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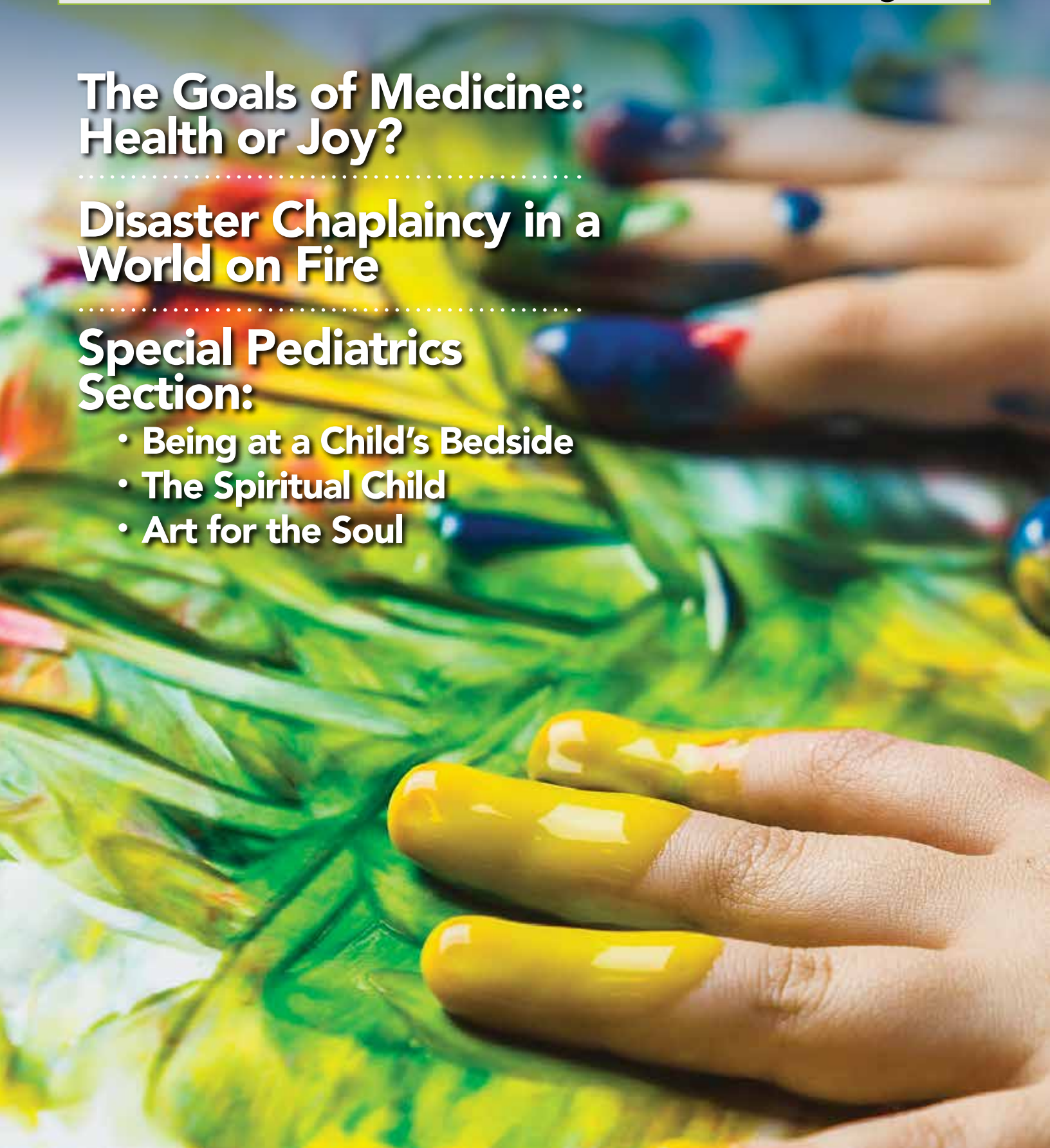
FALL 2015/WINTER 2016

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HealthCare Chaplaincy Network™ is a global health care nonprofit organization that offers spiritual-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Our mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve the patient experience and satisfaction, and to help people faced with illness and grief find comfort and meaning—*whoever they are, whatever they believe, wherever they are*. We have been caring for the human spirit since 1961.

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Rev. Eric J. Hall
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Victor Frankel, a psychiatrist and concentration camp survivor, famously said, "Man is not destroyed by suffering; he is destroyed by suffering without meaning."

When patients are critically ill or nearing end of life, that meaning takes on a new urgency. "Why was I put on this earth?" "What difference did my life make?" "Will I be remembered fondly?"

These are existential questions that may not have definitive answers, yet to a patient, the spiritual pain that accompanies questions like these can be just as real as physical pain.

In today's health care environment, where most providers are specialists, spiritual care is usually and appropriately left to the professional chaplains on interdisciplinary teams. Their clinical training includes how to relate to patients of different religions and ethnicities.

While chaplains are the spiritual care specialists, it is also important for the other members of the team to have some familiarity with spiritual care. After all, the patient is a whole person—physical, emotional and spiritual, and his or her search for meaning and comfort can arise throughout the continuum of care as well as near end of life.

So physicians, nurses, social workers, and other providers should be able within the scope of their own practice to recognize spiritual pain and engage with the patient on his or her terms. This should occur across the board—at any point in a patient's life, in whatever type of setting, and, moreover, whether or not a chaplain is available.

Studies indicate that in general many more inpatients desire conversations about religion and spirituality than have them, and that a large percentage of patients would welcome their physician's inquiry into these subjects. But this is thought of as a non-scientific and murky area ... an often bewildering stew of complex belief systems involving religion, culture and values ... a subject that non-chaplains typically are not given training in.

The literature is becoming increasingly clear that clinicians and other health providers want to include spiritual screening and history taking in their practice, but they don't know how. They desire training and best practices that will enable them to include this dimension of care in a way that is both efficient and effective. As a result, some medical schools have begun offering lectures on the subject, but to date this has not become widespread.

Clearly, there is a large, unmet need here. All disciplines could benefit from education about the integration of spiritual care in health care, whether through professional schools, online courses, webinars, conferences, or the like.

At HealthCare Chaplaincy Network's annual "Caring for the Human Spirit® Conference" last April, attendees representing all areas of the health care community—not just chaplaincy—welcomed the opportunity to gain a better understanding of how to assess and approach a patient's spiritual issues.

As one nurse said, "We came because we wanted to learn what was happening in the field ... what was best in the field ... and we're walking away with a renewed sense of purpose."

Throughout the continuum of care, patients and their families have many questions—some big, some small, but all important to them. When they are asking to be heard, chaplains should not be the only ears. With some training, all health care providers can step in to help walk with them in their search for meaning and help soften their spiritual pain.

Thank you for caring for the human spirit,

A handwritten signature in blue ink, appearing to read "Eric J. Hall".

The Goals of Medicine: Health or Joy? *And Lessons Along The Way*

By Linda Emanuel, M.D., Ph.D.



There's a place in human beings that can get affected when death comes up. It's not clear where in Gray's Anatomy to find it yet.

Two weeks before my 60th birthday I had to get an ultrasound to work up the vague abdominal symptoms I'd been having since winter.

The report was "large ovarian mass." It was noted as vascular, and that's medical code for probably stage 4 ovarian cancer. Not good. My doctor gave me the name of a gynecologic oncology surgeon. He was matter of fact. I was matter of fact. I did pull over to the side of the road, but more because I felt I should than that I needed to.

What had happened to my "refractory moment"—that time when the word cancer is uttered and nothing else computes? We'd taught other clinicians about it in our seminars on breaking bad news; most clinicians would nod wisely and agree that this happens to every patient and family member one way or another.

For now, I was in another place. A quarter century or so of my work in palliative care and end-of-life care had taught me about existential maturity; I had the maturity and tools necessary to manage my mortality. Everything in my life has been done with a succession plan; nothing really

needed me anymore.

All I wanted was that those I love knew that this was a cosmic love moment that would last us till their own cosmic love moment. Serenity spoke to me of the rightness of life's cycles and how songs are completed with their all-important last note. I called my family, friends, colleagues; I spoke of the participation we all have in the great connectedness of life. All seemed to be simple and as it should be. No need to figure which view is right; they are all right, all incomplete, all wrong, and it doesn't matter.

I just wanted to be part of creating vital relationships with those around me: a dying role that rose to the level of sacred in my mind. Some said I was in denial; any third grader would spot that one, they joked. And yet they also caught the sense of my experience, I think.

Then came the whirlwind of coordinated chaos. Scheduling doctors, choosing teams and getting tests. Suddenly my fellow travelers had bald or wispy heads and lashless eyes, and perambulated with IV poles. I was surrounded by friends and family and was being whisked from place to place, carried almost, like something precious at risk.

In the clinic waiting room some people moved slowly, painfully, and seemed painted in gray, existing

silently, slightly among those painted in color. The gray people stood out. They'd lost ... what? Hope? I thought not. I concluded they'd lost joy.

All those articles and conversations about hope and truth-telling and the therapeutic relationship came back to my mind and suddenly seemed misdirected. Even in palliative care we talked about offering patients something realistic to hope for. We'd bought this assumption as if it were a truth that people must have hope. Now I found that I disagreed.

People must have joy. Loss of joy is an emergency. Joy should be a sixth vital sign. We should have rapid response teams: mental health providers and chaplains to search and rescue people lost without joy.

Hope and joy are not the same thing. Perhaps for some, joy without hope of life is too difficult at that time. But still, it's really about joy; hope is one vehicle among others to joy. For those patients who have described dying as the best part of their life so far, hope for life was not what it was about. Not for me now either. The love involved in connecting, being part of something so much larger than me; that was what it was about.

Reading up about ovarian cancer's types, stages, and treatment options, I reflected that the lucky

ones were not the ones with a better prognosis as much as the ones with the wherewithal to access joy. What were the determinants of joy amidst travail, I wondered?

Then, still before my 60th birthday, life took another U-turn. The pathology came back: benign. It was just an ovarian cyst. Whatever cognitive capacity I had left had not processed the possibility of no cancer, at least not on any but an almost secret level. And now benign? Really? An incidental finding!

My first reaction was to feel guilty that I'd had a preview of something sublime. Like I was actually at my funeral—the kind where guests comment, “She’d have liked this.” So many gifts of loving kindness. And I wasn’t even in the cancer family. I felt like a fraud. Like I must have really known and all this joy was just about getting attention. Like I needed to give back ill-gotten gains. Was this survivor’s guilt? A miscarriage in role? People were as kind to me as if I still had cancer. But I didn’t; I felt like I’d overdrawn my account.

My journey was not with a terminal illness. It was a near-cancer

experience, and it had two important lessons for me after more than three decades in medicine. It taught me that:

1. Care should focus on patients keeping their joy more than not losing hope.
2. Loss and grief reactions are a function of persons’ assumptions about what matters.

But more than lessons, this patient journey gave me a gift beyond the physical health, which I’ll appreciate with a whole new hue now. It gave me the knowledge that joy exists when facing death too.

We have to help people facing illness find the joy since it can be elusive. Symptom management and reliable care systems help. But it’s also a personal matter. Helping our patients and their family caregivers find joy is part of our deep professional calling whether we work in curative or palliative disciplines. Our competence is an essential vehicle toward that end.

One person’s joy is not another person’s joy, and every search is

different. But any understanding about how to help people find or keep that in the face of illness would be at least as big a breakthrough as discovering penicillin. It’s probably something simple, like being present. Knowing that would change the way we practice, no?

Linda Emanuel, M.D., Ph.D., is the Buehler Professor of Geriatric Medicine at Northwestern University Feinberg School of Medicine in Chicago, Ill., and the director of the Buehler Center on Aging, Health and Society within the Institute for Public Health and Medicine at the medical school. Emanuel also serves as senior fellow at HealthCare Chaplaincy Network, New York.

Editor’s note: Abstracted with permission from an article in *The Journal of Palliative Medicine*, January 2015, 18(1):4-6.



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Let's Seat 'Chief Spiritual Officers' at Decision-Making Tables

By Rev. Eric J. Hall

Hospitals and health care systems have been directing more attention to how their patients rank the care and treatment they receive. If hospitals don't score well on standardized patient satisfaction surveys, they risk losing some Medicare reimbursement. Thus, a satisfied patient experience is becoming a priority of the medical establishment, and with this comes the emergence of the chief patient experience officer—or PX—in the executive suite.

I recently visited the PX of a large metropolitan medical center who was in the midst of a systemwide study in an effort to improve patient-centered care and eliminate stressors for patients. His office walls were lined with a series of "maps" of patients' progress through the day and night. It reminded me of a continuous EKG chart measuring heartbeats. Each time a hospital employee, whether nurse, doctor, or housekeeping staff, interacted with each patient, it was noted.

However, not once during these intensive surveys in all departments were the patients' spiritual needs considered. And this hospital has a professional health care chaplaincy department! I wondered why those chaplains did not figure into this plan to document patient satisfaction even for the most basic reasons such as requesting a blessing or prayer before surgery, or making communication between the patient, the family, and the health care team more congenial.

Professional health care chaplains are trained to listen to people in their time of crisis, and also to hear what is unsaid. For example, when a patient is afraid, perhaps facing serious or risky surgery, he or she may not want to express that fear in front of a loved one.

I know of a man who was facing his third round of chemotherapy and was truly scared. However, he did not want to relay his worries to his wife and add to her already high level of anxiety. A health care chaplain visited and let him know that she was there to be present and let him share his fears. The man eventually regained his health and was so inspired by the chaplain's intervention that he began training to become a professional health care chaplain himself.

Chaplains, trained to be present for persons of any faith or no faith, are also cultural liaisons. For example, they know that a Native American family typically will only talk about death in the third person. A chaplain is trained to work with them so that treatment and care can progress for their seriously ill family member. When there is family tension in a patient's room because they don't all agree on the course of care, the chaplain sits with the family and helps them to understand the situation and relieve the family's spiritual distress.

Sometimes a very religious family won't go along with the treatment recommended for their family member because they believe God will heal the

person if they have enough faith. Without denying God's existence, a chaplain knows how to reframe it from being God's choice, so that the medical staff can proceed with treatment.

So don't think for a moment that chaplains are simply "supporters." Health care chaplaincy is a clinical discipline. Doctors and nurses can heal the body, but healing the spirit takes a very different kind of training. And while many health care organizations are coming to realize that spiritual care matters to the patient's comfort, well-being and recovery, that discipline is still largely missing from the decision-making counsels of health care.

Jeff Bezos, the founder, chairman, president, and chief executive of Amazon, likes to include an empty chair at his management meetings to represent the customer, who

should always be a presence, uppermost in his team's mind. The empty chair implies that someone is missing from the conversation, from their place at the table.

Today there is a very obvious empty chair in our hospitals and health care systems, one that should be occupied by trained and certified health care chaplains who care for the patient's spiritual and emotional comfort, talk with families and caregivers, and help them navigate the system. As the "active listeners" trained in all cultural and religious backgrounds, they would bring the patient—the health care customer—to the table with them.

Some Catholic and Protestant hospitals have spiritual care professionals on their boards (although they may not be trained in health care chaplaincy), but in non-denominational systems, such representation is rare.

Part of the problem may lie with the practitioners themselves. Chaplains are, by nature, not like

the business entrepreneur Bezos. Nevertheless, they may be missing an opportunity to put their convictions to work for the benefit of the greater good of the patient and the health care system.

While hospitals rush to create more attractive rooms and serve better food, those things are not always on a patient's mind. As early as 2011 a study of more than 3,000 patients at the University of Chicago Medical Center suggested that many more patients desire conversations about religion/spirituality than have them. Patients' overall experience with being hospitalized and patient satisfaction might improve by addressing this unmet need. A 2012 nationwide survey concluded that "communication by doctors, nurses, and other staff was most important, while the facility accounted for a fifth of patient satisfaction." Likewise, a 2013 survey by The Beryl Institute of more than 670 hospitals and health care systems found that "the one behavioral priority remains

communication, which while broad in scope has significant implications for patient experience performance."

In an article in USA Today, Linda Dubay, M.D., the chief quality officer at St. John Providence Health System in Novi, Mich., said, "Bells and whistles make it a nicer environment for patients but if you are not addressing holistic spiritual care, they're not going to rate it well."

I'm all for the emergence of the chief patient experience officer. But I'd also like to see the chief spiritual officer, or CSO, in the C-suite of every health care system. This person, a board-certified health care chaplain, should fill the empty chair. Everyone else at that table needs input from this person because total patient care—and improving the patient experience—encompasses complete healing: body, mind and spirit.

.....
Rev. Eric J. Hall is president and CEO of HealthCare Chaplaincy Network.



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Disaster Chaplaincy in a World on Fire

By the **Rev. Sue Wintz, M.Div., BCC**



On May 12, 2015, Fran Pultro, the staff chaplain at St. Christopher's Hospital for Children in Philadelphia, Pa., had just sat down with a dear friend at a diner when sirens began blaring. His phone rang: the Amtrak Northeast Regional train en route to New York had derailed just a few blocks from his church in the Port Richmond neighborhood of Philadelphia.

Pultro, also the president of the 15th District Philadelphia Police Chaplains and a senior pastor at Calvary Chapel King's Highway, immediately began communicating with other police chaplains whose houses of worship were located near the accident site. Then, he quickly drove to the scene.

By the time he arrived, the injured passengers had been taken to local hospitals. So, he said, "I put

on my 'crisis chaplain cap' and went about the business of assessing the needs of the first responders. This was not self-deployment ... When things happen in your 'hood, you pitch in and help."

Train and plane crashes. Tornadoes, hurricanes, floods and wildfires. School, theater and workplace shootings. Acts of terrorism. All are disasters that bring destruction and sorrow, changing lives forever.

Trained disaster chaplains are an important part of the response team. Whatever the situation, highly trained professional spiritual care providers bring their skills to work in collaboration with other responders to sustain those who have been impacted: they listen to their stories, support them in grief, and help activate their spiritual and religious sources of strength, resilience and hope.

The National Voluntary Organizations Active in Disaster (NVOAD), a coalition of nonprofit organizations that coordinate planning efforts in response to disasters as part of their overall mission, affirms that, "Spirituality is an essential part of humanity. Disaster significantly disrupts people's spiritual lives. Nurturing people's spiritual needs contributes to holistic healing. Every person can benefit from spiritual care in time of disaster."

Persons who are impacted by disaster may have many questions and needs that raise spiritual issues. They may struggle with their faith and its meaning in light

of homes and belongings that are destroyed or lost; businesses and sources of income that are shut down; separation from loved ones; serious injuries to themselves or family members; or grieving the death of a loved one in the midst of catastrophe.

Spiritual care providers come to the spiritual aid of not only those impacted by the disaster itself, but also the first responders, relief workers, community leaders, hospital staff, law enforcement, and those who survived previous disasters and trauma.

Following a disaster, these various populations often need contact and a sense of belonging, the presence of others who can bring calm, a space for gathering with other survivors and mourners, and safe places to express emotions and talk about the event.

Disaster chaplains respond to these needs as well as work with other community organizations to care for the spirit, by assisting with shelters, feeding kitchens, and meeting rooms; the gathering of clothes and other necessities; and individual and community vigils as signs of support.

Both professional chaplains and other spiritual care providers from a wide range of agencies and traditions (e.g., congregational clergy and laity who are assigned by their denominations to provide disaster spiritual care) are among the many who respond with caring interventions in times of crisis. They come with various levels of training, experience, ability and motivations.

Responders who tend to render the most effective care are usually those with clear guidelines and professional boundaries.

At the train derailment site, Pultro entered only into safe zones—those areas where electricity had been disabled, and where no structures were in danger of collapsing and causing injury to rescue and recovery personnel.

"As is my habit, I remained out of the way of recovery operations for safety reasons, as well as being sure not to be underfoot," he said. "I behaved like a disaster chaplain should in such circumstances, listening and comforting to the best of my abilities, all the time keeping an eye open for signs of debilitating stress. Rescue and recovery had to continue."

In a desire to "partner with local spiritual care providers and communities of faith in providing appropriate and respectful disaster spiritual care," in 2014, NVOAD ratified National Disaster Spiritual Care Guidelines that had been developed by the coalition's spiritual care subgroup.

The document includes a description of the basic concepts and types of disaster spiritual care, the local spiritual care providers and communities of faith as primary resources for post-disaster spiritual care, the relationship between disaster emotional care and disaster spiritual care, the importance of spiritual care in all phases of a disaster, and the necessity for intentional self-care for spiritual care providers.

The guidelines also stress the foundational need for respect for diverse cultures and religious values and traditions, the awareness that impacted people are vulnerable to exploitation, and the affirmation of the importance of cooperative standards of care and agreed ethics.

Further, NVOAD developed a complete resource to encourage best practices in disaster chaplaincy, which has become the central training guide for those who currently do, or want to be trained in, this work. "Light Our Way: A Guide for Spiritual Care in Times of Disaster for Disaster Response Volunteers, First Responders and

Disaster Planners" is available online to download in both English and Spanish (www.nvoad.org).

Professional chaplaincy organizations often provide workshops on disaster training. HealthCare Chaplaincy Network contributed to the "Psychological First Aid Field Operations Guide," which can be downloaded from the online store on HCCN's website (www.healthcarechaplaincy.org).

As well, best practices in disaster preparedness has developed in the chaplaincy field, as part of a trend toward the emergence of consensus around best practices on other topics. A chaplaincy care department should have a specific role in any institutional disaster plan. Often this role involves care of family members and/or being part of a general labor pool. The department should have a specific protocol for mobilizing its staff and possibly selected community clergy during normal business hours and off hours.

Chaplain Tim Serban, chief mission integration officer at Providence Health & Services in

Disaster Spiritual Care Wisdom Sayings

OVERVIEW

- 1 No one who "witnesses" a disaster is untouched by it.

SELF-CARE

- 2 Everyone responding to a disaster needs to practice self-care and seek the support of others so that they leave the disaster experience changed but not damaged.
- 3 Self-care is a religious mandate particularly for leaders of faith communities. According to most Western religions, even the Creator of the Universe rested on the seventh day. Practice what we preach about time off!

BASICS

- 4 The first order of business is helping meeting people's base need of human care — food, water, shelter, medical. Only then are they even able to focus on spiritual needs.

- 5 Disaster spiritual care is more about team and less lone ranger.

- 6 Spiritual care and mental health are most effective when working cooperatively for the benefit of the client.

- 7 When in doubt, check it out.

DIVERSITY

- 8 The disaster spiritual caregiver must recognize the unknown god in diversity.
- 9 Spiritual care must be uniquely tailored to the spiritual community and/or individual affected.
- 10 Every disaster survivor must be treated as an individual created in the image of God. Some will require minimal assistance to regroup and move on, while others will need intensive support.

Portland, Ore., and volunteer lead of disaster spiritual care of the American Red Cross, advocates the use of Disaster Spiritual Care Wisdom Sayings, which are published in "Disaster Spiritual Care: Practical Clergy Responses to Community, Regional and National Tragedy" (see sidebar).

According to Serban, the 21 wisdom sayings grew out of the direct experience of disaster spiritual care experts and were created as a practical quick reference guide—"simple yet profound reminders"—for disaster spiritual care professionals in the midst of a disaster.

Since their publication, the sayings have been presented at international conferences and workshops and shared with responders on the scene at disasters, such as with Americorps and American Red Cross responders under a shelter in the middle of the tiny island of American Samoa following the devastating 8.3 magnitude earthquake and tsunami there.

"Some of the most meaningful

parts of this tool are not that they are unique; rather, they are reminders that we are affected by the disaster, and each of us needs to remember boundaries and self-care," Serban wrote in an article in PlainViews®, a publication of HealthCare Chaplaincy Network.

"Sometimes as the waves of grief become overwhelming," he continued, "it is vital to remember that true wisdom comes from our ability to honor people's need to 'pound on God's chest,' for example, without judgment, in safety, and with our pastoral presence."

Over three days, Pultro worked the accident site as a disaster relief chaplain, saying prayers for employees removing debris who showed signs of spiritual distress, serving as an ear to experienced first responders, acting as a liaison between rescue workers and anxious families, and comforting a family during the final search for a missing loved one. Of 238 passengers and five crew on board, eight were killed and more than 200 injured.

When the rescue and recovery operation was over, the majority of Pultro's self-care began. After periods when he sees death, he said he tends to "recover better" when he prays, reads the Bible, spends time with his family, writes, and involves himself in other productive activities.

"I also pray that there are no other disasters that will require the work of a chaplain," he said. "Yet I know this is unrealistic. So like others called to be chaplains, I work to hone my skills for the next time they are needed."

The work of disaster chaplains is often heartbreaking—and yet, these dedicated professional women and men also find it uplifting as they witness the resiliency of the human spirit.

The Rev. Sue Wintz, M.Div., BCC, is managing editor of PlainViews®, an online professional journal published monthly by HealthCare Chaplaincy Network, and HCCN's director for professional and community education.

CONNECTIONS

- 11 People do not care how much you know until they know how much you care.
- 12 Healing happens within human relationships.

I AND THOU

- 13 Listening to and being with are more important than talking at and doing for. If you cannot improve on silence, do not try.
- 14 Ministry of presence, not pressure.
- 15 Always ask, and re-ask: "Whose needs am I trying to meet?"
- 16 Disaster spiritual caregivers must struggle with the victims as they ask their questions ... not answer them. True wisdom is not in the answer when someone asks, "Why?"

PRACTICAL TOOLS

- 17 The best initial spiritual assessment tool begins with open-ended questions such as, "How are you doing?" or "How are things going today?"

- 18 Let them pound on God's chest; the Creator of the Universe can take our anger.
- 19 Draw the lines before you jump or you will end up in an overwhelming sea of need.
- 20 We, as helpers, may not have the power to "heal" but we can, through our work as disaster spiritual caregivers, plant a seed of hope. Hope is an essential part of all forms of healing.
- 21 Ritual is an important and effective means of healing.

Contributors to Disaster Spiritual Care Wisdom Sayings:

Stephen B. Roberts, Willard W. C. Ashley Sr., George Abrams, Yusuf Hasan, John Kinsel, Charles R. Lorrain, Pamela Norris Norwood, Naomi Paget, Tanya Pagan Raggio, Timothy G. Serban, Frederick J. Streets, and Julie Taylor.

From "Disaster Spiritual Care: Practical Clergy Responses to Community, Regional and National Tragedy," edited by Rabbi Stephen B. Roberts and Rev. Willard W.C. Ashley Sr., (©2008, SkyLight Paths Publishing). The publisher grants permission to copy this.

A Snapshot of Chaplaincy Standards

For the chaplaincy field, the past decade has brought about multiple standards, guidelines, and best practices. Many specifically refer to the growing discipline of palliative care. As a result, institutions should consider this structure—and more that is likely to emerge—when developing or bolstering spiritual care delivery and setting clinical site policies.

The first standards of practice in professional chaplaincy date back to 2009 when a consensus panel sponsored by the Association of Professional Chaplains (APC) drafted standards of practice for chaplains in acute health care. The benchmarks effectively align professional chaplaincy in health care with comparable disciplines, particularly nursing and social services.

The 13 standards of practice, which refer to chaplaincy care with patients, families, staff and the organization, and maintaining good chaplaincy care, include:

- **Assessment**—The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social spiritual/religious health.
- **Delivery of Care**—The chaplain develops and implements a plan of care to promote patient well-being and continuing of care.
- **Documentation of Care**—The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.
- **Respect for Diversity**—The chaplain actively models and collaborates with the organization and its interdisciplinary team in respecting and providing culturally competent patient-centered care.
- **Care for Staff**—The chaplain provides timely and sensitive chaplaincy care to staff via individual and group interactions.

- **Care for the Organization**—

The chaplain provides chaplaincy care to the organization in ways consonant with the organization's values and vision statement.

- **Research**—The chaplain practices evidence-based care, including evaluation of new practices.

Likewise, several consensus guidelines that include professional chaplaincy have emerged in recent years. All have undergone significant interdisciplinary peer review and have high credibility in their fields.

National Comprehensive Cancer Network Distress Management Guidelines describe protocols for screening patients for distress and ensuring appropriate treatment by psychological, social work, and chaplaincy professionals. They require certified chaplains to be fully integrated into the treatment team.

Other developments specifically relate to palliative care:

National Quality Forum (NQF) Palliative Care Guidelines call for, among other provisions, the development and documentation of a plan based on assessment of religious, spiritual and existential concerns using a structured instrument and the integration of the information obtained from the assessment into the palliative care plan; and the inclusion on specialized palliative care and hospice care teams of spiritual care professionals appropriately trained and certified in palliative care.

Building on the NQF guidelines, the **National Consensus Conference** published working models for spiritual care in palliative care that call for, in part, board-certified chaplains on the care team; ongoing assessment of patients' spiritual issues; and the integration of patient spirituality into the treatment plan with appropriate follow-up.

>> See infographic on "The Utilization and Efficacy of Professional Chaplaincy" on Page 13.

Capping these two advancements, the **National Consensus Project for Quality Palliative Care**, in its Clinical Practice Guidelines for Quality Palliative Care released in 2013, states:

- The interdisciplinary palliative care team, in all settings, includes spiritual care professionals—ideally a board-certified professional chaplain.
- A spiritual assessment process, including a spiritual screening, history questions, and a full spiritual assessment as indicated is performed.

The Joint Commission, in its Standards and Elements of Performance for Advanced Certification in Palliative Care published in 2011, requires a chaplain with "specialty training in palliative care" as a member of the interdisciplinary team.

Lastly, consensus is developing in the field of professional chaplaincy around a number of best practices.

Among them:

- All chaplaincy care staff should be certified according to the Common Standards for Certification of Chaplains and agree to abide by the Common Code of Ethics, which includes prohibition of proselytizing or in any way imposing one's own beliefs and practices on a patient.
- A complete patient history should include a review of the patient's spiritual and religious needs and resources.

In sum, these standards, guidelines, and best practices support a role for spiritual care that is focused on identifying and providing effective and efficient care to patients and family members with acute spiritual needs. It, therefore, requires a high level of training for the chaplain and a consistent, reliable presence.

THE UTILIZATION AND EFFICACY OF PROFESSIONAL CHAPLAINCY

GAPS TO FILL



Many more inpatients desire **conversations about religion/spirituality** than have them.

Source: BMC Palliative Care, 2012

More than one-quarter of all adults, including those 75 and older, **have given little or no thought to their end-of-life wishes**



Source: "Dying in America" report, Institute of Medicine of the National Academies, 2014

72%

of advanced cancer patients said their **spiritual needs were minimally or not at all supported by the medical system.**

Source: Journal of Clinical Oncology, 2007

PATIENT SATISFACTION

80%

of patients with spiritual/religious needs said the chaplain met these needs very well.

Source: Journal of Palliative Medicine, 2009

A strong association exists between **SATISFACTION** with **spiritual care** and **satisfaction with total ICU experience.**

Source: Critical Care Medicine, 2007

Spiritual care is associated with better patient quality of life near death.



Source: The Journal of Clinical Oncology, 2009

INSTITUTIONAL BOTTOM-LINE

INADEQUATELY-SUPPORTED SPIRITUAL NEEDS LEADS TO

- MORE DEATHS IN ICU
- HIGHER END-OF-LIFE COSTS

Source: Journal of Pain and Symptom Management, 2011

CHAPLAINCY SERVICES ARE RELATED TO



Source: BMC Palliative Care, 2012

SIGNIFICANTLY LOWER RATES OF HOSPITAL DEATHS

HIGHER RATES OF HOSPICE ENROLLMENT

CHAPLAIN VISITS RESULT IN

- ★ INCREASED SCORES ON PATIENT SATISFACTION SURVEYS (HCAHPS, Press Ganey)
- ★ OVERALL PATIENT SATISFACTION
- ★ PATIENT'S WILLINGNESS TO RECOMMEND HOSPITAL

Source: Journal of Health Care Chaplaincy, 2015



HealthCare Chaplaincy Network

Compiled by HealthCare Chaplaincy Network, 2015.
www.healthcarechaplaincy.org

To see more infographics, visit www.HCCNinfographics.org

The Chaplain Goes Virtual

Hospitals strain to offer as much spiritual support as patients often need. Here's one solution.

By Melinda Beck

The communication lines are modern, but the questions are often as old as mankind itself: Why am I in pain? Am I being punished? What happens after this life?

Mirroring the move to telemedicine among physicians, health care chaplains are listening to such concerns and offering spiritual support increasingly through Skype, FaceTime and other high-tech connections.

Since launching its "Chat with a Chaplain" service last year, the HealthCare Chaplaincy Network, a New York-based nonprofit, has facilitated nearly 5,000 exchanges between its on-call chaplains and people all over the world.

Healing role

The service is free to individual callers, but the chaplaincy network is also joining with hospitals to extend their own chaplaincy services to outpatients, discharged patients, family members, and others, for a monthly fee, which can range from \$1,000 to tens of thousands of dollars, depending on the hospital's size and expected volume.

The chaplaincy network aims to fill a growing need: There is mounting evidence that spiritual support plays an important role in physical healing. Yet even critically ill patients are spending less time in hospitals where chaplains typically work. Patients may also be disconnected from formal religion and still face agonizing questions and debilitating fears.

Most academic medical systems and about 70 percent of community hospitals offer some chaplain services, according to the American Hospital Association. But their costs generally aren't covered by Medicare or private insurance, so their resources are often stretched.

"Hospitals may have three chaplains covering 800 beds," says Rev. Eric Hall, the network's president and chief executive. "Many of them would like to offer more services, but there are limitations."

In the past six months, the network has signed agreements with 26 hospital systems to provide remote access to the network's on-call chaplains, facilitate virtual visits with the hospitals' own chaplains and/or license the organization's suite of spiritual TV programming.

The network's call center has as many as 18 board-certified chaplains available to return requests for contact, for as much as 18 hours a day. (Most are going about their day jobs as well.) While many forms of video chatting are available, most interactions are by phone or mail. "There's a lot of anonymity," Mr. Hall says. "People can wear their bunny slippers."

The chaplains say virtual visits have a different dynamic from face-to-face encounters, but often in positive ways.

"People can't see me nodding or my face expressing empathy, so I have to articulate more," says Maurice Appelbaum, an Orthodox rabbi who also works at Memorial Sloan Kettering Cancer Center in New York. He says that for patients, too, the lack of nonverbal cues means "there's more being said—sometimes things that have never been said before—and that's a powerful opportunity for healing."

Tailored features

Like all board-certified chaplains, those who work with the chaplaincy network are trained to work with people of all faiths, or none. The group also has online resources tailored to people

dealing with cancer, and to military veterans and their families. Combined, they have had more than 500,000 unique visitors in the past year.

Themes frequently mentioned include loss of a loved one, broken relationships, isolation and fear related to diagnosis. Common questions include "Why am I suffering?" and "Has God abandoned me?"

"Most people know that these questions are unanswerable. They want somebody to listen to them and affirm that, yes, this is unnerving," says the Rev. George Handzo, the network's director of health services research and quality.

The demand for spiritual support, in a variety of forms, is likely to increase as hospitals add more palliative care and hospice programs, often to patients in their homes.

"Most of the ministry that chaplains do is face to face, but there are certainly times when that's not possible, due to distance or incarceration or a contagious disease, and technology is opening up doors for us," says Margaret Atkinson, president-elect of the Association of Professional Chaplains.

"Wherever chaplains are, at the bedside or the other end of a video camera, it's about the human connection," she says. "That's what we are there for."

Melinda Beck is a health reporter and columnist for *The Wall Street Journal* in New York.

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“There is nothing more antithetical to our closely held belief that childhood is for laughter, growth and curiosity than the jeopardizing of a child’s life. Especially difficult to accept by parents and other caregivers is when a child has a life-threatening condition or terminal illness. Children are supposed to outlive their elders, not die before them, but tragically this is not always the case.”

— Archbishop Desmond Tutu, in his foreword to “Hospice Care for Children” (2009, Oxford University Press)

This special section on pediatrics discusses some of the issues that arise, skills that are required, and techniques that can be used in providing spiritual care to sick children and loved ones.

EXTREME CHAPLAINCY:

Being at a Child’s Bedside

By M. Karen Ballard, MCM, BCC

“I could never do what you do; I’m too tender, softhearted.” Time and again I hear this from families, friends and colleagues. I chuckle within and think, “I must be really hardhearted,” but simply reply, “Well, I cry a lot.”

Being a chaplain for any population in any sector can generate this type of response, but that my clinical work is actually pediatric palliative care appears to amplify people’s reactions.

It is out of our sense of vocation that pediatric chaplains accept the multiple challenges that come with engaging with our young patients and their sometimes grief-stricken families—challenges that are present because of a child’s vulnerability and innocence. Some of the same

challenges are probably present for those working with disabled adults and the elderly, and perhaps other populations.

While chaplains in probably all medical venues practice family-centered care, it reaches its pinnacle in pediatric chaplaincy. The infant, child or adolescent most often comes to us with parents, siblings, grandparents, and a host of other family members, many of whom are saying and wishing that they, and not the child, were the patient. This desire to reverse the situation creates an intense need for spiritual and emotional support.

There is no other relationship like the parent/child bond, making the need for support for both the patient and family members



an intricate dance of allowing the feelings to be what they are, offering hope and encouragement when appropriate, or being a quiet presence willing to be witness to the spiritual/emotional distress.

The pediatric chaplain is required to know and understand developmental issues both from a psychological and faith development standpoint so that their ministry can be age appropriate.

One interesting phenomenon is that many of the parents that chaplains encounter are adolescents themselves—some chronologically and some in their faith development. Age-appropriate care is essential in this type of situation. In addition, it sometimes raises the need for the chaplain to advocate for the appropriate care of the parents so that doctors and other providers will discuss the needs of the patient and the care plan in terms that the adolescent can understand and so that the medical team can appreciate how their reactions and requests may be unlike what they would expect from most parents.

For the patient, it is of ultimate importance for the chaplain to engage the child—no matter the age. Children are spiritual beings, whether or not they have been exposed to religious or spiritual training or environment. It is the privilege of the chaplain to engage that spirit to determine how best to support and accompany the patient.

Young children do not have the words to discuss their interior experiences with adults. It is the chaplain's opportunity to be present to them, to listen with open hearts to their play, imaginations and conversations, to discover when they feel fearful, anxious, sad or angry.

Staff care also needs additional attention in the world of pediatrics. The care team is comprised of adults who likely are parents, siblings, grandparents, aunts, uncles, cousins—all who can in some way

relate personally to the patient in the bed and the family in the room. While this familial identification may assist in creating empathy and compassionate caring, staff must guard against being overwhelmed by such identification. Boundary issues become a constant theme in staff education for the protection of the patient and family, as well as for the long-term care of the staff member.

The emotional toll on staff as they watch children suffer and die is beyond description. Being witness to the unabashed grief of parents or other family when a child dies is the most heartrending experience.

This toll is multiplied exponentially when the situation involves non-accidental trauma (abuse). The anger, disgust and

“Being witness to the unabashed grief of parents or other family when a child dies is the most heartrending experience.”

sadness can be palpable, making it difficult but extremely necessary to find ways to support and debrief staff so that they can care for the patient and family in the room without judgment and without their own emotions being evident. The role of the pediatric chaplain becomes critical in these situations by offering the staff the support they need and by sometimes providing the nonjudgmental support for the family when others may find it difficult to offer such support.

Perhaps the biggest challenge for the pediatric chaplain is dealing with the philosophical question of the suffering of the innocent. While not considered in doctrinal terms,



this is almost a daily conversation with families. “Why would God let this happen to my child?” “No child deserves this; what kind of world do we live in that allows children to suffer?” While most often expressed in the spiritual language of “why” questions, it engages the complexity of systemic societal issues of which our children are innocent victims.

And then there are the family members’ prayers for miracles—anguished, fervent prayers. “Why is God not answering my prayers?” Their prayers and groaning are so deep that it can take one to the depths of suffering.

Here at the crossroads of anguish and suffering amidst children and their family members—hope and expectation, the chaplain stands as witness, as companion, as one trusting that all is held in the power of the Transcendent Spirit. The chaplain’s nurture comes from living out his or her vocation and responding to the call to be in that place of witness, companion and trust.

M. Karen Ballard, MCM, BCC, is director, chaplaincy services at Akron Children’s Hospital in Akron, Ohio. She is a contributor to *“Palliative Care for Infants, Children, and Adolescents: A Practical Handbook”* (2011, John Hopkins University Press).

The Spiritual Child: How Healers Can Tap This Innate Awareness



By **Lisa Miller, Ph.D.**

Some years ago, when my oldest child, Isaiah, was 2 years old, his Great-Grandfather Henry died. Isaiah was the only one of the young great-grandchildren to attend the funeral. The common thought was that for a child, death is overwhelming, too much to understand, or even traumatic.

Isaiah sat by me, graveside at the Jewish burial. First we said the Mourner's Prayer, asking that Pa-pop's soul be received by the Creator, and then we each took a turn shoveling soil into the grave. The three-foot shovel was far too large for Isaiah, so he lifted a small garden trowel of earth to sprinkle on Pa-pop's casket.

Isaiah realized that he was doing something important. He even seemed to realize exactly what he was doing. He and I looked into each other's eyes, nodded, and then repeated what we had said together many times leading to the burial: "Pa-pop's soul goes back to God, and his body goes back to the good earth."

Back home, a few days later, Isaiah was playing outdoors when he

had a guided discovery. He ran up to a spot in the backyard, and pointed to the ground with a sense of clarity. I followed his finger to a wild turkey carcass. "Look!" he said. "His soul goes back to God and his body goes back to the good earth. Just like Pa-pop."

Isaiah was not remotely traumatized by death. He grasped death and eternal life. He had discovered something meaningful and sacred. Bringing himself, his prayers, and his contribution to the burial was a moment of spiritual connection with Pa-pop—a moment of personal spiritual growth.

Children are naturally spiritual. When we appreciate their innate spiritual awareness, we can help ground them in a sacred reality.

In my book "The Spiritual Child," I offer some of the ways in which natural spirituality presents in children, in the hope that these core spiritual capacities might be harnessed not only by parents but by chaplains, counselors, and other healers in their work with youngsters.

Editor's note: The following is excerpted from a chapter in "The Spiritual Child: The New Science of Parenting for Health and Lifelong Thriving" (2015, St. Martin's Press) by Lisa Miller, Ph.D., and is reprinted with permission.

1. A child's spiritual compass: trustworthy and good for life. A child's inner life is an instrument of spiritual knowing, a trustworthy inner compass that aligns itself for health, and orients toward the truth and spiritual values.

Even a single powerful childhood experience of spiritual awareness can be a lasting source of guidance through adulthood. We often speak of a "moral compass" that guides us to choose right over wrong. That moral compass is built upon the spiritual compass, which finds direction from the higher self—guided by the transcendent relationship.

Children often show a stronger spiritual compass than we might expect, enabling even young children to sense adult hypocrisy or prejudice—and to act on it.

Celine, a mother in her early 30s, had severed connections with the church of her childhood and religion in general, after a hurtful experience surrounding her teenage pregnancy and her eventual divorce from her daughter's father. But she let her 6-year-old daughter, Rya, attend Catholic school because the child liked to go to church with her grandmother, who remained quite observant. Celine worried that Rya would "be brainwashed" by the prejudice and hypocrisy of which she herself had been a victim, but she kept quiet about it because the personal history was so complicated.

One day Rya came home from school very worried but wouldn't tell her mother what troubled her. "Then all of a sudden she says, 'Mom, just so you know, I don't think you're going to hell. And I don't think I'm going to hell, either.' And I looked at her and said, 'Well, that's good. Why do you say that?'"

"Rya replied, 'In school today they said it's bad to be divorced because you're breaking the bonds you promised to make. They taught us that if you're divorced you're going to go to hell. And I don't think that's true.'"

Celine's worst expectations of misuse of religious doctrine were confirmed, but she was inspired by her daughter's response. Rya's inner compass was as strong as her mother's. Rya knew her own spiritual truth, and at the same time could incorporate the church as part of her loving bond with her grandmother.

If children have learned to access their inner compass themselves, they'll come to use it reflexively. As they near adolescence and the challenges grow more complex, even if they're drawn to explore unknown territory in the process, they'll be prepared to draw deeply from inner resources for guidance—equipped to find their own true north.

2. Children are hardwired to hold family sacred and sustaining.

Young children are naturally drawn to the specialness of family. They show us in so many ways what psychologists talk about as the "primacy of family," the family's role as the defining context for a child's development. The field of love is the basis for what I call the spiritual primacy of family, a child's defining context for spiritual development and values.

The field not only nurtures a child in the here-and-now family, but also connects them to the loving presence and transcendent connection across generations. As children develop more advanced language and cognition, they carry that connection forward firmly in mind and heart.

Liam was 10 when his Grandma Joan died. She had lived nearby and from birth he had had a very close and joyful relationship with her. She picked him up from school several days a week. They baked cookies and took adventures to the children's museums, aquarium, and swimming pool. On family vacations the two would take quiet walks in the woods or by the water. Nearly every significant event included Grandma Joan.

More than two years after her death she remains a loving presence for him. Sometimes he sits and thinks about her, especially when he's had a bad day, he told me. He recalled how on one such day, "I was just thinking about my grandma, and that thought went to another thought of just thinking of my grandma and how I love my grandma so much. There is so much of her that I wish I still had. Sometimes if I am lonely, I think of her. So I talk to her. It's like a prayer and kind of a conversation. It helps."

This spirit-deep relationship with family is one of the core assets of a child's natural spirituality. Children draw life lessons not only from the

strengths, but also the foibles and failings of various family members.

Circumstances can break down families and tear the field of love. Divorce, death, loss and trauma: the tear can seem irreparable. But families can purposefully reconfigure and use sacred intention to re-sanctify and mend the field of love. Most important, this means that families can remain "together" or spiritually whole even if someone is physically absent, whatever the reason.

3. Spiritual community gives your child an expanded family of kindred spirits.

What does spiritual community look like? From campgrounds to the sanctuary, all of these spiritual communities create opportunities that are beneficial to our children: intergenerational company, support, memories of those who have died, time for quiet reflection, ritual, song, friendship, and other spiritually engaged families. A spiritual community adds to the field of love, is an extended family-by-choice that shares spiritual values, celebrates you for your spirit, and cheers or prays you through challenges.

Spiritual community commits to the well-being of all, embraces each unconditionally, values all for their inner being, and includes them irrespective of outward merit.

Becoming part of a spiritual community presents opportunities for inner growth and a feeling of connectedness that are so important to children. We can ground them in the natural spiritual values we want to guide them, encourage them to develop their own inner compass, and support their desire to find a place or group of people where they feel that quality of spirit.

One can always play or pray alone, and that, too, is meaningful and sustaining. But to feel your voice resonate in a chorus of voices, to feel held or uplifted, inspired, soothed or healed with and through



others who care about you, this is the unique gift of spiritual community.

4. Spiritual multilingualism is your child's passport. Starting as early as 4 and certainly by 7, children absorb the language and customs of thought used to express spirituality in their family or spiritual community. Research shows that for children these names are prioritized as spiritually "more real." A team of Harvard [University] psychologists led by Professor Mahzarin Banaji investigated whether young children already had in-group versus out-group—my God is better than your God—perceptions around the names of the Higher Power. The team found in controlled experiments that a child as young as 6 will rate "God" as named by that child's faith as more omniscient than "God" as named by another geographically remote unfamiliar faith.

No matter what we may think about religion, we want to be sure children are open to the spiritual presence in all people. We do not want a child to build tribal superiority, which has nothing to do with a clear and open pipeline for natural spirituality.

The early mental packaging of a child's natural spirituality makes it imperative—read urgent—that our children become, in essence, spiritually multilingual and multicultural from an early age if we genuinely want them to have respect and appreciation for natural spirituality in other people and cultures.

5. Spiritual agency empowers children to create a culture of love.

Our children venture forth every day into the nitty-gritty human experience. They confront the good, the bad, and the complicated, from home turf to the playground and school cafeteria. When they encounter inconsideration, nastiness or selfishness, young children often reflexively choose to be kind and generous, to be helpful, and to step up and speak up when they see someone in need. Through the first decade, as they become more socially aware at school and in their worldview, they also become more self-aware of their own power to act in the world. The field of love isn't just there to support them; they can create it.

This growing awareness of spiritual agency becomes the practice ground for cognitive empathy—consciously choosing to understand a situation from someone else's perspective and to respond sensitively. In so many ways children are perceived and treated as having no agency, no power. And in many ways it's true: They can't drive a car, they don't control family decisions, and they can't put you in a corner for timeout when you lose your temper. But spiritually it's a very different story. Spiritual agency comes from within, and no matter what their age children have opportunities each day to make choices that exercise that power for good and that deepen their sense of ownership over their own choices.

The culture of love is about extending the field of love from family

to the wider world. When the field of love within the family is extended into a culture of love, our children themselves set standards derived from their core spiritual values. This is the power of spiritual agency.

6. Transcendent knowing: dreams, mystical experiences, and other special knowing. Children have a natural and engaged attitude to that which matters most in life: love, connection and oneness. Their heads and hearts engage strongly around transitions and at the borders of life, birth and death. For the young child, dreams, mystical experiences, and extraordinary knowing are simply a part of reality; they make sense and feel significant. As a psychologist, scientist and parent, I refer to children having these moments as "special knowing." This is the native spirituality of the not yet socialized child.

As the child grows older, the practice becomes one that the child can guide. The child can become conversant in engaging dreams to gain self-awareness and knowledge. Other special ways of knowing include mystical experiences, and children do have these. They will readily tell you about them if they feel comfortable doing so. (They're waiting for your nod!)

Lisa Miller, Ph.D., is professor and director of clinical psychology, and founder and executive director, Spirituality and Mind-Body Institute at Teachers College, Columbia University in New York. She is the author of *"The Spiritual Child: The New Science of Parenting for Health and Lifelong Thriving"* (2015, St. Martin's Press), which is on The New York Times' best-sellers list; editor of *"The Oxford Handbook of Psychology and Spirituality"* (2012, Oxford University Press); and co-editor of *Spirituality in Clinical Practice*, a journal of the American Psychological Association.

Need to Bolster Evidence-Based Pediatric Chaplaincy

By **Daniel H. Grosseohme, D.Min., BCC**



Momentum has been building over the past decade toward the development of a much-needed evidence-based chaplaincy, intensifying earlier efforts by several prominent chaplains and non-chaplains whose research laid the foundation for the present.

This shift toward a number of chaplains engaging in research and many others learning ways in which their clinical practice may benefit from it is an important step forward for the profession.

The need for such work is even more acute in specialized areas such as pediatric chaplaincy. However, evidence-based pediatric chaplaincy presents special challenges.

The first is the nature of pediatric health care in the U.S., which understands the child in the context of the family. Pediatric hospitals nearly all practice “family-centered care” in which parents have round-the-clock visiting and may perform some or all of their child’s daily care.

Pediatric research introduces the question of who is going to be the participant in a study: Is it the child or adolescent? The parent? Siblings?

The whole family constellation? The latter would be ideal and yet may be far from practical.

Research efforts have frequently had to focus on just one group: for example, children with asthma (Benore, Pargament, & Pendleton, 2008), or parents of children with cystic fibrosis (Grosseohme et al., 2010). There is only limited research on family units as a system, and the way in which faith relates to health and health behaviors. These topics are ripe for further study.

The second challenge to the development of an evidence-based pediatric chaplaincy is the need to broaden the field of investigators. Pediatric chaplains may contribute their expertise by offering to collaborate with experienced physicians, psychologists and nurses to help them generate evidence of how faith functions when children or teens are sick or injured, and to interpret the evidence from a theological perspective.

George Fitchett, D.Min., Ph.D., a professor and the director of research in the Department of Religion, Health and Human Values at Rush

University Medical Center, Chicago, Ill., has argued for the presentation of thick, rich descriptions of what chaplains actually do, and what difference it seems to make (Fitchett, 2011). Three pediatric chaplains have presented such cases for reflection (Grosseohme, 2015; Hildebrand, 2015; Piderman, 2015). The field would benefit from additional cases that focus on in-depth presentation of intervention and outcome.

Health care chaplaincy is indeed growing in its relationship to the value and usefulness of research. Pediatric chaplaincy has modest foundations and because of its focus on everyone—the child in the bed, the rest of the family, and the health care team—it warrants understanding of how faith functions in times of illness and brokenness.

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Spiritual Interventions By the Ages

By David Pascoe, MA, BCC, CFHPC

Children are not miniature adults. They have their own ways of making meaning of life at each stage of their physical, emotional, psychological and spiritual development.

At a very early age, children begin to develop spiritual understanding, including concepts of God, angels, heaven, hell, and divine reward and punishment. Specific beliefs will vary widely depending on the nationality, culture, religious beliefs, and values of the child's family.

This chart summarizes some age-appropriate spiritual interventions that may be helpful with children at various ages and stages in their understanding, as well as ways to support families and members of the interdisciplinary team (IDT).

David Pascoe, MA, BCC, CFHPC, is pastoral care coordinator in the Family Support Services Department at Primary Children's Hospital in Salt Lake City, Utah. He is a board-certified clinical chaplain and a clinical fellow in hospice and palliative care with the College of Pastoral Supervision and Psychotherapy.

Editor's note: In this chart, Pascoe's suggestions on age-appropriate interventions are linked to developmental stages based on "Stages of Faith: The Psychology of Development and the Quest for Meaning" (1981, Harper & Row), a best-selling book by James W. Fowler, Ph.D.

STAGE 0: UNDIFFERENTIATED		AGE: INFANTS AND TODDLERS (0-2)
Development:		Learning to trust the world
Spiritual Interventions:		
Children		<ul style="list-style-type: none"> • Embody their special place in God's eyes (e.g., Psalm 139: 13-16) • Treat them gently and with respect: speaking softly and holding, touching or rocking, if possible
Family		<ul style="list-style-type: none"> • Pray for the healing and well-being of the infant • Learn and support religious/spiritual beliefs of parents • Provide supportive listening and presence • Offer affirmation and prayer
IDT		<ul style="list-style-type: none"> • Help identify boundaries • Provide support for grief
STAGE 1: INTUITIVE-PROJECTIVE		AGE: PRESCHOOLERS (3-5)
Development:		Imaginative and egocentric
Spiritual Interventions:		
Children		<ul style="list-style-type: none"> • Be with them; be their friend: eye level, listen, play, pray • Ask open-ended questions about feelings and experiences
Family		<ul style="list-style-type: none"> • Learn and support religious/spiritual beliefs of parents • Listen to, pray with, affirm parents
IDT		<ul style="list-style-type: none"> • Help identify boundaries • Help identify grief and burnout • Provide some relief as another trusted caregiver
STAGE 2: MYTHIC-LITERAL		AGE: SCHOOL AGE (7-10)
Development:		Concrete approach to world
Spiritual Interventions:		
Children		<ul style="list-style-type: none"> • Use stories: "Without a story life makes no sense" • Build trust; assess spiritual needs, gifts, challenges • Affirm their personhood and skills • Support their sense of competence • Ask them how they pray; follow their lead
Family		<ul style="list-style-type: none"> • Learn and support religious/spiritual beliefs of parents • Listen to, affirm, pray with parents
IDT		<ul style="list-style-type: none"> • Communicate with team important things you learn • Help identify boundaries • Help identify grief and burnout • Provide some relief as another trusted caregiver
STAGE 3: SYNTHETIC-CONVENTIONAL		AGE: PRE-TEENS AND YOUNG ADOLESCENTS (11-14)
Development:		Adopting new ideas
Spiritual Interventions:		
Children		<ul style="list-style-type: none"> • Don't assume: exercise curiosity. • Listen! Listen! Listen! for their sense of "right and wrong" • Provide appropriate prayer/ritual • Always include the child in conversations and ask permission to pray • Affirm their emerging identity without judgment
Family		<ul style="list-style-type: none"> • Learn and support religious/spiritual beliefs of parents • Help parents hear the child's emerging voice • Listen to, affirm, pray with parents
IDT		<ul style="list-style-type: none"> • Communicate with team important things you learn • Help identify boundaries • Help identify grief and burnout • Help by identifying and reporting family system issues
STAGE 4: INDIVIDUATIVE-REFLECTIVE		AGE: OLDER ADOLESCENTS (15-19)
Development:		Working out their identity
Spiritual Interventions:		
Children		<ul style="list-style-type: none"> • Forming their own identity; do not judge their worldview • Questioning their parents' belief systems • Listen! Listen! Listen! • Provide spiritual support only as asked for • Protect their confidentiality (unless risk of harm)
Family		<ul style="list-style-type: none"> • Learn and support religious/spiritual beliefs of parents • Listen to, affirm, pray with parents • Help parents hear their voice, especially while still minors
IDT		<ul style="list-style-type: none"> • Communicate with team important things you learn • Help identify boundaries • Help identify grief and burnout • Help by identifying and reporting family system issues



Art for the Soul

By **Rev. Anne Lange, M.Div., BCC**

It is 2005, and I am in Nairobi, Kenya doing my first unit of clinical pastoral education (CPE). I am serving in the mixed-age burn unit at a local hospital: seven children under age 7 whose parents can only afford to visit one or two days a week, and a handful of adults, all with varying degrees of burns and stories involving fire.

I speak English and a little Swahili. Here, in the burn unit, the adults speak English and Swahili, and we could get by with what each of us know of both. But the children mostly speak the native tongue of their tribal group, too young still for the formal teaching of English and Swahili in school.

Pastoral care can be challenging if you only speak one language—and it's not the language of the persons you're caring for.

Still, I am determined to hear their stories of hope and fear, of who God is, and who my patients understand themselves to be. I am determined to connect with them.

Struggling to do so, I decide to pursue a non-verbal route and purchase a box of crayons and blank paper to help overcome the communication barrier. I am hopeful I have chosen an intervention that will give access to spiritual assessment, but uncertain if my

supervisor or peers will approve of my "unconventional" art intervention.

These simple supplies turned out to be key tools in my pastoral care box, for the children as well as for the adults. Through art, I heard from some adult burn patients who questioned where God was in the midst of their pain. I was introduced to a king who would save his sister from a fiery monster—drawn by a 7-year-old boy who found this as a way to speak about saving his sister from a burning bus accident. And I learned new Swahili words that evoked hysterical laughter from ailing toddlers.

What was a simple idea in Kenya, born out of desperation, has since become an integral part of my pastoral care ministry, especially in my care of children.

Children's work is play. Inviting youngsters to express themselves through art is a natural way to have them open up about their sense of hope, God, or the Divine; connection to family, friends and community; meaning or purpose; rituals; and fears they may have.

Art expression and spiritual assessment can go hand in hand. Utilizing a media like this that can evoke feelings and involve tangible and tactile senses can be just as

important as listening to the patient. Bringing art therapy and chaplaincy together can strengthen the chaplain's toolbox.

Fast forward five years. I was working in a large hospital in a major city at the time, and I was fortunate to meet an art therapist who was assigned to the same pediatric inpatient psychiatric unit. Together, we introduced a weekly "Spirituality and Art" group for teenage patients, and taught continuing education sessions for psychiatric staff on the importance of spirituality and art. We continue to collaborate today, presenting workshops on how art therapy theory and practice parallel and complement spirituality and spiritual assessment.

As chaplains, we are trained to listen, ask open-ended questions, develop spiritual assessments, and create sacred space. We recognize that not every patient—child or adult—will benefit from a pastoral care visit with an art intervention. It's not a one-size-fits-all kind of tool. Just as an art therapist selects from different art forms, processes and products, so must a chaplain intentionally choose art media that will help to evoke feelings and provide the possibility of a meaningful encounter. The questions one asks during the art intervention

are just as important as the materials one chooses.

Here are some key things to remember when using art as a spiritual assessment intervention:

- Art is an extension of the patient. Always ask for permission to handle the patient's artwork.
- Artwork created by patients is theirs. They may choose to keep it, share it with others, or even destroy it. If you want to share their artwork with the interdisciplinary team or use it in CPE, pastoral journals, or other public displays, make sure you get their permission.
- When charting an art intervention, name the type of materials used and the spiritual assessment ascertained. Quote patients' comments that are relevant to their treatment and care goals. Refrain from describing your interpretation of their artwork, which could be misconstrued by other disciplines.
- Collaborate with an art therapist if possible. Art is powerful, and art therapists are trained in how to effectively use art materials to help elicit, contain, expand and release powerful thoughts and feelings.
- Ask patients to share their thoughts about their art. Avoid judging the work or attempting to interpret it.
- Use phrases like, "I wonder about ..." to encourage conversation.

You'll be surprised at how effective art can be in pastoral care encounters to help unlock the feelings of patients, especially children.

Rev. Anne Lange, M.Div, BCC, is a board-certified chaplain and spiritual director in Princeton, N.J. She formerly served as the adult and pediatric psychiatry unit chaplain at Norton Hospital and Kosair Children's Hospital with Norton Healthcare in Louisville, Ky.

Interpretive Spiritual Encounters

Offer Children Space to Explore Spiritual Needs



By **Rev. Paul Nash and Rev. Sally Nash, D.Min.**

An interpretive spiritual encounter (ISE), at its simplest, is an episode of care in which a chaplain engages a child in an activity that is designed to function both as an assessment tool to identify spiritual needs and as an intervention. It is the encounter's participative nature that creates and offers time and space for the child to safely explore spiritual needs.

ISE takes personal choice and autonomy seriously. The power lies with the child as a chaplain seeks to gain ongoing consent, and to let the youngster take the lead, make choices, and feel in control of the process. This occurs by offering core activities that are appropriate to the patient's development levels, medical condition, abilities and interests.

A Bag of Spiritual Care Activities

To conduct ISE, chaplains visit the sick with their own bag of spiritual care activities. Regularly used activities for an initial assessment as well as an intervention include:

- Making a bead bracelet where the colors of the beads relate to different qualities such as peace, belonging, hope, strength, faith, and being loved;
- Creating a lolly stick doll, a little figure of a person drawn, crayoned or painted on popsicle sticks, and used to talk about what makes the child happy or sad; and



- Utilizing a "blob tree," a cartoon image of non-specific characters in different situations for a patient to interpret the characters' feelings and note the blob figure he or she most identifies with.

In meeting a new patient, the chaplain introduces himself or herself and offers an activity, usually

letting the child choose which one(s) is of interest. The child is allowed to engage in the activity however desired, including being able to stop at any point. During this time, the chaplain actively listens, watches, and with discernment and permission engages with the child. The chaplain invites the child to talk about what he or she has done and why, or explore other issues.

The chaplain makes an ongoing assessment of the youngster's spiritual needs based on what is occurring, and facilitates discussion around what has been shared and observed. If appropriate, the professional makes an offer to return.

Then, the chaplain records the assessment and intervention in the patient notes (according to protocol) and completes the appropriate record for the department, which includes logging future interventions, referrals, concerns, and further ISEs to explore.

Benefits of ISE

At its core, this method offers chaplains a model for assessment and ongoing assessment, as well as an

intervention that helps meet spiritual needs.

Benefits extend well beyond that. For chaplains, it prepares them with a clear objective for a visit, and being prepared but not prescriptive. It also makes it easier for them to explore rather than explain spiritual care in a pediatric context. Experience has shown that while engaging in these activities, children make connections to what is important to them at that time. Parents gain the chance to observe and better understand what a chaplain is doing.

For patients, this method puts the child in control, which is often an unusual experience in a hospital. It lets both the child and the chaplain interpret what is happening.

In addition, it provides the opportunity for religious care since activities can be faith related. For example, there is an Islamic version of the bead bracelet exercise, and the religious dimension of the Examen doll exercise, a lolly stick activity, can be used with Christians. (Examen is an Ignatian (Jesuit) spiritual exercise of prayerful reflection in which a person



reviews in the presence of God what has bought consolation or desolation and then offers those things to God.)

Overall, ISE enables chaplains to explore the spiritual lives of young patients in creative and accessible ways that may offer a normalizing experience and leave behind a visible reminder of the spiritual care offered and received.

Rev. Paul Nash is senior chaplain at Birmingham Children's Hospital in the U.K. **Rev. Sally Nash, D.Min.**, is director of the Midlands Institute for Children, Youth and Mission, St John's College, Nottingham, England, and chaplaincy researcher at Birmingham Children's Hospital. Their book "Exploring Spiritual Care with Sick Children and Young People" (2015, Jessica Kingsley Publishers), written with Kathryn Darby, presents ISE in greater detail. The Nashes developed and utilize ISE with their chaplaincy team; they find that the team members are passionate about ISE and find it extremely useful in their work.

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Editor's note: This column is all about inspiration—to pass along to your patients and colleagues.

"It is only with the heart that one can see rightly; what is essential is invisible to the eye."

— ANTOINE DE SAINT-EXUPÉRY,
"THE LITTLE PRINCE"



It Takes a Village

By The Rev. Jill M. Bowden,
M.Div., MPA, BCC,
Carolyn Fulton, LCSW, and
Karen Popkin, LCAT, MT-BC

"How are we going to make this work?" we asked ourselves.

Here is a father of three children, with a fairly new diagnosis, who now nears the end of his life. His daughter, age 8, had obviously inspired dreams in her father; among his final goals for his life was to walk her down the aisle. His dream of giving his daughter away was not going to be fulfilled unless we could think of a creative frame for the experience.

The ritual had to be unique; a wedding was wanted—a wedding we would do. And yet there are very real ethical issues about expecting a young girl only just beginning to see how desperately ill her father was to be a "bride"—even if it meant the world to her father. His idea was to give his daughter away to her brothers, ages 4 and 2.



How would these children think about that as they grew up? What would the balance of their relationships be if the intention was to put the older sister into the keeping of her younger brothers?

The patient's nurses were key. Could they help him do this or was it too much to expect? Nurses were the timekeepers, the ringmasters, and the traffic cops. They managed the schedule, including patient care, medications,

fluid balancing, pain control, and even getting the patient into his wedding suit and at the door of the chapel on time.

Friends and family, all in their best wedding attire, showed up with bouquets, corsages and boutonnieres, plus video cameras and cell phones to record the event.

Music—there must be music, and a creative music therapist rose to the occasion.

"As I was leaving the hospital," she recalled, "an e-mail message came from a patient representative who was reaching out to staff about creating a special ceremony for a patient. The ceremony had to happen the very next day. What would I offer musically?"

"I tried to imagine what this ceremony would look like. Such a devastating circumstance and yet also a celebration of love. Music can be used to create a safe space to host a range of emotions. How might I go about offering music that could be safe for the sadness of the patient's condition, honoring the love shared by all in attendance, and also maintaining hope for the future of the family?"

The music therapist chose to create improvisational music on the lap harp, using the key of G major as the tonal center to provide a sense of warmth, unity and stability. She employed open intervals to create a sense of space and gentle movement.

The form and structure of a marriage ceremony kept the tone joyful and yet solemn. The traditional opening, "Dearly Beloved ..." encompassed all present.

With gentle music holding the space, we proceeded through what we began to call a "Family Dedication Service" with these words: "Today we come together in love for each other to celebrate the importance of family, and to link this family with vows of love and support. Family is the center of all life; it is more important than any other connection in our lives, an unbreakable bond. Our family sustains us and holds us, loves us and keeps us safe. It is the center, the heart, of all that is sacred and beloved. In the words of [writer] George Eliot, 'What greater thing is there for human souls than to feel that they are joined for life—to be with each other in silent unspeakable memories?'"

There must of course be vows for a wedding to have meaning. The family joined hands in a circle, mother and children standing, the father in his wheelchair, and took these vows together: "Do you promise to love and support your family, in good times and in bad times, for all your life? Please say, 'I do.'"

The vows, followed by the familiar words from the book of 1 Corinthians, took on a much deeper meaning to all those present, as we thought about the love this father had for his family and the lengths to which he went for them with all the strength he had remaining: "Love is patient, love is kind. It does not envy, it does not boast, it is not proud. It does not dishonor others, it is not self-seeking, it is not easily angered ... Love ... rejoices with the truth. It always protects, always trusts, always hopes, always perseveres. Love never fails."

Creative planning for a post-ceremony party that the children would enjoy came from the dietary and hospitality team, and the security department and environmental services offered huge support by reserving the space and keeping it beautiful.

A social worker who played a significant role in the event said later, "It truly displayed how important and valuable interdisciplinary communication and team work is in working with patients and families. Every person who was a part of the process came with empathy, compassion, and a wish to honor this patient's final wish."

Nurses, physicians, social workers, patient representatives, chaplains, other hospital staff, family and friends all worked to help realize a father's dream.

It truly did take a village.

The Rev. Jill M. Bowden, M.Div., MPA, BCC, is director, chaplaincy services; **Carolyn Fulton, LCSW**, is a social worker; and **Karen Popkin, LCAT, MT-BC**, is a music therapist, all at Memorial Sloan-Kettering Cancer Center in New York.



Share Your Soul Care Story

Soul Care Project is seeking personal stories that illustrate the power, promise, or other ramifications of spiritual care.

Individuals, family caregivers, health care professionals, and others are welcome to submit their experiences, insights or advice regarding spiritual care and emotional support.

The "Soul Care Stories" will be posted on www.soulcareproject.org, a free online resource offering spiritual and emotional support for anyone in distress due to serious illness.

Soul Care Project is a new initiative of HealthCare Chaplaincy Network (HCCN). It includes self-assessment and screening tools, help guides, spiritual exercises, prayers, and the ability to connect confidentially with a professional soul care counselor via phone, email or video call. The counselors are board-certified professional chaplains who are trained to listen and accept without judgment someone's beliefs, faith and practice.

"People who share their stories will be benefiting themselves and others in the process," said Rev. Eric J. Hall, HCCN's president and CEO. "It can help to use writing as an expressive outlet, and it also lets others know that they are not alone, which can ease feelings of loneliness, hopelessness and despair that can result from spiritual pain."

To submit a Soul Care Story, visit www.soulcareproject.org/soul-care-story.

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