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Professional Practice

Dr. Diane Bridges on healing the soul

Caring for Seniors Touched by Post-Trauma Survival

For seniors who have survived war, genocide, terrorism (as well as post traumatic survival), institutionalization, and invasive procedures, powerful memories may be triggered and there may be further suffering.

These may present themselves in a variety of ways that may cause emotional, physical, and spiritual agitation. For example, people who survived the Holocaust might react negatively to small spaces if they had been transported in cramped boxcars, and, perhaps, rigid routines from concentration camps might be triggered by lengthy hospitalization. Symptoms such as anxiety and depression call us to pay attention to a patient's past history of trauma to the soul.

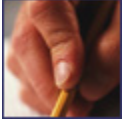
As gentle Mr. T's physical condition was rapidly deteriorating, staff were concerned that his emotional equilibrium was declining even more rapidly. Mr. T, a faithful man of prayer and faith, could no longer pray. He felt afraid of passing from this world to the next. It was not about pain control, nor did he seem to be hallucinating. He wept copious tears; he felt abandoned by God. He would become very withdrawn for long periods of time. I had come to know this kind man over a period of time and knew some of his history, but as many military survivors of the Great Wars, including my own father, I realized that these people secretly lived with some very dark stories. I suspected that in gentle ways I needed to "go to some of those places" with Mr. T. In revealing some of my own family's war stories, he one day burst into inconsolable tears and shouted: "I killed them; I opened the latch of the tanker and shot them to death. I can see their faces. Oh God, I'm going to hell! Have mercy upon me! Have mercy upon me!"

This poor tortured soul, who had fought so valiantly for liberty and peace, was now the victim of his own courage and valour. I put my arm around Mr. T's shoulder without any words. The Lord hears the cry of the poor. This man cried out for forgiveness. He needed to let go of what had held so much power over him in the past. A new journey of faith was about to unfold.

In the days following this episode Mr. T's health actually improved somewhat. I was able to be affirmative of Mr. T's military service and the services of his comrades. Reassurances of God's love and mercy calmed and comforted him as he struggled with issues of doubt and forgiveness. Soon after Mr. T died peacefully having received the anointing of the oils and the Sacrament of the Sick. The Department of Veterans Affairs and his parish community gave him a regal send off.

There is no magic wand to wave to heal the wounds of the soul, but I believe that we must convey to those whom we companion that the All Powerful will see to it that their wounds won't get the best of them.

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Advocacy

Rev. Dr. Steve Nolan on professional protectionism

Chaplaincy in the United Kingdom: Religious Care or Spiritual Care?

The history of United Kingdom (UK) chaplaincy goes back beyond the founding of the National Health Service (NHS). In the early post war period, chaplaincy was dominated by male Anglican priests, but slowly, as things changed socio-culturally so things changed within chaplaincy: there are now many more women, Free Church and non-Christian chaplains than there were 1948 and professional representation is now provided by a professional body, the College of Health Care Chaplains (CHCC).

With the socio-cultural changes and the weakening of the wider Church's role, there has come a weakening of the Church's role within the NHS – which, in my view, has both good and bad aspects. It seems inconceivable that sixty years ago anyone would have questioned the place of chaplaincy, let alone have suggested it be withdrawn; the professional body has an important part to play in establishing, or re-establishing chaplaincy's place within the NHS.

My own view is that we are limited by being too closely allied with religious care or, to be more accurate, by the common perception that spiritual care *equals* religious care. This perception is clearly apparent in a *Times* article, 'Hospital chaplains and the power of positive thinking' – published June 6, 2008 the subtitle ran: 'A fightback has begun over NHS cuts in *religious ministry*!' (www.timesonline.co.uk/tol/comment/faith/article4083128.ece)

I notice an anomaly at the heart of the way chaplaincy is currently positioned. On the one hand, in order to secure a chaplaincy post I need to provide some evidence that I am recognized/accredited by some religious organization, be that Christian, Jewish, Muslim, or whatever. However, once I am in post, the recognition/accreditation that qualifies me for post serves to disqualify me from ministering to sections of the constituency I am paid to serve: as a Christian (and a Protestant Christian at that), I can serve the religious needs of fellow (Protestant) Christian patients, but not patients who are Jewish, Muslim, etc. – or for that matter Catholic Christians.

So, I want to say that the main focus of my work is spiritual care, because this allows me to work with patients of any religious persuasion; it strengthens my value to the organization and justifies my salary cheque. However, I also want to continue to insist that those who can join me in this work must, like me, be recognized by a faith community. (I'm personalizing this, not because I want to represent my personal views, but because I want to express the contradiction in which I feel I am caught, personally and professionally.)

The difficulty I think we have as a profession (at least as I experience it in the UK) is that, although we emphasize (rightly) that our work is the work of 'spiritual care', the way we police the boundaries of our profession – insisting on religious affiliation – means that we are strengthening the misconception that we operate primarily as religious officiants, addressing primarily religious needs. Of course, we are not; and few who deliver our service would want to claim such, and few who experience the service we offer would express such. But my sense is that our professional protectionism fixes us in the psyche of service providers and managers as offering religious solutions to religious problems. (I think, to be fair, that in part this suits the service providers and managers, because religion is far easier to categorize, quantify and understand than spirituality – which, it seems to me, even those of us in the business have difficulty explaining succinctly!)

I think, as chaplains, at least in the UK, we are contributing to our own difficulties. If, by our protectionism, we are casting ourselves in the mold of religious practitioners, then it's perhaps understandable that, when budgets are squeezed, service providers and managers might think it is legitimate to cut chaplaincy posts and bring in local clergy (of whatever faith tradition) to fill the gaps in religious care. What we need to do, it seems to me, is be much clearer about what we offer – spiritual care – why it is important and why we are qualified to offer it – not simply because we are trained in the practices of a religious tradition, but because our training and experience in spiritual development (albeit within and informed by certain, specific religious traditions) equips us to be with others who are going through a period of intense spiritual crisis.

Of course, this approach challenges an overly simplistic sacramental approach to spiritual care – the value of which, I think, is in any case limited – and it faces its own challenge with respect to how it might be marketed to service providers and managers. But I think we as a profession need to face this challenge, which is, in part, to be more honest and transparent; in part, to give up the expectations of past privilege and to stand or fall on the integrity of our practice.

Rev. Dr. Steve Nolan is a full-time chaplain at The Princess Alice Hospice, Esher, UK. A Baptist minister, he joined the Hospice in 2004. He graduated from the University of Manchester and did Master's and doctoral work there in religion and representation, using film theory to explore the operations of liturgy on religious identity. He is currently training in Therapeutic Counselling (MSC), and has a research interest in the transpersonal. He has published work on the meaning of spiritual care (psycho-spiritual care) in non-religious contexts.



Education & Research

Chaplain Connie Regener on keeping nursing staff in the know

Honoring Religious Holidays

During certain times of the year, I issue memos to the staff of my hospital about upcoming cultural and religious holidays. I call them “nursing awarenesses” and make sure they include things a nurse or caregiver would need to know. This makes them practical and not purely academic. They have been wonderfully received. Here are three examples.

At **Ramadan** I clarify the exact dates, as this holiday moves from year to year. I give the number of the New Year and the traditional greeting, which is “*Ramadan Mubarak*.” I explain that Muslim tradition commands a fast during the daylight hours, and that includes water. The fast is traditionally broken with water/tea and a date, and a meal follows. I include that those who are sick, nursing mothers, and children are excluded from the requirements of the fast.

I also visit each patient who is admitted to the hospital during Ramadan to determine any religious needs, such as supplying a prayer rug or Muslim prayer beads. Next year the dietary department will be ordering dates.

At the **Jewish New Year** I also clarify the exact dates, as this holiday also moves from year to year. I give the number of the New Year (the most recent one was 5768) and the common greeting, “*L’shanah Tovah*.” I suggest that since God records the fate of humankind in the Book of Life during this week, indicating who will live and who will die during the coming year, it would be good for the staff to wish them well: “May your name be well inscribed.”

I also explain that on Yom Kippur, the solemn Day of Atonement, there are five prohibitions during the twenty-four hour period from sundown to sundown:

- No eating or drinking.
- No anointing with perfumes or lotions.
- No marital relations.
- No washing.
- No leather shoes can be worn.

In addition, I note that rabbis insist that those who are ill should not fast because health is paramount and takes precedence over any religious obligation. I have a letter from a local rabbi confirming this should one of the patients want “proof.” I also suggest that patients who wish to keep the spirit of the fast consider minimal food intake.

I visit Jewish patients to ascertain any needs for religious practices, such as using battery-powered candles in stead of burning candles at sundown on the Sabbath, and I then report back to the staff. The dietary department provides apples and honey for patients who may have these foods. This is a traditional way of welcoming the New Year.

At **Diwali** I give the dates of the five-day celebration, and note that the third day is the most important day. The traditional greeting is “Happy Diwali” or “Joyous and Prosperous Diwali.” I mention that this holiday marks the end of harvest and the beginning of the New Year, and has many elements in common with other New Year celebrations, including fireworks displays, meals with friends and family, exchange of gifts, reflection on past achievements, and hopes for the future. Nursing awarenesses include:

- Suggesting that battery-powered candles be used instead of the traditional oil lights.
- Monitoring traditional home-cooked foods being brought to patients, with respect to hospital policy.
- Reminding patients that feeling sad about being hospitalized during this time is normal.

I also mention that the U.S. House of Representatives recently passed a resolution recognizing Diwali as a Hindu, Sikh, and Jain holiday. I include a picture of the "Diwali Barbie" doll, which indicates mainstream acceptance of the holiday.

I consult with any staff members on specific patient issues. I also offer to share my religious census, in case any of the unit managers want to know which patients are celebrating which holidays.

The results have been extensive and far-reaching:

- Many of the nursing managers express relief that they are finally receiving definitive holiday dates.
- Several nurses approach me to practice saying the unfamiliar greetings.
- The memos give the chaplains credibility as much-needed resources for staff and to aid with sometimes unfamiliar situations.
- There is now an atmosphere of acceptance, where staff, too, feel free to express their values and practices.
- The patients express pleasure that the staff is aware of their religious holidays.

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Spiritual Development

Pastor Bob Ritchie on a patient's view of a chaplain

"What do you call this?"

While doing a unit of CPE, we were asked to write about pastoral care for our midterm. I wrote about a patient's view of life and the chaplain who visited him.

Looking back, we should have enjoyed it more. We could have been children longer, but our parents wanted us to mature. I guess we begged for it, too. There seemed to be a tension to it, but eventually the mature part won.

And then maturity leveled off. Until it did, life seemed to be about growing, and growing seemed to be about vocation, and vocation seemed to be about money, or happiness, or success.

Eventually it all got muddled and a lot of time was used up. Happiness came as long as we lived the present. Like snow, life covered up anything unattractive; salve, not solution.

Then when I landed here in this hospital suffering from a stroke, I hit the bed like a wall; running at it full speed, and collapsed. I felt I had nothing to show for all of my maturity. I couldn't understand what I had missed. I had done it all; my parents and my wife said I did.

She visits; they don't, having died years ago. She reassures me, and talks about what is going on in our big house, and how the neighbors are fixing theirs up. Bill, our next-door neighbor, got a hole in one on Sunday morning. News from the neighborhood – something even yesterday I would have thought cool – but today I think of Africa, and of starving water buffalos and people with them – not in that order, but stronger than golf.

Then in comes this guy, "Who are you?" I ask.

"A chaplain," he answers.

"What do you do?"

"Listen," he says.

I hesitate. "Listen to what?"

"You," he answers.

"I have people who come to me for that," I said, "A wife, neighbors and children."

"What do you talk about?" He asks.

"Holes in one."

And he says, "He doesn't."

"Doesn't what?" I ask.

"Talk about holes in one," he answers.

And I say, "Why?"

And he says, "What?"

"Holes in one," and I repeat, "Why?"

"Because there is more," he responds.

And I say, "I remember," and I do. "Back before all of the maturity began. When I paid attention to God and the world, and knew what I wanted to hold onto, even when I had nothing but God and life, good health and youth."

"That's it," he said. He had been listening. I thought he had left, but he hadn't.

"That's what I talk about," he said, "Well, rather, you do. Do you have more?"

And without hesitation I replied, "Much."

And he said, "Let it happen."

And I did, it poured out like water. I thought I had been dying, but this was life at its fullest, not experienced so maturely since childhood.

"What do you call this?" I asked.

"Caregiving," he answered.

"To me?"

"To both of us," he said, "It is spiritual growth."

It was then I could see that maturity is about more than the things we can touch.

Pastor Bob Ritchie pastors The Bennington Congregational Church in Bennington, NH. He has found his first unit of CPE at Havenwood Heritage Heights in Concord, NH, rewarding and informative to his parish ministry. Bob enjoys writing and writes a weekly column for the Monadnock Ledger Transcript called "Moments of Bliss." In his spare time he continues a "lifetime" of work on counseling and divinity degrees at Gordon Conwell in Hamilton, MA, and enjoys the solitude of rural living with his wife and two shelties.



BioethicsWalk

BioethicsWalk addresses bioethical issues that chaplains face in their day-to-day work. *PlainViews* invites our readers to share their responses to each *BioethicsWalk* column, which will be published in the following issue. We also invite our readers to submit areas of concern/interest about which they would like Nancy to write.

If you'd like to respond to *BioethicsWalk*, please send a comment of no more than 100 words. You can use the e-form below (click on "hearing from you," link) or submit your commentary to the editors in the body of an e-mail (or as a Microsoft Word attachment) sent to Info@PlainViews.org. Please put the phrase "*BioethicsWalk*" in your subject line. Comments that are too late for the previous issue can be viewed in TalkBack.

We look forward to [hearing from you.](#)

Summer Reading

Sociologist Raymond de Vries taught me that the sociologist's goal is to observe a culture, then describe it so clearly that a member of that culture can say, yes, I recognize my life. Sharon R. Kaufman, a medical anthropologist, has done just this for anyone who counts themselves as a member of the culture called "end of life care." Her book, . . . *And a Time to Die: How American Hospitals Shape the End of Life* (University of Chicago, 2005) is a must-read for chaplains. Kaufman spent several years minutely observing the ICU, the ethics committee, and long-term care. Nothing escaped her notice, including the presence of chaplains, their role in the care of dying patients and their families, and their struggles with how end of life decisions may be framed or carried out under the cultural and economic pressure to make individual cases conform to established story lines: the "heroic" pathway of technology; the "revolving door" pathway of the chronically ill. She also describes two states – "waiting" for death, and "life with no end," when technology is life-saving but not life-restoring – that exist in tension with the drive to "move things along" toward resolution and reimbursement. Go find this book. It may not suggest itself as ideal vacation reading, but it is a page-turner.

More on sociologists and reading: I've just finished co-editing a set of six essays collected under the title, "Chaplains in health care: What is their role in improving quality?" This essay set is the final product of The Hastings Center's research collaboration with The HealthCare Chaplaincy, made possible by the Arthur Vining Davis Foundations, in which we explored the relationship between the "professionalizing" profession of chaplaincy and the quality improvement movement in health care. Authors include Ray de Vries and fellow sociologist Wendy Cadge, on what is gained – and lost – when an occupation decides to become a profession; medical educator and religious studies scholar Margaret E. Mohrmann, on the challenge of "ethical grounding" for a health care profession that is also a ministry; and clinical ethicist Martin L. Smith, on the parallels between chaplaincy and clinical ethics as professionalizing professions whose members may benefit from more frequent and conscious collaboration. Chaplains Martha R. Jacobs and George Fitchett, and other scholars who study chaplaincy, also contributed to this essay set. It will be published in the November-December issue of the *Hastings Center Report* and will be available online; watch this space for details.

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Advisor. She is a frequent presenter at grand rounds and other ethics education programs for health care professionals. She volunteers on the Chaplaincy Service at Memorial Sloan-Kettering Cancer Center in New York City.

She is a graduate of Smith College and holds the Ph.D. in English Literature from the University of Glasgow and the M.Div. in Christian Ethics from Union Theological Seminary.



LongView

Chaplain Judy Seicho Fleischman on caring for persons living with HIV and recovering from trauma

Healing Community: Transforming Trauma in Relationship

A clue to the journey on which I was embarking arrived in the form of a question from a chaplaincy mentor.

While interviewing me for a chaplaincy position, he cautioned, "Whoever serves in this role will be a lightning rod for this community. Some people thrive on this energy and some people are depleted. You need to ask yourself, which type of person are you?"

That was two- and a half years ago. Since that time, I have been privileged and challenged to deepen my understanding of this question while providing professional chaplaincy services. The setting has been an adult day treatment center for people living with HIV who face increased health risks. During this time, I have become increasingly aware that healing manifests in relationship. I consequently sought an integrative approach, which led to developing a model of inter-relational, interdisciplinary care entitled, "*Healing Community*."

This model tailors treatment for individuals living with HIV and additional stressors including: homelessness, trauma, mental illness, drug addiction, alcoholism, domestic violence, and criminal activity. These factors contribute to their increased health risks, such as self-medication, self-isolation, and non-adherence to medical treatment.

Senior administrative staff and the substance use specialist estimate that 90% of clients report history of trauma and 90% report history of drug addiction and/or alcoholism. Over 50% are diagnosed with a mental illness.

The need for a compassionate container for caregiving is evident. This need led to an historic initiative, which in turn led to my hiring. The initiative was between Housing Works' West 13th Street Adult Day Health Treatment Center, the largest of four sites in NYC, and The Healthcare Chaplaincy (HCC). This effort marked a shift for the Center in defining spiritual care from pastoral counseling to professional chaplaincy.

The Center's then executive director wanted to integrate spirituality in an inclusive, broadly-defined manner. He saw this as a foundation for healing in an interdisciplinary context.

The resulting contract called for HCC to recruit a board-certified or certification-eligible, professional chaplain who would provide twenty-one hours of care per week to clients and notably to staff, which was a new concept for this facility. Also, HCC provided two documents: a "Best Practices for People Living with HIV/AIDS," and a "Spiritual Assessment" template tool.

Noteworthy demographics include: 76% of all clients identify as male, 56% as African American/Black (predominately African and Caribbean American) 39% Hispanic, 5% Other. 4% identify as Transgender. Many clients identify as Gay (same sex partnering) or Bisexual. These demographics indicate the role that sensitivity to racial, multi-cultural, sexual orientation, and gender identity issues plays in serving these clients.

Clients' religious demographics reveal inter-relational issues as well. The general intake census for religion, meaning what clients report during admission process is: 48% unknown, 7% none, 12% Protestant, 5% Roman Catholic, 4% Baptist, 3% Muslim, Buddhist 1%, and 19% Other. What they report in the chaplain's presence is quite different. Based on over one hundred spiritual assessments as well as hundreds of individual sessions, 85% of clients identify as Christian, primarily Protestant and Roman Catholic. Significantly, many also report feeling alienated from their religious communities and/or their "Higher Power" (in monotheistic terms, God as they understand God to be).

Facing multiple hardships and unable to resolve discrepancies between espoused and operational theologies, many clients verbalize feelings of self-loathing and/or ambivalence in relationship with their Higher Power. Furthermore, many report feelings of guilt and shame as well as fear of abandonment in relationship with their religious communities and/or Higher Power. The strategy many clients then employ is self-isolation.

Another important factor is the theme of loss in relationship. Individuals experience statistically higher deaths in their circles of loved ones. These likewise occur at an earlier age than in the population at large. Coping with a sense of loss is often less than adaptive. Self-isolation and self-medication with drugs and/or alcohol are common.

Recognizing these interwoven issues, the organization adheres to a 'harm reduction' rather than abstinence based model of treatment. The healthcare program assembles an impressively diverse interdisciplinary team, including full medical and social work services and many other disciplines such as creative arts therapies, vocational rehabilitation, and forensic (incarceration history) counseling. The Center also operates a targeted outreach program to transgender persons. Advocacy (local to international) is a primary mission.

Finding the treatment modality that serves best has been a personal journey. During my first year, the greatest challenge was the steep learning curve in providing clinically meaningful documentation including chart notes for my billable services. Constant vigilance to detail is crucial for coordination of care and to demonstrate compliance with care and funding guidelines to overseeing external agencies in a climate of changing political conversation over "appropriate use" of these funds. I struggled to offer care and to document within the twenty-one hours allotted per week.

During my second year, my focus shifted to larger issues of client safety and staff sustainability. A sense of urgency increased as we experienced a higher number of client deaths than in previous recent years, including several suspected suicides from drug overdose or neglect of medical treatment regimen.

Seeking to respond to the elevated stress, I began to frame challenges as inter-relational and to promote a spiritual foundation in terms of interdependence.

Healing Community integrates spirit-centered care, mindfulness meditation, and therapeutic play within an interdisciplinary context to promote healing in relationship.

Spirit-centered care is inter-disciplinary care in an integrative care setting, which is rooted in a person's experience of spirituality as the expression of what they value. Mindfulness meditation is a widely applied clinical method, which Jon Kabat-Zinn describes as "paying attention . . . nonjudgmentally." [1] Therapeutic play, from my perspective, is the experiencing of wholeness through creative expression, both verbal and non-verbal.

Inspiration for this inter-relational view of healing draws on two images from the spiritual traditions in which I practice. Buddhist cosmology offers Indra's net, which extends infinitely and contains a jewel in each of its vertices. Each jewel perfectly reflects all the others. This illustrates what Zen teacher Thich Nhat Hahn coins as "inter-being" or interdependence. Transformation manifests in the moment of directly realizing this interdependence. [2]

The second image is drawn from Jewish mysticism and depicts revelation at Sinai, the moment when the people assemble and as Rabbi Arthur Waskow states, "become a community" [engaged in] "a constantly unfolding process of revelation in which everyone in every generation is able to be present. . . to join in partnership with God." [3] This revelation is a covenant or contract in relationship.

These images frame *Healing Community* as an inter-relational practice, which in Zen terms could be called "direct realization" and in Jewish terms, "ongoing revelation." Significantly, it can be presented in a secular manner, hence accessible to everyone. Contract in relationship is not new to this setting. I simply applied it in a new way.

The contract began in me. Identity and community became major issues for me in this setting. I wondered how could I offer care, even while utilizing professional chaplaincy skills, to a largely Christian demographic when this is not my path of spiritual practice? Also, as a Caucasian woman from a middle class

background, how could I authentically engage with those for whom race, ethnicity, and poverty (to name a few issues) are daily challenges in relationship? Finally, how could I embody pastoral authority within a community, which tended to identify me as their pastor, a traditionally Christian, male authority figure?

This difficult process of introspection led me to embrace being different as an expression of being interdependent. Then, I could direct these differences to be of service.

Seeking to understand the purpose and scope of our contract in relationship, I began a research effort. My goal was to identify common values based on patterns emerging from individual sessions with clients and staff as well as spiritual assessments and groups. I utilized Non-Violent Communication (NVC), a model developed by psychologist Marshall Rosenberg, to formulate a needs assessment.

It is notable that clients and staff expressed differences in what they identified as paramount concerns. The primary needs stated by clients were: safety, trust, dignity, guidance, purpose, and belonging. Among staff, the primary needs stated were: sustainability, integrity, fulfillment, appreciation, and rest. To meet some of these needs, I advocated for a quiet, contemplative space, called the "Reflection Room," and for a bulletin board, which we named "Healing Community."

The room was decorated sparingly. Above the entrance, we posted a photograph taken in New York's Central Park of children of different races holding hands and lying on the ground to encircle one word in the center: "Imagine." Spiritual groups meet in the room as do other groups. The room also is available for general use consistent with guidelines posted on the door.

Inside the room, we placed a clear vase with vine cuttings growing roots. This was inspired by a verse from Psalm 80, "I took a vine cutting out of Egypt and planted it . . . and it struck root." These vines offered a poignant reflection for those reporting significant displacement and marginalization issues.

A large, framed print of abstract art that was hung on the wall became a powerful metaphor for making meaning of one's experience. During groups, I refer to the art as "what's happening" and the frame as "what it means to me." It focuses client's attention on intention.

For instance, I asked a client reporting panic attacks, trauma history, and a gambling addiction to visualize the abstract art as himself standing at the slot machine. I pointed to the frame and asked, "what's your fear?" He replied, "losing." I then asked, "what's the bigger picture?" He smiled and replied, "trusting the unknown." I guided him in a succinct, breath-centered prayer using his words. "Breathing in, trusting" and "Breathing out, fear." He has repeated this prayer often and reports it as an effective intervention when feeling panic arising.

The "Healing Community" board resides close to the Center's entrance and promotes a sense of purpose and belonging. We decorate it seasonally. We attached a mirror and above it, posted the phrase (in English and Spanish): "Look Closely." Below, we posted a monthly "reflection" such as November's "How am I generous?" Clients contributed succinct writings or drawings to a compilation entitled, "Stories of Generosity," which was presented to the assembled community on Thanksgiving.

Staff contribute as well. December's "what does peace mean to me?" resulted in a peace banner. The endeavor offered a bright antidote to despair and hopelessness. People were grieving deaths (some quite recent) of loved ones, some of whom were clients. Participants shared tears and laughter as they reported experiencing themselves as members of an extended family.

Recognizing the need for co-creative ritual, I reached out to clients and staff in preparing for then frequent memorial services. Clients participated in all aspects. This helped to contain and contextualize grief as a shared journey.

Entering my third year in the Center, I suggested and collaborated with several clients and the director of creative arts therapies to initiate a "Reflection Board." Its purpose is to hold participants' reflections on what had become our monthly "Healing Community" theme. The board has the appearance of a big mirror. The reflections have evolved. For instance, for this June's, "How do I feel about working together?," one client drew a big circle with a dot at a distance from it. Beside the circle, he wrote, "them" and beside the dot, "me." His contribution empowered peers to express inter-relational stressors as well as benefits.

I also initiated a *Healing Community* monthly outing, which connects with the monthly theme. Each trip is co-facilitated whenever possible with a colleague to link our disciplines. During our first outing, a psychiatric social worker joined to offer a trip to a museum whose artwork illustrates the interplay of spirituality and psychology with the theme of "Transformation." This June's trip was to a community garden with the theme of "Working Together."

Current spiritual groups reflect pressing issues, namely: "Living with Dying," "Moving On," "Spirituality and Recovery," "Spirituality and Health," and a monthly "TranSpirit" (for transgender persons and friends). Additionally, a minister from a nearby church offers a non-denominational, Christian Sunday service and Bible study.

I integrate mindfulness meditation, voice dialogue (a psychological method of integrating aspects of oneself, developed by Drs. Sal and Sidra Stone), breath-centered spontaneous prayer, and therapeutic play (especially music, movement, and touch).

During groups, rather than stating "group rules," I facilitate a process for clients to enter into a contract concerning guidelines for communicating. As we close, participants enter into a contract to take up a mindfulness practice, which we articulate together, during the week. This usually incorporates a form of breath-centered prayer. Simple repetitive phrases reflect meaning, such as "breathing in calm, breathing out fear." Many clients report this as a skillful intervention, which helps them to reduce self-harmful behaviors, promotes insight, and fosters healing friendships.

We celebrate interdependence as a community with an event in July called, "A Day of Unity: Celebrating Diversity, Expressing Who We Are." It incorporates a participatory music and art program. This month will mark our three-year anniversary.

These efforts have born fruit. While the issues appear to be complex, and there have been a number of coordinated organizational initiatives including *Healing Community* outreach, this endeavor has contributed to several tangible outcomes.

I see clients more engaged in treatment. Staff are more aware of self-care and client care as a collaborative and shared responsibility. Most of all, I see a more appreciative and pro-active community reshaping itself to simultaneously value differences and express these with a sense of common purpose.

Our next step might be to produce measurable data to quantify impact on specific clinical issues and outcomes.

A poignant portrait of the impact of these efforts arrived just before Father's Day this year. During "Moving On" group, an African American woman whose son had unexpectedly died in his early 20's, shared her rage: "I am angry with my Father [referring to her Higher Power] and don't understand." A Hispanic woman in her mid-20's said, "It makes me sad because I think of my kids [in foster care] who I haven't seen in years. My kids and my father. He's the reason I've got them. I don't want to think about that." As we went deeper, clients cried and reached out to one another. As our time together drew to a close, I said, "let's stand" and led the group in a breath-centered spontaneous prayer with everyone holding hands. This transformed into a group hug. While reflecting alone immediately afterwards in silence, a client returned to the room. He had forgotten his paper. Seeing me, he said, "this room finally served its purpose." I nodded silently.

I look forward to extending this vision widely, beginning with a website, www.sensingwonder.com. As our world grows larger and smaller, *Healing Community* is our shared purpose and awesome responsibility. Like a lightning rod, we can be energized when inconceivable power moves through us. Nothing to fear. Nothing to hold us back. How marvelous!

Footnotes:

[1] Jon Kabat-Zinn, *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*, Hyperion, 1994, 4.

[2] Thich Nhat Hahn, *Being Peace*, Parallax Press, 1987, 87.

[3] Rabbi Arthur Waskow, *Seasons of Our Joy*, Beacon Press, 1982, 191-192.

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Hal Stone, Ph.D., and Sidra Stone, Ph.D., *Embracing Our Selves, The Voice Dialogue Training Manual*, 1989, Nataraj Publishing. Resources available at: <http://www.voicedialogue.org>.

Rabbi Arthur Waskow, *Seasons of Our Joy*, Beacon Press, 1982, 191-192. Resources available at: <http://shalomcenter.org/>.

Jon Kabat-Zinn, *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*, Hyperion, 1994, 4. Resources available at: <http://www.umassmed.edu/cfm/>.

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MyPractice

As professional chaplains we need to be in dialogue with each other about what we do, how we do it, and why we do it a certain way and how these practices benefit our patients. The ultimate goal of **MyPractice** is to build a consensus about what constitutes “good practice” and eventually establish “Standards of Practice” for chaplains. As with quality improvements in our institutions, this is an ongoing process in order to improve our practice.

To have a description of a practice that you use in your setting considered for inclusion here, write it up and send it to *PlainViews* for consideration. The Association of Professional Chaplain's Quality Commission's Best Practice Committee will work with the Managing Editor of *PlainViews* to review submissions and select articles for publication. Your submission does not necessarily need to be cutting edge (although that's okay, too). We want to identify “good practices” that could be recognized as standard practice.

PlainViews will highlight one article in the second issue of each month. **Readers are invited to respond to the featured practice.** Responses will be posted as they are received. This is a great opportunity to start a process that will move us forward in professional chaplaincy.

If you'd like to respond to **MyPractice**, please send a comment of no more than 400 words. You can use the e-form below (click on "hearing from you," link) or submit your commentary to the editor in the body of an e-mail (or as a Microsoft Word attachment) sent to Info@PlainViews.org. Please put the phrase “MyPractice” in your subject line.

We look forward to **hearing from you.**

A Clinical Advancement Program for Chaplains

After I had been at Cincinnati Children's Hospital Medical Center (CCHMC) for a number of years, and my staff had begun to grow, someone on my staff raised the question about the possibility of advancement in the hospital system. What they were wondering about was the opportunity for promotion, for moving into leadership roles. They noticed, for example that, while senior nursing directors might be recruited from both within and without the walls of CCHMC, most of the assistant directors were recruited from the ranks of the staff nurses – persons who had shown leadership abilities and were being given an opportunity to take on formal leadership roles, and thus move up in management. Were there similar opportunities for staff chaplains? The answer, not surprisingly, was no. We were a small department, which had a director, and associate director (who was director of CPE) and then everyone else.

But this led me to think more about the issue. CCHMC was committed to fostering professional growth in all its disciplines, but what incentive (other than satisfaction for a job well done) was there apart from an annual performance review? Around this time I began to notice that such disparate clinical professionals as social workers and dieticians were instituting a clinical advancement program (informally known as a “clinical ladder”). I wondered if such a model could be implemented for chaplains. I consulted with a clinical advancement “guru” to check it out. She was very encouraging, and with the support of my boss, I set to work to develop a clinical advancement program for chaplains.

The guru and I, along with one of my staff chaplains, began by looking at the process developed by the social workers. There was much in their process and standards that was translatable; we did not need to reinvent the wheel. Then, we produced the following purpose statement for the program:

- To encourage all chaplains to strive for excellence through professional growth
- To promote recruitment and retention of experienced and skilled chaplains within the medical center.
- To increase the clinical competence and clinical leadership skills of the staff.
- To strengthen the clinical and programmatic leadership of the department.
- To recognize chaplains with superior clinical and leadership skills.

Two critical tasks emerged. One was to come up with three job descriptions – one for each level. Level I was the baseline – all new hires would enter as Level I. It essentially required Board Certification (APC, NACC, NAJC) and professional pastoral experience. Levels II & III added skills and competencies of such rigor that time and investment would be needed to develop them.

The other task was to define the process. This meant deciding what materials would be required and what the review process would entail. We borrowed most heavily from our colleagues. Materials include such things as a CV, documentation of clinical work, letters of reference from clinical peers, a justification statement, etc. Review for Level II would be a paper review by committee; for Level III it would include a face-to-face meeting with a committee. If the review found that the chaplain demonstrated competence at the next level, then the chaplain received a promotion and a 10% raise (which is standard in the hospital).

Two things were communicated at the outset. One was that no one was required to move “up the ladder.” We hire at a base-line level of competence and recognize that some chaplains are content simply to do their job and do it well. The other was that all conversations about advancement needed to start with the director and would have the goal of beginning a dialogue about the chaplain’s readiness to make this move. The chaplain would be discouraged from formally applying until there was agreement that s/he was ready and his/her materials were in good order.

All of this was put together in a manual which was presented to the staff in 2004. Since then, one chaplain has successfully completed the process and four others are preparing to complete it in the next few months. We believe that this process keeps faith with our staff by offering tangible rewards for professional development. It also places us among our professional peers in defining and rewarding professional excellence.

Rev. Canon William E. Scrivener, B.A., M. Div., BCC, is Senior Director of Pastoral Care at Cincinnati Children’s Hospital Medical Center where he has served since May, 1990. He received his B.A. from Lehigh University in 1969, and his M. Div. from the Episcopal Theological School in Cambridge, MA, in 1973. He has served several parishes in Connecticut, served on the staff at Children’s Memorial Hospital in Chicago, and, prior to coming to Cincinnati, served as Director of Pastoral Care at the Stamford Hospital, Stamford, Connecticut. He is a Board Certified Chaplain in the Association of Professional Chaplains (APC) and a certified Supervisor (Educator) in the Association for Clinical Pastoral Education, Inc. (ACPE). He is currently the President of ACPE. He is married to Susan Pace, and they have three children.

Send your comments about MyPractice to info@PlainViews.org.



Review

Sarah Masters reviews the film

Hard Road Home

A statistic from the Bureau of Justice tells a story. "From 1995 to 2005, the number of jail inmates per 100,000 U.S. residents rose from 193 to 256." That implies that the number of ex-convicts who have returned to society is also on the rise.

Hard Road Home brings film viewers into the lives of Julio Medina and members of the Exodus Transitional Community (ETC), the center Medina created to help ex-offenders navigate the transition from prison to life on the outside. ETC is situated above a storefront church in the East Harlem section of New York.

Julio Medina was arrested for dealing drugs and served 12 years for the crime. During his incarceration, he availed himself of the New York Theological Seminary Masters Program at Sing Sing Correctional Facility. Medina says the program gave him "more than he can name - his education, his faith, his vocation, his life back." Following his release, Medina committed himself to helping ex-offenders through ETC.

The road for Medina was a long one, from drug dealer to prison inmate to founder of Exodus Transitional Community to a place beside President Bush in 2004 at the White House National Conference of Faith Based Community Initiatives.

By following the lives of Medina and three ex-offenders, *Hard Road Home*, directed by award-winning filmmaker Macky Alston, provides a unique and unprecedented look at the staggering challenges ex-offenders face. Their prison records make it nearly impossible for ex-offenders to survive without returning to a life of crime.

Prior to the screening of *Hard Road Home* on the PBS series Independent Lens, Alston said: "I hope that *Hard Road Home* will melt the hard hearts of all viewers who define people who have committed crimes and been in prison by the worst acts they have committed. I hope that viewers will recognize themselves in the lives of the people at Exodus as well as recognize the exceptional heroism of the formerly incarcerated people of Exodus who are committing themselves 24/7 to the salvation of a population at radical risk. I hope that people, following the broadcast, will go to hardroadhome.org and identify ways that they can join the movement to help formerly incarcerated people lead lives of meaning and security—lives maximized for the positive benefit they can have to society, rather than reduced to the damage they have done to it."

Completed: 2007
Running Time: 74 Minutes
Director: Macky Alston
Producer: Selina Lewis Davidson

If you are interested in purchasing this film, you can do so at www.hartleyfoundation.org. Just click on "Film Titles" on the home page and then "Top New Films" for more information. The cost is \$19.99 for a DVD.

Sarah Masters is the Managing Director of the Hartley Film Foundation, a non-profit organization dedicated to production, cultivation, support and distribution of the best documentaries and audio meditations on world religions, spirituality, ethics and well-being.