ADVANCING THE INTEGRATION OF SPIRITUAL CARE IN HEALTH CARE

Caring for the Human Spirit™ magazine

FALL 2014

Dying in America...
Understand the choices around end-of-life care

Brain Dead...who decides to "pull the plug"?

Can chaplains reduce a hospital's readmission rate?

6 things every spiritual care provider should know about suicide

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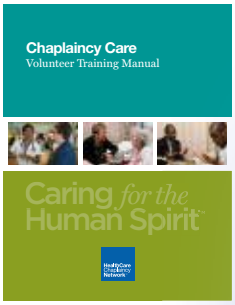

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A HEALTHCARE CHAPLAINCY NETWORK PUBLICATION

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Please share this magazine with your associates.

HealthCare Chaplaincy Network is a national healthcare organization that helps people faced with illness, suffering and grief find comfort and meaning regardless of religion or beliefs. Our mission is to advance the integration of spiritual care in healthcare through clinical practice, research, and education in order to improve patient experience and satisfaction. We have been caring for the human spirit since 1961.

Learn more at www.healthcarechaplaincy.org

WELCOME TO Caring for the Human Spirit®

Rev. Eric J. Hall, MDiv, M
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Chief Executive Officer
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It was gratifying to see the many very positive responses like these to the inaugural issue of Caring for the Human Spirit magazine.

> *"Your inaugural issue was just passed on to me. A great tool. Congrats."*
>
> *"Thank you for sending the first issue of Caring for the Human Spirit! Congratulations on a very good publication."*
>
> *"I recently saw a copy of a co-worker's 'Caring for the Human Spirit' magazine. A very valuable resource. Would it be possible to be included on your mailing list? In the meantime I will borrow hers. Thanks very much."*

Plainly there was an unmet need that our magazine filled, exploring the intersection of health care and spiritual care for an audience of professionals… doctors, nurses, chaplains, social workers, hospital, hospice and nursing home administrators.

Much has happened in the healthcare arena since our first issue went to press. Chief among this is the release of the Institute of Medicine (IOM) report, *Dying in America, Improving Quality and Honoring Individual Preferences Near the End of Life.*

The report recognizes that "a person-centered, family-oriented approach that honors individual preferences and promotes quality of life through the end-of-life should be a national priority." Emphasis is placed on palliative and hospice care, which are represented in this issue.

The report also cites the pressing need to improve end of life care in America, which gets to the root of what this magazine is about...Caring for the Human Spirit throughout illnesses of all kinds, up to and including end-of-life care.

In this Fall issue of our magazine we explore a number of other important matters facing healthcare practitioners today, including the often agonizing decisions related to brain death; the sensitive issues surrounding caring for LGBT patients; and the need for caregivers to take the time to take care of themselves.

As with our first issue, we invite you to submit articles on aspects of today's care that you'd like to see communicated to our large and influential global audience.

Thank you.

Chaplains Embrace Evidence-Based Practice

By George Fitchett, DMin, PhD

In healthcare, every profession is expected to follow the best evidence-based practices available. What does that mean for healthcare chaplains?

Tom O'Connor, a leading Canadian chaplain-researcher and early advocate for evidence-based spiritual care defined it as "the use of scientific evidence on spirituality to inform the decisions and interventions in the spiritual care of persons." Adopting an evidence-based approach to their work represents a major change for chaplains whose spiritual care has for the most part, been shaped by expert opinion and the traditions of the profession.

Chaplaincy leaders however, have recognized the importance of embracing this challenge. For example, Standard 12 of the Standards of Practice for Professional Chaplains in Acute Care adopted by the Association of Professional Chaplains in 2009 states, "The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research." (See http://www.professionalchaplains.org/content.asp?pl=198&contentid=198) Support for evidence-based chaplaincy care continues to grow. For example, at their Summer 2014 meeting, the European Network of Healthcare Chaplaincy issued a strong statement about the importance of evidence-based chaplaincy care. http://enhcc.eu/

While chaplaincy leaders have embraced the importance of evidence-based chaplaincy care it has been unclear whether practicing chaplains shared their view. To answer this question my colleagues and I examined data about chaplains' attitudes and practices with respect to evidence-based chaplaincy care. The data we used came from surveys of 773 healthcare chaplains including chaplains working in the Department of Veterans Affairs (VA, n=440), active duty military chaplains assigned to healthcare settings (n=164), and chaplains working in civilian settings (n=169). We found strong endorsement of an evidence-based approach among all three groups of chaplains.

Approximately three-fourths of the VA and military chaplains and 42% of the chaplains in civilian settings considered their current chaplaincy practices to be evidenced based. Over half of the VA and military chaplains and 94% of the civilian chaplains said they would like their chaplaincy care to be more evidence based. In addition, approximately half of the VA and military chaplains and 35% of the civilian chaplains reported currently using measurement tools in their chaplaincy care.

Respondents to our survey also recognized the need to address significant barriers in the movement toward evidence-based practice. These included developing measures of chaplain care and measures of outcomes relevant to chaplain care, as well as the lack of research about the effects of chaplain care. Notwithstanding these barriers, our results point to strong support among practicing chaplains for an evidence-based approach to chaplaincy care. Additional surveys, especially among chaplains in civilian settings, should be undertaken to confirm these findings.

Evidence-based practice is important for two reasons that are reflected in the recent European Network of Healthcare Chaplaincy statement. "Although it is not straightforward to evaluate spiritual care practice it is important to conduct research in order to improve the quality of care. . . . Sharing research findings will also inform healthcare providers and faith communities of the role and importance of chaplaincy and thus promote chaplaincy services." The findings from our survey indicate that practicing chaplains are ready to engage this important work.

The study described in this article is available at: George Fitchett , Jason A. Nieuwsma , Mark J. Bates , Jeffrey E. Rhodes & Keith G. Meador (2014) Evidence-Based Chaplaincy Care: Attitudes and Practices in Diverse Healthcare Chaplain Samples, *Journal of Health Care Chaplaincy*, 20:4, 144-160.

George Fitchett, DMin, PhD, is professor and director of research, Department of Religion, Health and Human Values, Rush University Medical Center.

DYING IN AMERICA

Understand the Choices around End-of-Life Care

IN SEPTEMBER 2014, TWO EVENTS HAPPENED THAT WILL INFLUENCE THE WAY IN WHICH END OF LIFE CARE WILL BE PROVIDED. BOTH WILL MEAN CHANGES FOR CLINICIANS IN ALL HEALTH CARE DISCIPLINES.

By the Rev. Sue Wintz, BCC

INSTITUTE OF MEDICINE (IOM) REPORT

The first is the release of a new report by the Institute of Medicine called *"Dying in America: Improving Quality and Honoring Individual Preferences near End of Life"*. The IOM Report Brief says, "The committee finds that a palliative approach typically affords patients and families the highest quality of life for the most time possible." The goal of the report was to provide facts and information in order to both continue the improvement of end-of-life care and encourage public and personal discussion.

The premise of the IOM report is that a lack of an end-of-life plan created well in advance typically leads to prolonged hospitalization, soaring medical bills and unnecessary pain and suffering for everyone. While acknowledging that much has been done to implement palliative care at the end of life to provide the highest quality of life for the longest possible time, there continues to be a need for improvement.

The committee proposed a list of twelve core components for end-of-life care.

- Frequent assessment of the patient's physical, emotional, social, and spiritual well-being
- Management of emotional distress
- Referral to expert-level palliative care
- Referral to hospice if the patient has a prognosis of 6 months or less
- Management of care and direct contact with patient and family by a specialty level palliative care physician
- Round the clock access to coordinated care and services
- Management of pain and other symptoms
- Counseling for patient and family
- Family caregiver support
- Attention to patient's social context and social needs
- Attention to patient's spiritual and religious needs
- Regular personalized revision of the care plan and access to services based on the changing needs of the patient and family

Most importantly, the report identifies that conversations that take place between providers, patients, and family care givers aren't as good as they should be, calling for more training for health care providers and promotion of family and public discussion around palliative and end-of-life care.

IMPACT ACT

Secondly, the U.S. House of Representatives and Senate passed the Impact Bill, which was expected to go to the president for his signature. The bill affirms the importance of hospice care, which is also mentioned in the IOM Report: "For people with a terminal illness or at high risk of dying in the near future, hospice is a comprehensive, socially supportive, pain-reducing, and comforting alternative to technologically elaborate, medically centered interventions. It therefore has many features in common with palliative care."

The news coverage of the Impact Act pointed primarily to the requirement of the bill for hospices to be inspected at least once every three years, removing the practice of hospices going eight years or more without ever being surveyed.

However, the bill carries more than the important new regulation about inspections; it also requires:

- Medical review of those few but significant programs that have a certain percentage or number of patients who receive care for more than 180 days as hospice care is intended for those who have no longer than six months to live.
- Standardized patient assessments
- Sharing of data on quality measures
- Reporting how resources are used
- Improving ways in which medical information is shared between facilities
- Focused attention and procedures to what a person's care preferences are for treatment and their goals of care.
- Better communication between hospice providers and patients/families

"It cannot be stressed enough how essential it is for us to have conversations with our loved ones about end of life."

WHY THIS IS IMPORTANT

At first glance, it may seem that both the IOM Report and IMPACT Act are directed toward improving clinical practice, which they are. Yet they also have two important takeaways for all of us.

It cannot be stressed enough how essential it is for us to have conversations with our loved ones about end of life. What are our deepest beliefs and values? What kind of treatment do we want, or not want? What are the emotional, spiritual, religious, cultural, and social aspects of life that we want our medical team to know about and incorporate into our care?

Both also provide the beginning of a "checklist" we may want to develop for when the time comes that we seek end-of-life care for a loved one or ourselves. Think of them as questions we will want to ask of our medical providers to determine if the program or facility they are recommending will meet not only our needs but also the new growing national requirements for the best end of life care possible.

Both documents are available online. The IOM report can be found at http://bit.ly/1pCow3J . The IMPACT Act is at http://1.usa.gov/10edc8O .

The Rev. Sue Wintz, BCC, is managing editor, PlainViews® online professional journal plainviews.healthcarechaplaincy.org

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For Lesbian, Gay, Bisexual, and Transgender Patients

By Rev. Jakob Hero

"This guy is being unruly," an ER nurse said to me over the phone. "Chaplain, could you come and help calm him down?" What I discovered when I entered the patient's room, was not an unruly male patient. Instead, I met a young transgender woman—a person born male who lives as female. She was justifiably upset, the medical staff interacted with her as if she were male, even placed her in a shared room with a male patient.

As chaplains we are empowered to ameliorate situations where lesbian, gay, bisexual, and transgender (LGBT) patients feel unsafe, unwelcome, or mistreated. But first, we need to understand what stands in the way of adequate support in the healthcare setting.

BARRIER 1: Assuming that differences do not matter

In an attempt to show acceptance, we can unwittingly communicate that we do not value the other. Ignoring the richness of diversity in people's lives and identities does not create equality.

Tip: Communicate acceptance

As chaplains we can acknowledge that the life experiences and identities of our patients are valid and important parts of the wholeness of their humanity: their gender identities, whom they love, and how they relate to their own bodies.

BARRIER 2: Fear of saying the wrong thing

It can feel intimidating to not have the right words. In the example above, the patient was listed as male, but clearly presented as female. No one knew how to address her, because no one asked.

Tip: Ask for clarity

When unsure as to how a person identifies or whether to use male or female pronouns, it is perfectly acceptable to ask. However, it is important to be aware of why you are asking. Questions that directly benefit communication with the patient (e.g. "What pronouns do you use?") are helpful. Questions that satisfy curiosity (e.g. "What was your name before you transitioned?") are not helpful.

BARRIER 3: LGBT vulnerability and lack of emotional safety

In addition to the typical stressors any patient feels, LGBT people seeking medical care often face mistreatment and discrimination. This is particularly true for the transgender community. The 2010 National Transgender Discrimination Survey, by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, found that 28% of transgender-identified respondents had delayed seeking medical care when sick or injured due to discrimination, 19% had been refused basic medical care, and 2% were victims of violence in doctor's offices.

Tip: Be sensitive to the added stress that LGBT patients face

Even if we do not fully understand someone's identity or life experience, as chaplains we can still provide comfort, support, and a non-anxious presence. We have the unique training and skills to meet people in the places where they need support and often all we need to do is stand with them as allies in their fear and vulnerability.

When we see that the patient is not an "unruly guy", when we speak her true name—regardless of her legal name— when we care for the spirits of those longing to be seen, this is the work of a chaplain.

Rev. Jakob Hero, MDiv, MA,
Center for Lesbian and Gay Studies in Religion and Ministry
www.clgs.org

Engaging a Younger Audience

On the Importance of Chaplaincy Care

By Lisha Bodden
Manager, Donor Relations, HealthCare Chaplaincy Network

How many lives have you touched today?

You're standing amidst a bustling throng of young people who are both equally eager to talk and listen to you after the key question of the evening is dropped in your lap: "So, what do you do?"

Smiling, you respond, "Have you ever known someone with chronic or terminal illness?"

The banker, the fashionista, the real estate broker all pensively nod in agreement, each of their faces taking on a faraway look as often happens with the mention of serious illness.

Drawing them back to the present, you continue. "Well I work for an organization called HealthCare Chaplaincy Network. We're a not-for-profit that helps people and families facing illness and suffering find comfort and meaning by providing compassionate spiritual care in hospitals, online and elsewhere, for all – whoever they are, whatever they believe."

Immediately everyone wants to know more. They mention a friend or family member who had cancer and how they wished they had known what to say or who to direct them to for guidance and comfort.

The need for answers underlies the creation of our Young Professionals Council, a group of people who understand the importance of HCCN's mission and are willing to help socially propel the Chaplaincy's work to their professional and social circles.

In today's world, spiritual and emotional distress can affect anyone and everyone. It has become apparent that serious illness and trauma has no age, demographic, sex, religion or race. Young professionals, at some point in their careers and personal lives, will likely come into contact with and experience loss, trauma, spiritual and emotional distress. This past summer the creation of the Young Professionals Council took shape, with the objective of engagement with and collaboration between young men and women ages 25 to 45.

ypc Young Professionals Council

By hosting a series of quarterly events in and around the city, targeted towards this younger demographic, HealthCare Chaplaincy Network expects to develop an active following among this group, accelerated by the group's social media savvy, with all its bells and whistles, hashtags, followers and friends, and create a buzz about the work the YPC is doing.

#cheerstothecause

Can chaplains reduce a hospital's READMISSION RATE?

By Roberta Holley, Rabbi David Keehn, and Jess Geevarghese

Myth:

Chaplains are nice to have in hospitals but not essential. Chaplains are a luxury, not a necessity.

FACT:

We live in a healthcare environment that's driven to deliver higher quality care while lowering costs. Without the data and evidence that chaplains contribute significantly to these goals, some hospitals might be unwilling to have paid chaplains on staff, and fewer people would get the expert help that chaplains provide.

THE NEED:

Chaplains can develop and manage pilot programs to begin building the case that chaplains contribute significantly to higher quality care and an improved patient experience – both of which contribute to an organization's bottom line and reputation.

The American healthcare system exists in a state of flux. The Affordable Care Act has put increasing pressure on hospital administrators to provide high-quality care more efficiently. What can we do to assist our administrators? While keeping to our core mission of providing spiritual care, we can strengthen chaplaincy's contribution to the overall goals of the hospital.

Hospital administrators are concerned about hospital readmissions and patient experience. The ACA in 2012 authorized the Federal Centers for Medicare and Medicaid Services to penalize higher-than-expected 30-day readmission rates for heart failure, heart attacks, and pneumonia by decreasing those hospitals' Medicare payment rate across all discharges.

Numerous studies have indicated that hospital readmissions are a significant problem, both for patients and the healthcare system in general. At the national level, among older Medicare beneficiaries, 20% of hospitalized patients are readmitted within 30 days and 56% are readmitted within a year. A 2009 study estimated the cost of these unplanned re-hospitalizations at $17.4 billion a year. Many of those readmissions are due to unanticipated change in a patient's condition or a planned follow-up treatment. But some result from patient confusion over new drug regimens, inadequate follow-up with primary care physicians, anxiety, and isolation.

"Can Chaplains Lend Their Talents to Readmission Reduction?"

HealthCare Chaplaincy Network asked the question, "Can chaplains lend their talents to readmission reduction?" With a grant from the New York Community Trust, we partnered with New York Hospital Queens to seek an answer. Initially, the project focused specifically on patients suffering from heart failure, heart attacks and pneumonia, as studies have shown that these are the three populations with the highest likelihood of readmission to hospitals within 30 days of discharge (and the three groups that the Centers for Medicaid/Medicare Services tracks). Then, as the pilot continued, we expanded the patient population to Medicare fee-for-service patients with a high risk for readmit status.

Every discipline has a role to play, and concurrently, NYHQ

had a social work intervention for the same population. We worked closely with the hospital team to ensure smooth communication between the two groups. Ultimately, the patients we saw were older adults who had been readmitted after the social work intervention, or those who refused the social work intervention and who were not seen by social work due to distance, but were considered high-risk patients with any diagnosis.

What Did the Pilot Involve?

Roberta Holley, an experienced hospital chaplain, visited patients over a six-month time frame in the hospital to conduct a chaplaincy visit. Then, she would describe the program and ask if the patient would participate. If the patient consented, Chaplain Holley visited the patient while in the hospital, once or more depending on length of stay. Once he or she was discharged, Chaplain Holley would call twice in the first week and once a week for the next three weeks to follow up on their transition home, conduct a chaplaincy visit over the phone to address any spiritual/emotional concerns, and ask specific questions regarding care. If the patient expressed any medical concerns or questions, Chaplain Holley would connect the nurse case manager to the patient.

What We Learned To Date

While the project was aimed at patients, caregivers need just as much care, if not more than the patients. Caregivers were anxious, needed someone to hear them out, and often had no one to talk to about the situation. The importance of chaplaincy support of the family caregiver seemed a critical finding that has not yet been reported in a science of chaplaincy paper.

Most patients welcomed the spiritual, emotional and practical support given in the hospital and post-discharge. Men were less likely to get into deep meaningful conversations. The practical support included Chaplain Holley working as a liaison to care management and being a sounding board about difficulties procuring prescriptions, medical equipment, need for palliative care, and advance directives. Chaplain Holley could see the effect of chaplaincy with angry patients or caregivers, whose feelings would ease with dialogue. While this was a chaplaincy intervention, Chaplain Holley was part of an excellent interdisciplinary team comprising chaplaincy, care management and patient experience departments.

Chaplain Holley has worked with 158 patients, of whom 16 were discharged to a facility, five died and one refused the program after consent. The program is still under way. To date, 20 patients were readmitted, which is slightly lower than NYHQ's average readmission rate for the core measures. While the results are preliminary, we don't expect to be able to draw definitive conclusions of the effect on readmissions. However, we anticipate that the insight of the qualitative findings has created a new space in the existing literature. Our findings have set the foundation for designing empirical studies in this realm of chaplaincy research and quality improvement programs nationally. We will report on results when final.

Chaplain Holley says, "As the chaplain, I realize that it is a privilege to take the time to hear the patient or caregiver out, to discuss the issues and concerns that are affecting quality of care and recovery, and to have the ability to take action on their behalf. This action may range from praying, to interceding with the multidisciplinary team that affects the patient's care."

Roberta Holley is the chaplain dedicated to the New York Hospital Queens' readmissions reduction project. Rabbi David Keehn is director of pastoral care at New York Hospital Queens. Jess Geevarghese is senior director of business development and initiatives at HealthCare Chaplaincy Network.

Editor's Note: This article originally ran in the May/June issue (Vol.24, No. 3) of Vision, the publication of the National Association of Catholic Chaplains.

End of Life Care From a Jewish Perspective

By Barry M. Kinzbrunner MD, FACP, FAAHPM

Judaism teaches that life is of infinite value, so much so that it is taught in the Talmud, a commentary on Jewish law dating back to ancient Babylon, that the laws of the Sabbath may be violated if a life is at risk. Yet, Judaism clearly recognizes that all life comes to an end.

How Jews deal with the many issues that arise as life draws to an end is complex and varies considerably among various Jewish groups and individuals.

JEWISH MEDICAL ETHICS DEFINED

Utilizing Jewish law, the cardinal principles of medical ethics have been defined from a Jewish perspective. Autonomy is voluntarily limited from the perspective that traditional Jews choose to make decisions consistent with Jewish law. Beneficence is fully operative, and encompasses both the physician's obligation to heal and the individual's obligation to seek beneficial care. Non-maleficence, the avoidance of harm, is also incumbent on both the physician and the individual, within the constraints of an appropriate and acceptable risk/benefit analysis. Justice takes into account both the benefits to the society as well as the resources available to meet various health care needs.

DEFINING TERMINAL ILLNESS AND END-OF-LIFE DECISION-MAKING

Using these definitions and other precepts of Jewish law, traditional Judaism has established a primary definition for terminal illness as a prognosis of 1 year or less, and a special category reserved for patients who would be described in hospice and palliative care as "actively dying", termed "goses."

EUTHANASIA, ASSISTED SUICIDE, OR ANY OTHER FORM OF INTENTIONAL HASTENING OF DEATH IS CATEGORICALLY FORBIDDEN.

Patients who are near the end of life may refuse treatments that are deemed ineffective, futile, or will only prolong suffering, and such treatments may also be withheld. However, once treatments are started, they generally cannot be withdrawn, since withdrawal of such treatment may be seen as an active shortening of life.

Food and fluid, even when provided by artificial means, are considered by all orthodox and some conservative rabbis to be basic care, and therefore, must be provided to all patients, with the only caveat being that it should be done in a way that is beneficial and not harmful. Advance directives in the form of a living will, a durable healthcare power of attorney, or both, is generally permitted, with the proviso that, for the orthodox community, a rabbi knowledgeable in the area of healthcare decision-making be included as a named surrogate in order to ensure that decisions are made in accordance with Jewish law.

Note: This reflects an Orthodox point of view. Jews who are affiliated with one of the Non-Orthodox Jewish movements (i.e. Conservative, Reform, Reconstructionist) or consider themselves "unaffiliated" may choose to follow either their own movements recommendations or take a more secular approach to some or all of these issues.

Barry M. Kinzbrunner, MD, FACP, FAAHPM is Executive VP and Chief Medical Officer of Vitas Healthcare based in Miami, Florida. (www.vitas.com) Dr. Kinzbrunner has over thirty years of professional experience in hospice and palliative medicine.

Spirituality in Aged Care

Professional Development Program Launched

By Cheryl Holmes, CEO, Spiritual Health Victoria

AGEING can be a time of profound spiritual reflection as people seek to find meaning in their lives and look for a continuing sense of hope and purpose. Residents of aged care facilities are often reliant on staff and volunteers to recognize their need for spiritual conversation and to ensure that their need for spiritual care is met.

The Spirituality in Aged Care Professional Development Program is an innovative education resource designed to assist aged care providers to better understand what is meant by spirituality and spiritual care, and to identify and respond to the spiritual needs of ageing residents and clients as part of their everyday practice.

The program was officially launched on June 26th by David Stout, a resident of Hedley Sutton Community. In launching this education resource David shared how important it was to have his spiritual needs met within the place that had become his home. This was particularly meaningful for David as he had lost contact with his faith community after his move into residential care.

I reminded those who gathered for the launch that "getting old is not for the faint-hearted." The program was developed by Spiritual Health Victoria over three years in consultation with aged care interest groups and practitioners and was extensively piloted across a range of residential and community based aged care facilities in both regional and metropolitan settings.

The program is comprised of six core modules, on subjects such as Listening Skills, and Spiritual Care for the Person with Dementia. The modules can be facilitated by a spiritual care professional from any facility and delivered one at a time over two half days or over a whole day.

More information about the program is available by visiting the website www.spiritualhealthvictoria.org.au/agedcare or by contacting Cheryl Holmes at Spiritual Health Victoria
Email: ceo@spiritualhealthvictoria.org.au
Phone: (03) 8415 1144

Left to Right: Pauline Arnold (Chaplain, Echuca Community Aged Care Wharparilla and Aged Care program original pilot facilitator); Gordon Wegener (Lutheran Chaplain and Chair Board for Lutheran Aged Care Australia); Ilsa Hampton (Strategic Projects Manager, Baptcare); John Clarke (Director of Mission, Uniting Agewell)

David Stout (Resident, Hedley Sutton Community Baptcare and Cheryl Holmes (CEO, Spiritual Health Victoria)

brain dead

Who decides to "pull the plug"?

"There's a great misunderstanding around what brain death is and is not," says the Rev. Ronald Oliver. "Very few families understand how a person can be dead if they are still breathing on life support. Some equate removing life support or signing a DNR as murder."

While many believe that death does not happen until the heart stops beating and the lungs stop breathing, brain dead is the same as dead.

There have been many high profile cases of families, hospitals, and state laws coming into conflict over how death is actually defined.

The murky Area around "medical futility"

The concept of medical futility empowers doctors to withdraw life support in futile cases no matter what the family wanted. While there are statutes in some states about how to determine death, until medical futility can be legally defined and state or federal regulations put in place, this is still a largely murky area that bothers doctors and nurses. It's important for chaplains to understand their organization's policies and practices around issues of futility.

No one wants to be blamed

"One of the biggest problems with dying is that medical science can keep a dead person 'alive,'" said Patricia Malcolm. "They say, 'I can't be the one to pull the plug; I don't want to be blamed.'"

With families, Malcolm said, we have gentle conversation; we ask them what their loved one was doing six months ago or three months ago. Sometimes they have an epiphany and realize just how much has changed in their loved one's medical condition.

Malcolm told of a woman whose four sons were with her and saw how bad she looked with all the IVs and tubes. But the youngest son said no to letting his mother go. "I sat down on the floor with him and held him in my arms. He said, 'Miss Pat, I have to show my mom I'm a good boy.' He didn't want her to die until she knew she could be proud of him. I told him we are always proud of our kids. Leave her a legacy. Go in that room and tell her what you want her to hear." Malcolm said he was finally able to do that and let her go. "He thanked me for helping him through it."

What Chaplains Need To Do

"Chaplains, especially those who work in neurological and intensive care units, should have basic clinical skills," says the Rev. Ronald Oliver. "Get integrated with the clinical staff, tell yourself 'I can be the one to fill the clinical gap,'" he said. "Once the doctors release the information, I would look for someone in the family who is not lost in the emotion and say, let me walk you through this; somebody needs to understand and that person can be the messenger for the family system.

The chaplain needs to help return the responsibility to the family. Doctors, knowing that brain dead means dead, want permission to pull the plug, yet the family says 72 hours ago he looked fine. The chaplain can help move the scenario from "I killed my child" to "It was the hardest thing I ever did, but I did the right thing."

Rev. Patricia Malcolm is staff chaplain for the pain and palliative care service at Christiana Health System in Wilmington Delaware

Rev. Ronald Oliver is system vice president of mission and outreach at Norton HealthCare in Louisville, Kentucky

Condensed from an article by Marian Betancourt in PlainViews®, the online professional journal for chaplains. You'll find the entire article in our open access issue of PlainViews here: http://plainviews.healthcarechaplaincy.org

Prayer Requests fulfill a Deep *Spiritual Need*

Rev. Amy Strano, Manager of Programs and Services, HealthCare Chaplaincy Network and Unitarian Universalist Minister

By Rev. Amy Strano

"I need prayers because my fiancé died two weeks ago. His funeral was last Friday. He was a wonderful person - nicer than anyone I had ever met. I was divorced and he was a widower but we were like teenagers in love. I had no idea that someone could treat me so well. Now I have to figure out how to live life without him and I just can't imagine that. I can't believe he's gone. He had a massive heart attack at work and now he's just gone. Just like that. I have faith in God but I just don't understand this - he was such a good person." – Amanda R.

Prayer requests are one of the many new initiatives that HealthCare Chaplaincy Network has undertaken to help people in need find spiritual care and comfort.

This year we launched two helpful new websites, ChaplainsOnHand.org and CantBelieveIHaveCancer.org.

We take a multi-faith approach to caring, understanding that regardless of religion or beliefs, in time of pain there is the commonality of feeling afraid, angry, and lonely. "Why is this happening to me?" "What now?"

"My mother passed away in July and now I'm having surgery. I really miss her and wish I could talk with her about this. Besides being my mom, she was my best friend." – Jody D

Traditionally health care chaplains serve in hospitals by the bedside of patients and their families, offering a calming presence in a time of crisis, and reflecting with those facing loss, grief and illness on the big questions of life. But the face of health care in the U.S. is changing. More and more people are outpatients, without access to board-certified health care chaplains, and more and more are finding themselves isolated or disconnected from family or community, with no one to turn to in time of crisis.

In response to this need our websites include a new service, Chat with a Chaplain, through which people can contact us via phone, video calls, and email requests, and be connected with a professional board-certified health care chaplain. Here is where visitors also have the option of submitting a prayer request.

"I want relief from the pain in my heart over the loss of my wife of 38 years. It's been 9 months since she has passed and I miss her." - Kenneth B.

So far over 1,000 people have contacted us directly this way, many with prayer requests. At our HealthCare Chaplaincy Network weekly staff meetings, we read these requests aloud, and hold them in collective prayer.

"I have terminal ovarian cancer. I have stopped all treatments. I'm so tired. I find myself feeling guilty about that. I have two young daughters and I want to spend the little time I have left with them, but I just don't have the strength anymore. I wish I could shake the guilt and anxiety and find joy again." – Julie M.

Our mission, at HealthCare Chaplaincy Network, is caring for the human spirit. I want to thank all the many people in need who have articulated their pain and entrusted us to pray for them.

"Reconnect Your Role *with* Your Soul"

Half-day retreat on the spirituality of work for healthcare workers

Healthcare is a demanding field and takes an emotional toll on the people on the front lines: doctors, nurses, chaplains, social workers and others. To help these professionals, in the New York area and nearby, reconnect their role with their soul – whatever their beliefs – HealthCare Chaplaincy Network sponsored a half day retreat that explored three ways to relieve the stress of caring for others.

More than a hundred people took time out of their busy schedules to slow down for a moment and attend the retreat.

The first session centered on the spiritual practice of meditation, led by Chaplain Miriam Healy, a Zen teacher born and raised in Ireland. Explaining the meaning of Zen, Healy urged the audience to "Just breathe. Drop the story. Drop the speculating, the analyzing. Just breathe. Chaplains often experience the last breath of a patient," she said, "and you know what breathing means.

"Zen helps you return to your life," she explained, "and you need the energy of others, so practicing with a group is a good way to do it."

Healy introduced Michael McComiskey, an expert in the ancient Chinese art of Qigong (pronounced chi gong), who led the group in deep breathing exercises.

The second session was led by Rabbi Amy Goodman, assistant director of hospice development for MJHS Foundation. She stressed that keeping a "Sabbath" was important, comparing it to the story of God resting on the seventh day after creating the earth. It's helpful to have some regular ritual that is not about your work, something that represents a time of rest, such as a regular dinner with friends or family."

She suggested finding sacredness of time within a workspace, even if only for the moment, as well as creating ritual practices at work to help stop yourself and re-center. Hand washing is something that all healthcare workers do before visiting a patient, "so make that a sacred moment before each visit," she suggested.

The third presenter was Nicholas Mosca, an MDiv from Harvard who won a competition there for his work at the intersection of humor and theology.

"People are skeptical about humor in such serious workplaces as hospitals," he said. "It can be mistaken as making fun of the patients, but when used with compassion it can relieve stress." That's important because busy healthcare workers tend to not take the time for self-care.

Mosca distributed blank sheets of paper, asking attendees to break into small groups and make a list of pain caused by the job. Then think about how to question the pain, and finally, suggest a playful twist to relieve the stress of the situation.

Based on the enthusiastic response to this first half day retreat, more events of this kind will be planned.

Developing the Spiritual Care Workforce

By Helen B. McNeal

"Who will tend to me when I'm nearing the end of life and want to discuss God and spirit?"

That's a question that permeates the healthcare environment today. It's clear that the religious landscape is changing in America, according to the Pew Forum on Religion and Public Life. Twenty-eight percent of adults have left the faith in which they were raised. Sixteen percent say that they are unaffiliated with any faith at all. And that number jumps to 25% if you look at 18-to 25-year-olds.

For those of us who are concerned about the workforce of tomorrow and who will tend our spiritual care needs, this trend suggests two things. First, any religious professional working in healthcare will need to be adept at providing support to those for whom God either takes a different guise or is not a part of their lives. Secondly, when those unaffiliated with a particular spiritual tradition seek spiritual support, it may be from someone not identifiable as a religious professional. They may turn to a nurse, a social worker, a physician or someone else with whom they are comfortable.

These needs are being addressed by online courses developed by the California State University Institute of Palliative Care (CSU) and HealthCare Chaplaincy Network that result in a Palliative Care Chaplaincy Specialty Certificate. The goal is to help religious professionals confidently and competently provide support to those with a serious or chronic illness.

In 18 months, we've trained more than 350 religious professionals, and feedback indicates that many more are interested. As a result we've introduced a course on Mental Health for Spiritual Care Providers, and a new advanced course on palliative care is in the pipeline.

Spiritual care principles must be infused in the training of all who work in healthcare, not just those designated to tend to spiritual needs.

The CSU Institute for Palliative Care also includes the integration of modules on spiritual care, developed again by HealthCare Chaplaincy Network's professionals, in our Post-MSW Certificate in Palliative Care and our Advanced Practice RN Certificate Program. This broader integration of spiritual care principles ensures that every health care professional working in palliative care is also a spiritual care provider, ready and available on the front lines.

Religious orientation and commitment varies with each individual, but all of us deserve access to support when we need it. For some, that is every Sunday. For others it is every Friday or Saturday. For most of us, it is also when we are faced with a serious or chronic illness that is turning our lives upside down. I'm selfish. I want to have access to trained support when I need it. Don't you?

Helen B. McNeal is Executive Director, CSU Institute for Palliative Care at Cal State University San Marcos (CSUSM) www.csupalliativecare.org/

Important Role Models

FOR COMPASSIONATE CARE: PROFESSIONAL CHAPLAINS

By Stephen G. Post, Ph.D.

Chaplains and Departments of Clinical Pastoral Care could take a more active role in teaching the skill sets of compassionate care to other healthcare professionals and trainees. The empathic skill sets of chaplaincy should be learned more widely, although there will always be a need for the pastoral specialist with insights into the dynamics of patient spirituality.

What is needed is more than detached empathy, which pretty much anyone can be taught.

Patients who are suffering want an affective (or emotional) empathy. Affective empathy describes the professional's ability to both understand what the patient is going through (cognitive empathy) and experience a nonverbal resonance with the patient emotionally. Where the practitioner of detached empathy accurately summarizes and reflects back the patient's illness experience, the practitioner of affective empathy will be able to synthesize this experience and respond to it with a true emotional presence. This too can be taught, but it is more a seasoning process and not everyone is equally cut out for it.

Stephen G. Post, Ph.D. is President of the Institute for Research on Unlimited Love (www.unlimitedloveinstitute.com) & the author of *Is Ultimate Reality Unlimited Love?* (2014), written in response to a final request of Sir John M. Templeton two weeks before his death, with a title he designated. "Foreword" by Drs. John M. and Pina Templeton, MD.

Defining Compassionate Care

Compassionate care is a deep response to suffering at the affective level and appropriate action to relieve it. It fits exclusively in the context of suffering, which is what distinguishes it from the more general empathy. Here are some items that a compassionate care scale might include.

1. I can't resist reaching out to help when one of my patients seems to be hurting or suffering.
2. I drop everything to care for my patients when they are feeling sad, in pain, or lonely.
3. When I believe my patients are having problems I do all I can to help them.
4. When faced with a patient who is suffering I want to avoid them.
5. My attitude toward those who are suffering is non-judgmental.
6. When I am in the presence of a suffering patient, I feel a strong desire to act.
7. I am willing to go out of my way to effectively relieve my patients' suffering.
8. I am more comfortable addressing the physical needs of the patient rather than the emotional needs.
9. When I encounter a suffering patient I fear becoming emotionally involved.
10. I feel the relief of suffering to be central to my professional identity.

Chaplains with a Duty to Teach

Chaplains can serve as role models for other healthcare professionals who might benefit from chaplains as much as patients do. Empathy and compassionate care are mainly transmitted rather than taught didactically, and the venues for this transmission can be developed in clinical settings and in professional schools.

Why should Departments of Clinical Pastoral Care put high emphasis on education of other professionals?

Because when clinicians, nurses, residents and other staff stray far from empathy and compassionate care they all report erosion in enthusiasm for their professions. This erosion is strongly associated with poorer quality of care, patient dissatisfaction, increased medical errors, and lawsuits.

Patients will also benefit. The drive for human connection increases greatly during times of major distress and serious illness, and this is intensified in the depersonalized environment of a hospital room. The presence of a compassionate clinician is a gift that can achieve as much for patients as a great many medicines.

Perhaps most persuasively of all, healthcare systems benefit. Aligned with the Institute of Medicine's six aims for quality health care, which include patient-centered care, the new HCAHPS (Hospital Consumer Assessment of Healthcare Providers & Systems) questions ask patients if they have been treated with care and respect, were communicated with well and had things explained to them, and felt responded to adequately by nurses, doctors, and other staff. These surveys are now required for any healthcare system receiving Medicaid or Medicare reimbursements, which are pro-rated based on HCAHPS scores.

Departments of chaplaincy and clinical pastoral care all can reach out to their surrounding institutions with renewed vigor now that empathy skills are a matter of bottom line compliance. There is an opportunity here for a new offensive in which these departments take on educational leadership in hospitals and professional schools, teaching techniques from verbatim analysis to attentive listening, and serving to elevate the institutional ethos.

Needs to Be Part of the Medical Treatment

By Rev. Eric J. Hall

A friend of mine was recently hospitalized for complicated heart surgery. During the next few days following that surgery, there was a constant flow of hospital staff members coming to his bedside to check his vital signs, or his intravenous drip, or to adjust the window shades and refresh his water bottle. None of these people spoke to him other than a cursory good morning or afternoon. When his surgeon came in to check on him, he opened a laptop computer into which he entered information as he examined my friend's surgical sutures and asked various test questions to see if he was responding properly from the surgery.

In addition to residual pain from the surgery, my friend was worried about the future and could not sleep well because of all the interruptions. As the days passed, he became more and more depressed. While he seemed to be getting first-rate medical treatment, nothing was being done to address his emotional needs. Not one person – including his surgeon – asked him how he was really feeling or let him know that they understood what he was going through. He was getting first rate medical care but he was not feeling cared for. What seems to be missing in this scenario is empathy, the ability to recognize emotions being experienced by another.

Empathy may not even be on the agenda in medical school or in hospitals. In fact, the word suffering was rarely used by clinicians and leading medical journals because it was considered overly emotional. Nevertheless, anxiety, confusion, and uncertainty, are what many patients endure while their bodies are being treated with the best science and technology. But within the collection of body parts to be examined, tested, probed, medicated, and operated on, there is a human spirit that is suffering. As health care becomes more corporatized, more like big business, it seems less humane. Hospitals are in the business of treating human beings – their patients – and that patient's satisfaction is becoming more important if the hospitals want to retain their funding. Some have tried sprucing up the décor and the menu, but they need to add empathy to the menu.

When empathy – or lack thereof – in health care makes Harvard Business Review, it's time for hospitals to take notice. Dr. Thomas H. Lee wrote in HBR, "Social network scientists have shown that emotions and values can spread in a community with the same patterns as infectious diseases." He believes that if empathy was stressed in health care settings, "We would see an increase in the proportion of clinicians and other personnel who are clearly tuned in to what was really happening to patients and their families."

Hospitals that have embraced palliative care and include board certified health care chaplains on the interdisciplinary teams are filling this need. The role of these chaplains is to address the emotional and spiritual needs of the patients no matter their religion or lack of religion. But this practice needs to become universal in health care.

Cleveland Clinic has sponsored an Empathy and Innovation Summit (www.empathyandinnovation.com) for the past five years. These four-day events in Cleveland attract people from all over the world – physicians, nursing executives, CEOs and industry leaders. Their theory is that no health care provider can afford to offer anything less than the best clinical, physical and emotional experience to patients and families. Health care organizations exist because of the patient and doing the right thing means doing it with empathy and compassion.

The University of Utah hospital actually publishes ratings – from one to five stars – of all their physicians based on comments from patient surveys on their "Find a Doctor" website (www.healthcare.utah.edu/fad/). Like Yelp and Trip Advisor rate restaurants and travel destinations, here the patients are surveyed about the personal treatment they received from the staff with questions about whether or not the doctor made eye contact or showed concern for the patients' questions or worries.

Perhaps if every health care provider were to read Harper Lee's Pulitzer Prize winning novel, *To Kill a Mockingbird,* they would learn empathy from the main character, Atticus Finch. In a racially divided town in Depression-era Alabama, Atticus Finch defends African-American Tom Robinson in a trial against a white woman who claims the man has raped her. Finch is among literature's most empathetic characters, and in what is perhaps the book's most quoted line, he says, "You never really understand a person until you consider things from his point of view -- until you climb into his skin and walk around in it."

We need people like that in health care, caregivers who have both brains and heart. And perhaps a new hospital CEO position – Chief Empathy Officer.

Note: This article was reprinted from The Huffington Post.

HOW TO IDENTIFY & HELP VICTIMS

Rape and domestic abuse have been in the news a great deal lately. Even so, the vast majority of incidents go unreported. Many chaplains and clergy are unaware of the extent of these crimes and may not know how to recognize them when they see it.

A recent symposium, "Domestic Violence and Sexual Assault, From Crisis to Confidence," was presented by HealthCare Chaplaincy Network and the National Association of Jewish Chaplains. It was designed to educate chaplains and clergy in recognizing these very common occurrences and learning what they can do about it.

The presenters were Juanito Vargas, associate vice president of community projects and hotlines of Safe Horizons, the nation's leading victim assistance organization, and Rabbi Diana S. Gerson, program director of the New York Board of Rabbis and a consultant to the New York Police Department on domestic violence.

Sexual Assault and Rape

Here are some facts that point to the scope of the problem. Forty-four percent of the victims of sexual assault and rape are under the age of 18. Eighty percent are under 30. One in six women will experience rape or sexual assault in her lifetime. One in 33 boys and men are also sexually abused but they rarely report this kind of abuse, so the number is likely higher. Two thirds of this abuse is committed by someone known to the victim, 60 percent is not reported to the police, and 97 percent of rapists never spend a day in jail.

Many women are physically abused and sexually assaulted by their intimate partner; this includes coerced activity such as controlling contraception, forced nudity, or viewing of pornography. Common reactions from these women include self-blame and guilt, embarrassment, denial, feeling betrayed and worthless.

When it comes to rape and sexual assault, we tend to blame the victim. *"Was she drunk?" "What was she wearing?"* "Why was she there in the first place?"

The audience was cautioned not to project their biases onto the victim. If you're not a drinker, for example, don't censure the victim for having been drinking.

Rather, assess for emotional trauma, and determine if they able to talk about it yet. Find out what kind of support systems they have, such as family or friends they trust.

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Healing and Advanced Care as an Issue of SOCIAL JUSTICE

By Rabbi Richard Address

Rabbi Richard Address, D.Min, is the founder and director of www.jewishsacredaging,com. He served for over three decades on staff of the Union for Reform Judaism. He co-chairs the Committee on Spirituality and Diversity for C-TAC (Coalition to Transform Advanced Care).

The doubling of life spans within the last century has been a product largely of medical technology, public health advances and a greater awareness, especially lately, of the role of life style choices.

The gift of time that we have been given has been the gift that has allowed us to contemplate our own sense of meaning, and, in light of advanced care, that time can be the catalyst for a level of personal "healing" that was never possible until our contemporary times.

This gift of time raises the stakes, in a sense, because it takes the dialogue on the issue of how to deal with the impact and reality of advanced care to a new level. The importance of having conversations about one's medical care and end-of-life wishes has never been more important. The discussions themselves can be a factor in one's healing process, for it is often in the context of those discussions that a person can come to see his or her life in review, to be reminded of the love of family and friends and to say things that have often gone unsaid.

The issues of advanced care and how the costs of that care impacts families and society may very well be one of the key social justice issues for the next decades. The concept of healing as it relates to advanced care needs to include serious conversations about how society makes that healing possible. That issue is a social justice issue that impacts not only our generation, but also, our children's and grandchildren's. The ethical issue of who and how we pay for the care we will need is not a fantasy question; it is very real and very present.

Likewise, as we move into this uncharted future, we need to be cognizant of another reality of our society: diversity. America is changing, as it always has been. Our strength, in many ways, is in our diversity of cultures. Not every culture chooses to see life's ending the same as others. Part of our challenge in discussing healing in advanced care is to be aware that different peoples may see this issue through their particular cultural eyes and it may not be moral or ethical to impose one view of healing and caring on everyone.

The question is how to make the passage from life a journey of dignity and sanctity.

Editor's note: This was adapted from Rabbi Address's remarks at the 30th Rabbi Marshall T. Meyer Retreat co-hosted by the Interfaith Center of New York and the Coalition to Transform Advanced Care held on September 22, 2014.

Serving Those who Served the People

Reflections from a Veteran's Administration chaplain

By The Rev. Stephen Brandow

The V.A. population is very different from the patient population that chaplains generally serve. These men and women have been scarred by war. They've seen things and done things that haunt them for a long time after their service has ended.

War is hell. But peace can be hell too. Our warriors return home only to find that things have changed on the home front. The fact is, things haven't really changed, but they have. Home used to mean comfort, security, safety, familiarity. Now, for many returning veterans, it means uncertainty, stressfulness, strained relationships and feelings of alienation. Trading the structure, order and camaraderie of military life for those of family and work is often overwhelming. And the scars of combat are frequently below the surface.

Unless you've had the experience of being an emergency responder or trauma worker it's difficult to imagine the emotional or physical toll of combat, having to be on guard every minute, and knowing that life is at risk with every decision.

I have the privilege of serving as a chaplain at one of the 153 hospitals and medical centers that make up the V.A. system. In addition there are 773 Community Based Outpatient Clinics and 260 Veteran Centers , all providing care to veterans and their families. This is a complex and diverse system, and hints at the scope of the veteran population that needs to be cared for.

The men and women we serve span a number of generations, each with their own distinctive characteristics, from the respectful grace of the World War II veterans who populate the Community Living Center, to the tech savvy young people who have been returning from our most recent conflicts in Iraq and Afghanistan. The bonds of service and willingness to take up arms in defense of others has left these brave men and women with emotional scars that take a long time to heal.

As a chaplain in such a setting I join with fellow chaplains of various faith traditions to explore some of the most basic questions about meaning, purpose and value at the level of the actions of individuals, groups and the nation as a whole. Many of the warriors that I meet in my daily rounds have been marked by their service and have learned that they were capable of more than they ever dreamed, and the actions required of them during service don't always fit neatly into the civilian mindset.

As chaplains we assist veterans to negotiate questions related to ultimate meanings as well as the intermediate meaning of their actions during service. It's a complex place where faith meets practice and the chaplain is there to honor the service, the service member, and the future meanings which these brave men and women are working to create.

The Rev. Stephen Brandow is staff chaplain at V.A.H.C.S. Alexandria and past president of the National Association of V.A. Chaplains

6 Things Every Spiritual Care Provider Should Know About suicide

By
Joanne L. Harpel, MPhil, JD

Suicide is a poorly understood, stigmatized, often taboo subject, and for spiritual care providers called upon to support a grieving family or community, it can be tricky territory. Yet what spiritual care providers say and do deeply resonates with survivors of suicide loss, and can **help sustain their connection to their belief system and faith community, and begin to restore their sense of equilibrium.**

Joanne L. Harpel is a world-renowned expert on suicide bereavement and postvention, working in the U.S. and internationally with families and communities coping with suicide loss. joanneharpel@icloud.com and www.linkedin.com/in/joannelelewer-harpel
Photo credit: Kerry Payne

To help guide you, here are six things every spiritual care provider should know about suicide:

1. Suicide Is Complicated.
Suicide is not a sign of weakness, selfishness, irresponsibility, a character flaw, or a coward's way out. Research shows that more than 90% of people who kill themselves have an underlying mental disorder at the time of their death -- most commonly depression, bipolar disorder, schizophrenia, or substance abuse, or some combination. These illnesses (which aren't always recognized, diagnosed, or treated adequately) can cause immense psychological pain and utter hopelessness. And just as with heart disease or cancer, even with treatment they can sometimes be fatal.

While extremely stressful life circumstances are often a factor and/or the catalyst, suicide isn't simply the result of stress. The desire to kill yourself – and actually acting on it – is not a normal reaction even to exceedingly stressful situations. We all recognize that the overwhelming majority of people who lose their jobs or their marriages or receive a devastating diagnosis or are bullied don't then take their own lives. But when you're experiencing those circumstances through the lens of mental illness and the accompanying distorted thinking and inability to see a hopeful future, your decision-making can become compromised, and you begin to see suicide as a viable – and perhaps the only – option.

Even if there were clear warning signs (and often there aren't), suicide can be shocking, and feel as if it came out of the blue. And while we may never know the "reason" any individual person dies by suicide, in virtually every single case, there's a complicated mix of underlying factors at play.

2. Grieving family and friends are likely blaming themselves and one another.
It's very common for loved ones to replay those final days over and over, desperately searching for an answer to the single most pressing question: "WHY?" They ruminate over the things they said or did (or didn't say, or didn't do) believing it's somehow all their fault. Or they angrily blame: the wife who left him, the boss who fired her, the mother, the principal, the bully, the therapist. God. This round robin of guilt and blame can be devastating to a family's ability to support one another in their mutual time of greatest vulnerability. Although thankfully it generally subsides over time as a greater sense of perspective about the suicide becomes possible, in the immediate aftermath (including at the funeral), it can be very intense.

3. You probably carry your own beliefs and feelings about suicide.
The historical stigma about suicide is rooted, of course, in many different religious traditions – condemning it was largely meant to be protective. The problem, of course, is that forbidding and stigmatizing suicide doesn't necessarily prevent it. Yet what it does do is make those left behind feel abandoned, alone, misunderstood, and judged.

What is your own faith tradition's

current view about suicide? It's possible you may not even be entirely sure (I'm reminded of a man who was studying to be a priest when his father killed himself; he realized he didn't even know whether his faith would permit his father to be buried in the same cemetery as his mother).

What are your personal beliefs about suicide? Is there part of you that deep down thinks it's shameful or disgraceful? Even if you admit it only to yourself, it's important to know how you honestly feel.

If you find that there are gaps in your understanding or you hold a view you'd like to re-examine, educate yourself (and do it soon, before you suddenly find yourself sitting across from a weeping family member who's desperately asking you for reassurance that their loved one is safe). You can start by simply looking at your faith's website – there's often a public statement about their understanding of suicide. Read contemporary religious commentary and/or some of books listed below and talk to colleagues and mentors that you respect. And candidly self-reflect on whether counseling the suicide bereaved is something you can do in good faith. We all have limitations, and this may be yours. But in all events the grieving deserve authenticity and genuine presence, so if it truly can't be you, please identify someone else who could step in.

4. You may not feel totally prepared.

Even if you feel confident in your understanding and views, you may nevertheless find the prospect of helping a family or community cope with suicide a little daunting. What exactly about it makes you anxious? What specific situations do you worry you might face? Do you feel your training and experience have adequately prepared you? What additional information or guidance would you need in order to feel more fully equipped?

I recently worked with a rabbi who wanted to open a dialogue

The author and her brother, Stephen, an honors graduate of Yale, who went on to Harvard Law School and married his college sweetheart. But at 26 he suddenly developed bipolar disorder, and despite the love of family and friends, and efforts to get him the right treatment, he took his own life less than a year later.
Photo ©1991 Joanne L. Harpel

with his congregation about the importance of talking openly about suicide and mental illness, but feared he wouldn't "get it right." His honesty and willingness to reach out for guidance helped him realize that in fact his own instincts were largely on target and trustworthy; he just needed a little more education about the issues in order to feel entirely confident.

5. You have a unique and extremely important role to play.

Whether you're talking with individual family members or delivering a eulogy, you have a powerful opportunity to make a meaningful difference. You can help others understand that the person who died was very likely suffering from an illness and was in terrible pain (even if it wasn't obvious from the outside). Just be mindful about saying things like "he's in a better place," which can have the effect of normalizing or even glorifying suicide, a risky message to those who might be vulnerable themselves.

You can offer reassurance that it's a myth that asking someone if they're suicidal can somehow put the idea in their minds, reinforce the importance of help-seeking, and provide information about local mental health resources as well as the National Suicide Prevention Lifeline. (800-273-TALK).

And most importantly, you can model both open communication about these fraught subjects and compassionate, nonjudgmental support.

6. You matter, too.

We know from research that during the course of our lifetime, more than 85% of us will lose someone we know to suicide. If you've been touched by suicide yourself, you may be caught off guard by how hard this work hits you. As a spiritual care provider it's in your nature to take care of others. Take good care of yourself, too.

TO LEARN MORE

- *Understanding Depression: What We Know and What You Can Do About It, by J. Raymond DePaulo, Jr.*
- *No Time to Say Goodbye: Surviving the Suicide of a Loved One, by Carla Fine.*
- *An Unquiet Mind: A Memoir of Moods and Madness, by Kay Redfield Jamison.*
- *Night Falls Fast: Understanding Suicide, by Kay Redfield Jamison.*
- *Why People Die by Suicide, by Thomas Joiner*
- *Why Suicide? Questions and Answers about Suicide, Suicide Prevention, and Coping with the Suicide of Someone You Know (2nd ed.), by Eric Marcus.*
- *After a Parent's Suicide: Helping Children Heal, by Margo Requarth.*

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Domestic Violence

Back as recently as the 1970s, If a woman was brave enough to make a domestic violence complaint, she needed to prove there were a number of beatings. One was not enough. Some old laws in some states even allowed wife beating provided the weapon was no larger than a broom handle. It wasn't until 1994 that the Violence Against Women Act (VAWA) was passed making domestic violence a crime.

The audience was told not to ask the victim "Why do you stay?, a question that can come off sounding judgemental. Some victims volunteer that love keeps them from leaving. "I love him. He's a good father. Just get him to stop hitting me." Or, "Today he's not so bad." As a chaplain you have to remain neutral. You can make a safety assessment without scaring the victim off, simply by asking "What's going on?"

Domestic violence is about power and control. It's a learned behavior. A boy grows up in a family where his father beats his mother for whatever reason and the boy learns that this is the way you deal with women, and the pattern is repeated again.

Chaplains and clergy need to have formal training in domestic violence, so they can help congregants and patients. We don't want to put the problem in the closet, we want people to come forward and talk about it so we can help.

Some suggestions for faith leaders and chaplains: Get to know your domestic violence (and sexual assault) agency; get them on the speed dial; get the people ready to go where they need to go.

RESOURCES AND ORGANIZATIONS YOU SHOULD KNOW ABOUT

- National Domestic Violence Hotline – 1-800-799-SAFE (7233)
- Safe Horizon 24-hour domestic violence hotline 800-621-4673 (HOPE); rape and sexual assault, 212-227-3000.
- Sexual Assault Victims Advocacy Center, 24/hour crisis line 970-472-4200
- *What to Do When Love Turns Violent,* a practical resource for safety planning, dealing with the police, keeping your children safe and a list of domestic violence organizations in every state.

HealthCare Chaplaincy Network™

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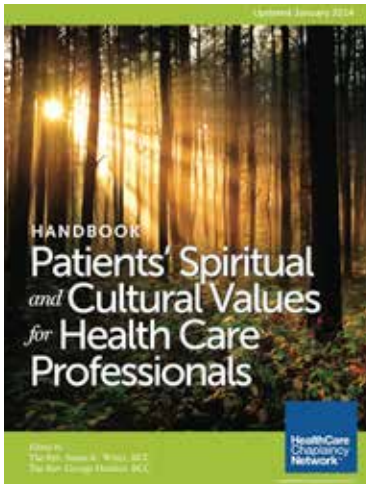

* Includes up to 2 hours of telephone support annually. If your institution requires more time, the cost will be $100 for every additional hour.

If you would like additional help meeting Joint Commission standards, we are available for additional consultation. Also we will be adding more components to the JC R/S Readiness Program.

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For more information, contact David Fleenor, Senior Director, Chaplaincy Services and Clinical Education at 212-644-1111 ext. 231 or dfleenor@healthcarechaplaincy.org

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