in awe of the staff around us who seem to take anything in stride, but we should remind ourselves that sometimes they are looking with need at us and are open to us. Remaining aware of just that can be foundational to our interactions and interventions.

Elizabeth Schultz, BCC, John W. Ehman, BCC, and Ray Lewis Jr., BCC, are staff chaplains with Penn Medicine.

Spiritual care helps save ED staff from burnout

By Rabbi Nadia Siritsky

In *Conjectures of a Guilty Bystander*, Thomas Merton wrote, “There is a pervasive form of contemporary violence to which the idealist most easily succumbs: activism and overwork. The rush and pressure of modern life are a form, perhaps the most common form, of its innate violence. To allow oneself to be carried away by a multitude of conflicting concerns, to surrender to too many demands, to commit oneself to too many projects, to want to help everyone in everything, is to succumb to the violence of our times. The frenzy of our activism neutralizes our work for peace. It destroys our own inner capacity for peace. It destroys the fruitfulness of our own work, because it kills the root of inner wisdom which makes work fruitful.”

These wise words present a challenge for those of us working in healthcare, especially in the emergency department. The very definition of working in such a setting is to want to help everyone, and to be thrust in the midst of an array of conflicting concerns, all of which are urgent, and many of which are the direct result of the violence of our times.

Compassion fatigue and vicarious trauma are often the consequence of working in healthcare, but they can be particularly challenging for those working in the Emergency Department. The pace and the acuity contribute to this, as does the sad reality that most emergency responders only see the patient at their worst, and rarely get to see them healed and recovered. This contributes to a lack of compassion satisfaction, which Beth Hudnall Stamm identifies in her research as a mitigating factor (see https://nbpsa.org/images/PRP/ProQOL_Concise_2ndEd_12-2010.pdf).

Burnout, while common for healthcare providers, can lead to a variety of other concerns, ranging from staff retention issues and patient experience challenges, to safety concerns due to forgetfulness and even health problems. As such, addressing staff compassion fatigue and burnout is critical.

The pastoral challenge is to enter the emergency department and not succumb to the chaos and violence that pervades that space, to be present with providers and to help them to reconnect to Merton’s “root of inner wisdom which makes work

fruitful.” Carving out space for caregivers to debrief and reflect upon meaning and purpose is the primary goal. Meaning-making is the key to developing the capacity to find compassion satisfaction.

Dr. Viktor Frankl taught, “Life is never made unbearable by circumstances, but only by lack of meaning and purpose.” While it may seem difficult to schedule or prioritize, pastoral care and support for staff working in emergency departments must be a top priority. Helping staff carve out time to reflect upon the meaning and purpose of their work will help them to derive greater satisfaction, which in turn will ensure improved patient care.

Leviticus enjoins us to love our neighbor as we love ourselves. This means that it is not selfish to schedule time for rest and reflection on the emergency department’s to-do list. Even if it is simply taking a moment to pause and breathe at the beginning and the end of a shift; or ensuring that the chaplain’s rounds include emergency department staff, not only patients; or taking a moment to pause in silence when a patient dies — each of those moments can become anchoring moments that can root caregivers during stormy times.

Rabbi Nadia Siritsky, MSSW, BCC, is vice president of mission at Jewish Hospital in Louisville, KY.

The holy movement: Ministering to families in the ED

By Nicholas Perkins

I believe that ministering to families in an emergency department is a holy movement. Interdisciplinary care team members offer compassion based on communication and collaboration. The information that chaplains share with nurses and physicians can focus on the number of family members present, how they are related to the patient, and their location as they wait for information. I understand how the tone of my voice, body posture, and whether I sit or stand can affect a grieving family.

Serving individuals in the aftermath of tragedy requires that I respect the effects of shock in the same way I would put a warm blanket around a cold person. I cannot underestimate the effect of small gestures to a family in the emergency room, such as hot tea for a worried parent or coloring books for a tired child. A simple act can foster emotional availability and accessibility.

The initial interaction with a family sets in motion a theology of care that respects the physical, emotional, and spiritual boundaries of others. Due to the ever-changing rhythm in emergency departments, a chaplain needs specific skills such as a non-anxious presence, suspending judgment, and refraining from generalizations.

I can unintentionally influence encounters based on how the case may intersect with my history. When I ministered to the family of an abused child, I was aware of how my own adverse childhood experiences affected the situation when the patient shared that his father mistreated him. As challenging as it is, ministering to families in an emergency department invites me to be aware of how my history can affect specific encounters.

One model for ministry in this arena is based on Jesus and the two disciples on the road to Emmaus. Jesus, in the narrative, neither walks ahead of the disciples nor behind them. The pastoral care in that act bears fruit when I simply journey with a distraught person. I could communicate that I am leading if I walk in front, but walking behind could convey that I am pushing. Therefore, I walk beside the person or family to express that I am journeying with them.

I try to create an environment of engagement for families despite the myriad circumstances that bring them to an emergency department. I meet them when

they enter, and I inform nurses and physicians of their arrival, since they usually want medical information about their loved ones. I understand how emergency departments can be chaotic, where information is delivered quickly and in medical jargon, and stress among families is amplified due to the intense pace that limits control and predictability. The rapport that I hope to build with a family begins when I take the time to explain in a general way why I may have to leave and that I will return soon.

Families appreciate it when I share this because it offers them something stable in an unstable time. There is a unique rhythm to serving families in emergency departments, in large part because chaplains may be the only ones who have the time to be with them during critical moments. It is important to distinguish between care that respects boundaries and that which crosses them during emotionally charged crises in these settings.

I remember the afternoon that a member of a Muslim family died in the emergency department. The patient's brother shared the details of Islamic burial customs and rituals. One aspect of the ritual involved not touching the deceased upon the removal of the endotracheal tube and IV lines, while another concerned the ablution of the body by a family member. The room in which the patient died was messy due to the resuscitation efforts.

I understood that purity was important to this ritual, despite our different cultures and religions. Although the brother and I had a difficulty communicating, his gestures indicated that he would perform the washing when he returned with his mother. He let me know through the gentle motion of his hands that we could understand one another, even in the distress of the moment and our mutual challenges with communication. When he left, the staff and I swept the floor, removed the trash, wiped counters, adjusted the lighting, secured the curtain, and reverently placed a white sheet over the deceased. We did everything we could to respect the family and their faith rituals.

The brother was very appreciative when I escorted him and his mother into the room. Our efforts let him know that we valued him and recognized his dignity. We upheld the rituals of another religion and modeled how actions instead of words can augment the holy movement that involves ministering to families in emergency departments.

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Research Update: Spiritual Care in Emergency Medicine

By Austine Duru and Marilyn Williams

An urgent trip to the emergency room is often a stressful experience. Besides the obvious stressors — fear of the unknown, pain and frustration, long wait times, and complicated medical procedures — such trips often unleash underlying emotional and spiritual distress. In what might seem like a chaotic environment, the professional chaplain is often a calming presence for patients, families, and the healthcare team. In this article, we explore some of the literature that speaks to the unique roles of professional healthcare chaplains, spirituality, and pastoral care in emergency medicine and trauma care.

In their article “Utilization of Pastoral Care Services for a Screening, Brief Intervention, and Referral-to-Treatment Program at an Urban Level I Trauma Center,”⁽¹⁾ published in the *Journal of Emergency Nursing*, Tiffany L. Overton and her colleagues write about collaborating with chaplains to help alcohol-dependent patients at JPS Health Networks, Fort Worth, TX. Screening, brief intervention, and referral to treatment (SBIRT) programs have been shown to reduce alcohol-related injuries and have been mandated for use at all designated trauma centers since 2008. This was a unique opportunity to partner with chaplains in a research trial program that used the “CAGE (cut back, annoyed, guilt, and eye-opener) questionnaire and the Alcohol Use Disorders Identification Test (AUDIT)” [page 560]. The authors found two benefits: “First, our chaplains are able to take advantage of a teachable moment by helping patients make connections between drinking and their injuries, if such connections exist. Second, pastoral care providers have the ability to talk about the emotional dynamic behind the drinking (stress, guilt, and so on). Patients inherently trust chaplains, and chaplains are trained to listen and guide our patients” [page 562]. This pilot has several implications for chaplaincy, such as chaplains collaborating as research investigators, primary and advanced chaplaincy skills, reimbursement of chaplaincy services, and chaplaincy training and staffing.

In a recent pilot study, KentuckyOne Jewish Hospital launched an innovative chaplain intervention program that integrated skilled chaplains into the ED. Rabbi Nadia Siritsky, BCC, a social researcher by background and the vice president of Mission for KentuckyOne Jewish Hospital, shared this pilot project at the NACC

National Conference in April, 2017, during a workshop titled “Metrics for Spiritual Care: A KentuckyOne Health Intervention.”⁽²⁾ Current findings suggest that this program has shown significant ways pastoral care can reduce compassion fatigue and burnout while improving patient experience in the emergency department. This study is yet to be published but has implications for spiritual care in emergency medicine, chaplain education, and interdisciplinary collaborations.

In “Rural Emergency Nurses’ Suggestions for Improving End-of-Life Care,”⁽³⁾ Renea L. Beckstrand, Kelly E. Smith, Karlen E. Luthy, and Janelle E. Macintosh seek to “identify suggestions that emergency nurses have to improve EOL care, specifically in rural emergency departments” [page 214]. A 57-item questionnaire was sent to 53 rural hospitals in four western states, including Alaska. The results yielded four major themes: “providing greater privacy during EOL care for patients and family members, increasing availability of support services, additional staffing, and improved staff and community education” [pages 216-217]. The chaplain or clergy was identified as an important support service and a key partner in the care of the dying patient and their families. This study also raises questions about the well-being of the rural emergency caregivers, quality EOL care, and using volunteer services to meet some of these needs in rural settings.

Another study published in 2015 in the *Journal of Emergency Nursing*⁽⁴⁾ looks at the perceptions of emergency nurses in providing EOL care in the emergency department. This study by Lisa A. Wolf and her associates uses survey data (N=1879) and focus group data (N=17). The quantitative survey shows consistently positive attitudes toward caring for dying patients and their loved ones. An analysis of the transcripts from the focus group, however, reflects concerns and challenges to providing EOL care in the ED. Although overall, emergency nurses were comfortable in providing EOL care, the lack of space, time, and staff made it challenging. This study did not address the availability or role of chaplains in providing EOL care.

Another study looks at the presence of families during resuscitation and/or invasive procedures. This study, by Christine R. Duran⁽⁵⁾, surveyed nurses, respiratory therapists, and physicians. Overall, clinicians had positive attitudes toward family presence. However, they did have concerns about safety, the emotional responses of families, and performance anxiety. Nurses had more

favorable attitudes than physicians. Also, patients and families had positive attitudes. This study did not address whether a chaplain was present to provide care to the family during resuscitation or the invasive procedure. In addition, it would be of value to survey chaplains regarding their attitudes about family presence as well as the attitudes of patients and families regarding chaplain availability.

In a pioneering survey of emergency department staff published in 1998, Ann Gill Taylor, and her colleagues set out to investigate the ED staff members' personal use of complementary therapies and their recommendations to ED patients.⁽⁶⁾ The investigators from the Center for the Study of Complementary and Alternative Therapies at the University of Virginia School of Nursing surveyed 10 emergency department staffs across the southeast. The results suggest that the three most frequently used complementary therapies for personal well-being were back rub or massage, music, and prayer or spiritual practices. Also, "back rub or massage and spiritual practices including prayer and group support were most frequently recommended to patients" [pages 496-497]. Since its publication, this study has become a foundational resource for subsequent studies focusing on alternative and complimentary therapies and the growing popularity of such services across the nation. The implications of this survey for chaplaincy and spiritual care services are obvious, especially in emergency medicine and trauma care.

In trauma situations, often the perception of care can affect the post-trauma experience of the patient or family members. Steven C. McCormick and Alice A. Hildebrand set out to investigate this in a study conducted at Maine Medical Center in Portland, ME, titled "A Qualitative Study of Patient and Family Perceptions of Chaplain Presence During Post-Trauma Care,"⁽⁷⁾ published in Volume 21 of the *Journal of Health Care Chaplaincy*. The analysis of 25 interviews draws out three key themes: "the attributes valued in the chaplain's presence, the elements necessary to form relationship with the chaplain, and the role of the chaplain in helping patients to discover and express meaning in their experiences" [page 65]. The authors conclude, "An understanding of the proposed assessment model can guide chaplain interventions and benefit all members of the clinical care team" [page 60]. The findings and assessment models are both relevant and can serve chaplains working in emergency medicine and other healthcare

settings. The study also has broader implications for pastoral visitation and evidence-based chaplaincy care. A link to the full article can be found here.⁽⁸⁾

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Associate certification begins in 2018

The NACC Certification Commission and the NACC Board of Directors are pleased to announce a new certification level: Associate Certified Chaplain.

Adding the Associate Certified Chaplain level will offer NACC certification to those who are already providing strong spiritual care in their organizations, dioceses, and communities and who need to meet certification protocols. In this way, NACC continues to advocate for its members and for the overall profession of spiritual care. It also aligns NACC with other chaplaincy strategic partners offering a similar certification opportunity, and provides a growth point for those working toward eventual full board certification.

The Certification Commission created NACC-Specific Qualifications and Competencies for Associate Certified Chaplains. This protects the Common Qualifications and Competencies, which were approved jointly by the five spiritual care Strategic Partners.

The *NACC-Specific Qualifications and Competencies for certification of Associate Certified Chaplains* follow the CQCs with the following exceptions:

- **A minimum of 32 hours of graduate-level study is required** rather than a graduate degree.
- **A minimum of two units of CPE are required** rather than four units of CPE.
- **A minimum of 1,000 ministry hours post-CPE is required.**
- Competencies to be met include ***all NACC-Specific competencies and all competencies in the Professional Identity and Conduct and Professional Practice Skills sections.***
- The Spiritual Care Encounter has substituted ***competency OL 4.1*** for ITP2, as Associate Certified Chaplain Applicants are not required to cover ITP2.

Conversations about the new program focused on the persons who might benefit from this level:

- Diaconate and lay ministry formation programs vary widely, so we needed a set number of hours of graduate-level study for persons in

such programs (many of whom are already functioning in chaplaincy positions).

- We wanted to retain CPE, yet recognized the challenges of completing four units, due to hardships or accessibility to CPE.
- We felt that a requirement of work hours would give seasoning to the persons seeking this level.
- We focused on the Professional Identity and Conduct (PIC) and Professional Pastoral Skills (PPS) sections in the competencies as these are among the competencies most cited by interview teams as NOT met by applicants.
- The competencies mentioned in NACC-Specific Competency OL4.1 cover and exceed what is noted in ITP2.

The NACC-Specific Qualifications and Competencies for renewal of certification of Associate Certified Chaplains follow the CQCs with the exception of ***completion of 30 hours of educational activities per year*** for the five-year renewal period, rather than the 50 hours required of the BCC. The hours would be focused on the competencies required for Associate Certified Chaplain certification in place at the time of renewal.

PREREQUISITES FOR CERTIFICATION AS AN ASSOCIATE CHAPLAIN:

- Be Roman Catholic or a member of one of the churches in union with Rome.
- Have completed at least 32 graduate-level hours of theological studies from an accredited academic institution or pastoral formation or ministry program.
- Have completed an undergraduate degree from a college, university, or theological school accredited by a member of the Council for Higher Education Accreditation (www.chea.org).
- Have completed a minimum of two units of Clinical Pastoral Education (Level I or II) accredited by the Association for Clinical Pastoral Education (ACPE), the United States Conference of Catholic Bishops/Commission on Certification and Accreditation (USCCB/CCA), or the Canadian Association for Spiritual Care (CASC/ACSS).
- Have completed a minimum of 1,000 ministry hours post-CPE experience. The 1,000 hours may be employment or volunteer ministry hours.

- Be a full member of the National Association of Catholic Chaplains. In order to receive a certification application, you must have completed a full membership application and be current on your payment of annual fees.

QUALIFICATIONS:

All of the above, and:

- A current letter of ecclesiastical endorsement requested by the NACC National Office.
- Adherence to the NACC Code of Ethics and knowledge of the requirements of that Code (Code of Ethics 100).
- Current completion of the NACC Ethics Accountability Statement (Code of Ethics 206.11.1).
- Application for Associate Chaplain Certification.

SUBMITTED MATERIALS

- Completed Associate Certified Chaplain application form.
- Autobiography addressing personal, professional, and faith development with numbered pages.
- One current example of provision of spiritual care utilizing the Associate Chaplain Spiritual Care Encounter Cover Sheet addressing, at minimum, Competencies OL4.1, PPS10 and PPS11
- Final evaluations by applicant of two CPE units.
- Final evaluations by the CPE supervisor of two CPE units.
- Associate Chaplain Narrative Statement documenting how the applicant meets the Common Competencies required for certification in the sections: Professional Identity and Conduct (PIC) and Professional Practice Skills (PPS) (excluding PIC8 and PIC9 which will be assessed through materials and within the interview), and the four NACC-Specific Competencies (ITP2.2, OL2.1, OL2.2, and OL4.1).
- Integrative Theological Essay (Competency ITP2.1), addressing the applicant's familiarity with the documents and theologies of the competency, including ministerial examples demonstrating how the theologies have enhanced the applicant's practice of spiritual care.
- The certification application fee, two-thirds of which is non-refundable if the process is discontinued for any reason.

- Current letter of recommendation from the person to whom the applicant reports in his/her place of ministry. If the applicant is not currently ministering, a letter from anyone in a reporting position who can attest to the ministerial experience of the applicant is required.
- Letter of Recommendation: If the applicant is a lay person, the applicant requests a current letter of recommendation from his/her pastor or from a priest in active ministry, to be submitted by the pastor/priest directly to the NACC national office.
- Certificate of completion of e-learning module and post-test on NACC-Specific Competency ITP4.1.
- An official transcript of undergraduate degree.
- Official documentation of the 32 graduate-level hours of theological study. Coursework must be clearly noted by title, faculty for the course, length of course, dates and graduate hours provided for the course.
- Documentation of 1,000 ministry hours (employment or volunteer) completed post-CPE. Applicant will document required ministry hours (on Ministry Hours form) and request ministry supervisor(s) to submit directly to the NACC National Office a current letter that attests to the ministerial hours and dates, including a brief description of the ministry provided.
- Current completion of the NACC Ethics Accountability Statement (Code of Ethics 206.11.1).

The Certification Commission, interview team educators, and interview teams look forward to opening the certification process to those who are partnering in the ministry of spiritual care in many and diverse ministries. In this way, all of us can continue the healing ministry of Jesus in the name of the Church.

Acceptance and commitment therapy unites spirit and psychology

Jason A. Nieuwsma, Robyn D. Walser, Steven C. Hayes, and Siang-Yang Tan, eds. *ACT for Clergy and Pastoral Counselors: Using Acceptance and Commitment Therapy to Bridge Psychological and Spiritual Care*. Context Press, Oakland CA, 2016.

By Dan McGill

Acceptance and commitment therapy is a particularly effective form of cognitive behavior therapy that is coming to be seen as a helpful bridge between spiritual and psychological care. Unlike other forms of cognitive behavior therapy, it does not attempt to change the content of a person's thinking. Rather, it trains people to simply accept the content of their thoughts and emotions nonjudgmentally, while at the same time making commitments to live by the values one chooses, regardless of the content of thoughts and emotions.

Simply stated, ACT is very similar to the meditative practices of many religious and spiritual traditions, both Eastern and Western. Practitioners of Zen Buddhism, as well as Christian centering prayer, can easily recognize very familiar patterns of spiritual practice in the basic structure of ACT. However, ACT focuses minimally on the particular content of any spiritual or religious tradition, making it amenable to incorporation with a wide range of traditions. Rather than attempting to resolve all conflicting emotions or spiritualities, ACT helps a person simply allow differences to be present.

Though the editors and authors of this book make no such claim, the basic willingness to simply hold differences makes ACT a profoundly helpful approach to interfaith dialogue. However, it is also very practical and has been demonstrated to greatly help many people resolve significant spiritual and psychological problems.

An essential insight presented in this book is the difference between our selves. The self that we develop over time within the world of language is useful but also can prove problematic, since language sees things as good or bad, leading people to see their own souls as bad because they either did or suffered something considered bad. A deeper self exists, however, one present from the beginning of

our life, which might simply be called the observing self. This self, our more essential self, is always present as an observer watching our life. We move across our lifetime from youth to old age, but this observing self never grows old. Nor, perhaps, is it ever young. It just is. ACT recognizes that this more essential self is often called the soul or spirit of a person in religious traditions, and it does not discourage this insight. ACT is very willing to work with the religious or spiritual life of an individual.

This book introduces ACT surprisingly well before turning to its possible application within the various religious traditions, as well as in the various fields of ministry, including chaplaincy. It serves very well the Integration of Theory and Practice Competencies (ITP) 1, 2, 3 & 6. It is an excellent integration of theory and practice, spirituality and psychology.

Dan McGill, BCC, is a Dignity Health chaplain at Marian Regional Medical Center in Santa Maria, CA.