Chaplaincy Amid Disaster

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Disaster preparation reminds us of life's fragility

By David Lichter
Executive Director

Ten years ago, Rabbi Stephen Roberts and the Rev. Willard Ashley Sr. edited and published *Disaster Spiritual Care: Practical Clergy Responses to Community, Regional and National Tragedy*. One of our NACC members, Tim Serban, MA, BCC, who has been serving in disaster spiritual care for years and is currently American Red Cross Disaster Spiritual Care national lead, contributed an article on “Attending to the Dead: Morgues, Body Identification, Accompanying and Blessing the Dead.”

Do you remember any of the natural disasters of 2008? I know — you will probably need to research that question as I did.

I did not remember that, at that time, 2008 ranked third in the most expensive disaster years on record (see https://www.livescience.com/5253-2008-devastating-year-natural-disasters.html), then add the hundreds of thousands of deaths. In China several tropical cyclones and an earthquake resulted in more than 220,000 dead and $200 billion in damages. In Myanmar, Cyclone Nargis killed an estimated 135,000 people. In the United States, Hurricane Ike struck Galveston, TX, causing $30 billion in damages; and Hurricane Gustav struck the Caribbean and Gulf of Mexico, wreaking $10 billion in damages. Also, 1,700 tornadoes ravaged several states.

I offer two observations on this topic and, in light of reviewing again, the content of the book. One is the obvious, but profound, disruptive nature of disasters. We reflect on the deepest truth of human nature and humanity, our vulnerability and fragility. We can live for a time with the illusion of being immune to the suffering and severe loss that can accompany disaster. However, our fragility hovers over us daily, prodding us to acknowledge and live with our vulnerability. We can try only to protect and prepare ourselves in every phase of our lives. Yet, we have from our Christian tradition a way of viewing life’s fragility as *prolixitas mortis*, as Gregory the Great called it, or the extended experience of death in life, the daily experience of and practice of what death will be — the ultimate experience of our vulnerability when we hand ourselves over to the mystery beyond this life. As baptized believers, we know that we live within the mystery of Christ’s suffering and death. We not only participate in it, but Christ participates in, accompanies and holds us in the midst of every form of disaster. So, in some respects, a profound part of our preparation for disaster is living daily in the mystery of our redeemed fragility and vulnerability — not trying to shield ourselves from loss, but recognizing that the One present today in our fragility will be there tomorrow in our loss.

Secondly, the book made me reflect upon the ripple effect of every disaster. As a nodal wave moves outward, so do the effects of disasters, and we cannot underestimate how far it might go. We can all probably surface personal stories where we were surprised by those who were secretly living with a loss because of their relationship to someone affected by a disaster miles or countries away. We can reflect on the sacredness of our common humanity as we realize how profoundly interconnected we are. While we fittingly raise funds for those immediately affected, as spiritual care providers, we also know the often hidden but inescapable bond that exists among us and sets off a communal compassion. In our midst is always someone more deeply affected by a disaster far away. So we tread gently in times of disaster and acknowledge tenderly the sisterhood and brotherhood we share in our human family.
The preface of the book notes, “Disasters fall into the paradoxical category of the ‘expected unexpected.’ Each individual disaster is unexpected, but disasters and trauma are expected.” Later, the authors make the point that the book most likely will be put on the shelf after the reader becomes familiar with the content, only to reach for it when a disaster strikes. I suspect this issue of *Vision* will be treated the same way. However, I do hope you, as a reader, become familiar with content of this issue on preparing for and how to minister in disasters. We are grateful to the authors and to all our members who sacrifice their time and other commitments to serve in the disaster spiritual care ministry.
Deploying to a disaster: Pack lightly, be flexible, care for yourself

By Linda Walsh-Garrison

It was just a Monday morning for most of us. Stretch to quiet the screeching alarm. Begin the week with coffee, a shower, and a commute to our daily lives. But on Oct. 2, 2017, the radio announcer reported that this morning was different for 59 people at a Las Vegas concert. They would not wake up; hundreds were injured; and thousands lost their sense of security — changed forever in an instant. While my coffeemaker gurgled, I tried to comprehend the news as a vision of confusion, fear, stampeding, blood, and shock ran through my head. Immediately, my heart felt heavy because I couldn’t imagine this unimaginable experience. And while my mind drifted through its visions, the phone rang. “Good morning,” I said, “this is Linda, Red Cross Disaster Spiritual Care.”

On that morning, 14 more Disaster Spiritual Care responders prepared to join me. No one who witnesses a disaster is untouched by it. We follow in the footsteps of legions before us who serve in extreme circumstances. Events that change lives and alter the course of normal also spontaneously change the anatomy — the adrenalin and shock alter neurological responses and mental capacities. That initial gasp tightens the diaphragm and deprives the brain of oxygen. Trust is swept away by an incomprehensible truth, and time is needed to process and assess the damage. But this burden need not be carried alone.

Victims of any disaster (fire, flood, terrorist, medical, car accident, etc.) often describe the first 72 hours as a dream of disbelief. These moments are driven by autopilot for survival until a point of safety is reached. As chaplains, we have heard the audible exhale as the prelude to process and assessment. Two questions need to be answered: “What just happened?” and “How am I going to cope?” This is when the trained spiritual care team becomes engaged to validate the personal experience, help to decipher it, and provide a safe space for the exploration of next steps. Obviously, there are no answers, but decisions need to be confidently made. These moments offer the opportunity for a victim to become a survivor.

Having experienced the immediate process of trauma recovery, I am a firm believer in the spiritual process and choose to be a responder. My own deep inhale when the phone rings is my unsettled prelude to the information from the voice on the other end. Hearing the awful details, I feel my muscles tighten as my own thoughts stir with questions: “How could this happen?” “Who could do such a thing?” “What could these people be feeling?” “How many are peripherally affected?” and finally, “How do we reach out?” This is when the clock starts.

I’ve heard first responders compared to terrier dogs — always ready and waiting for the chase. In quiet times, we are restless, and then we leap when called. This is often what it feels like to me. Once I agree to travel to an event, the “hurry up and wait” period begins. Adrenalin is rushing in the first few hours where communication and preparation are often complicated: spouses, families, jobs, and pet-sitters all must agree to be rearranged to accommodate the two-week deployment. I have learned to pick my events carefully, as my spouse stresses when I am in unstable disaster territories. Once, after a major tornado alley event, our responders saw an unexpected tornado that flipped the roof over their heads and raised the stress levels back home. These considerations are real, and the American Red Cross takes our safety seriously.
Next, we wait for the orders to arrive. It could be four hours or 48. This uncertain period requires patient flexibility, and I have found it a good time to review my notes and manuals from past deployments. I will call colleagues for general counsel and spend time centering in my own belief system. Self-care is the most valued tool on any deployment — knowing our strengths, endurance, and values lessens our vulnerability. We need to care for ourselves, as well as each other, and do so on collaborative teams sharing hard work and long hours in very chaotic surroundings. The organized, familiar workplaces at home are unknown at a disaster response. Packing tools to keep you grounded is imperative. For some this is a journal, music, knitting, or phone games; for me, it’s morning meditation and coffee.

Because each event is unique, the most relevant tool is an open mind, as we cannot predict our environment or our duties. In a perfect world, we would be stationed at the family assistance center, or in shelters, or memorials, but this is not promised. We often are handing out water, assisting staff processes, idling for clearance, searching out locations, and hosting courses. Some of us will be in planning and never see a victim; instead, we might be consulting with local faith and business leaders to help them prepare for the repercussions of a large traumatic event. While our presence is felt everywhere, our placement is less defined, but we always are providing support somewhere, sometimes in surprising ways.

The true deployment begins when the orders arrive with a flight time. Now, as my stomach tightens, I will make all the confirmation calls to my office, sitters and house support. Next, a last re-check of my backpack for earplugs, badges, the mission card, clothing and comfortable shoes. Lastly, I will say goodbye to my loved ones with a lingering hug. Those last hugs are what will sustain me as I willingly dive into the deep pool of devastation. And they will be the beacons for my return home — changed forever, grateful, awaiting the next call.

*Linda Walsh-Garrison, BCC, is the southwest and Rocky Mountain division advisor for Red Cross Spiritual Care.*
Chaplains minister throughout California wildfires

By Katy Hillenmeyer

When California’s deadliest wildfires ripped through Sonoma County and surrounding counties in October 2017, they inflicted suffering unlike anything this region has endured. They also tapped a deep reservoir of compassion that united us, bearing witness to our community’s capacity to love one another without distinction — a commitment our founding sisters infused in our health system.

As spiritual care providers at Santa Rosa Memorial Hospital, the North Bay’s Level II trauma center, our chaplains frequently respond to life-shattering events. But the scale of this disaster, which took 44 lives, leveled more than 5,200 homes, and forced evacuations and closures at our city’s two other hospitals, redefined “all hands on deck.” Our six hospital-based chaplains needed help responding to the surge at our 329- and 80-bed hospitals, at a time when our coworkers and physicians, too, had fled their homes, evacuated dependent family members, lost power or cellphone service, and commuted around roads blocked by flames or rescue vehicles.

But thanks to rapidly responding in-house chaplains, joined by grief counseling partners from Hospice, mental health professionals, community clergy and volunteer massage therapists, we triaged this collective trauma and targeted crisis support accordingly.

From the early morning of Oct. 9, when wind-swept embers rained down on neighborhood after neighborhood, people with medical and non-medical needs alike streamed in through our hospital doors. Some suffered from burns and smoke inhalation; some were pregnant and, during active labor, had been transferred from nearby hospitals; others walked in simply seeking shelter.

Here are some chaplains’ firsthand accounts:

- “As the on-call chaplain the first night of the fires, I was called in about 5 a.m. Originally, I was asked to support families who were taking refuge in the hospital lobby and cafeteria. One woman was blind and in a wheelchair, with no phone, no money and just the clothes she was wearing. She’d been separated from her family at one of the city’s evacuation shelters. We got her some food in the cafeteria, where predawn service had kicked into high gear: executives and painters alike pitched in as cooks, all focused on tending to the hungry and sick. It brought a semblance of calm and comfort in the midst of chaos.”

- “With one unconscious, gravely burned patient, emergency nurses asked me to help locate his loved ones. This foreign-born gentleman’s cellphone and wallet provided the only clues, and the idea that he might be thousands of miles from family haunted me. I was later relieved to read in the newspaper of the way his friends rallied to his bedside.”

- “Another patient, who has lived with a physical disability since birth, shared how her friend saved her that first night by pushing her wheelchair from one open space in a park to another, maneuvering her to a new place every time the embers began to fall. He kept her covered with a blanket, burning his own face and arms to protect her.”

- “Just after the fires began, I visited an elderly patient severely burned on her forearms and hands. She’d been the primary caregiver for her husband. Despite strenuous effort, she was unable to get her husband out of their home in time, and he died. She was left to deal with her injuries, her grief, and her displacement. Thankfully, she had a loving family to care for her, but she faced a long, painful road.”
• “An ICU patient I visited had been admitted just before the fires started. She was intubated and sedated, and her husband was at her bedside. During her hospitalization, fire had destroyed their home. Two or three days later, she died. Throughout the week, her husband expressed gratitude that his wife had been spared the anxiety of losing their home.”

• “One patient whose home burned down surprised me with his exuberant spirit. He and his wife had spent the previous several months wrestling with the idea of selling their house and downsizing during their retirement, but that the thought of moving and ridding themselves of decades of possessions had felt daunting. Now, he didn’t have to deal with all of that, he said, and felt truly free.”

• “Long after the fires were contained, the vulnerability of burned-out families continued to manifest. One older woman fell and injured herself in the temporary quarters where she and her husband, who has dementia, had moved. As she recovered from surgery, she confronted worries about the burdens already carried by their adult children, as they manage their own lives. I can still see the stress on her face as she shared about the long journey she faced back to normalcy, not sure she would ever achieve it.”

• “I met a man whose uncle died in the fire. Most of the stories we heard came from patients, physicians, staff and volunteers who — in the hundreds — lost material possessions. But some people lost their lives. It was important to be fully present with this man as he remembered his uncle. It was a sacred act to accompany him in the silence and the grief and to receive his story with a compassionate heart.”

Chaplain Sr. Kimberly Willis cites Sue Monk Kidd’s book The Invention of Wings, in which the author writes, “Empathy is the most mysterious transaction that the human soul can have, and it’s accessible to all of us, but we have to give ourselves the opportunity to identify, to plunge ourselves in a story where we see the world from the bottom up or through another’s eyes or heart.”

In the weeks after the firestorm, our healthcare team empathetically walked alongside co-workers and other community members whose lives the fires upended. It happened through fire-relief apartments and dormitories, outfitted seemingly overnight out of former hospital campus conference rooms and offices. It includes English- and Spanish-language support groups led by our Hospice team and November Schwartz rounds with clinicians who experienced the fires through different lenses of personal and professional hardship. Those rounds drew a standing-room-only crowd of colleagues together to a confidential, supportive forum where all could process grief, survivor’s guilt, and other emotions.

Throughout this suffering, people have tenderly held one another, stopping others they once might have passed quietly in the hallways to inquire caringly about the other’s welfare.

One of Chaplain Steve Lewis’s reflections captures a sense of the solidarity that continues to bind our community. He lived through a similar firestorm in San Diego about 15 years ago. His home was saved, but the ground was scorched within 20 feet of his front door.

“I had the good fortune to be able to return to my home within a couple hours and was able to personally thank the fire crew that had saved my house,” he said. “I discovered that it was an all-female crew of prison inmates. Sometimes moments of grace come from the most unexpected sources.”

*Katy Hillenmeyer is the director of mission integration at St. Joseph Health-Sonoma County in Santa Rosa, CA.*
First responder to Orlando nightclub shooting considers lessons learned

By Mary Columbo Reichert

On June 12, 2016, a lone gunman entered the Pulse nightclub in Orlando, FL, and created terror where there had been mostly music, drinks, and dancing before. In the end there were 49 dead and 58 injured; 44 of them came to my hospital.

The call came at 3 a.m. “Come in, we have a mass casualty — multiple shootings.” I made coffee as I dressed (I’d worked a full shift already that day) and started the drive to the hospital.

“Mary, the shooter is in the building,” my supervisor said, referring to the hospital. Later, we learned this was not true, but at the time, we had no idea. “Come and meet in the garage. Be cautious and aware of your surroundings.”

I dictated a text to my son as I drove. In my most calm voice, I told him that I was on my way to work for a mass casualty, that I didn’t know the details, but I’d text when I could. Don’t call me. I’ll text. I love you. I wasn’t sure I’d survive this; I thought of the firefighters on Sept. 11, 2001, going into the towers as others ran out; I prayed.

The chaplains entered the hospital together. My first sight was law enforcement officers in full gear, guns drawn. I headed to the ED and began meeting patients, using my minimal Spanish to collect names and phone numbers (it was Latin night at the club). I held hands, offered a peaceful presence or prayer. I assured each patient that we would take the very best care of them and that we would do our best to find their family and fill them in.

Protocol requires the hospital to go on lockdown after a shooting when the perpetrator is unknown. Lockdown means no one comes in or goes out. But at some point, families were allowed into the building and led to a conference room to wait. My next assignment was there. I introduced myself and led an ecumenical centering prayer for the group. I listened to those who wanted to talk and allowed others their silence. I provided rosaries and Wi-Fi passwords and escorted people to different locations.

Every patient who entered was assigned a “Doe” name so we could provide immediate medical treatment. The chaplains’ role was to identify the patient and locate family. I spent the rest of my day cross-referencing those names. At the end of the day, I still had a full page of names not found. I found out later those people had died at the scene.

When I got home around 4:30 p.m., I was physically and emotionally exhausted. I called family and responded to texts. I noticed blood on my clothes and washed them. I ordered pizza and finally broke down when the young delivery boy arrived.

Some people surprised me with their concern and some with their silence. Some annoyed me with their trite or judgmental remarks. The next day I attended a community vigil where I cried and prayed and hugged strangers. The following day, I returned to work.
We had our regularly scheduled work to do, but the atmosphere was changed. We had already begun receiving messages of support and gifts of gratitude from the community and across the country. Strangers called constantly, offering to come and visit, sing or pray. We probably offended many when we respectfully — and sometimes forcefully — declined their offers. (These strangers didn’t have the training or clearance required for our hospital.)

During the event, our adrenalin flowed and we focused on patient care; now we began to care for ourselves and our colleagues. Each member of the staff had a different experience and processed it differently. Teammates who weren’t present felt excluded, relieved, or guilty that they didn’t participate. Teammates who were there tried to purge the sights and sounds from their memory and find a safe place to share their feelings.

Counselors were available onsite for confidential walk-in visits. Chaplains led circle sessions where employees could share their stories and process emotions within a group. We also were available for private sessions. Someone made rainbow ribbons we wore as a sign of solidarity. We provided paper and markers and created a wall where team members could leave public messages (most of them about love, strength, and solidarity). Leadership hosted listening sessions where department members could provide honest feedback on how things went and how they felt. On the one-year anniversary, my department lead a service of song, prayer, reflection and hope for team members, and a plaque was dedicated to that night and the care we continue to provide our community and each other every day.

The journey continues. Counselors have remained available at the hospital, and some groups continue to meet regularly. Members of our administration and medical team provide guidance to hospitals across the country that want to be prepared for a similar event. When tragedy hits another community, the hospital buys banners and we send our own messages of support. My heart breaks each time, and I stop watching the news.

I learned some important things about myself and chaplaincy.

1. God chose me, and I go where I’m called. I never considered myself a first responder, but there I was.
2. God provides. I’m not fluent in Spanish, but I spoke well enough to help. I was calm and professional in every interaction.
3. I am human. By midday, I was tired and grumpy.
4. We all need sanctuary. The Spiritual Care Office became a resource hub, and chaplains had no private space to rest and restore ourselves.
5. Boundaries are important. The Spiritual Care Department received many calls from people looking for resources or information on how to help. Although we tried to be polite, we couldn’t answer every question or meet every need. “Stay in scope” was my reminder of what my responsibilities are and are not, and to allow myself to say no and care for myself.
6. Self-care is key. After the event, I made time to do things that restore my soul.
7. People yearn to see goodness. The day after the event, people were already sharing photos and stories of specific services offered and witnessing to compassion and hope.

Mary Columbo Reichert, BCC, is a chaplain at Orlando Regional Medical Center.
Hurricane Harvey forces system to put plans into action

By Nancy Cook

Living in southeast Texas on the Gulf of Mexico for the past six years has given me an acute appreciation for hurricane disaster preparation. I am told that each hurricane is different in its manner and aftereffects. In 2005 Hurricane Rita dropped about 8 inches of rain; in 2008 Hurricane Ike dropped 18.9 inches of rain. Both caused billions of dollars of damage. In 2017 Hurricane Harvey dropped between 40 and 60 inches of rain, with about $180 billion in damages. In all cases some residual loss is felt and held in the collective memory of the community.

Harvey was extreme in that it hit southeast Texas as a hurricane, went back into the gulf and returned as a tropical storm. It was the flooding that took the biggest toll on the community. Some residents could not flee the flood fast enough and perished. Others were boatlifted by volunteers before a federal disaster response was established. Many areas flooded over the rooftops of homes.

As the hurricane approached, CHRISTUS Southeast Texas Health System opened its command center. Arrangements were made to fly in nurses, supplies, and water. Neonatal intensive care babies and renal dialysis patients were airlifted to CHRISTUS hospitals in Louisiana. The hospital did a “compression,” discharging patients who could be discharged and moving patients on the sixth and fifth floors to the fourth, third, and second floors. A temporary lounge was set up for discharged patients who could not get back into their homes. Nurses flown in from other CHRISTUS hospitals lived on the upper floors and were restricted to the campus.

Disasters have phases that foster certain emotions and feelings (Zunin and Myers, 2008). In the threat and warning or pre-disaster stage, communication and preparation can lessen the impact of the potential disaster. Knowing the hurricane was 48 hours away allowed for mobilizing our facilities and strategizing needs. The next stage is impact. Again, hit by Harvey as both a hurricane and a tropical storm, the impact phase lasted about five days. For survivors, this can be a time of intense fear and panic. The rescue or heroic phase is the time after the disaster where adrenaline flows. This is a time of intense action. In my hospital, it involved hyperactivity with the assumption of irregular assignments and tasks. For example, the chaplains were responsible to maintain and manage a semitrailer of portable showers.

The honeymoon phase can be experienced when outside agencies such as the Federal Emergency Management Agency and the American Red Cross come to help. The collective consciousness might have a sense of relief that the worst is over. However, the disillusionment and reconstruction stages can happen in the aftermath. Outside agencies pull out of the area, people resume their normal routines, and life seems to get back to normal. But not all families ease back into normal. Families that have lost their homes find that they must pay a mortgage and rent an apartment at the same time — for those lucky enough to secure an apartment at all. Families that have lost their cars find the same scarcity of low inventory and high demand.

The spiritual care team was active with our patients and employees through all these stages, serving the greatest and most acute needs. We mobilized pre-disaster, assessing who could serve as essential staff and who had to attend to their own homes in preparation for the hurricane. With essential staff, chaplain representation at every emergency management meeting allowed for continually assessing the spiritual and emotional needs of patients and staff.
We were able to maintain regular spiritual care services, including daily Mass, initial visits, overhead prayer, family care and ethics consults. The team assessed additional needs in the care of employees working, living, and confined to the campus. A lounge and game room was established so people coming off their shift had a place, other than their sleeping room, to go, debrief, and socialize. We named this venue the Hurricane Harvey Lounge. We maintained this service until the reconstruction phase.

The team also was mindful that in the reconstruction phase, not all employees and members of the community were getting back to normal. Some were left grieving the loss of loved ones, of home, of pets, and of any sense of stability. In preparation for this phase, the chaplain team set up opportunities of defusing, debriefing, and counseling through a series of venues and options. The team developed a needs list via the directors. We found that it was better stewardship to target resources to identified employees. These employees benefited from the offering of scrubs, pillows, blankets, and towels. Additionally, CHRISTUS Health gave a bonus to CHRISTUS employees who worked during the disaster. The system also gave money to those employees dramatically affected by the disaster.

*Nancy Cook, BCC, is regional director of spiritual care at CHRISTUS Southeast Texas Health System.*
How do chaplains address ethical issues after a disaster?

By Tim Serban

In every disaster or mass casualty event, a volunteer chaplain will face many dilemmas. We have learned that no two disasters are the same. However, complex ethical dilemmas will very often emerge unexpectedly.

The Oxford Living Dictionary defines an ethical dilemma as “a situation in which a difficult choice has to be made between two courses of action, either of which entails transgressing a moral principle.” During a disaster relief operation, the solutions might depend on the circumstances that unfold.

Below, I present some of the dilemmas that spiritual care teams have faced in recent years. Some offer resolutions; some do not. However, making time to wrestle with the questions will be more beneficial than the actual or suggested resolution to each dilemma.

9-11: What do we bury if we have no body? The Catholic family of a fallen firefighter goes to its priest chaplain and asks, “The only thing they found was his FDNY turnout coat. They don’t believe they will ever find his body. My pastor says the Catholic Church will not permit a burial without a body. What do we do?”

Flight 93: Families of the United Flight 93 victims are gathering in Shanksville, PA, for a national memorial service with first lady Laura Bush, and Secret Service officials need to identify family members with a unique lapel pin. They ask the Disaster Spiritual Care leader, “What neutral symbol would be appropriate and respectful to all faith traditions?” In the limited time, the team suggests the image of a dove holding an olive branch with a rainbow as the backdrop. This became the family pin for the families of the Flight 93 victims that day.

Hurricane Katrina: The Disaster Mortuary team leader and Northern Command asked American Red Cross Disaster Spiritual Care leaders, “How can we support the needs of two religious groups who traditionally perform a ritual washing of the body as part of their burial rite? We have leaders of the Jewish and Muslim faiths requesting to provide their ritual washing. How can we honor the ritual when we are unable to identify the faith of any casualty?”

Together this group determined that a general washing of the body would not be offensive to any faith community. As a solution, a simple washing station was added at the end of the autopsy process to honor those whose tradition required it while respecting all traditions. This was an acceptable solution, given the nature of this complex disaster.

Airport morgue: A local chaplain reports the New Orleans airport has become a temporary emergency field hospital. Survivors, including some frail nursing home residents, are being identified with red, green, yellow, and black tags. Those marked with black tags are not yet dead but are being placed alongside those who already have died in a temporary morgue. How will you respond and how will you support those who are labeled in this area?

Honoring the dead: Red Cross Disaster Spiritual Care teams are asked to partner with the Disaster Mortuary teams doing the recovery work of those who have died. The teams ask the chaplain to honor the dead by providing a meaningful prayer to honor the life of each person when their body is recovered. What might you do?
Boston Marathon bombing memorial: An impromptu memorial emerges in front of the barricades across Boylston Street, when the crowd gets word that the street will open soon. Spontaneously the crowd decides to relocate the entire memorial on the sidewalk street corner. What remains after the large memorials of candles, running shoes and makeshift cards are piles of dead flowers, rain-soaked cards and unrecognizable debris. A person picks up a garbage bag and begins loading the remaining debris. What dilemma might occur if as a Red Cross volunteer with visible Red Cross clothing you are observed filling the garbage bags and disposing of them in the trash?

In the months after Hurricanes Harvey, Irma and Maria, the Las Vegas shooting, and the northern California fires, countless ethical dilemmas have emerged, and they are being addressed by those who courageously responded. It is too early to fully appreciate the depth and impact of these recent dilemmas, and we will not engage with them yet, out of respect for our many responders. Our goal is to continue to learn from each experience and to remain flexible and compassionate in the face of each disaster or tragedy.

Tim Serban, BCC, is the American Red Cross Disaster Spiritual Care national lead and the chief mission integration officer for Providence Health Oregon.
Before crisis hits, build trust with community clergy

By Fr. Freddy Ocun and Melinda A. Smith

Chaplains take pride in developing cultural and religious competencies and providing spiritual and emotional support to individuals from all faith traditions. But sometimes support from the patient’s own faith community can offer comfort, provide sacramental support, and address existential issues with a depth of experience not immediately available to a hospital chaplain. Particularly in times of crisis or disaster, it is helpful for chaplain staff to have ongoing relationships of mutual trust with community clergy and interfaith leaders.

At Providence St. Vincent Medical Center in Portland, OR, our Pastoral Services team works with community clergy from different faith traditions whose support often is requested by patients and their families. These clergy visit the hospital weekly, upon request, to attend to a patient’s spiritual and emotional needs. In case of a hospital or community disaster, these relationships and contacts are available to mobilize interfaith support and resources.

However, these relationships benefit patients and their families in many other ways. A visit from their own religious tradition represents a connection with a wider faith community when patients are experiencing crisis, isolation, or distance from their customary faith support. This experience can be particularly acute for patients from immigrant communities. Individuals in crisis, facing a difficult diagnosis, or at the end of life might begin to reconsider a long-abandoned spiritual identity and wish to reconnect with a faith tradition. In a disaster situation, when individuals’ homes, families, and communities might be threatened, connection with a leader from their own tradition might provide comfort and safety.

Initiating and maintaining these community relationships take time. At Providence St. Vincent, one member of the Pastoral Services staff serves as interfaith liaison for the department, maintaining the list of community clergy contacts, keeping in touch with faith leaders by phone, and coordinating referrals for patients who request visits. The liaison chaplain maintains a relationship with Ecumenical Ministries of Oregon and attends monthly meetings of the Interfaith Council of Greater Portland. Participation in these community organizations allows Pastoral Services to talk about the spiritual needs and experiences of various faith groups. It also allows us to show the greater interfaith community the hospital’s investment in caring for individuals from all religious traditions. The hospital also partners with a nearby Presbyterian church that has agreed to serve as a place of shelter for hospital patients and staff in case of a large-scale community disaster.

All staff chaplains take responsibility for talking with clergy when they are present in the hospital, for noting their visits in patient charts, and for providing them with collaborative feedback. Steve Bleak, a Latter Day Saints faith leader who has served as a community clergy visitor at Providence St. Vincent for eight years, highly values the relationships formed with chaplains and staff. “I have felt the spirit of our Lord Jesus Christ in our collaboration with Pastoral Services Director Father Freddy and his fellow chaplains,” he wrote to us. “There is a certain friendship in this service that has filled my heart with love and joy as we have visited the members of our church. Never have I experienced a negative moment.”

Kirk Kennedy, another LDS community clergy visitor, adds that he appreciates being part of Providence St. Vincent’s integration of faith and medicine at every level of care. Both see Providence St. Vincent’s commitment to collaborating with diverse faith groups as foundational to providing good care in the community — at times of individual crisis as well as community disaster. The hospital also benefits from similar collaborative relationships with local Muslim and Jewish faith leaders, as well as other faith communities.
As part of the disaster preparedness plan, Pastoral Services participates in the Incident Assessment Team and coordinates a family resource center that provides information and offers spiritual support for patients and family affected by the disaster. Chaplains provide assistance with coping, healing, spiritual and emotional support; listen to concerns and questions; and facilitate stress mitigation by talking through experiences. In a disaster, chaplains also use their contacts to connect with community faith leaders and to activate interfaith resources and support.

Building relationships of mutual trust with community clergy requires significant time, resources, and energy. However, this collaborative work can bear rich fruit in providing improved spiritual care for our religiously diverse patients, as well as trusted community connections for times of personal crisis and community disaster. As healthcare moves toward creating healthier communities together, chaplains and community clergy have this opportunity for collaboration as they minister together in the common cause of promoting the spiritual wellness of those entrusted to their care.

Fr. Freddy Ocun, AJ, is director of pastoral services, and Melinda A. Smith, BCC, is a chaplain at Providence St. Vincent Medical Center in Portland, OR.
Lessons learned on the run from Hurricane Katrina

By Kay Gorka

Are you ready?

We ask this question in many variations throughout our lives. Are you ready to go on vacation? Are you ready to get married? Are you ready for Christ to come?

On Aug. 29, 2005, when Hurricane Katrina landed in New Orleans, I was not ready. It was the first day of my first job as a chaplain after residency. If you asked me then, I would tell you that I had things in order. I was 25 years old, had a great job, great friends, great church, and was living the lifestyle I enjoyed. I had a comfortable routine. If you asked me how my day was, I would say nothing new.

I am often reminded of that day when I see the natural disasters that have ravaged our world as well as the wars and violence that force millions of people from their homes. Jesus said the poor would always be with us, but it is hard to imagine that the poor would mean us.

Within a week of the hurricane, I was living alone, disaster-fatigued, numb, and in denial, even though I had heard about what could happen for the year that I had been living in New Orleans. I saw on the news, read in the newspaper, and heard at my hospital that the hurricane was coming. I did not know whether I was going to stay or leave until 30 minutes before I left.

I learned three valuable lessons that I apply to my ministry and home life today.

Make sure you have enough gas in your tank. I had worked the night shift, and my car was on empty when I got off work on the day that Katrina arrived. One gas station in town was still open and had gas, and by the grace of God, I was able to fill the tank. I decided to drive toward Mississippi and thought that I could stay in a hotel someplace along the way. I was in Jackson 12 hours later when I realized that was not going to be possible.

It is important to know your disaster plan both in and out of the hospital setting. Always implement your own care plan. Ask yourself what you need to work on. You don’t want to be out of gas when you are most in need. You cannot anticipate every need, but it is important to plan ahead (see https://www.ready.gov/build-a-kit). And sometimes that means you need to ask for help before you are in a crisis.

Change your perspective. After a week in Jackson, I went to my family’s home in Dillon, MT. There I watched for a month as the water level in my neighborhood rose to 7 feet. Knowing my home was one-story tall, I imagined the worst. I was told that the hospital could not guarantee me a position, but they would pay me for the first month. I thought I would have nothing left. But when I returned, I found that all of my belongings were untouched. The capacity of our own imagination is amazing. (There are so many people who suffered far worse devastation and loss. Take a moment of silence for them.)

My response to the threat of my security caused too much stress for me in that first month. Sometimes the stress in these times is caused by our own perceptions and not reality. It is often said: When we
change our perceptions, we change our experience. It is important to remember that truth has the capacity to reach beyond that which we can see or even sense.

**Act predictably.** When I was present to the circumstances and being with others, and acting in the way we have been trained as chaplains — listening, assessing, and developing a spiritual care plan— then I was able to maintain my integrity and find peace.

It somehow is easier to care for others because we know how to listen to the needs. We affirm and assess. We have interventions, and we ask our interdisciplinary team for help. But can we do it for ourselves? If we can, we are better equipped to respond with confidence, courage, and compassion for ourselves and others.

We continue to face disasters, devastation, and violence. They enter our lives every day just by turning on the television or going to work in a hospital. As a result, we can get sucked in and manipulated, numb to the impact, and even jaded or cynical. I invite you to remember to care for yourselves so we have enough fuel to sustain us in this work; to be open to change your perspectives; and to act predictably, utilizing the gifts you cultivated in your chaplain training. It is critical that we continue cultivating and creating an environment that fosters healing rather than being caught and lost in the destruction. Only when we are ready to be creators can we meet our world where it is and leave it better than we found it.

*Kay Gorka, BCC, is manager of spiritual care services at Providence Sacred Heart Medical Center in Spokane, WA.*
So you want to volunteer? Start here

By Tim Serban

What are the steps to become an American Red Cross Disaster Spiritual Care volunteer?

In the past, Red Cross simply collaborated with our cognate chaplaincy organizations as part of the Federal Aviation and Family Assistance Act. But recently, Red Cross has created a new national function called Disaster Spiritual Care. It is equal partners with Disaster Mental Health and Disaster Health Services (nursing). We recognized on earlier deployments that chaplains bring a tremendous amount of obvious experience, creating a safe non-judgmental presence consistent with Red Cross fundamental principles of neutrality, universality, and impartiality. However, board-certified chaplains were not as easily able to integrate into a mass casualty event or natural disaster without some training and preparation to ensure that they were prepared for the hardships — to say nothing of working within an incident command structure.

Also, while we would have liked to staff every response only with board-certified chaplains, we realized there are simply not enough BCCs to support the many natural and human-caused disasters and tragedies that happen locally and nationally. As a result, our cognate chaplaincy partner organizations bring a strong team approach and a consistency in the area of leadership.

In the past, Red Cross would call on the NACC for available chaplains and they would be deployed by name. However, today there are clear and focused steps to follow to become a Red Cross Disaster Spiritual Care volunteer.

To get started:

1. **Sign up:** Go to www.RedCross.org and sign up to be a basic volunteer. (Note: Disaster Spiritual Care is not an option listed on the website, as one needs to be screened to meet the eligibility requirements, including a mandatory background check.)
2. **Verify DSC initial eligibility in one of three ways:**
   - Board-certified chaplain (APC, ACPE, NACC, NAJC, CASC, CPSP, ICPC, or cognate partner)
   - Spiritual care training from a National Voluntary Organizations Active in Disaster partner that has established a recognized course
   - A recognized faith leader in a local faith community provided with a demonstrated letter of endorsement from a leader of the endorsing faith tradition (Online ordination programs are excluded.)
3. **Complete** a live eligibility screening (40-50 minutes with a regional or division DSC lead or adviser).
4. **Complete the Disaster Spiritual Care Overview** course: online web-based training (one hour) with post-test
5. **Complete Psychological First Aid:** four hours of in-person or web-based training
6. **Complete fundamentals in Disaster Spiritual Care:** generally in-person five-hour instructor-led training, although virtual training will be available soon. (Cognate chaplaincy groups often will offer this course during a national conference, but the previous steps need to be completed first.)
7. **Engage** with your local regional chapter or DSC adviser to begin integrating DSC into local response efforts. Remain in contact with your Regional, Division and National DSC leads.

*Tim Serban, BCC, is the NACC liaison to American Red Cross Disaster Spiritual Care and the chief mission integration officer for Providence Health Oregon.*
Listening with the heart breaks down barriers of belief

By Dan Olivieri

I was asked recently by a patient how I could visit people of different faiths. I think that for this patient, it seemed like an impossible task. After all, there are so many differences and mindsets.

Although I am Catholic, I consider myself to be an interfaith minister. In the hospital, the chaplain is one of many disciplines. The aim of the interdisciplinary care team is to be patient-centered, such that the medical expertise offered to the patient is shaped by the patient’s own faith, beliefs, and values. The chaplain’s role is to support patients in accessing their own wisdom in the healing process.

I answered the inquiring patient by saying, “You just try to connect with what is in a person’s heart and be willing to listen. The heart holds universal themes that are common to every religion. What you love. What moves you. What gives you joy. What causes you sorrow. What gives your life meaning. What charges your battery. What inspires you.”

When I get out of my own way, when I drop my own judgments and allow myself to be centered in my own heart, then I can relate to anyone’s heart — if they wish to share it. And if they don’t wish to share it, then more power to them, and I wish them well.

The heart holds universal themes common to every religion, but even more so, there are universal themes common to every human being. One does not have to be religious. Some years ago, I entered the room of an older male patient who had a cancer diagnosis. The man’s wife was sitting on her own cot in her husband’s room. She was a practicing Buddhist. The man immediately said to me, “You have nothing to offer me because I am an atheist!” He proceeded to list all the reasons why. I listened, but it seemed to me that this gentleman was sharing a lot of head-centered information — not really much different from how a religious person talks about their dogma or their belief system.

After he spoke for a couple of minutes, I thanked him for sharing what was important to him and said, “Let me ask you two questions. What inspires you? How are you able to be present to your own vulnerability?”

The patient responded. “Beauty inspires me.”

“What beauty? How do you experience beauty?”

“In music.”

“Oh, what kind of music?”

“Mozart.”

“Really!?”

The man’s face began to light up as he waxed eloquent about the mastery of Mozart. He looked to me like a saint talking about divine rapture. After he finished, I looked at his wife and said, “Wow, that sounds like quite a spirituality!” He then talked about the vulnerability of his illness and how being in
nature supported him as well as the support of others who care about him. This man who initially had rejected me due to a preconceived idea now invited me into his heart, into his sacredness, and I have never forgotten it. It didn’t matter to me that he identified himself as atheist. What mattered to me was what gave his life meaning and purpose. As he shared, the room took on an air of companionship for the mere act of open listening.

There is such an incredible difference in quality of life when coming from the head and coming from the heart. The head and the heart need to come together, but the head without the heart is cold, and the heart without the head is aimless.

We humans have our experiences of truth, of conviction; moments of realization and revelation. Religions are based on experiences of Truth. But when the head takes control, there is a tendency to want to protect that truth by doing what Richard Rohr used to call “circling the wagons.” Coming from the head, we circle our wagons and form clear boundaries between the insiders and the outsiders, the righteous and the infidels, the right and the wrong. But there is another way, a heart-centered way. Many of us remember the poem by Rumi that says,

-Out beyond ideas of wrong-doing and right-doing, 
there is a field, I will meet you there. 
When the soul lies down in that grass, 
the world is too big to talk about.

Rumi was speaking about orthodoxy and the trap that orthodoxy can fall into when it is ruled by the head. There is a grand silence that contains all Truth. That silence is located in the center of each of us, and when we find that center, there is a capacity to be all things to all people, as St. Paul wrote.

It is in this spirit that I aim to practice an interfaith approach to ministry and to life. I feel blessed to hang out at many different campfires and speak different theological and religious languages. — although in order to do this, I’ve had to work and suffer through an awful lot of my own fears that I have been conditioned to believe.

I remember a sign on the wall at the entrance of my Redemptorist Novitiate in Oconomowoc, WI, where I spent a year of informal study in 1979. It said: “Nothing in this world is to be feared, only understood.”

May the field of our hearts be centered in the grand silence that unites us all in the one truth of existence.


Dan Olivieri, BCC, is a chaplain at Dignity Health, Dominican Hospital in Santa Cruz, CA.
2018 plenary speakers cover many disciplines

“Alone we can do so little, together we can do so much” — Helen Keller

By Beth Lenegan

In July, chaplains from across the country will gather in Anaheim, CA, with the realization that we cannot do our ministry alone. Two associations will come together to look toward the future as professionals who value the diversity of our members and patients and who continue to discover new research and resources. This gathering happens in the framework of prayer, hospitality, and fun. This year’s conference committee identified the main theme as Partners in Shaping the Future with four underlying topics that will be explored by our plenary speakers: collaboration, supporting diversity, research, and professionalism.

On Thursday, July 12, Dawn Gross will begin our conference speaking on the art of collaboration. Together, working with one another, as well as with those in our places of ministry, we can be truly present for those individuals in our care. We are chaplains in community, not in isolation. Dr. Gross holds a combined MD and PhD from Tufts University School of Medicine and the Sackler School of Biomedical Sciences, where she was trained as both physician and scientist. She is currently a hospice and palliative care physician in California, host of a call-in radio program, Dying to Talk on KALW 91.7, and is a speaker, writer and educator. Dr. Gross will begin our time together by reminding us of the importance of joining in partnership for the welfare of many.

On Friday, July 13, we will be reminded of the importance of supporting diversity with our second plenary speaker, James Mason. We are called to accept and appreciate people of all races, creeds, and cultures. Each of us will be challenged to how open we are with colleagues and those we minister to. Dr. Mason is the chief diversity officer for Providence Health & Services in Oregon. He is the former director of the Office of Multicultural Health for the State of Oregon and one of the founders of the National Association of State Offices of Minority Health. Dr. Mason will lead us to think beyond the traditional meaning of diversity.

Steve Nolan will be the third plenary speaker on Saturday, July 14. He will explore the current research in the area of chaplaincy, spirituality and healthcare. One area of his research is the concept of hope. The Rev. Dr. Nolan is a chaplain at Princess Alice Hospice and a visiting research fellow at the University of Winchester, England. He has been described as an “appealing presenter, integrating lived experience of chaplaincy with solid research in such a way that participants at all levels of skill and competency could understand and relate.”

As we prepare to go home, we are sent forth in recognition that we are professionals with integrity. It is with the gifts of compassion and integrity that we are professional leaders in diverse areas of chaplaincy. On Sunday, July 15, Adrienne Boissy will speak to our current and future role as professionals. Dr. Boissy serves as Cleveland Clinic’s chief experience officer and previously led its Center for Excellence in Healthcare Communication. She is a staff physician at the Cleveland Clinic Mellen Center for Multiple Sclerosis and has a secondary appointment in bioethics. She attended Boston University and worked in neurobiological research at Brigham and Women’s Hospital in Boston. She completed her medical training at Pennsylvania State University College of Medicine and finished her neurology residency and neuroimmunology fellowship at Cleveland Clinic.

Each of these speakers will unite the community of chaplains gathered in Anaheim and in their unique way challenge us to remain partners as we move into the future.

Beth Lenegan, BCC, is plenary chair of the 2018 conference and director of pastoral care at Roswell Park Cancer Institute in Buffalo, NY.