Pay more attention to the powerful force of empathy – by Mary T. Tracy
NACC adjusts Strategic Plan to account for tumultuous times – by Jack Conrad
What do nurses need to know about chaplaincy? – by Michele Le Doux Sakurai
Moms’ reluctance to let dying children go forces tough reflections – by Jim Manzardo
Simple chaplain interventions make a measurable difference – by Marty Folan, BCC, MPS
PTSD at end of life requires extra thought and compassion – by Rev. Alejandro De Jesus

Book Review
Book describes constructive uses of confrontation in spiritual care – by John Gillman
(Review of Confrontation in Spiritual Care: an Anthology for Clinical Caregivers)
Pay more attention to the powerful force of empathy

By Mary T. Tracy

What if we treated our empathy with the respect that we afford grief? Grief can be described as a powerful river that threatens to overflow its banks when we ignore it – or an ocean that threatens to drown us when we wallow in it. Either extreme – ignoring or losing ourselves in grief – can make an already difficult process more painful, complicated, and disorienting.

Fortunately, we have many helpful tools for navigating grief – Elisabeth Kübler-Ross and David Kessler come to mind, along with more recent work by Lucy Hone. But I sometimes wonder if empathy is a similar animal to grief – a powerful force that does damage when ignored, disrespected, or indulged as an end in itself. What if we learned to treat empathy as a marker of our humanity that demands a place at the table of our rational, spiritual, ethical reflection?

This idea has become increasingly urgent for me as I see how many people have lost faith in God or church, have lost contact with a faith community, or have lost faith in themselves and their own goodness in God’s eyes. At the same time, many others have actually grown stronger in faith, in awareness of our dependence on God, aware of the good that God can do through us.

The bond for both of these groups – those who have found their faith strengthened and those who have had their faith broken – is a powerful stream of empathetic resonance. I find myself helping others redirect their empathy into ethical, accessible channels of compassion, so that my colleagues, family, and friends can avoid a sense of powerlessness. For example, after a tragic fire claimed two young lives, my hospital partnered with the Red Cross to install smoke detectors in the homes of local families. I think it was as at least as emotionally helpful to the volunteers as it was to the neighbors receiving the service.

As for the alienated and those who have lost faith, I believe the way forward is to build relationships. That is true within our church communities, and I am starting to see how this can work very similarly and often in a more gratifying way within our mixed communities at work, in families, in neighborhoods, and at school.

For example, the day before Ash Wednesday, I emailed colleagues with a suggestion to pick a Lenten commitment that removed obstacles to our deeper joy in God, rather than one that imposed unnecessary hardship just for the sake of sacrifice. One colleague, a self-described atheist, responded to me personally, saying he had long ago dismissed God as a criminally negligent father. We went back and forth until we established common ground around our shared desire to avoid being “criminally negligent” neighbors to our brothers and sisters.

I had a similar conversation with a colleague at another Catholic institution who confessed her lack of faith as if it were the most dangerous, shameful thing she could say. And this was while talking about mission formation and how to do it better! But she proceeded to share some creative
initiatives about social justice work, which brought us back to what united us in our desire to live out social justice principles in the institutions where we serve.

However, such conversations can also descend into conflict around differences of faith perspective and moral standards. When conflict arises in my own mind about the relationship between faith and works, I reflect on how both Moses and Jesus responded to complaints about unauthorized personnel doing good works. I especially appreciate Moses’ response, roughly paraphrased as: If only everyone felt so moved to do such good!

All this has fed my growing sense that empathy can divide us if we let it, and it can connect us if we have the courage to establish it as common ground. I also believe that those who are motivated by this common empathy and yet do not have the comfort of faith in a loving, self-sacrificing, servant-leader God are more at risk of running dry.

I might be wrong – particularly for individuals like the two I just mentioned who may be drawing on a kind of faith that defies words. After all, they are working for Catholic institutions, but they could go elsewhere and do the same kind of work without all the crucifixes on the walls. What keeps them so integrated into a God-centric world? I suspect it is a subconscious perception that the God-centric mission/vision/values fit with their sense of empathy, more so than non-God-centric organizations in the same line of work.

A very small minority of people lack any sense of empathy, but it would be wrong to blame them for social and political problems. That would be like blaming deaf people for failing to hear an alarm. But sociopaths themselves suffer gravely in their lack of actual human suffering. My understanding is that they lack any of the joy of love and suffering with.

If we can redefine the most important social fault line as empathy vs. inability to feel, perhaps we can act with greater care for all – including the ones more likely to hurt themselves and others by sociopathic choices. We would certainly be in a better position to mitigate the damage done either by lack of empathy or by empathy run amok.

Mary T. Tracy, BCC, is director of pastoral care at Cleveland Clinic Marymount Hospital in Garfield Heights, OH.
NACC adjusts Strategic Plan to account for tumultuous times

By Jack Conrad

The last few years have been extremely difficult in so many ways for all of us, but certainly for the NACC staff and board. We are into our third year of COVID-19 and all of its implications. We were happy for David Lichter when he announced his retirement. His legacy is a large one. However, over the past year this required the board to focus on searching for a new executive director. We were so happy to find Erica Cohen Moore, who is bringing great excitement and energy into NACC.

So when the NACC Board gathered in Milwaukee in person in March for the first time after two-plus years, it was exciting. A good portion of the Board was new from three years back. Erica was new, and several staff members are preparing for retirement in 2022. So much was on our plate. But the interaction and camaraderie was wonderful and it led to great discussions about the next five to ten years.

We are heartened that COVID-19 has shown chaplaincy to be an essential function in healthcare. The need for professional chaplaincy will continue to rise. So we have updated our Strategic Plan to include four main areas: Ministry and the Church; Education and Marketing; Racial Justice, Diversity, Inclusion, and Belonging; and Structure and Finance.

Ministry and the Church

NACC is not just a wonderful organization dedicated to its healthcare roots. It is also an essential part of the pastoral ministry of the Church. Thus, we look to not only strengthen our members but also to grow our presence in more fields. In the last two years we have formed a relationship with the Catholic Prison Ministry Coalition, which has certainly raised our awareness of the need to assist prison chaplains. There are also police and fire chaplains, military chaplains, corporate chaplains, and more. All these people are part of the outreach of the Church.

Because of this expansion of scope, we need to organize NACC to create and curate programs for the development and formation of all who serve in the Church’s pastoral care ministry.

Outside of healthcare, much needs to be developed to provide for these new areas of chaplaincy, including levels of certification. We are forming an ad hoc committee to re-evaluate and re-envision the Associate Chaplain certification. This may well become an entry point for people who are interested in chaplaincy but aren’t now required to have a BCC for their ministerial position (e.g. prison chaplain, port chaplain, etc.). We see this also as an important way of advancing our membership.

We will also continue to grow our relationship with our Partners in Pastoral Care to take the competencies we have already developed and create a program that can be used by dioceses throughout the country. We will better utilize technology to deliver programming to ministers (volunteers, lay ecclesial ministers, chaplains, clergy) throughout the country.

We will also work with the ACPE and other organizations to increase the number of CPE classes available to people interested in ministry outside of healthcare (e.g., first responders, human trafficking, corrections, etc.)
This will require new organization on the part of NACC, and will require us to perform the next strategic goal well.

Education and Marketing

As mentioned before, chaplaincy has evolved, especially during the pandemic, as an essential function within healthcare, but it still is not recognized enough by the public. With our Strategic Partners, we plan extend our marketing initiatives above and beyond the “Choose Chaplaincy” campaign to increase awareness of the vital vocation of chaplaincy.

In addition we want to raise awareness in other institutions by proactive outreach to our colleges/universities. We will continue to support our Strategic Partners while maintaining independence as a Catholic organization. And we will be intentional about training pastoral care leadership who are involved in the development of our chaplains.

Racial Justice, Diversity, Inclusion and Belonging

In the last two years, our society has been reckoning with the disparities in our country and the world. This needs to be a focus for our organization as well. NACC will promote racial justice, diversity, inclusion and belonging among its members and assess/remedy inequities within the association. NACC is committed to providing formation and education to its leadership, staff and members in diversity, inclusion and belonging. We will:

- Require two CEUs annually on the subject.
- Continue to welcome and support members from our BIPOC communities and develop ways to lift people up into leadership roles who are from diverse or underrepresented communities.
- Grow our resources in Spanish and other languages.
- Continue to review competencies so they reflect the need for the diversity of chaplaincy.

Structure and Finance

To accomplish these goals, NACC must have the necessary personnel, financial resources, and technical tools. We are committed to:

- Seek grants and development support within NACC and in conjunction with our strategic partners.
- Increase membership via the CAC and Partners in Pastoral Care.
- Develop a comprehensive communication plan so that we can demonstrate NACC as the quality certification organization that it is.

So there you have it. NACC is looking to build on a wonderful 50-plus-year history and lean into the future to secure the profession of Catholic chaplaincy. We bring a wonderful ministry to all that we serve, and through our strategic goals hope to advance our profession.

*Deacon Jack Conrad, BCC, is manager of spiritual care at CHRISTUS St. Vincent Regional Medical Center in Santa Fe, NM, and a member of the NACC Board of Directors.*
What do nurses need to know about chaplaincy?

By Michele Le Doux Sakurai

As I headed to the last room at the end of the hall, I was stopped by the nurse. “That patient is a pastor and has had pastors and parishioners in and out all day. He is well supported and won’t need a chaplain.” It was late in the day, and I decided to wait.

The next day, while I was getting coffee in the oncology unit’s hospitality room, the patient’s wife approached me. “You’re the chaplain for the cancer patients, aren’t you? Please visit my husband. He is only 42, and the prognosis isn’t good. He is struggling with why God is doing this to him, and he can’t speak of his doubts to any of his clergy friends or community members. If you visit, please wait until everyone has left. Otherwise, he won’t feel free to speak.”

The patient’s visitors left at the dinner hour, and I knocked on his door. After I introduced myself, I asked if it was a good time, and he said yes. He spoke of dedicating his life to God, and he couldn’t understand how God could allow him to get this awful disease. He had a wife and three small children. Who would take care of them if he died? Where was God in these moments of fear and despair? Such thoughts would make him a pariah in his faith tradition. He feared that if his colleagues and church members knew his fears, he would die alone.

This patient lies at the heart of what chaplains do best. The nurse assumed that since he was visited by other pastors and parishioners, he had the support he needed. This nurse, like many other team members, will assess a patient’s spiritual needs and make the needed referrals. But sometimes, as in this case, the nurse did not have the tools to accurately evaluate a patient.

This is not atypical. Many nurses, and other team members, don’t know or care to know about chaplaincy. I spoke with a family member whose father was in the hospital for six weeks after a traumatic auto accident. Their pastor visited a couple of times, but she complained to me that no chaplain visited. She was overwhelmed and didn’t know what was available at the time. There was no nurse or team referral for her. I have worked with my share of nursing supervisors who would never refer to a chaplain, and I have worked with nurses who believed that all chaplains do is pray.

One nurse even told me that, at a painful and difficult death, she ordered the chaplain out. She had bonded with the patient, and she said, “I’ll handle this! He’s mine!” But later, after her shift, she sat in an outdoor natural setting and felt overpowered by her own feelings. She never considered for a moment that the chaplain could be a source of consolation for her.

Our local Catholic university requires all nursing students to take “Theological Dimensions of Suffering and Death,” and I am privileged to be on the team that teaches this class. I have the unique opportunity to help nursing students understand what chaplains do, as well as the importance of a chaplain on the team.
As you look at your ministry, what do nurses need to know about chaplaincy for you to better serve your patients? Are there biases or prejudices that become barriers to your ministry? If you had the opportunity to educate nurses while they were training, what would be the most important thing for them to know? How does your institution train your nurses about chaplaincy – through employee orientation, mission meetings, department meetings, etc.? Please send your stories, insights, and needs to vision@nacc.org. I will be happy to take your wisdom and suggestions and provide an article that can be shared with the entire NACC.

*Michele Le Doux Sakurai, BCC, has spent 27 years in chaplaincy. She has retired from hospital chaplaincy and is now providing educational support.*
Moms’ reluctance to let dying children go forces tough reflections

By Jim Manzardo

Over the past decade or so, I have learned to take a both/and world view, seeing mostly gray, and consequently I become more easily frustrated with black-and-white thinking in others.

But sometimes I still catch myself doing the same thing. I’m thinking of four similar cases in the PICU, in which parents’ theological perspectives stirred some angst in me.

In all of these cases, the mothers had a very similar theology, and I had my own very different thoughts about where God was in these situations.

Clinical Background

All four of these moms were forced to confront the most incredibly painful experience of any parent, the possible death of their child – two from drowning, one from a motor vehicle accident, and one from an inoperable brain tumor. These moms were abruptly thrust into the complex world of the PICU, with its own culture and language, and they were forced to make the most difficult decisions of their lives.

All four children were intubated. In the first three cases, neurologists told the parents that it was *highly unlikely* their child would eat, drink, speak, walk, see, or have awareness of their surroundings. In the last case, the mom was told unequivocally that the tumor’s growth would eventually stop her child’s heart.

But of course, *highly unlikely* communicates just enough uncertainty, the fact that medicine is not an exact science, and leaves open the door for possibility – a door some parents enter by choosing a tracheostomy for their child. In the cases of the MVA and brain tumor, the moms requested a tracheostomy, against the initial recommendations of the medical team. For these moms, there was a window of time to experience all the feelings and crises and to consider their options. For the two children who had nearly drowned, after that window, both were extubated and did not need a tracheostomy.

These mothers were from varying levels of education (one was a surgeon). Two were African Americans, one Haitian and one Mexican. They all had at least one other living child.

Theological Framework

All of these moms spoke of God as their ultimate source of hope, capable of not simply keeping their child alive, but of reversing the clinical, or physical, realities of their child. That is, making their child walk, talk, eat, drink, and be aware of their surroundings again. In two cases, their faith put them on the defensive with the medical team, seeing them sometimes as working against them, and even, in one case, being of the devil.
They all said that the only option their faith gave them was keeping their child alive. To choose otherwise was quite simply to fail to have faith, to fail to believe in the power of God to heal. Shifting from aggressive to palliative care, to them, was tantamount to taking their child’s life.

Their expression of their feelings varied. It seemed that the sharing of tears, and of admitting fear and sadness, was seen by them to be a weakness, an indication of a lack of faith in their God to heal. And I confess that in my career on many occasions, I probably “pushed” the other person to share more deeply than they wanted to, leaving them feeling quite vulnerable. In two of these cases, I wonder if that contributed to the moms shutting me out.

My Interaction

I listened to all these moms and spent varied amounts of time with each of them. In one case, I had only one visit. The boy had been at another facility for a while, and after the accident, the mother had been told her son would die in 48 hours. She told me with confidence that she had faith in God, that God would heal her son and the fact that he was still with them was a confirmation of her faith and answer to the prayers.

As with the other three children, her son lay in bed, eyes open but not tracking, not moving his body voluntarily, with a G-tube for feeds. This is relatively common in the PICU, and I encourage parents and staff to communicate with the spirit of the child locked within the body. I also try to understand how parents communicate with their children. When I asked the mother how she knew what her son needed, she looked at him and indicated that in that moment he was bothered by our talking. When I asked how she knew, she said because his eyes were open. That is how mom knows something is bothering him. Otherwise, his eyes are usually closed. I was speechless and felt heartbroken. When I asked how I could help support her, she asked for prayer. When I asked for what she would like me to pray, her eyes welled with tears, as she said, “that God awaken and heal him.”

My Reflections

What are these situations trying to teach me? What is the change to which I am being invited?

Humility, always. So much of life is out of my control, and it is mostly mystery. My heart broke for these moms, of course, but I also found myself thinking at times, “God is not going to physically heal your son. No, the doctors are not gods, but your God has put them in your path, they have good intentions, a ton of experience and knowledge, AND your child is only here now because of their interventions. It is time to let your child go, be in peace.”

Of course, I never say this. But I know it is what many who work in the PICU are thinking. All of our knowledge and experience shapes our response. We know, but still forget, that it is this parent’s first time, and it is their child, and they are the ones who must go through this hell on earth. I know that each person is unique and brings with them their own histories, cultures, and internal and external resources. The two Black women might have been carrying, consciously or unconsciously, an underlying mistrust of the medical system. The Mexican and Haitian mothers’ language barrier may have contributed to their understanding of their situations.
On the one hand, I understand how incredibly difficult it is to be in these parents’ shoes. I know from other parents that there is no greater pain than the death of one’s own child. On the other hand, I experience much distress with these parents’ theology. I know that their faith gives them a feeling of control in an otherwise totally out-of-control situation. It seems, though, that their faith has become an obstacle. My subjective, judgmental view is that these moms are actually showing a lack of faith in their God, and impeding their God from allowing the natural course of events to unfold.

I know that modern medicine puts these parents in these situations and also then becomes an obstacle to the natural dying process. In some ways, I see these four cases as a battle of God, or parents’ image of and belief about God, vs. modern medicine. But it does not have to be a battle. In fact, many parents see God working through modern medicine and its practitioners and either from the start or over time feel themselves working in partnership with the medical team.

I also know that these encounters, and the thousands of others I have had in my career, have greatly influenced my own theological perspective. So much is out of our control here every day: the accidents, the illnesses, their outcomes, technology’s continued development, parents’ responses, including their theological perspective, and their varied ability to make very difficult decisions. In this very out-of-control space, I/we daily have to surrender, to let go, and accept what we cannot change. The reality is I know and have control over so little, including who, how and where God is.

Jim Manzardo, BCC, is clinical care coordinator chaplain at Ann & Robert H. Lurie Children’s Hospital in Chicago.
Simple chaplain interventions make a measurable difference

By Marty Folan, BCC, MPS

Chaplains play an essential role in the healing of patients. But anyone outside the ministry, including administrators, will ask, “What do chaplains do with patients?”

While most other healthcare workers provide meds, take tests and readings, poke, prod, and wheel them around, a chaplain’s primary duty is to enter into the suffering, pain, despair, hopelessness, and, sometimes, joy of a patient’s experience and be with them.

To listen. To feel. To reflect. To spiritually assess. To empower. To pray with. To support.

The healthcare industry is slowly shifting toward measuring the quality of care. Under the Affordable Care Act, the Centers for Medicare and Medicaid Services began reimbursing hospitals based on quality of care delivered – above quantity.

And so it goes with the chaplain profession. We were once required to meet daily quotas for patient visits, distribution of Bibles, rosaries or prayer cards, but the shift to quality outcomes regulates our ministry as well. Quality outcomes are observed and measurable changes in a person’s ability to cope.¹

Below are four tools for measurable changes.

TOOL 1: A Stool

The University of Kansas Hospital at Kansas City conducted a randomized controlled study of 120 adult post-operative patients.² One physician was selected to visit all patients. For 60 of them, he stood by their bedside. For the other 60, he sat down beside them. Patient perceptions on the quality of visits differed significantly.

Patients who got a seated visit believed the doctor remained with them longer than he actually did. They believed he answered all their questions, was not in a hurry, was fully present, concerned, and listened to them.

Patients who met with the doctor who stood over them at the foot of the bed reported opposite results. They believed his visits were shorter. They experienced him as rushed. They felt he did not have time to answer all their questions and that he was not as concerned as they wished.

Sitting down beside patients sends spiritual messages:  I am with you. I am on your level. I am close with you. I am not rushed. I care.

As a director of spiritual care, I purchased stools for all chaplains to sit on during patient visits.

TOOL 2: An Intervention
An 80-year-old woman fought long and hard against cancer. Her son was her greatest support. Her provider and patient care team admired her courage and persistence, yet they knew the end was near. Day after day, visit after visit, the patient’s son remained with her, as his mother battled back.

A chaplain who had ministered to and supported the patient from the time of admission returned for a visit. The son excused himself from the room. At the end of the visit, after the chaplain departed and the son returned at his mother’s bedside, she passed away.

A measurable outcome? In the son’s own words, The chaplain aided her in letting go.

**TOOL 3: Prayer**

With resources diminishing in both the Catholic Church and Catholic healthcare, collaboration is more important than ever. When I served as director of spiritual care services at St. Nicholas Hospital in Sheboygan, WI, I reached out to prayer groups at five local Catholic churches, and they offered to pray for patients who requested prayer. Chaplains would inform patients that the prayer groups volunteered to take one day of the week each and pray for them on a first-name basis. Over the course of nearly eight years, the average percentage of patients who asked for prayer ranged from 80 to 99 percent each week.

Did prayer provide a measurable outcome?

Harold Koenig, associate professor of medicine and psychiatry at Duke University School of Medicine and senior author of the *Handbook of Religion and Health*, said traditional religious beliefs have a variety of effects on personal health. Koenig’s book documents roughly 1,200 studies on the effects of prayer on health. The results are mixed and controversial.

However, he said, results of studies show that religious people tend to live healthier lives and people who pray become sick less often. Other results include:

1. Hospitalized people who never attended church have an average stay of three times longer than people who attended regularly;
2. Heart patients were 14 times more likely to die following surgery if they did not participate in a religion;
3. Elderly people who never or rarely attended church had a stroke rate double that of people who attended regularly;
4. In Israel, religious people had a 40 percent lower death rate from cardiovascular disease and cancer;
5. and, Koenig said, “people who are more religious tend to become depressed less often. And when they do become depressed, they recover more quickly from depression.”

**TOOL 4: A Gift**

He was a grumpy patient in ICU. Noncompliant. Didn’t say much. No visitors came to see him. After a meeting with the patient care team, Chaplain Bob stopped by and introduced himself. A wave of the hand indicated no interest.
Familiar with the signal, Bob said, “I know you’ve been here a while, so I just wanted to stop by and see how you were doing. But if you’d rather not talk, I understand.”

The patient rolled over and looked up at Bob and motioned for him to stay. Bob sat down and listened. The patient spoke of his love of hunting and a memorable fishing expedition. Bob expressed interest and asked the patient to share memories. The patient recalled his catch of a 300-pound Atlantic bluefin tuna in detail. As the patient told Bob how it took more than three hours to reel in the catch, Bob noticed his patient’s smile grow wider, his eyes beamed, and he relaxed back in his bed.

The patient discovered meaning in sharing his story with someone who cared to listen.

Chaplain Bob returned to the patient’s room before his shift ended. He brought a gift from the hospital gift shop: a plaque with a fisherman on a boat.

Grumpiness was replaced with a smile and kind words for his patient care staff. He expressed appreciation to them and apologized for his bad attitude.

At the next patient care meeting, Bob was asked, “What did you do that helped?”

Bob said, “I sat down. I listened to his story and let him know I cared. His fishing outing was a meaningful experience, and he simply wanted to tell someone. I connected with him, and he appreciated it.”

Marty Folan, BCC, is former director of mission integration and spiritual care at St. Joseph Medical Center in Brainerd, MN.

Notes

¹ See https://spiritualcareassociation.org/faqs/1515-vi-outcomes-quality-indicators.html


⁵ Can prayer heal? Scientists have some surprising evidence that prayers help in some amazing ways. (Cover Story). (n.d.) >The Free Library. (2014). Retrieved May 02 2023 from https://www.thefreelibrary.com/Can+prayer+heal%3f+Scientists+have+soms+surprising+evidence+that...-a079974106
PTSD at end of life requires extra thought and compassion

By Rev. Alejandro De Jesus

Jim was a 72-year old veteran admitted to the Community Living Center from a nursing home. He served in the Army for four years, post-Korea. Afflicted with advanced amyotrophic lateral sclerosis (ALS), he used an electric wheelchair and communicated through electronic devices. He also presented with depression due to PTSD. He had no history of alcohol or substance abuse. He was Roman Catholic.

Jim had been divorced four times. One son had no relationship with him, while another was in prison. He refused to talk about his children in general, and preferred not to discuss his marriages. When he was admitted, he was placed on 24-hour watch due to his prior attempt at suicide – by driving his wheelchair to the middle of street.

My initial spiritual assessment centered on two main concerns: (a) a deepening loss of meaning in life, exacerbated by his worsening ALS as well as family issues; and (b) intense need for emotional support, a broken self-image and deep disappointment at his life and the lives of his children. In terms of spiritual distress, this veteran could be rated as between 9 and 10, with 10 as the highest suffering.

However, a couple of things were going right: his strong faith and his steadfast devotion to the sacraments and other spiritual resources. He attended not just Sunday Masses but also the weekday Masses, and regularly received Holy Communion. I also taught him to use his iPad, and later his keyboard, to count the Hail Marys when praying the rosary, since he could not use the beads. Much later, when he could not use even the keyboard, I provided him with rosary prayers on CD.

Jim’s outstanding spiritual resources were an effective counterbalance to his level of suffering, lowering it to perhaps 5, or even a 4, since he not only identified the resources that could help him cope and find meaning, but had also learned to ardently utilize them.

My care plan, therefore, helped him use his faith to make sense of a worsening disease, as well as broken family relationships and expectations. During Lent, I guided him through meditation on the sufferings of the Lord, leading him to realize tearfully that he shared in those sufferings through his debilitating and “humiliating” illness that seemed close to the “violence done to Jesus” (actual quotes from his iPad and monitor). I affirmed his realization and pointed out that receiving Communion unites us with the Lord, in both his joys and suffering.

He slowly opened up to me, expressing gratitude for being able to gradually accept the limitations imposed by his illness. I helped him identify the hurts and fears that underlay his anger, realizing it was uncertainty about the future that caused his anxiety. A few weeks into the care plan, he scribbled, “body wrek inside good” (sic).

A few days before he passed away, he struggled to make a few sounds and to move his body to tell me something. I replied, “I know what you mean, Jim. I love you, too.”
The prophet Jeremiah (4:19) cried: “My heart, my heart – I writhe in pain! My heart pounds within me! I cannot be still.” In similar verses, the prophet uses what theologians call the language of lament. We have almost lost this language in our religious communities but it is one that humanity fully understands – for who has not experienced pain in their lives? Esther Fleece notes⁴ that we need lament, since it pertains to that “passionate expression of our pain that God meets us in. It’s real talk with God about ways we are hurting. It’s an honest prayer to God about where we are, not where we are pretending to be.”

Jim’s entire world was crumbling, together with his physical body and his tortured mind. What saved him was his ability to express all this in lamentation, in a free-wheeling weeping and pleas for mercy to a God he was convinced was still listening to him. The spiritual writer Ron Rolheiser² pointed to the Book of Lamentations in the Bible as precisely describing Jim’s dilemma: that sometimes, all we can do is put our mouths to the dust and wait! The moment Jim discovered that lamentation is also prayer, his journey of hope in God was facilitated.

By receiving the sacraments, praying the devotionals, coming to confession, writing about his feelings, and remaining open to inspiration, Jim was actually overcoming the fear of dying. How inspiring indeed to do this while his debilitating illness was fast curtailing his modes of expression, until he could hardly move anything. But none of this could silence Jim’s lament. Esther Fleece truly describes Jim’s journey: “Lament is about tapping honestly into our emotions in a deep and primal way that sometimes transcends words. I am comforted to know that God meets us here, any way we choose to cry out.”

Jim is sadly not an exception with regard to suicide ideation and other mental health problems. Federal data shows that an average of 16 veterans die by suicide a day.³

As a mental health problem that develops after life-threatening events, like combat encounters, PTSD manifests in upsetting memories, trouble with sleeping or nightmares, and frightening thoughts.⁴ At other times, the sufferer may exhibit avoidance symptoms such as staying away from things that remind them of the traumatic experience or avoiding thoughts or feelings related to it.⁵

Medically, it can manifest as high blood pressure, respiratory distress, or obesity. A person can become easily startled and feel on edge, or even unexplainable anger. It also manifests in distrust of others as well as emotional numbness. Many patients also deal with other mental problems such as depression, anxiety, alcohol and substance use disorder, as well as thoughts about harming themselves.⁶

Complicated as PTSD already is, now try to imagine these sufferers at the end of life.⁷ Some of them experience what is termed as trauma triggers,⁸ that is, experiences that cause “instantaneous, unconscious, and highly charged associations with the traumatic event.” I witnessed an 88-year-old World War II veteran, a couple of days before he died, screaming at the top of his lungs, “Sulfur! Sulfur!”

Ministry to veterans require a compassionate heart that understands their profound woundedness and fragility of spirit. The scars of the war go deeper than the surface, and many moral and spiritual wounds pester them till their dying moments. Those who minister to them must be willing, ready and be of strong character to hold their bleeding and throbbing hearts gently.
Rev. Alejandro De Jesús is board certified by the NACC, the National Conference of Veterans Affairs Catholic Chaplains, and the National Association of Veterans Affairs Chaplains, and has a specialty certification in mental health as well as hospice and palliative care. This article is adapted from a talk at the Integrative Medicine and Mental Health Conference at the University of California Los Angeles, on March 9, 2019.

¹ "Reclaiming the Lost Language of Lament" by Esther Fleece Allen, retrieved from https://faithgateway.com/blogs/christian-books/reclaiming-lost-language-lament/#.YoLd4OjMKUl

² Sacred Permission To Be Human and the Tools To Handle Frustration, October 5, 2014, retrieved from https://ronrolheiser.com/sacred-permission-to-be-human-and-the-tools-to-handle-frustration/#.ZFJtc3bMjMm


⁵ "Understanding PTSD Treatment," National Center for PTSD, U.S. Department of Veterans Affairs, retrieved from https://www.ptsd.va.gov/understand_tx/index.asp

⁶ "What is Posttraumatic Stress Disorder (PTSD)?" American Psychiatric Association, retrieved from https://psychiatry.org/patients-families/ptsd/what-is-ptsd#:~:text=Posttraumatic%20stress%20disorder%20(PTSD)%20is,sexual%20violence%20or%20serious%20injury.

⁷ "Transforming VA Care at the End of Life," Thomas Edes, MD, MS Director, Home & Community-Based Care Geriatrics and Extended Care Office of Patient Care Services U.S. Department of Veterans Affairs May 20, 2010, retrieved from https://heller.brandeis.edu/health-industry-forum/materials/2010/may-19-20/Edes.pdf

Book describes constructive uses of confrontation in spiritual care


**By John Gillman**

The purpose of this timely collection of essays by spiritual care experts is to “illustrate how confrontation can be used in healthcare and its wider culture.” The editors have assembled the contributions of fourteen authors who share their wisdom on the benefits of confrontation in various spiritual care settings.

Offered with care in the context of an empathic relationship, skillful confrontation can facilitate a soulful human encounter and greater healing. Unfortunately, however, the first image of confrontation that may come to mind is getting into one’s face, raising one’s voice, issuing ultimatums, or laying down the law. The skilled use of confrontation in spiritual care is usually none of these. But offering “constructive critique,” which conveys a softer nuance, is not for the faint of heart – or for those who have not yet fully embraced their professional authority or pastoral identity.

The authors represent a variety of professional backgrounds: ACPE certified educators, several chaplains, a few managers of spiritual care departments, along with one student and one physician. Their examples illustrate remarkably well the effectiveness of confrontation. Gordon Hilsman, who wrote four chapters and co-authored two others, portrays how such direct interventions can be instrumental in the journey to recovery for those with drinking problems. Wes McIntyre explores the “transforming potential of being confronted.” Jill Rasmussen-Baker, a manager of the spiritual care department, describes how she used confrontation with her supervisor, for example, to maintain current staffing levels.

Other authors explain how they have used confrontation with gang members in the ED, the dying, mental health patients, the homeless, struggling church communities, the grief-stricken, and those suffering from moral injury. Both successful and unsuccessful approaches are woven into these narratives.

I would have liked to see greater attention to the use of confrontation in the Scriptures, spanning the prophetic tradition (Nathan confronting David), the psalms of lament (unrestrained protest to God), the witness of Jesus (confronting, for example, the accusers of the woman caught in adultery), and Paul’s “bold speaking” (Greek: *parrhesia*) to the early fledging community of believers.

I wholeheartedly recommend this volume of essays as a valuable resource for chaplains, managers, educators, and CPE students.

*John Gillman, ACPE Certified Educator, is an adjunct professor of New Testament at the Franciscan School of Theology in San Diego, CA.*