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Coping With Pain: Physical, emotional, spiritual

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Giving meaning to suffering helps create healing

By David Lichter
Executive Director

Over 40 years ago, the day before I left for my 30-day Ignatian retreat, I visited my aunt, Sr. Joannella, SSND, who was suffering from a painful cancer. She said that day, “David, I am going to offer up my pain for you this next month, as you make this retreat.” I carried that commitment with me. I was the purpose for her pain during that personally and spiritually challenging time. When I visited her after the retreat, she was still grimacing, but now with a perplexing frown as well. “What was going on these past weeks, David! I never experienced so much pain!”

She died not many days after that final visit, but the experience was profound for me, not so much because I felt her presence, but because I was touched and strengthened by the purposefulness of her pain.

This issue of Vision addresses pain in all forms and how our spiritual care profession provides support and resources to those in pain. We can look many places for definitions, such as the North American Nursing Diagnosis Association, which defines pain as a state in which someone experiences and reports severe discomfort or an uncomfortable sensation. Most include descriptors of an unpleasant sensory experience. Yet it’s more than a sensation or awareness of some physical discomfort, as it includes a perception or interpretation of the discomfort, as well as some emotional content — thus, on a scale of one to ten, how bad is it?

I appreciated Chapter 23 in the Oxford Textbook of Spirituality in Healthcare. “Suffering,” written by Betty Ferrell and Catherine Del Ferraro¹, provides ten tenets of suffering, with number nine being, “Suffering is not synonymous with pain, but is closely associated with it. Physical pain is closely related to psychological, social, and spiritual distress. Pain that persists without meaning becomes suffering.” Pain seems to have an inextricable link to suffering, as we are creatures of meaning, and we find ourselves interpreting both the cause and meaning of pain. Where did this come from? How will I handle it? How will I bear it?

One research article, “The Meaning of Healing: Transcending Suffering,” by Thomas R. Egnew², was very enlightening. Although it attempted to find “repeatable actions that reliably assist physicians to promote holistic healing,” the study concluded, “Healing is an intensely personal, subjective experience involving a reconciliation of the meaning an individual ascribes to distressing events with his or her perception of wholeness as a person.” (Italics mine.) Isn’t that a wonderful description? The meaning I am giving to this “distressing event” or this pain is being reconciled with my perception of the wholeness of my person.

I thought the final description of the above study so well captured spiritual care, no matter who is providing it: “Healing may be operationally defined as the personal experience of the
transcendence of suffering. Physicians can enhance their abilities as healers by recognizing, diagnosing, minimizing, and relieving suffering, as well as helping patients transcend suffering.”

“Transcendence of suffering” doesn’t imply some otherworldly experience, but accompanying the one in pain as he or she reconciles this pain with and puts into the context of the totality of who she or he is, thus making healing possible. My aunt was a woman of God who experienced all of life in the totality of her religious call. I believe she “transcended” pain and suffering that month. As much as she experienced pain, she also experienced healing, as her purpose for pain that month was intimately connected with Jesus’ battle with and for me, and my own spiritual battles of resisting his love and forgiveness.

In some ways, she came first to mind when I read Pope Francis’ 2016 World Day of the Sick message: “Illness, above all grave illness, always places human existence in crisis and brings with it questions that dig deep. Our first response may at times be one of rebellion: Why has this happened to me? We can feel desperate, thinking that all is lost, that things no longer have meaning. ... In these situations, faith in God is on the one hand tested, yet at the same time can reveal all of its positive resources. Not because faith makes illness, pain, or the questions which they raise, disappear, but because it offers a key by which we can discover the deepest meaning of what we are experiencing; a key that helps us to see how illness can be the way to draw nearer to Jesus who walks at our side, weighed down by the Cross. And this key is given to us by Mary, our Mother, who has known this way at first hand.”

Much pain can be medically treated. Palliative care can offer physical comfort. But as that is being offered, it’s never an isolated treatment. As the research shows, we live in the fragile and tenuous reconciling movement where each person seeks to place that pain in his or her own perception of purposefulness, making healing possible even in the enduring reality of pain. What a sacred place to be.

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Spiritual inputs from brain can modify physical pain

By Kiran Tamirisa

As a physician specializing in pain management, I have seen many patients react in many different ways to their conditions. Physical pain all too often leads to emotional or spiritual pain. But although they can be closely tangled together, they can be separated. As the Indian mystic poet Rabindranath Tagore (1861-1941) said, “Let me not beg for the stilling of my pain but for the heart to conquer it.”

We can define pain as “an unpleasant sensory and emotional experience that is associated with actual or potential tissue damage or described in such terms.” A key feature of this definition is that it goes on to say, “pain is always subjective.”

One can classify pain as acute and chronic. Acute pain is generally associated with an injury, is sudden in onset, and resolves once the cause is treated. It responds well to several treatment modalities. Chronic pain may or may not be associated with injury or disease and usually persists after the cause has resolved and is unresponsive to treatments. Acute pain tends to have a sharp, intense quality and may serve as a warning sign that your body is threatened — for example, fracture of a bone.

In pain transmission, a mechanical injury releases chemicals that create electric energy at nerve endings. Electrical stimulus is then transmitted to the spinal cord by peripheral nerves, which connect to second-order nerves that carry the pain stimulus to the lower centers in brain called the thalamus. From the thalamus, the nerves connect to centers in the cerebral cortex that interpret the pain like sharp, dull, burning, etc. Also, some nerve fibers are connected to the limbic system, which controls our emotions. Thus, a pain stimulus can alter one’s emotions. From here the nerves travel down the spinal cord, connect to the pain centers there, and influence pain transmission. Thus, emotions can also affect the pain. Therefore the main control of the pain transmission is in the spinal cord.

I compare the spinal cord to an equalizer of a public address system, where several connections are made from the input and output and can change the sound. Similarly, the spinal cord modifies pain and changes its character and intensity. We understand now that by controlling the brain, we are able to change the way we can perceive the pain. Also, nerves and their connections change constantly depending upon their inputs. Religion and spirituality can influence inputs from the brain and alter the way pain is transmitted in the spinal cord and thus play an important role in the experience of pain.

Although some people use “religion” and “spirituality” interchangeably, they are different. Religion is a set of practices and beliefs and involves a relationship with a god. Spirituality is the experience of connectedness, meaning and purpose in life and integrating aspects of self, which may or may not involve relation with God. Spirituality gives individual autonomy with one’s own interpretation of the soul.

Both spirituality and religion, with their many common elements, can influence lifestyle, attitudes, and feelings about pain and death. Religion can help people live more profound lives as well as strengthen or console people during suffering and in preparation for the inevitable consequence of illness by providing a meaning to life and death. Religion can supply family and healthcare professionals with a sense of strength, security and faith during the times of need like a flashlight showing the path in darkness.
Spirituality is a personal understanding of the principles of religion. Healthcare providers with this understanding can help realize how and why the patients perceive and express their pain, and they can help with the healing of pain.

In my Hindu tradition, suffering and pain are seen as a consequence of one’s inappropriate actions during this life or a previous life. It is not seen as a punishment, but as a consequence of previous actions (something very similar to a loan from the bank!) Hindu traditions promote coping with suffering by accepting it as just a consequence and understanding that suffering is not random. Hindu religion distinguishes between the body and the soul. While the physical body can feel the pain and suffering, the soul does not. As the soul is not affected, there need be no concern over temporary suffering. Patients may gain comfort by viewing the pain as only a temporary condition and one that does not affect their inner Self.

Suffering is thought to be a part of the unfolding of karma and a consequence of past inappropriate action. Suffering is also inherent in the cycles of living and rebirth. Hindu traditions promote the acceptance of suffering as being a just consequence under the laws of karma; the realization that suffering is transitory while in this world, and not affecting one’s true Self; and the view that suffering is not solely negative.

In essence, pain is an emotional response to stimulus. Many factors — social, familial, cultural, psychological, spiritual — can alter this response. Emotional stress like depression and anxiety may aggravate the response to the pain. On the other hand, pain can lead to depression and anxiety. Chronic pain, leading to depression, which in turn leads to increased pain, creates an unhealthy cycle. Therefore, healthcare professionals should address not only biological pain but also the psychological and social needs of the patient to treat the patient holistically.

Also, pain sufferers who are both religious and spiritual are likely to have a better psychological well-being, positive strategies and better health.

Spirituality-based strategies are commonly used to cope with chronic pain. Many chronic pain patients use religious and/or spiritual forms of coping such as prayer and spiritual support to cope with their pain. Some researchers have found that some types of religious and/or spiritual coping are adaptive, while other types are maladaptive. Positive coping includes collaborative problem-solving with God, helping others in need, and seeking spiritual support from the community and from a higher power. Negative coping includes deferring all responsibility to God, feeling abandoned by God, and blaming God for difficulties. Positive coping results in improved well-being and fewer symptoms of depression and anxiety.

Abundant literature speaks to the importance of religion and spirituality in treating chronic pain. These coping techniques should be tailored according to the individual. This is not in lieu of regular treatment but in addition to it.

Sometimes people doubt how spirituality and religion can alter pain perception. The way I explain is by comparing it to sunglasses — which do not alter the sunlight, but do alter the way we see it, making it comfortable to our eyes. Similarly, spirituality and religion change the pain perception and assist to cope with it with less suffering. Pain is inevitable; suffering is optional.

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Spiritual care can make a difference for patients in chronic pain

By Anne Millington

Many people live with chronic physical pain, suffering greatly from osteoarthritis, fibromyalgia, migraines, neuropathy, spinal stenosis, sciatica, compression fractures, and more. Living with pain is tough, and in the words of a chronic pain clinic patient, “Pain brings you down. It makes you depressed. Pain is completely overwhelming. It plays weird tricks on your brain.” Living with pain is also isolating, particularly since it is a largely invisible condition. As a patient experiencing severe neuropathy noted, “I see all these people going about their daily routines, looking normal. I suppose I look somewhat normal on the outside too, but they have no idea of the physical hell I am experiencing.” (Identifying details have been changed.)

Since opioids are no longer liberally prescribed, many modern pain therapies include large doses of physical therapy and exercise — which require great commitment and effort by the patient. “There are treatments for pain, but they require a partnership between doctor and patient,” said Dr. Cyrus Yazdi, a board-certified pain medicine specialist at Beth Israel Deaconess Hospital-Milton. “Patients need to be motivated to improve.” But that motivation can be difficult to sustain when pain is overwhelming and isolation is high. As Dr. Yazdi notes, “Feeling seen and heard and appreciated can bring patients a lot of comfort and inspire them to be disciplined about their pain therapies.”

Chaplains can provide spiritual care to chronic pain patients in ways that reduce isolation and provide much-needed hope for a better future. One patient was so crippled and hunched over by painful arthritis that he could not walk and even struggled to lift his head. During our visits, he shared stories with me about his previous life, family, and career, and spoke of the challenges of his current physical condition. As I was leaving his room one day, he did his best to turn his head to look up at me and said, with a relieved smile, “Thank you for your visits. They really take the edge off of my day.” While I certainly could not fix his condition, by listening to him I brought him some relief, at least temporarily. Relieved from the throes of isolation, even for a moment, patients may well develop fresh hope for connection in a way that motivates them to adhere to pain management programs.

Pastoral caregivers can draw from formal models such as the Spiritual Assessment and Intervention Model (Spiritual AIM), developed by Shields, Kestenbaum and Dunn (www.healthcarechaplaincy.org/docs/2015_conference/workshop_c1_spiritual_aim_articulation_evolution_and_evidence.pdf). According to this model, patients tend to have three core spiritual needs that play out in interpersonal relationships: the need for self-worth and belonging, the need for meaning and direction, and the need for reconciliation. Under stress, patients tend to experience one of the three needs most dominantly, and thus the Spiritual AIM model proposes a different type of pastoral intervention to address each need.

When patients need self-worth and belonging, for example, they often blame themselves for their illness or worry that they are now a burden to others. I remember an encounter with a
patient suffering from spinal stenosis who feared “being a burden to my husband.” She continued, “He has to do everything for me now, and he also has to do everything around the house, home maintenance, paying bills, you name it. He’s a good sport, but he deserves so much better than this.” According to the Spiritual AIM model, an appropriate intervention in this case involves creating “a community of two” that affirms and supports that patient’s value to others. I told the patient that I appreciate her, and I raised examples, based on the stories she shared with me, of how her husband appreciated her as well. In response, she lit up with the hope that she might not in fact be such a burden, and she spoke about her goal to accompany her husband to an upcoming family wedding.

The model proposes a different pastoral intervention, however, when a patient has a core need of meaning and direction. I recall visiting a man in his 30s, a construction worker who a few years back had fallen 25 feet off a ladder at a job site. Multiple fractures to his back, pelvis and legs left him wracked with physical pain. He was too disabled to continue the construction work that he loved, and, worse, had become addicted to opioids. I assessed that he needed meaning and direction, as he expressed confusion and uncertainty around how he should manage his life in the wake of his injuries. Of particular concern was his estrangement from his son, who “gradually drifted out of my life after I divorced his mother.” He wanted to strengthen his relationship with his son, but was unsure how: “Should I call him more? Should I invite him to visit? Or maybe I should wait for him to call me” In this case, Spiritual AIM recommends guiding the patient in discerning and committing to a course of action. I did my best to help the man commit to calling his son once a week. While he still had a lot of physical challenges ahead of him, having a clear plan to improve his relationship with his son gave him hope for the future and more motivation to cooperate with pain treatments.

Patients who have a need for reconciliation, the Spiritual AIM model claims, frequently blame others for all conflict. Although they desire to love and be loved, by blaming others they escalate tension and tend to be surrounded by strained and broken relationships. One patient with acute migraines raged at everyone around her and had alienated her family, friends and even the hospital care team. She was particularly angry at her daughter. “All my daughter cares about is my money,” she declared, jaw clenched. “So I sure showed her last Christmas. For her gift I gave her a check, then I stopped payment on it at the bank so she couldn’t cash it. She’s furious and won’t talk to me now. See? If she doesn’t get my money, she won’t even talk to me!” For such patients, the model recommends serving as a truth teller, gently guiding patients toward an awareness of how their behavior has hurt or alienated others. After listening to her story with a particular eye toward building her trust, I “wondered aloud” about what the incident must have been like for her daughter. While confrontation risks alienation, the patient seemed receptive. With a flicker of remorse passing over her face, she quietly responded, “I would have felt very angry if she had done that to me.” While I do not know if this led to any reconciliation, perhaps now the patient could work toward a better relationship and envision a better future for her life.

Pastoral caregivers can also draw from the Spiritual AIM model to cultivate patients’ sense of connection to God. One patient with a need for self-worth and belonging claimed, “I’m in pain
because God is angry with me. I brought all this on myself.” In response, I affirmed God’s love for him, and reassured him that God does not want him to suffer. In an additional encounter, a pain patient with a need for reconciliation declared, “I’ve done everything I could for God, and God gives me nothing but the shaft in return.” In this case, I intervened by “holding the mirror up” to ways God might be an ally, not an enemy. With any luck, these interventions gave the patients involved increased hope for better connection to God and, by extension, additional motivation to stay the course with their pain treatment therapies.

As pastoral caregivers, we can definitely motivate patients to live well with chronic pain by decreasing patient isolation and instilling hope for a better future with an improved sense of connection to others. However, our ability to be present to the pain of others depends on our courage to be present to our own pain, be it physical, spiritual, or both. What we fear and avoid in ourselves, we will fear and avoid in others. What in our life hurts? Are we sufficiently motivated to manage our pain? Has our pain isolated us from others, from God? What is our own core spiritual need? When we earnestly address our own pain, we too can become “joyful in hope” (Romans 12:12), as we naturally open ourselves to greater breadth and depth in our connection to all others, including to the patients we seek to serve.

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When pain can’t be fixed, presence remains

By Kathy Ponce

When I was around 10 years old, I dreaded going to the dentist. My mom would call for me after school, and the two of us would walk the three or four blocks to the dentist’s office, where I would wait, terrified that I might have a cavity. On those visits when I did need drilling done, I’d say to myself, “O Jesus, you suffered and died on the cross for me. The least I could do for you is to offer up these few minutes of pain.”

While my prayer as a 10-year-old helped me to bear the discomfort more easily, as an adult, “offering it up” does not fit with my theological understanding. But by substituting “opening it up” (to God) for “offering it up”, we are inviting a Voice beyond our own to speak to us in times of pain and suffering. Sometimes we, as humans, are able to do that. Sometimes we’re not. Sometimes we hear that Voice, sometimes we don’t.

The sisters at my elementary school told us many stories about self-flagellation by certain saints, and about those who actually prayed for pain so that they could be more like Jesus. As a child, this sounded pretty noble. As I grew older, I realized that as we go about our lives, doing what we can to help the people we meet during our years on earth, no one needs to ask God for pain to mortify the flesh. There is plenty of pain to go around.

As chaplains we almost daily encounter care recipients who seek an answer or explanation from God. They ask the big WHY question: “Why is God doing this to me? What did I do to deserve this?” I’m often reminded of a John Callahan cartoon in which a guy on the beach has tripped on his way back from the refreshment stand, spilling snow cones and shakes and hot dogs onto the sand. The caption reads, “How could a loving God allow a thing like this to happen?”

But the pain and suffering of our brothers and sisters that we chaplains encounter in our ministry is often gut-wrenching, and gives us pause as we hear their stories. Our hearts go out to them. We know, however, that at times of great pain, we (all of us) tend to regress a bit. The ways that we rationalize or try to understand discomfort when we are healthy just don’t work when we are overtaken by pain and distress, whether it is physical, mental or spiritual. We, as humans who trust in a loving God, easily resort to “the big Why.”

Over the years, our Roman Catholic tradition has posited many reasons for pain: God is testing us “like gold through fire.” We are earning “time off” from purgatory. Free will and resultant bad choices are responsible for pain. God doesn’t allow pain and suffering unless some greater good can come from it. Our pain can become redemptive if we unite it with the suffering of Christ and “offer it up.” God wants to increase our trust in him. Pain and suffering are the work of Satan. The more we suffer, the greater will be our heavenly reward. Jesus suffered and he was God’s only Son. (To that, I’ve heard patients respond that Jesus only hung for three hours, while they’ve been crucified by physical pain and suffering for weeks, months or years!)

Similarly, religious traditions far older than Roman Catholicism have promoted reasons for suffering or suggestions that help to make pain more bearable: Suffering is due to bad karma
from past lives. Pain in the present incarnation ensures a happier reincarnation in the future. God will punish the unjust. God suffers with those in pain (Harold Kushner).

But for all those explanations, none of us has ever truly understood why there is human pain. (Adam eating the apple and being thrown out of Paradise just doesn’t cut it for most thinking adults.) Sure, sometimes pain is a natural consequence of not having taken good care of oneself, or engaging in dangerous sports, or taking unnecessary risks, but often, there seems to be no explanation.

Viktor Frankl has sometimes been credited with having said, “Between stimulus (pain) and response (suffering) there is a space. In this space is our power to choose our response. In our response lies freedom.” As chaplains, we often want to work within this space. That is not always possible, especially if care recipients are experiencing acute pain or acute suffering. Many chaplains have a personal theory about pain and suffering — but we find that patients don’t really want an explanation. They want help for their pain, whether physical, emotional or spiritual, and they want some comfort in their suffering. There are so many adjunctive techniques that we chaplains can use in trying to ease our care recipients’ discomfort in addition to standard medical practices: guided imagery and other relaxation techniques, music, cognitive re-structuring, forms of therapeutic touch, and meditation, among others.

Our most special skill and gift as chaplains, however, remains our ability to accompany patients in their pain. Particularly in the frantic world of modern medical care, where every health professional has a particular function and limited time, presence with and listening to one who is suffering is a gift that is uniquely the chaplain’s. It can never be underrated. My favorite definition of a chaplain is that, when every other caregiver runs out of the room because it is nearly unbearable to witness such physical, emotional or spiritual suffering, a chaplain will stay, offering presence and support borne of loving and being loved by God and sharing a common humanity during a time when another person often feels alone and abandoned.

In the act of accompanying another, we are in a tiny way modeling Christ’s promise in the Gospel of Matthew: “I will be with you until the end of the age.” Presence/accompaniment has always been and remains a very worthy gift for all of us who are chaplains to share. It is perhaps the gift that is most needed in an often impersonal and unresponsive world.

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Emotional pain may spill over into body or spirit

By Nicholas Perkins

There is nothing discriminatory about emotional pain. It impacts the family whose children died in a house fire as much as it does the survivors of a mass shooting. It can affect the individuals who witness it just as it does the person who endures it. Emotional pain can change how we view ourselves and the world.

What is emotional pain? An answer requires much thought, since the factors are as diverse as those who experience it. Social exclusion, betrayal, infidelity, and death can cause emotional pain. It is synonymous with psychological pain, because it presents as unpleasant suffering or feeling. Unlike physical trauma, the symptoms of emotional and psychological pain are difficult to observe; it can take time for them to reach what I label as the critical mass stage. The emotional pain that I felt after I left an emotionally and verbally abusive marriage manifested as poor sleep and appetite, disinterest, withdrawal, confusion, doubts, and fear.

I liken emotional pain to an iceberg, and the portion below the water can cause as much damage as what is above the surface. After all, it was the jagged pieces of the berg beneath the surface that sank the Titanic. Since God calls me to relationship, I must discern how my emotional wounds can affect that. A hospital chaplain can be triggered by certain encounters and events, so I am challenged to think about the certification competencies that address self-reflection, attitudes and feelings, and my own physical, emotional, and spiritual well-being.

The person I am today is a result of everything that I have experienced and learned in my life. Recent research into adverse childhood experiences confirms that childhood is one of the most developmental and fragile times of life. Examples of adverse childhood experiences include any form of abuse, emotional and physical neglect, incarcerated household members, separation or divorce, and substance abuse within families.

Stress during childhood and adolescence can affect cognition, relationships, behaviors, and health, including patterns of crisis and coping. The trauma that I endured was stored in my body and mind until certain events triggered it. In effect, the unhealed emotional pain that was packaged in my subconscious mind set the stage for adverse experiences later in life.

Children learn their blueprint for relationships in their family of origin. If a child was raised in an abusive home, their template for relationships can condition them to choose partners that mistreat them. The odds loom large that they will repeat in their adult lives the relationship patterns that they saw in their family of origin.

Women and men who leave emotionally and verbally abusive marriages often say they wish the perpetrator would have split their lip or blackened their eye. People can see that trauma, and the law can prosecute it, but a verbal and emotional abuser often behaves differently in public than he or she does in private. In my emotionally abusive marriage, I eventually kept a record of my former spouse’s abusive behavior because it set the grounds for my petition for a declaration of nullity.
In an emotionally abusive relationship, the perpetrator and victim seem to share a pain that has its origins in the relationship that they saw in their families of origin. He feels how her words slice him to the core as she pirouettes around the kitchen oblivious to his heartache; she feels how his well-aimed criticisms devalue her self-worth as he attributes them to ordinary and playful banter. There is nothing humorous about abuse, or the denial mechanisms that enable it.

Spiritual anguish can be associated with medical or emotional issues. The person may disconnect, withdraw, and doubt the existence – even the love – of God. An individual who wrestles with spiritual pain during an emotional or medical crisis could feel punished by God, like God is penalizing them for past sins. The chaplain or caregiver who speaks with somebody who faces spiritual pain can learn a lot about how they view God.

How do we comfort a person who endures acute emotional or spiritual sorrow? I emulate the people who aided me; their presence reflected concern without comments or ideas. It is important to appreciate that how one feels emotionally can affect physical and spiritual feelings. The body, mind, and spirit share a unique harmony; if one suffers, the other two suffer. A person who endures emotional distress has the need to feel safe, so letting them know that they are is helpful.

An important first step in healing my emotional wounds was to be with people who let me share my feelings. They let me walk into the wilderness of my pain without trying to stop me; they listened to the feelings beneath my words and reminded me that I was not alone. The most important thing that I experienced was how wonderful it felt to not receive unsolicited advice or suggestions. I understand through my own suffering how an empathic connection during a crisis requires very few words. Authentic concern and the desire to be present in the wilderness of one’s pain are enough.

Nicholas Perkins, BCC, is a chaplain at Franciscan Health in Dyer, IN.
When does pain serve a useful function?

By John Stangle

Intractable pain — debilitating physical pain — seems to have no value. Whatever is necessary to alleviate it is considered justified, as long as it doesn’t cause further pain or destruction. But is there a level of pain that can be accepted, or that even has value for human beings? The answer is yes, but there are many “buts.”

We seem to have evolved into a culture where any pain is seen as unacceptable, and one thing that leads to pain is lack of patience. Here we are talking about the psychological and even physical effects of a delayed golf tee time, or waiting in line at the supermarket, or yields to others at a four-way stop sign. Not accepting some such psychological pain could lead to fights at major sale times or to road rage.

So, we can define pain as having degrees, from slight to extreme. We might also see these extremes for both psychological and spiritual pain. It is a well-known adage in family medicine that “pain is a warning sign.” Sometimes it warns that we have extended our physical activity to unadvised, or even dangerous, levels. Do we really want to get rid of this pain and continue on? This is especially a temptation in the athletic world. Is wiping out the pain worth the risk of future debilitation? The athlete must ask this question, and those working with athletes must be aware of the situation. Likewise, medical doctors must weigh the risks of alleviating patients’ physical pain to the detriment of the natural warning system.

On the other hand, there is another old adage: “no pain, no gain.” While usually applied to athletic training, it is also relevant in the worlds of physical rehabilitation, scholarship, emotional relationships, and many other areas. Here we recognize that some pain is useful and even desirable.

And what about spiritual pain? A person can often feel extreme pain over actions taken that impinge on the spiritual — the meaning of one’s life and love. To believe one has gone against one’s core positions can cause debilitating anguish and self-hatred and depression. While some pain in decision-making can be expected, to reach a state of scrupulosity and frozenness is unhealthy. This is pain that needs to be dealt with spiritually and psychologically. Sometimes guidance and introspection can help the situation. Just as the medical doctor responds, “Some pain is expected, but let me know if it gets worse,” so too can a spiritual mentor affirm the difficulty and complexity of the situation while giving helpful boundary guidance.

Ultimately each individual must deal responsibly with the pains in his or her life, but it is easier said than done. Likewise, those in the helping professions have a mandate to alleviate harmful and unhealthy pain — all the while recognizing that the culture around them may draw that line in a different place.

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Listening to residents’ concerns helps alleviate spiritual pain

By Michele A. Boccia

After a serious illness, Joan was admitted for long-term care. Sister Peg relocated from her convent because she was no longer able to walk on her own. Tess was unable to recover after several months in the rehab unit and was moved “upstairs” for more complete care.

Illness separates sisters from their communities and lay people from their homes. The transition is often so rapid, they may not be given the chance to pack up 50-plus years of their lives. These situations and others are the source of emotional and spiritual pain faced by the residents who live at Maria Regina Residence.

Maria Regina is a ministry sponsored by the Sisters of St. Joseph, Brentwood, NY. Numerous sisters of the order continue to serve in the facility, bringing their deep spirituality into residents’ lives. As a Catholic nursing home, the pastoral care department functions as a parish and offers Mass daily, community rosary, adoration, feast day celebrations, etc. Residents’ spiritual needs are met on many levels. However, in reviewing the results of a resident survey and listening to residents’ concerns, we heard about nonphysical pain, and most especially their spiritual pain.

Several sisters expressed that they missed the religious programs that were offered in their convents. One said, “I feel like my spirit is dying.” In response to their feedback, we expanded on Pope Francis’ Extraordinary Jubilee Year of Mercy, and a Year of Abiding in God’s Love was born. Each month we invited guests to give prayer presentations, musical performances, talks about art, and scripture. Some of our speakers included our bishop, the host of the Catholic Faith Network, theologian Sister Elizabeth Johnson, an imam, and a member of the Audubon Society to speak about God in nature. Local parishes, volunteers and congregations affiliated with us were invited. The response was overwhelmingly positive. It brought a sense of worth to the residents and an understanding of the depth within them in this new setting.

They also needed connection with those around them. We created two groups facilitated by volunteers, one for sisters and one for lay people. “Tea with the Saints” is our sisters group. Each Friday, fifteen sisters explore the life and ministry of a saint. If they could have tea with this saint, what might they ask? How does his/her life relate to theirs? The conversation is fluid and engaging. When I walk by, I often hear laughter and delight. In the lay group, a resident reads a story from Guideposts magazine and facilitates a discussion about the topic, which often veers off to personal stories about participants’ lives and families. A volunteer is there for support, but the group has gelled and runs on its own. It’s lively and dynamic. Members of both groups have bonded with each other, yet they welcome new residents with smiles and cheerfulness. Many residents have expressed, “This is the highlight of my week.”

What do a resident survey, Year of Abiding in God’s Love and two groups have to do with alleviating spiritual and emotional pain? Just about everything. Asking residents their opinion about what matters to them is a way of saying: “You are important to us. We care about you.”
Having outside guests attend programs makes residents feel like they are part of the larger community and can lessen feelings of isolation. Being part of a small group fosters friendship and intimacy. Residents have expressed that these programs have brought life, joy and normalcy to their experience in the facility.

We also seek ways to assuage loneliness and despair by deeply listening as we take an initial spiritual assessment. When Sally arrived she was angry and distraught. She was in her early 70s; her illness was progressing, but her mind was still sharp. During our initial conversation, I learned that she was an avid knitter and gardener. I connected her with a nearby sister who knits “cancer caps” for people going through chemo. The two hit it off and meet weekly to knit together, and often the sister brings a note of thanks from one of her recipients. Sister and Sally have recently started knitting “pocket prayer patches” to give to residents during our annual retreat. Sally was also encouraged to join the gardening club. She’s now a key member. She still gets distressed at times about living in a nursing home, but with her interests being tended to, these incidents have vastly diminished.

Sister Loretta is another example of how pastoral care tends to nonphysical pain. Because her body was no longer responding to physical therapy, she became a long-term resident, and we often found her in her room weeping. Exploring her feelings, I learned that members of her parish used to visit her in the convent to seek her counsel and advice. Through her tears, she expressed a loss of meaning and purpose. We affirmed Sister Loretta’s feelings, and suggested that she consider Maria Regina as a new ministry. We invited her to sit with the dying, welcome new residents and to join our newly formed choir. As she engaged with those around her, she began to brighten and feel more at ease with her new life.

Spiritual and emotional pain can be caused by loneliness, a sense of despair, isolation, sadness, and lack of meaning — conditions that are prevalent in nursing facilities. However, by listening to residents and learning about their lives and interests, we can find creative outlets to nourish their spiritual and emotional needs. We have more to do, but it is working at Maria Regina.

Michele A. Boccia, BCC, is director of pastoral care at Maria Regina Residence in Brentwood, NY.
Chaplains can ease patients’ fears of opioid addiction

By Linda Dickey

By now, everyone’s heard about the opioid problem. There’s no reason to repeat the statistics. Addiction rates and overdose deaths are shockingly high, and we know that prescribed drugs are implicated in thousands of cases. That’s why responsible doctors and many hospitals have made a strong effort to stop overprescribing the drugs. Dosage tapering is mandated, prescribing rates are tracked, and monitoring of staff is continuous.

Also, since it has been well established that pain has an emotional-psychological aspect, many hospitals now offer alternative modalities, such as cognitive behavioral therapy and other kinds of psychological therapy for chronic pain problems. I would argue that chaplain visits are making a difference, too.

It’s not surprising that many of our patients are concerned. I know next to nothing about the medicine part of dealing with pain. But I do know this: Patients are worried about addiction and dependence. Some have a family member who’s addicted to something—and they know there’s a genetic aspect to addiction. Or their worry is more global. They’ve come to the hospital to address a painful condition, and what they really want is for pain to end as a result of the treatment. They certainly don’t want to substitute one kind of pain with another that’s possibly worse: the pain of addiction that can lead to death.

In the last 10 years, I have visited many, many patients in a variety of settings—in hospice, in a VA hospital, in a cancer hospital, in a nursing home, and where I work now. Only twice have I visited patients whose pain was truly near or at a 10. I think I know what that’s like; I had appendicitis this year. My pain was near a 10. I couldn’t really talk or think — let alone walk — while it was going on. It held all of my consciousness while it lasted. That level of pain, which obliterates you, deserves as powerful a medication as possible.

For less extreme pain, chaplains have tools that can ease anxiety, like meditation, which most chaplains can teach patients quickly and easily. And we offer distraction. Think of the well-known selective-attention test in which subjects in a psychological experiment are asked to view a video and count how many players in white pass a basketball. Many of those who concentrate on this task entirely fail to notice a gorilla walking on the court. (You can see the original video at https://www.youtube.com/watch?v=vJG698U2Mvo.) Pain can be the gorilla. Distraction can be an effective pain medicine — and it has no side effects.

Obviously, chaplains will gladly pray with patients who wish it. Many find that prayer helps, especially when the patient asks us to pray for others. Prayer also changes the subject by focusing the patient’s attention on his or her relationship with God.

To those who believe the correct theological response to pain is to deny it, or that it is God’s deliberate way of teaching us a deserved lesson, I want to say no! Patients may tell us about
how others have it worse, and we can surely acknowledge this truth. But Jesus doesn’t ever tell people that suffering makes them better. He doesn’t say suck it up; make your upper lip stiff. He never says don’t complain, be stoic. In his Good Samaritan parable, the Samaritan treats the robber’s victim with oil and wine (medicines of the day). Healing people’s pain is what we want to do.

Some Catholics have a practice of “offering it up,” discussed elsewhere in this issue — and that idea is also in our toolkit. A fellow chaplain told me about her experience of offering up her pain from a late miscarriage for someone she knew who was suffering from terminal cancer. She said she didn’t know how the process worked, or even exactly what offering her own suffering for that of another person meant, but, she said, it seemed to give her pain meaning and purpose — which chaplains know all about.

I hope that chaplains will undertake research studies to demonstrate our value as part of the medical team in addressing pain. If we can prove that we add value without any risk of addiction — and I don’t think it will be hard to prove — we’ll be part of the solution to the problem of pain.

*Linda Dickey, BCC, is a per diem chaplain at a hospital in New York City.*
Art and nature can help patients manage their pain

By Susan De Longis

How can chaplains address the pain of patients who identify as “spiritual but not religious”? Prayer and traditional methods of pastoral care are effective for those practicing religion, but we all know that the population of the “nones” is growing, and our plans of care within an interdisciplinary model must evolve with them.

A variety of alternative techniques can support patient self-awareness and expression, but along with new opportunities come new concerns. Spirituality, combined with or in place of religion, is unique to each individual. A growing trend toward selecting what suits one’s personal needs has generated a multi-billion dollar industry, with varying degrees of credibility and credentialing. Further, alternative spirituality can sometimes move into New Age or occult practices. Catholic chaplains are challenged to discern and respect this diversity in our patients, while maintaining the integrity of our own beliefs.

We must not only maintain appropriate boundaries within our scope of practice, but in compliance with the guidelines of the Church. Resources can be found on the Vatican website, “A Letter to the Bishops of the Catholic Church on Some Aspects of Christian Meditation”¹ and the USCCB document “Guidelines for Evaluating Reiki as an Alternative Therapy”². These teachings are primarily based on a lack of scientific evidence and/or a foundation in non-Catholic religions.

However, I’ve used literature, music, and art in a variety of ways. A young man I worked with on palliative care service faced a lifetime of painful spine surgeries. After two months in a small, dark room across from the nurses’ station, and in constant pain, he withdrew into himself. At wits’ end, I suggested we move him to a newly available large and bright room in a quiet corner. He immediately responded to this healing environment, sitting up, engaged and alert. I gave him a book of beautiful nature photos, which refreshed his spirit, opening his closed system of intense suffering. I later showed him materials I had for coloring, from which he chose a complicated tropical bird. On returning, I was stunned by the brilliant colors and incredible detail of his work. With his pain now managed and his sense of self recovering, he was ready to invest in life again, and our beautiful bird soon flew out the door.

A devout woman in her mid-50s was a rare example of a hospice patient placed on home infusion for uncontrolled pain. It wasn’t working, and a deeper suffering lay hidden. She loved and missed the outdoors. Her sister played soft music with nature sounds, and I recommended turning her bed to face the large window framing her garden. Given her level of spiritual maturity, spiritual direction was most appropriate. Employing Ignatian scripture reflection, she used the gift of her imagination to enter into a passage, reaching a new comprehension of the deep sorrow in her troubled relationship with her husband. She was able to transcend her pain in every sense, in a transforming experience of forgiveness and reconciliation within herself, with God and with her husband. She let go of the inner conflict that had plagued her for decades, turning her attention toward completion of end-of-life tasks, including the composition of a loving, inspiring letter for her children. Her pain now well managed, infusion was discontinued and she calmly prepared for her journey home.
Another patient exasperated the staff at her residence. She was bitter and had constant, vague complaints of pain, which I observed usually followed episodes of anxiety. But she loved Asian art and allowed me to share a lovely book. She offered wonderful insights that helped her reconnect with herself. Her image of God was distorted by a life of conflict and an angry daughter, telling her to repent or she’d go to hell. I emphasized God’s love for her, and she delighted in this new understanding. As unconscious venting gave way to meaningful expressions of buried anger and disappointment, her bitterness dissolved and her pain was well managed. Having opened herself to God’s love, affirmed during many pastoral visits, she was reconciling her life and death within herself, with God and with three of four estranged children. She died with her family present, expressing and receiving genuine love for the first time.

Art and nature are, of course, very helpful when working with children. One young father tragically died, leaving several young children. Following an age-appropriate time of quiet sharing, each wrote a message on colorful balloons. They released them to a beautiful sky and watched, with eyes of wonder, as they soared, building a concrete image of lasting comfort and connection.

In every place I’ve worked, I’ve been fortunate to have regular time set aside with staff for spiritual care reflections. This offers experiential learning to understand, integrate and utilize the many-faceted resources and skills of the chaplain. A creative, interactive approach is personally helpful to staff and builds familiarity with the concepts and language of existential suffering, pastoral assessment and response, and the measurable outcomes that serve patients, staff, organization, and mission.

In exercising our creativity, we invoke the Holy Spirit as our constant partner. We serve as a model for others to recognize and express their own strengths and gifts in the universal language of meaning and beauty, instilled by our Creator. For some, we may be their first experience of unconditional love. Ultimately, our love is a witness to the miraculous and intimate love of God. Nourished and growing, our own daily spiritual practice increases our empathy for our patients in their struggles and joys. All that we are inspired to do in the beautiful mystery of love will draw those who are suffering closer to the true source of all peace and healing in the love of Christ.

_Susan De Longis, BCC, practiced and taught in hospital, hospice and palliative care settings as a chaplain, bereavement counselor, and family systems specialist for 27 years._

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References

²http://www.usccb.org/_cs_upload/8092_1.pdf
Listening compassionately to the pain and suffering of elders

By Sr. M. Peter Lillian di Maria

Suffering is a mystery — a challenge for all who have suffered — and each person’s story is unique. Often, we struggle to understand the suffering we experience while we are going through it. We never actually know in the present moment what precisely is happening to us; we are too busy trying to cope. It is frequently only long afterward that our eyes may be opened, and we can begin to understand how our suffering and pain may have changed us or challenged us. It is different for each of us.

But I have learned in my many years of ministry experience that having another listen to our story helps us find a place of serenity, and in this place of calm we can begin to understand healing. Helping others connect to the meaning of their suffering without judgment may not remove the suffering, but it may change the person’s approach toward it. Most elders can describe their pain but often need that compassionate listener to help them name their suffering. This is especially true for those who are memory impaired.

I have been privileged to travel with Dr. Michael Brescia, executive medical director of Calvary Hospital in the Bronx, NY, over the course of many years as he has lectured on palliative care and the five domains of pain (physical, mental/psychiatric, familial, spiritual, and emotional) that people experience. His presentations and my own experiences have caused me to reflect on how our elders experience these domains of pain, usually in the midst of debilitating diseases.

Each of the pains mentioned above can lead to a distinct type of suffering. Each person describes the experience of suffering differently, as it takes place deep within a person’s soul. People describing what their pain feels like may use distinct terms like “gnawing,” “dull,” or “sharp.” However, it is often difficult for people to share their suffering in more concrete terms.

We find the power of listening in the Emmaus story when Jesus comes upon the disciples as a stranger and listens. After they finish speaking, he speaks about the scriptures and reminds them that the prophets said the Messiah would suffer and die; in doing so, he would enter into eternal glory. They are so moved by his listening, his speaking, and, more importantly, his presence, that they return to Jerusalem with a renewed sense of peace. Our presence for those who suffer is the true meaning of compassion, which comes from the Latin compati—“to suffer with.” My experiences ministering to our elders with dementia has taught me the importance of living the word compassion. All people who suffer, especially those with dementia, need someone who will listen.

We can learn from the Emmaus story and apply its teachings to people who are living with dementia. As we listen, we understand their condition, and we allow their story to unfold in their time and in their reality. They, like all people, are coping with many forms of pain and suffering.
Physical pain is the easiest to detect, and often, the appropriate intervention can relieve it. But when we begin to assess for other types of pain and suffering associated with dementia, it is important to understand dementia and its progression. People who constantly say “I want to go home” are experiencing emotional and familial pain. If we can connect to the emotion by listening compassionately, we can affirm their need to be heard and to feel safe. Their desire to “go home” may mean they need to be somewhere familiar with people who know them. Where is this place? “Home” is where that person’s family is — it could be with parents, a spouse, their children, or any other place where he or she feels safe.

Sometimes we redirect too soon. Redirection may be appropriate eventually, but when we respond to the emotion first, we do as Jesus did in the Emmaus story; we connect the dots for them within their reality so they can feel that someone understands their emotional and familial pain. In doing so, we acknowledge them as the persons they have always been, and we validate that their concerns can still be shared and understood. We help them to know that their life continues to have meaning, even as their dementia progresses, robbing their memories and unwinding the fabric of their lives. They can share only what this disease of their brain allows them to believe is their present reality. The spiritual and emotional suffering they may be experiencing begins to be eased by our compassionate listening.

What does compassionate listening call us to be for those who suffer? Compassionate listening: Challenges us to be One in the Ministry we share to bring Peace to those who feel Abandoned. It allows us to Share in the Silence of peoples’ Inner being, Opening their hearts and bringing a New hope within.

Our foundress, Venerable Mary Angeline McCrory, once said, “Let us never lose sight that there is no substitute for love.” Her words are an affirmation to those who do all things in love and compassion as they minister to those who suffer.

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Chaplains can advocate for proper pain management

By Kathleen Kaskel and Patricia Moyle Wright

Few things can affect a person’s total well-being more than dealing with pain. It’s hard to focus on any conversation with visitors, or even with a sensitive, compassionate chaplain. Pain can be visible in restless movement, squinted closing eyes, quiet moaning, wincing across the face, protective guarding of body parts, withdrawal to touch, or even pulling away sheets that annoy.

Within the human person lies an integrated totality. Particularly when dealing with long-suffering or life-limiting illness, our emotional, psychological, spiritual and social/communal well-being or dis-ease will contribute to perceptions of pain. We gain insight into our complicated human nature and how this can factor into pain management by considering how family estrangement, guilt from participation in war, isolation or abusive relationships, fear of mortality and death, religious struggle (e.g. “God won’t give me more that I can handle”) — all play a part in managing pain. Repetitive triggers of misery (like vomiting, itchiness, intolerance to variance of temperature, air hunger, inability to swallow) or intractable physical pain all destroy the peace of both patient and family.

What can a chaplain do to alleviate this type of suffering? If the person can answer, ask if they have pain and report your findings to the nurse. If the person cannot answer, notify the nurse that during your visit, the person displayed whatever signs of pain you observed, and then remain with the patient until the issue is addressed.

Waiting for relief from pain causes profound suffering for patients and those around them. Chaplains and other healthcare professionals can suffer deep moral distress when witnessing suffering in the clinical setting. And, since pain management interventions often fall within the purview of nurses and doctors, the chaplain may sometimes feel helpless.

Yet there are ways a chaplain can advocate for a patient who is suffering. One of the most pressing issues for patients in pain is feeling dismissed. On three separate occasions, I (Kathleen) experienced dismissal of my reports of severe pain. As I was questioned by skeptical providers, I felt utterly abandoned. In addition to that, watching the silent screams of my mother as she received wound care tore at my soul. As chaplain and daughter, I advocated for improved pain management with the hospice staff. Simply taking a patient’s pain seriously can make a difference.

Chaplains are experts at easing patients’ feelings of abandonment and journeying with each person through illness, suffering, despair, and grief. In addition to validating patients’ emotions, chaplains can support the interdisciplinary team’s pain assessment by inquiring further into any nonpharmacological pain interventions the patient uses and sharing this information with providers. The chaplain can also use reassuring touch, focused listening, prayer, life review, silent synchronous breathing, and music with patients to help alleviate suffering. All of these strategies help chaplains advocate for their patients, facilitating a significant contribution to the total well-being of vulnerable people — and also to families and healthcare staff.

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A spiritual intervention for pain palliation

By Rabbi Melech Lensky

When patients share about the physical pain they experience, I feel sad that they must live with this challenge, and disappointed that I cannot palliate it in some way. (Granted, chaplains are not “fixers,” but hopefully there stirs in our souls a wish to help others and improve their lot.)

Recently, I read an interesting article titled “Pain, Spirituality, and Meaning Making: What Can We Learn from the Literature?” Authors Carol J. Lysne and Amy B. Wachholtz concluded from a study that “Words and images that evoke the presence of love, support, and/or comfort appear to have a salutary effect on pain.” (www.mdpi.com/2077-1444/2/1/1)

This prompted me to ask how I might put this finding into practice in a spiritual fashion in ministry. The result is this intervention. Please read it, use it if you wish, and feel free to share your thoughts, suggestions and findings about it.

The Intervention

Step 1: Ask the patient to share generally about his or her spiritual values and sources of support.

Step 2: Ask the patient what words evoke love, support or comfort; or what symbols, images or objects provide love, support or comfort. As a follow-up, ask how these words or images support the patient.

Step 3: Ask the patient to close his or her eyes for 60 seconds and to focus on the word or symbol. The chaplain can guide the meditation by gently reminding the patient from time to time to keep his or her focus on the word or symbol.

Step 4: Ask the patient how the “meditation” affected him or her. Did it tamp down the level of pain? Did it make the pain easier to bear? What else did they feel?

Step 5: Ask the patient if he or she could perform this meditation by himself or herself from time to time to tamp down the pain or make it easier to bear.

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Out of Rwandan genocide, a Tutsi priest offers forgiveness


By John Gillman

Some books are not for the faint of heart, and this is one of them. In the late spring of 1994, as many as one million people were slaughtered in a genocide in Rwanda. The author, a Catholic priest belonging to the Tutsis, lost more than 80 family members and 45,000 parishioners during this killing rampage. In this dramatic story, Fr. Ubald portrays the horrendous nature of the massacre and his overwhelming grief expressed in sleepless nights of tears.

Neighbor turned on neighbor, family members against their own, and seminarians and priests against one another. Such betrayal recalls the foreboding words of Jesus, when households will be divided with father against son and mother against daughter (Luke 12:49-53).

In an apology in 2017, Pope Francis expressed sorrow for the Catholics who were complicit in carrying out the genocide. Afterwards, many left the church. Others remained. Fr. Ubald recalls his mother as being a woman of great faith. Reduced to poverty after her husband was murdered in 1963, she nonetheless found ways to support her family. Looking back on this time, Fr. Ubald “thought of how God had taken care of my family.” Like Job, he did not “charge God with wrongdoing” (Job 1:22). But years later, after learning that his mother and most of his family had been wiped out during the genocide, Fr. Ubald, feeling an indescribable “great darkness,” wondered: “Why had God allowed such a thing to happen, and why was I not allowed to die with them?”

In spite of his immense loss, he carried the cross of genocide, preaching the example of Jesus whose life even up to his death was marked by forgiveness and mercy. Fr. Ubald encouraged the perpetrators, large numbers imprisoned afterwards, to beg pardon and seek forgiveness, for this is the only path to freedom. Experiencing a profound personal healing during a visit to Lourdes, he forgave the burgomaster who ordered the killing of his mother. Seeing the picture of the two of them together smiling speaks loudly about healing and reconciliation.

Listening to the testimony of the victims, many embittered, Fr. Ubald urged them to offer forgiveness, even before pardon is asked. Through his retreats and prayer gatherings at home and abroad, including the United States, he has been sought after for his gift of healing and his ability to facilitate reconciliation.

This book reads as a memoir, with retreat-like exhortations. Readers will be shocked by the enormity of brutality of which humans are capable and will undoubtedly be inspired by the power of forgiveness to heal a fractured people, a forgiveness that leads to inner freedom and renewed bonds of connection.

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