ADVANCING THE INTEGRATION OF SPIRITUAL CARE IN WHOLE PERSON CARE

Caring for the Human Spirit® magazine

SUMMER/FALL 2025

PSYCHODYNAMIC CHAPLAINCY AND THE FUTURE OF SPIRITUAL CARE

WHY IT MATTERS NOW

HIDDEN IN THE ORDINARY

FINDING THE SACRED IN NURSING CARE

SCA CHAPLAIN MASTERCLASS SERIES:

FALL SEMESTER STARTS SEPTEMBER 2025

A HEALTHCARE CHAPLAINCY NETWORK™ PUBLICATION

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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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A LETTER FROM REV. ERIC J. HALL

Dear colleagues,

At HealthCare Chaplaincy Network and the Spiritual Care Association, we are pleased to present a new Caring for the Human Spirit magazine to inform, inspire, and support our shared calling as spiritual caregivers.

No doubt like all of our readers, HCCN and SCA have had a busy and eventful 2025 thus far:

- In April, we published Psychodynamic Chaplaincy: Psychological and Spiritual Integration in Healthcare, a foundational paper on incorporating principles of psychoanalytic theory into the practice of spiritual care. We are now creating a new course for chaplains interested in integrating psychotherapeutic approaches in their work.
- Working with 20+ chaplains with 10 – 20 years' experience in first response, in June we released the first-ever board certification program in first responder chaplaincy. Offering 3 different tiers of training, the program prepares chaplains to respond in emergency situations and to support police, firefighters, and EMS personnel.
- Our Nursing Division is developing a concept paper/model to clearly define the role of Spiritual Care Nursing Specialist and provide guidance on screening, assessing, and meeting spiritual care needs of patients in any healthcare setting. We are also launching the site NurseCE.org to support nurses in securing continuing education credits for their efforts to increase their spiritual care skills and confidence.
- HCCN and SCA are establishing an Artificial Intelligence (AI) Commission to examine the application of AI in the spiritual care field. We have recruited 20 volunteers with the goal of developing a resource to assist chaplains in utilizing AI in their practice.

Of course all of these efforts are based on the premise, on which we all agree, that individuals' spirituality – whether represented by a particular religious tradition or not – is an important element in their healthcare and in all areas of their lives. With the ever-increasing pace of change along with the uncertainty gripping the world of healthcare, it is also one of the elements that is most easily neglected.

I am so grateful to you for ensuring that this neglect does not happen, and that care of the human spirit remains central to the healthcare endeavor and other areas where people experience profound change and challenges. Thank you so much again for your dedication to our common goals, and I hope this issue of Caring for the Human Spirit further inspires you toward greater depths and heights in your work.

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PSYCHODYNAMIC CHAPLAINCY AND THE FUTURE OF SPIRITUAL CARE

by David Roth, PhD,
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In April 2025, the Spiritual Care Association (SCA) released its most recent foundational paper, Psychodynamic Chaplaincy: Psychological and Spiritual Integration in Healthcare. If you've never read a foundational paper before, think of it as part vision-casting document, part practical roadmap—a way to help leaders, practitioners, and institutions see where we need to go and why. In this case, the foundational paper invites the profession of chaplaincy—especially in healthcare—to reconnect with its psychodynamic roots and reimagine its future.

For chaplains in hospitals, hospices, long-term care, and outpatient facilities, this is both a challenge and an opportunity. The challenge: much of our current training pipeline has drifted away from the deep, psychologically informed 100-year-old roots of Clinical Pastoral Education (CPE). As a result, most chaplains working in the field today offer a worthwhile spiritual presence but little more. The opportunity: a clear path forward that equips chaplains to meet today's spiritual and existential needs with the full depth of our heritage – but at the cutting edge of the behavioral and social sciences.

A TRADITION WITH DEEP ROOTS

One hundred years ago, in 1925, Anton T. Boisen created what he called "clinical pastoral training," what is now most often called clinical pastoral education or CPE and is the standard required preparation for a healthcare chaplain. Boisen's original training program was strongly influenced by his reading of Freud and the emerging psychoanalytic revolution that led to the development of modern psychology as well as reforms in medical education that put aspiring clinicians into direct contact with patients. He insisted that the care provided by chaplains must address the deep, personal, psychological, and spiritual realities of each unique person being cared for by the chaplain and not only sectarian theological concerns.

At the same time Oskar Pfister, a Swiss pastor who was a protégé of Freud, learned psychoanalysis and brought its revolutionary insights in his pastoral work. Over the decades, pastoral care leaders such as Seward Hiltner and Wayne Oates, and most notably today Pamela Cooper-White, have developed and expanded the psychoanalytically inspired and informed psychodynamic tradition that is flourishing today.

WHY THIS MATTERS NOW

Healthcare has changed dramatically in recent decades. People live longer with chronic illness. Families are navigating medical complexity that would have been unimaginable a generation ago. Clinicians are experiencing burnout, moral distress, and compassion fatigue. At the same time, the spiritual landscape is shifting. Fewer patients identify with organized religion. More describe themselves as "spiritual but not religious." Yet the hunger for meaning, connection, and hope remains as strong as ever.

In this context, chaplains are called on to help patients, families, and staff make sense of suffering, loss, and uncertainty.

The SCA foundational paper's message is clear: good intentions, all-purpose spirituality and general empathy are not enough. We need chaplains who can listen deeply, work with emotional complexity, and help people find meaning and purpose in the midst of their crisis, distress, loss, grief or perplexity.

THE POWER OF DEEP LISTENING

At the heart of psychodynamic chaplaincy is the practice of truly deep listening.

Deep listening goes far beyond "being a good listener." It's an attuned, reflective presence that notices not just words, but tone, pauses, posture, and even (and sometime most importantly) what is unsaid. It hears the echo of early life experiences in the way someone tells their story. It recognizes unspoken fears, repeated themes, and deep wounds that may never have been named – or even recognized.

This kind of listening is shaped by profound self-awareness. To do this, chaplains must

reflect deeply on their own inner lives in order to meet others at depth. Donald Winnicott's idea of the "holding environment" applies here: a safe, non-judgmental, empathic space where growth and healing become possible.

Deep listening can transform a conversation into an encounter where someone feels truly seen and heard—perhaps for the first time. It's a skill that takes training, practice, and astute supervision to develop fully.

HELPING OTHERS FIND MEANING AND PURPOSE

Deep listening is not an end in itself—it's the doorway to the chaplain's central task: helping people find meaning in their present circumstance and in the larger context of their life.

Illness, trauma, and loss disrupt the stories people tell about themselves and the world. They raise questions:

- Why is this happening to me?
- Who am I now?
- What can I hope for?
- What does this mean for my relationships, my identity, my faith?

Systems and Group Dynamics

Psychodynamically trained chaplains don't rush to offer answers. Instead, they accompany others in exploring what gives their life coherence – meaning and purpose– even when so much has been ignored, avoided, lost, or stripped away.

Psychodynamic chaplains also recognize that care is never simply "one-to-one." Patients, and all of us, exist within networks of relationships—families, "loved ones," caregivers, and communities of various sorts —and chaplains too are embedded in meaningful personal and professional relationships, in teams and institutions, all of which are laden with significance.

Drawing on Tavistock-style Group Relations theory, clinical chaplains learn to see what is happening:

- Within the patient
- Between people
- In the institution as a whole

This systems awareness helps chaplains navigate conflicts, clarify roles, and address unconscious group dynamics that can either support or undermine care. It also helps chaplains to understand their own roles in the system, and how their presence and actions might provoke, soothe, or unsettle.

CLINICAL CHAPLAINCY: A PRECISE MEANING

The term "clinical chaplain" is often used to mean "a chaplain working in a clinical setting." In the foundational paper's framing it means something more specific: a chaplain whose training and practice are psychodynamically informed and therefore of particular clinical value.

Such chaplains draw on psychoanalytic (and now neuropsychoanalytic) theory along with systems thinking and the broader social sciences. They work at the intersection of depth psychology and theology—not as therapists, but as therapeutically skilled spiritual care providers. Without diminishing

the spiritual they participate fully in interdisciplinary care by bringing valuable emotional and relational insights into clinical decision-making.

As such, psychodynamic chaplaincy is not a niche specialty but offers a depth of clinical competence that adds strength to the whole healthcare team and serves patients and their loved ones in ways and at moments when more "traditional" spiritual care would not suffice.

TRAINING FOR THE 21ST CENTURY

Many current chaplains were never taught how to use concepts like transference, countertransference, or the holding environment, for example, in their practice. Few have any understanding of systems dynamics in groups or the seven primary emotional systems. The foundational paper, therefore, makes a strong case for expanding training in psychodynamic chaplaincy.

Training objectives for clinical chaplains include:

- Developing the self as the primary tool in care, with both psychological and theological self-reflection
- Listening deeply and analyzing human behavior and religious symbols for meaning
- Establishing therapeutic bonds across diverse life situations and cultures
- Understanding group dynamics and systemic processes
- Working effectively as part of an interdisciplinary clinical team
- Applying relevant behavioral and social sciences in practice

The call is clear: it is time to create, promote and deploy psychodynamically based CPE programs for those new in the field and advanced training units for those already in the field, as well as certificate programs, group relations conferences, and ongoing supervision opportunities to build a pipeline of chaplains equipped for today's realities.

THE INSTITUTIONAL CASE

It must be noted that psychodynamic chaplaincy is not only good for patients—it's good for healthcare institutions. Evidence shows that professional chaplains contribute to patient satisfaction, reduce staff burnout, and strengthen team cohesion.

In an era of cost-conscious healthcare, matching spiritual care resources to patient needs and institutional aims is key. For administrators tracking return on investment, especially when cost cutting endangers the continued funding of spiritual care departments and chaplain jobs, the presence of highly skilled, psychodynamically trained clinical chaplains adds significantly greater measurable value. As a result, it also suggests greater chaplain job security.

A CALL TO RE-ENGAGE

The SCA foundational paper is more than a description of a specialty—it's a call to action. It urges us chaplains to reclaim our heritage, deepen our competence, and position ourselves as essential contributors to the psychological, emotional and spiritual well-being of patients, families, and staff.

In a healthcare environment that is almost always fast-paced and fragmented, the psychodynamically informed chaplain offers a unique and rare set of skills spanning the spiritual, social, emotional, cultural and clinical realms.

COLLABORATION, NOT ENCROACHMENT: THE SCOPE OF SERVICE

One common misconception is that psychodynamically informed clinical chaplains might be encroaching on the domains of licensed mental health providers. While these specialties' scope of service boundaries are not entirely distinct, a crucial distinction remains: psychodynamically trained clinical chaplains do not offer mental health diagnoses. Although they may utilize resources like the Psychodynamic Diagnostic Manual (PDM) or the Diagnostic and Statistical Manual of Mental Disorders (DSM) for assessment, their role is not to diagnose mental health conditions.

Instead, like every other clinical team member, the psychodynamically trained clinical chaplain does not work alone. Coordination, collaboration, and communication with other clinicians are necessary to ensure quality of care. They may also serve as a supportive liaison to a particular faith community or other spiritual community, fostering greater wellness for patients. For instance, while nurses may diagnose "Spiritual Distress", collaboration with a psychodynamically trained clinical chaplain can provide optimal, psychodynamically based care.

TRAINING CHAPLAINS FOR THE 21ST CENTURY: A CALL TO ACTION

Boisen explicitly positioned theology among the ever-changing social sciences. As such, he no doubt would have anticipated adapting the work of chaplains to changes in our time, including the decline in membership of religious congregations and the rapid emergence of a population that describes itself as "spiritual but not religious". Boisen was a close collaborator with the relational psychoanalyst Harry Stack Sullivan, who published Boisen's articles in the journal Psychiatry. Clifford Geertz's non-sectarian definition of religion, which focuses on meaning-making and the establishment of "powerful, pervasive and long-lasting moods and motivations," offers a framework for clinical chaplains to provide spiritual care to anyone, regardless of their formal religious identity. This even extends to those who find meaning and purpose in secular movements like the health food movement or CrossFit.

The SCA foundational paper emphasizes that clinical chaplaincy training must be both deeply rooted in the Boisenian tradition and on the cutting edge of related fields. Key objectives for such training should include:

- Mastery of the Clinical Process: Demonstrated ability to make use of the clinical process and the clinical method of learning.
- Self as Tool: Development of the self as a work in progress, and understanding the self as the principal tool in clinical chaplaincy care, which includes the ability to reflect and interpret one's own life story both psychologically and theologically.
- Deep Listening and Empathy: Demonstrated ability to listen deeply, empathize, reflect, analyze problems, and identify and evaluate human behavior and religious symbols for their meaning and significance.
- Therapeutic Relationship Building: Demonstrated ability to establish an empathetic therapeutic bond with persons and groups of persons in various life circumstances.
- Critical Self-Analysis: Demonstrated ability to provide a critical analysis of one's self including but not limited to spiritual and/or religious orientation and background.
- Group Dynamics Understanding: Demonstrated understanding of the dynamics of group behavior and a variety of group relations.
- Cross-Cultural Communication: Demonstrated ability to communicate effectively and engage in spiritual care delivery with persons across cultural and social boundaries.
- Supervised Growth: Demonstrated ability to utilize individual supervision for personal and professional growth and for developing the capacity to evaluate one's spiritual growth and development.
- Team Collaboration: Demonstrated ability to work effectively as a member of an interdisciplinary clinical team.
- Integration of Social Sciences: Demonstrated ability and ongoing commitment to effectively use the behavioral and social sciences, particularly those that support a psychodynamic approach to chaplaincy.

UPCOMING DATES

Psychodynamically Informed Chaplaincy Case Study Group

Beginning **Tuesday, September 3** (and every first Tuesday after), join colleagues live on Zoom for a unique monthly opportunity to deepen your clinical insight.

From **6–7:30pm Pacific | 9–10:30pm Eastern**, an actual chaplaincy case will be presented and reviewed with supervisory input from experienced, psychodynamically-trained chaplains and CPE supervisors. Psychodynamic principles will be explained and applied directly to the case, giving you practical takeaways for your own work.

Free for SCA members. No registration required–just bring your curiosity and clinical questions.

Click Here to Join the Zoom

Read the foundational paper:

Psychodynamic Chaplaincy: Psychological and Spiritual Integration in Healthcare is available from the Spiritual Care Association's website.

Watch for upcoming training opportunities: SCA will be offering courses, supervision groups, and events for chaplains who want to deepen their skills in psychodynamically informed care. Whether you are new to the field or a seasoned professional, there is a place for you in this next chapter of spiritual care.

Chaplain Masterclass

Spiritual Care Association

Fall Semester Masterclasses Announced

Fall 2025 - The Process of Health Care Chaplaincy

Thursday, October 16, 2025, 11:30am ET

Masterclass - Beyond Self-Care: Helping Help Teams and Leaders think more Systemically about Burnout and Well-Being

Presenter *- Brian Hughes, APBCC,*
Director of Employee Well-Being & Spiritual Health, Optum Health
Alex Donovan, BCC,
Associate Director of Employee Well-Being & Spiritual Health, Optum Health

Wednesday, November 19, 2025, 1pm ET

Masterclass - Helping the Helpers: Advancing the Practice of First Responder Chaplaincy

Presenters*- Russell Myers D.Min, Retired EMS Chaplain*
Nikki Holm, EMS Chaplain, MA, BCC
Rev. Gwendolen Powell, MS, MDiv, BCC

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AFFIRMING PRESENCE: PRACTICING SPIRITUAL SAFETY FOR LGBTQ+ PATIENTS

By Russell VanHoose, Chaplain and Educator

He didn't look up when I walked in.

The intake notes said no religious preference, but the nurse had asked me to check in: "He hasn't really spoken since the family left. He's alone now."

I introduced myself gently. Let him know I was with hospice. Offered to sit with him or simply be quiet in the room.

He gave a small nod, his eyes still fixed on the ceiling.

After a while, I asked, "Has faith ever been part of your story?"

That's when he looked at me.

"Only as something I had to get free from," he said.

Moments like that shaped what I now call *affirming presence*. It's not a formal program—at least, not yet. It's a posture. A way of showing up that honors dignity, especially for those who've learned to expect harm when a chaplain enters the room.

Of course, presence like this should be the norm. It's what spiritual care is meant to offer. But for too many LGBTQ+ patients, it isn't. Naming that gap is how we hold ourselves accountable—to care more clearly, more consistently, and more tenderly.

In hospice, the usual titles start to slip. The chaplain settles into listening more than speaking. The nurse becomes a quiet witness. The patient is suddenly larger than a diagnosis—storied, complicated, unfinished. And in that opened space, unspoken things surface: regret that's waited decades, love that never found words, faith that once felt solid now coming apart in the hush of dying.

> "THAT WASN'T OKAY. I'M SORRY SOMEONE DID THAT TO YOU."
> —A CHAPLAIN'S WORDS CAN HEAL MORE THAN MEMORY.

For LGBTQ+ patients—those who identify as lesbian, gay, bisexual, transgender, queer, questioning, or other marginalized identities—spiritual care almost never starts on neutral ground. It begins with caution. And given their history with religious spaces, that caution is more than understandable; it's earned.

Clinical research confirms what many already know from experience. More than half of hospice and palliative care providers believe lesbian, gay, or bisexual patients are at increased risk of discrimination, and nearly a quarter have witnessed it firsthand (Stein et al., 2020). In a national study, 15% of providers reported observing disrespectful care toward LGBTQ+ patients, and 43% had seen discriminatory treatment of their partners or spouses (Berkman et al., 2023).

These aren't isolated incidents. Families of LGBTQ+ decedents report lower quality on multiple measures of end-of-life care (Kemery, 2021), and a recent scoping review highlights persistent training gaps, along with the disenfranchised grief often carried by LGBTQ+ care partners (De Jong et al., 2024).

In this context, kindness matters—but kindness alone is not enough. For many queer and trans patients, a sense of spiritual safety is decided in the first five seconds of a visit.

5 PRACTICES OF AFFIRMING PRESENCE

These five habits help chaplains—and the wider interdisciplinary team—create spiritual safety. They're not scripts. They're relational postures, practiced in the quiet space between intention and presence.

1. Ask what spiritual care means to them.

When a patient says *"no preference,"* it may not mean they have no beliefs. It might mean *"I've been harmed,"* or *"I don't trust this part of the system."* That phrase often carries history. We can't assume neutrality. Begin with gentle, open-ended curiosity. Ask how they've made meaning in their life, who or what they lean on, or what matters most right now. Let the patient define what care looks like—even if that care is silence, or distance, or not involving you at all.

2. Use the words they use. Names.

Pronouns. Relationship terms. God-language, or its absence. These details are not superficial—they're sacred. When we mirror the words someone uses for themselves and their people, we're saying: *I believe you. I honor how you've named your life.* This isn't about correctness. It's about trust. Precision isn't performance; it's the way we communicate respect. To speak someone's name with intention is to speak dignity aloud.

3. Don't skip past harm.

If someone tells you, *"The last chaplain tried to fix me,"* resist the urge to pivot, soften, or explain. What's needed isn't a theological clarification—it's human recognition. Say something honest: *"That wasn't okay. I'm sorry someone did that to you."* You don't need to defend yourself or the profession. You just need to witness what they've already survived. Sometimes, one sentence—offered without defense or distance—can reset the room and reopen the possibility of spiritual care.

4. Offer blessing without hesitation.

You may be the last spiritual voice they hear. And while your presence matters deeply, your words can still carry weight. Not words meant to fix, convert, or spiritualize—but words that bless. Speak grace freely—not in spite of who they are, but because of it. Because they are beloved. Because their life has mattered. Because no one should have to earn tenderness at the end of their life.

5. Stay a little longer.

Presence precedes certainty. You don't have to know what to say. You don't need a clear outcome or a perfect closing. What matters most is that you remain. In hospice, where so much is unresolved, presence is often the only thing that holds. When you sit a few minutes past your scheduled time, when you stay through the silence, when your eyes don't flinch from theirs, you're telling the truth that matters most: *You are worth staying with.*

When chaplains, nurses, aides, social workers, and volunteers embody these practices together, spiritual safety becomes a shared gift, not a specialized task. It's not about adding more to anyone's role. It's about recognizing the power we already carry—and choosing to use it with care.

WHY IT MATTERS

Hospice chaplaincy isn't about delivering the perfect prayer. It's about making room—at the edge of life—for truth, love, pain, and the whole self. Not just the parts that feel spiritual. Not just the pieces that fit. And not just for the people we already know how to bless.

We can't rewrite anyone's spiritual history. What's been done by churches, by caregivers, by the systems that shaped us can't always be undone in a single visit. But we can help offer a final chapter that feels honest. One in which someone is seen. Named. Held in dignity. Sometimes that's all we can do. And sometimes that's enough.

For some LGBTQ+ patients, it may be the first time they've been fully witnessed by a spiritual caregiver—and the last. That's why affirming presence isn't extra. It's not a bonus for those who happen to ask for it. It's not a soft skill. It's the care itself. It is the work.

And the good news is—we can all practice it. We can all return to presence. To humility. To care that doesn't rush to fix, or explain, or correct. Just care that stays.

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AUTHOR BIO

Russell VanHoose is a hospice chaplain and longtime educator developing a model for practicing *affirming presence*—a relational approach to LGBTQ+ spiritual care.

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CHAPLAINCY AND INTERFAITH ENGAGEMENT:
A MINISTRY OF PRESENCE ACROSS BOUNDARIES

By Chaplain Chad Meister

Chaplaincy, at its core, is a ministry of presence—a sacred vocation to accompany individuals through moments of vulnerability, transition, and meaning-making. In an increasingly pluralistic world, this calling necessarily intersects with interfaith engagement. Whether in hospitals, prisons, universities, or the military, chaplains regularly encounter individuals and families shaped by diverse religious, spiritual, and cultural traditions. This reality calls for a reorientation in posture and practice from previous decades: from offering tradition-specific religious services to providing spiritually attuned, patient-centered care; from assuming shared belief to cultivating deep religious literacy and cultural humility; from ministering as a representative of a faith to accompanying others with openness, curiosity, and respect for their unique spiritual landscape.

Yet interfaith chaplaincy does not require the chaplain to relinquish her or his own faith commitments. Rather, it demands the cultivation of humility, empathy, and interpretive openness. A chaplain serves not as a theological referee or a representative of generalized spirituality, but as a witness to the sacred in all its forms. This work is generally not about dispensing religious content (though there are times when that may be appropriate), but about helping people access their own spiritual languages, practices, and sources of strength—especially in moments when those resources feel distant or obscured. In this way, interfaith chaplaincy becomes a kind of hermeneutical practice—not the exegesis of sacred texts, but the attentive interpretation of lived experience. It involves discerning the spiritual needs embedded in each person's story and responding with care that is both personally attuned and tradition-aware.

Paul Ricoeur's concept of "linguistic hospitality"—his evocative metaphor of dwelling in the language of another while welcoming the foreign word into one's own home—serves as a fertile starting point for reimagining chaplaincy in pluralistic settings.[i] Marianne Moyaert extends this metaphor into an ethically charged framework for interreligious encounter and spiritual care. For Moyaert, linguistic hospitality is not merely about translation; it is an embodied posture of humble vulnerability, a way of being-with the religious other while remaining authentically present in one's own tradition.[ii] In chaplaincy practice, this means engaging deeply with the patient's symbolic, theological, and emotional world—not in pursuit of assimilation or theological dilution, but in committed companioning. Moyaert insists that genuine interreligious encounter does not seek to neutralize difference; instead, it embraces discomfort and resists false equivalences. The chaplain remains rooted in their own tradition while making space for the sacred particularity of the other. The chaplain thus becomes a translator of presence: someone who holds space for the other's sacred language to be spoken, while staying grounded in their own interpretive home. This opens a fragile but vital shared space, not of agreement, but of mutual recognition, dignity, and difference coexisting ethically and relationally.

This work also invites the chaplain into deeper engagement with her own spiritual identity. Encounters across religious differences often reveal not only shared human longings— grief, love, hope, transcendence—but also the contours and limitations of one's own faith. In listening to the sacred stories and practices of others, the chaplain is drawn into a reflective process that can illuminate the assumptions, boundaries, and gifts of her own tradition. Rather than destabilizing faith, such encounters often deepen it—fostering a more honest, spacious, and mature spiritual

posture. They challenge the chaplain to hold complexity without defensiveness, to embrace mystery without demanding resolution, and to bear witness to the sacred without needing to control its expression. In this way, interreligious engagement becomes not only a form of care for others, but also a transformative path of self-discovery and spiritual growth. Interfaith engagement, then, is not an act of relativism or detached tolerance, but a courageous and faithful encounter in which difference is neither minimized nor feared, but honored.

A recent encounter illustrates how this ministry of presence can become a vessel for interfaith healing, even in the most agonizing of circumstances. Late one night, just before midnight, I was called to the pediatric unit. An infant was actively dying, and the family had requested a chaplain. As I entered the room the emotional intensity was palpable. I met a religiously diverse family: the mother identified as a Protestant Christian, the father as a Muslim, and the grandmother as a Roman Catholic. Each hoped that their own tradition could be reflected in a prayer or ritual, but there was no time to summon a pastor, imam, or priest. The situation required immediate attention.

Some initial tension arose as they quietly debated which faith should "lead" the moment. Recognizing the sacredness and difficulty of the situation, I offered a path forward: a shared ritual in which each voice could be heard. With their consent, I read a prayer from the Book of Common Prayer for the mother, a passage from the Qur'an for the father, and a classic Catholic prayer for the grandmother. We moved through the prayers and readings together, slowly and reverently, each voice and tradition finding a place in that sacred space. By the end, the tension had softened. There were tears, affirming nods, and a shared sense of comfort that lingered in the silence. Each family member later shared how meaningful the experience was for them. In a moment of profound grief, what could have been a source of division became a shared expression of love, faith, and presence.

In a world often marked by religious misunderstanding, suspicion, and fragmentation, chaplaincy offers a compelling model of faithful presence and bridge-building. It embodies the possibility of spiritual care that honors both the integrity of the patient and the commitments of the caregiver. Interfaith chaplaincy is not merely a pragmatic response to pluralism; it is a moral and spiritual vocation—a practice of bearing witness to the sacred in many forms and standing with others at the threshold of mystery. In this way, it is a profound expression of human solidarity, spiritual maturity, and sacred service in our time.

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AUTHOR BIO

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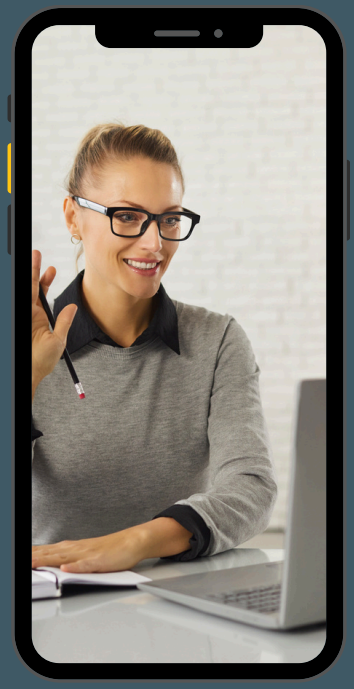

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CHAPLAINING FROM THE THRESHOLD:
GRIEF, PRESENCE, AND THE ONGOING CALL

By Gene Quiocho, MDiv, Former Hospice Chaplain, PhD Student in Psychology

It's been just a few months since I stood beside my father's bed, held his hand, and whispered goodbye. I had spent the past few years offering spiritual support at hundreds of deathbeds as a hospice chaplain—but nothing prepares you for your own father.

His passing didn't just break my heart. It cracked something deeper open.

Now, in this space between what was and what's still becoming, I find myself straddling two roles: former hospice chaplain and grieving son. Spiritual caregiver and spiritual seeker. It's a liminal space—a threshold—and it has changed how I understand the work of presence (Boss, 2016).

There's a sacred rhythm to chaplaincy work. We enter rooms quietly. We ask gentle questions. We listen more than we speak. We hold silence like a warm cup between our hands (Fitchett & Nolan, 2015).

But after my dad's death, I found myself resisting that rhythm. I didn't want to be still. I didn't want to sit in another room where someone was dying. I needed to move through my own grief without needing to explain it.

And so, for the first time in years, I stepped back. Not from my calling, but from the container I'd been holding for others. I needed space to grieve, to reflect, and to study. That's when I began my PhD in psychology—an academic journey, yes, but also a personal one. Every lecture on trauma and healing felt like it was whispering to something unfinished inside me (Neimeyer, 2012).

One of the last visits I made before I resigned was to a woman named Ann. She was nearly blind, non-verbal, and often non-responsive. But when I hummed 'It Is Well' in Russian—her childhood hymn—her lips moved in time with the melody. Her face softened. In that moment, presence was enough.

Healing doesn't always look like answers. Sometimes it just sounds like a song you can barely sing along to.

I think about Ann a lot these days. Not because of what I offered her, but because of what she offered me: a reminder that healing doesn't always look like answers.

As I sit with my own sorrow, I'm learning how to be present again—not just with others, but with myself.

Too often, we think chaplaincy is about showing up whole. But my experience has taught me that showing up human is more than enough.

The grief I carry hasn't made me less of a chaplain. It's made me a more honest one (Cadge & Sigalow, 2013). I no longer try to rescue people from their pain. I join them in it.

And maybe that's the invitation for all of us: to trade performance for presence, certainty for connection, and professionalism for spiritual authenticity.

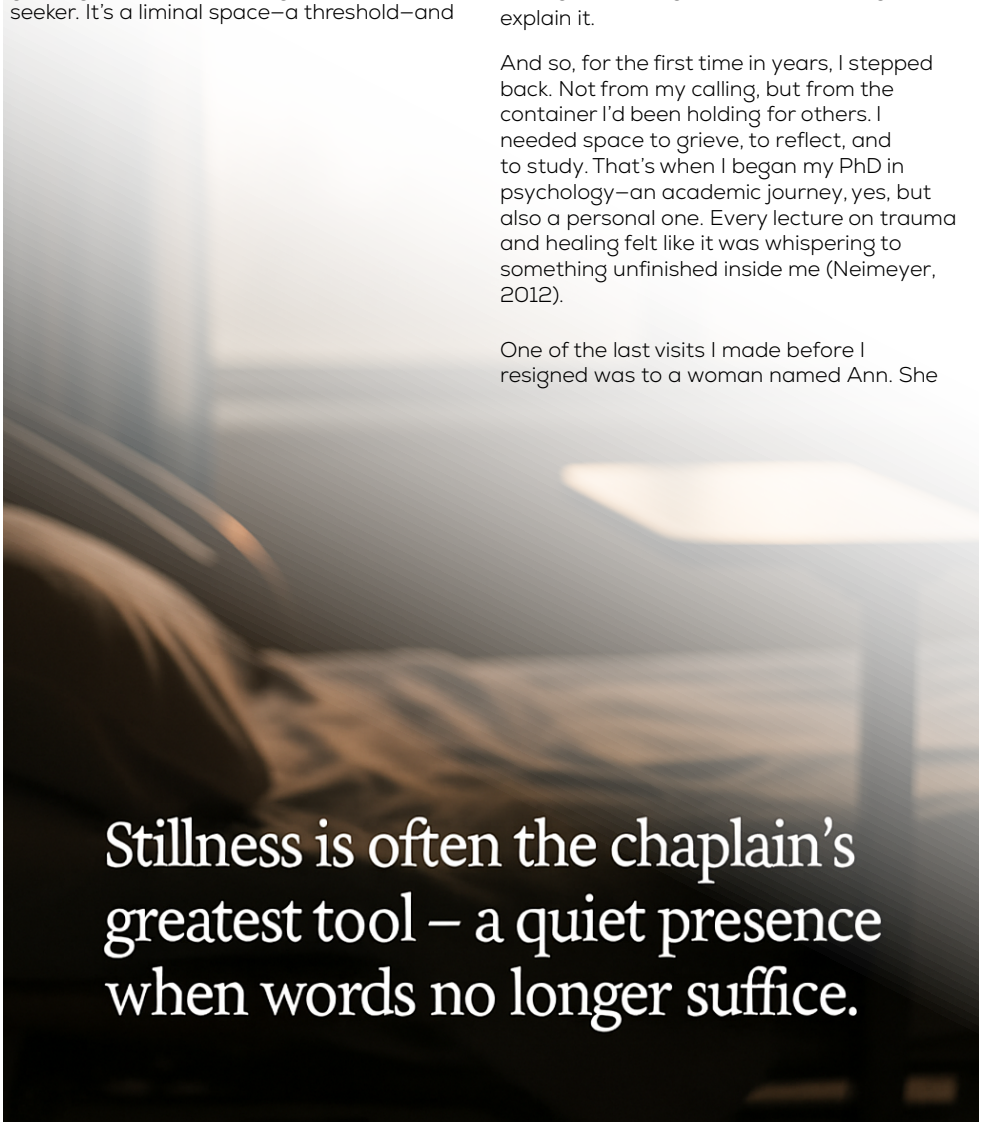
One of the gifts of stepping away has been rediscovering that formation is never complete. We are shaped by every room we enter, every goodbye we say, every piece of ourselves we're willing to bring to the work (Doehring, 2019).

As I pursue my doctorate, I'm exploring the intersections of psychology, grief, and spiritual care. Not in a theoretical sense—but as someone walking through the very terrain I study.

This isn't just scholarship. It's survival. It's soul work.

I don't know exactly what's next for me. But I do know that my calling hasn't left me. It's simply evolving.

These days, I find myself drawn to helping others navigate the same thresholds I've



stumbled through: chaplains facing burnout, caregivers holding invisible grief, professionals wondering if their pain disqualifies them from doing sacred work (Galek et al., 2011).

I want to tell them what I've learned: You are still worthy. You are still called. And you don't have to have it all together to be a healing presence.

You just have to show up—with whatever you have.

Because even in our brokenness, we carry something holy.

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AUTHOR BIO

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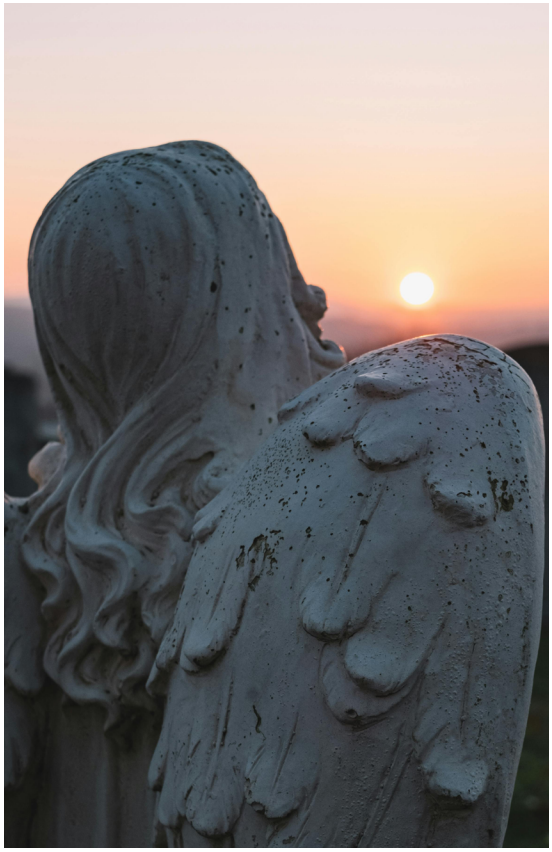

EXCERPT FROM: WHEN THE PAGER RINGS FOR A SCHOOL SHOOTING:

A CHAPLAIN'S CALL INTO COLLECTIVE GRIEF

By Rebecca Jane Elkins, BBSR, MAPC, MDiv

WHAT WE LEARN, WHAT WE CARRY – *THE INVISIBLE DEBRIS*

In the days that followed, I found myself sitting quietly in the chapel, in nature, and in conversation with colleagues, still holding pieces of that afternoon in my spirit. The trauma had passed through the hospital like a storm, but some of its debris remained—tucked into the corners of memory, sitting heavy in the body. As chaplains, we do not leave unscathed. We carry stories, fragments, glances, and prayers that never quite leave us.

There are moments when I wonder if I did enough. Should I have said more? Been present longer? Supported staff more fully? These are the quiet questions I often carry—unmeasurable, sacred burdens that don't fit into metrics or case logs.

But I also carry what I learned. I carry the fierce resilience of young girls who had just survived the unimaginable. I carry the unspoken grief of nurses holding back tears to keep working. I carry the compassion of colleagues who whispered, "Let me know if you need anything," even when they were hurting too. I carry the knowledge that sacred care often looks like small, unglamorous things—pausing, noticing, adjusting a door. I carry the silence of the one who was in such shock, she could not speak for herself, her foster parents, foster siblings, and case worker. I carry the knowledge of the wounded girl whose transfer was a blur of urgency, but whose life mattered no less in our hands. I carry her grandmother's anguish, her mother's shaking hands, and her father's whispered, "Thank you," as the helicopter lifted away.

I also carry a clearer understanding of my own limits—and the importance of tending to my interior life with the same intention I offer others. As Doehring (2015) reminds us, meaning-making after trauma is not just for patients; it is also for caregivers: "Healing begins when we name suffering and hold it with compassion in a space where meaning can be reimagined" (p. 122). What we learn shapes what we offer next. What we carry becomes the altar from which we bless the next room we enter.

Responding to Mass Trauma: A Chaplain's Checklist

1. Prepare in Peaceful Times

- Complete training in Psychological First Aid (PFA) and Trauma-Informed Spiritual Care
- Build trust with emergency and trauma teams before a crisis strikes
- Participate in or help develop your hospital's Mass Casualty Incident (MCI) protocols

2. Be Present Without Rushing

- Stay grounded—breathe, observe, and assess emotional tone before speaking
- Use your trauma sensitivity to minimize re-traumatization (e.g., noise, touch, interruptions)
- Attend to staff distress as it arises; offer them silent presence or brief spiritual reflection

3. Follow Up and Debrief

- Coordinate with chaplaincy peers to follow up with affected staff
- Participate in interdisciplinary debriefings; offer pastoral presence and insight
- Tend to your own emotional processing with supervision, journaling, or spiritual direction

Resource Links:

Trauma Survivors Network (TSN)
National Child Traumatic Stress Network

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AUTHOR BIO

Rebecca Jane Elkins, BBSR, MAPC, MDiv, is a staff chaplain specializing in trauma services at Northside Hospital in Lawrenceville, Georgia.

Doug Longstaffe, MDiv, STM, Regional Director, Spiritual Care and Multifaith Services, Vancouver Coastal Health Authority

HOLDING SACRED GROUND AMID THE RISE OF AI

EXCERPTED FROM: SPIRITUAL CARE IN THE AGE OF AI AND QUANTUM

ENTERING A WORLD OF UNCERTAINTY WITH FAITH

Spiritual Health Practitioners are used to working with many uncertainties, and I am not speaking only of funding issues! SHPs sit at the edge of the unknown with patients awaiting diagnoses and prognoses all the time. They regularly journey with patients as they feel their way and think their way through existential questions that are highly subjective and largely unknowable. And through all these challenges they exercise the kind of faith that exists only in uncertainty.

As with spiritual care, so too is there a plethora of uncertainties in our future with AI, but this is no excuse for becoming immobilized. A freeze response may work for a rabbit with a fox in hot pursuit, but that metaphor will not work for our situation with AI. A more appropriate metaphor is a train that is coming through, whether we like it or not. We have a choice. We can get on the train and have some say in whether it speeds up or slows down and for what hazards we will put on the brakes. Or alternatively we can pretend nothing requires our involvement and let the train race through without us. This choice exists for society in general, but even more so for healthcare, because it is listed as one of the most highly impacted sectors facing the AI revolution. So, we have even more reason to get on board and exercise some influence. There are existential dangers with AI but there are also enormous opportunities, the likes of which the world has never seen. Let us now explore some of the possibilities for Spiritual Care that we can exercise in faith, which is to say in the face of uncertainty.

> A FREEZE RESPONSE MAY WORK FOR A RABBIT WITH A FOX IN HOT PURSUIT, BUT THAT METAPHOR WILL NOT WORK FOR OUR SITUATION WITH AI.

SITUATING SPIRITUAL CARE IN THE EQUATION

At the heart of Spiritual Health Practitioners' training in Clinical Psycho Spiritual education (known in the US as Clinical Pastoral Education) is an incredible focus and emphasis on self-awareness as both a spiritual practice and how one becomes able to enter the most existentially challenging dialogues. But self-awareness involves many areas, some of which even spiritual care practitioners need help with understanding. Enter Jacques Ellul, a French Christian writer who, long before "AI" was a buzzword, rocked the academic world with his first book, The Technological Society. First published in French in 1954, it was translated into English ten years later and has had many

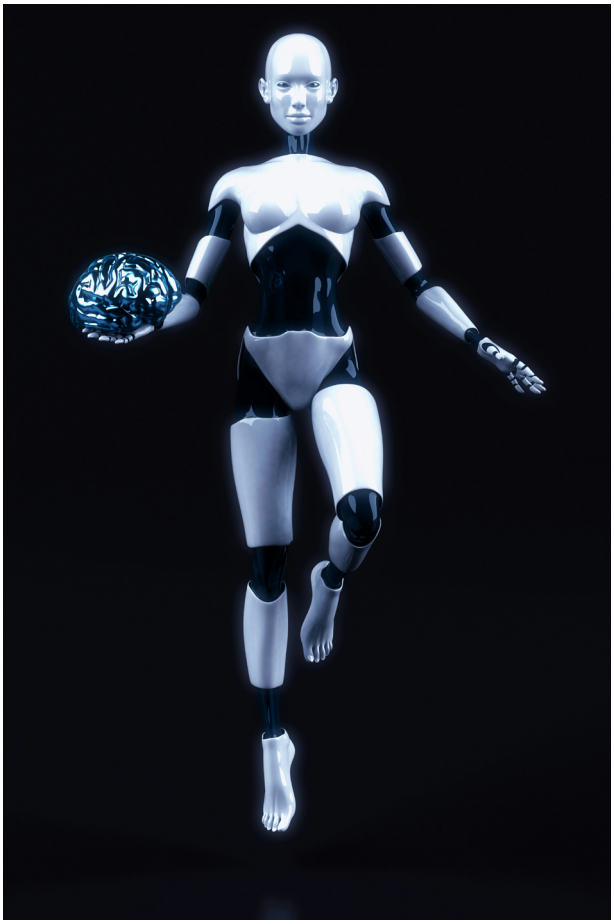
reprints. It is essentially a sociological critique of modern machine-age society. Ellul's main contention was that humans always use what they create, and that technology, along with its related organizational processes, usually leads us, rather than us leading it. This was an incredibly important societal self awareness that the world needed to understand about itself, especially in a mechanized and nuclear age.

> WE ARE UNIQUELY POSITIONED IN OUR ABILITY TO SIT WITH THE UNKNOWN TO HELP HEALTHCARE UNDERSTAND ITS RELATIONSHIP WITH TECHNOLOGY—AND ESPECIALLY WITH AI.

Today, with the emerging age of AI, Ellul is more relevant than ever, because his writings demonstrate how the phenomenon of humans blindly serving the "means" of technology above any reflection on purpose or ends, is unfortunately an innate human tendency. Such a species' proclivity is beyond dangerous when such "means" now include not only the atom bomb but AI, let alone the two combined. In other words, it is essential to understand our relationship with technology if we are to reflect on how we should approach regulations and different ways of utilizing AI.

The above wider context having been stated, we need to acknowledge that Spiritual Care operates mostly in the Healthcare arena. In that realm, there are no atom bombs, but there is AI, and there will be increasingly more AI each year. Here, then, is where we must begin to situate Spiritual Care. Our place and therefore our main contribution is to be found in where it always has been in healthcare – bringing self-awareness, spiritual warmth, insight and values to bear in crucial conversations with patients' families and staff. We are uniquely positioned in our ability to sit with the unknown, not only with individual patients but with healthcare leaders who need to navigate these uncharted waters. Our relationship as individuals and a species to technology, and especially to AI involves the spiritual dimension of humanity and SHPs need to help leaders in understanding the human side of the equation as we interface with AI in healthcare.

We do not know computers like the people in IT, just as we do not know medicine like the doctors and nurses in the medicine program, or surgery like the surgeons and nurses in the surgery program. Yet we have always had an important role in such programs because we know people, especially in relation to their spirituality. We may say similar things of ethicists, psychologists, and social workers.



Each will bring something to the AI table not because of any expertise in AI, but because of their long-held expertise in the realms of ethics, psychology and the social sciences. As SHPs, we know that the ends do not justify the means, but we also know that the means should not drag us to an inevitable end that is the result of us blindly doing something simply because we can. We know that people have spiritual needs that they may project onto AI, while others will reject its use as the new thing that they consider as unclean. We understand the human tendency to idolatry as well as the pull towards puritanical isolationism. Whether it is bedside care or assisting health authorities with major systems decisions, we have all this and more to offer.

In addition to assisting patients to negotiate their relationship with the use of AI in healthcare settings like the hospital, as more patients become familiar with basic Quantum principles, new spiritual questions will emerge. For example, patients may wonder about the theological/spiritual implications of the sheer existence of superposition, entanglement functioning at a distance and the impact of the observer over that which is being watched. They may also be reeling at some point from future discoveries made by AI that we cannot yet know. This sort of thing has already been experienced by those of us who have ever spent time with physicists or mathematicians nearing the end of their lives. Such patients will sometimes reference things like their knowing that time does not really exist, but whether this translates into any sense of comfort is another matter. This is where it will be helpful for us to keep up with the writings of people like Robert Lanza MD, who functions as something of a bridge between the new physics and cellular life in human form. See his books Biocentrism and Beyond Biocentrism for an understanding of consciousness as a biological phenomenon and its interface with quantum physics.

> THE MEANS SHOULD NOT DRAG US TO AN INEVITABLE END SIMPLY BECAUSE WE CAN—THIS IS WHERE SPIRITUAL CARE MUST STEP IN.

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FROM DIALYSIS CHAIR TO CHAPLAIN'S DESK:
SERVING THROUGH THE STORM

By Rev. Carlos A. Panameno

At the United States–New York State Chaplain Response Team, Inc. (US-NYSCRT), I've had the privilege of leading an incredible team of volunteer chaplains who are deeply committed to spiritual care in crisis. As CEO and National Chief of US-NYSCRT, my journey into this field hasn't been typical, and I believe that's exactly what gives it strength.

Before I was Rev. Carlos Panameno, I was a young man on the streets of New York, angry, lost, and part of a notorious Salvadoran gang. I had seen too much too soon: violence, betrayal, addiction, and despair. I came close to death more than once. But God had another plan. It was in the darkest corners of the city that I encountered light. The grace I didn't know I needed broke through, and everything began to change. My life today is not just about ministry; it's living proof of what redemption looks like.

Now, I serve as a chaplain at the DaVita Dialysis Center in Port Washington, NY. What's different? I'm also a dialysis patient. I offer prayer and presence from the same chair where I receive treatment. It's not a role, it's a calling forged in fire. This dual experience has shaped my understanding of suffering, empathy, and healing in ways no textbook could ever teach.

My formation includes a **Diploma in Christian Ministry and Theology** from the Spanish Eastern District Bible Institute of the Assemblies of God (RAMA Nassau). I'm currently pursuing a **Master of Divinity (M.Div.)** at Winebrenner Theological Seminary, working toward the **Board-Certified Chaplain Credential (BCCC)**. I've completed training through the Spiritual Care Association, including the **"Crisis, Trauma, and First Response Certificate Course for Chaplains"** and **"Understanding CMS Codes for Clinical Chaplaincy,"** enhancing my grasp of trauma support and Medicare & Medicaid (CMS) standards for documentation.

I'm also a **U.S. Navy veteran (USS INDEPENDENCE CV62)** and a graduate of the **Hempstead Civilian Police Academy**. My early career was in architecture; I hold a **Bachelor of Science in Architectural Technology** from New York Institute of Technology (NYIT). For over 20 years, I've worked as a front-end web developer, specializing in digital ministry platforms through WordPress and Joomla.

In my 30+ years with the Assemblies of God, I've served as a youth pastor, teacher, and Royal Rangers Senior Commander, founding three outposts and mentoring countless young men. But the title I cherish most is "Servant." Because spiritual care is not just support, it is soul-level, clinical care. We don't just show up for others. We *stand with them*, especially when the world walks away.

"We have this treasure in jars of clay, to show that the surpassing power belongs to God and not to us." – 2 Corinthians 4:7

This verse is personal. I am a jar of clay, cracked, scarred, but still carrying light. From the gang-infested blocks of New York to the chaplain's office at DaVita, God has led me on a path I never imagined. Today, I'm committed to raising up future chaplains, those who know that true ministry begins with brokenness, and that even in the storm, we are never alone.

AUTHOR BIO

Rev. Carlos A. Panameno is the National Chief and CEO of US-NYS Chaplain Response Team, Inc.. A U.S. Navy veteran and former gang member turned chaplain, he currently serves at DaVita Dialysis Center in Port Washington, NY.

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HEAD VERSUS HEART

By Rev. Ken Chamberlain, M.Div, BCC

There is a sizable Hmong community in the area where I live and work. The Hmong are an ethnic group originally living in Southern China, Vietnam, Laos, Thailand and Myanmar. There are also strong populations of Hmong in Minnesota and Wisconsin. The Hmong are an ethnicity rather than a religious group. Their traditional belief system is animism, but there can be Hmong in almost any faith group.

A male patient who was Hmong was clinging to life in our ICU. He had gone through an extensive and hours-long surgery. Even a week later he had never regained consciousness. Life-support measures were becoming more and more intense – our strongest ventilator, various cardiac support devices, and finally the patient was put on ECMO support. ECMO, essentially a modern heart-lung machine, is the most intense form of life support our hospital had at that time.

The patient was married and had seven sons and daughters; all of whom were in the ICU the day we withdrew the machines keeping him alive. Besides his sons and daughters, there were many spouses and grandchildren. Our hospital had strict visitation guidelines but was allowing this entire family to be there because the patient was expected to die quickly.

Though the patient was married, and his wife was in a place of honor beside his bed, the final word about removing medical hardware came from the couple's eldest son. He himself was less than thirty years old, and the weight of making that decision weighed heavily upon him.

The entire medical crew in the ICU, doctors and nurses alike, were convinced that the patient was brain dead. He had simply been without oxygen too long, and he had made no purposeful movements the entire week before this day. Unfortunately, the definitive test was to do an MRI of his brain, but that couldn't happen as long as the patient was on the ECMO machine. Even without the MRI, hospital staff believed the patient was already dead, medically and legally speaking. His heart was still beating, but only because the machinery was doing all the work for him.

An unexpected thing happened, though, when we turned all the hardware off. His heart continued to beat. The family, along with the entire clinical crew, watched the monitor over the patient's head to see when his heart would stop. Through a translator the family asked, "When is he actually going to die?" The medical team felt he was already dead, and we were just waiting for his heart to stop to make it official. The family, it seemed, believed he was still very much alive and would continue to be so until his heart finally stopped. We were at odds with each other, culturally and medically, until the surgeon walked into the ICU.

Our lead cardiothoracic surgeon,* who is Asian-American, quickly recognized the quandary we were all in. He spoke, loudly enough for everyone to hear.

"What we are seeing here is the difference between Eastern and Western medicine. For Westerners, we believe brain activity determines whether you are alive or not. So, we have all felt he was already dead, even though his heart is still beating. For those from the East, the activity of your brain is secondary to the beating of your heart. Eastern medicine feels that you are alive until your heart stops. This family is still seeing a heartbeat, so they won't accept that he has died until his heart actually stops."

Before long, the patient's heart did stop. The family was appropriate in their grieving, and we did the best we could to support them all. It was a real learning experience for all of us that day. We all saw the same thing happening, but we saw it in two (culturally and medically) very different ways.

**Dr Kuo Fon Huang*
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- *D.Th. in Thanatology*

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EMS POEM:
COMPASSION, FROM THE LATIN, 'TO SUFFER WITH'

By Russell Myers, D.Min

If the day ever came when I could do this work and it didn't bother me, that would be the day I needed to quit and find another job.

What was I thinking?

I somehow had the idea that I could provide care to people who were suffering and it would be their suffering, and I could somehow leave it behind at the end of the day.

But at the end of the day, I realized that their suffering was still with me and it bothered me and sometimes I felt like crying for no obvious reason.

A touching song on the radio or a Hallmark moment would get me every time, but why?

It was confusing.

Oh, I got it, but I didn't get it.

Then I thought, well, this stuff ought to bother me. It tells me I'm human.

Over time, I began to embrace it. I didn't want to become a robot.

I wondered if I should be concerned about burnout.

I figured out a way to recognize the clues. If the day ever came when I could do this work and it didn't bother me, that would be the day I needed to quit and find another job.

I need to feel the suffering of the other, somewhere in my soul.

I found another clue, plain as day, right there in the word compassion.

Compassion, from the Latin, "to suffer with."

By its very nature, compassion hurts.

It touches my heart and I feel a sense of sadness when others are hurting.

Now, at the end of the day, I do carry some of that pain home with me.

Some days I carry home a lot of pain.

But I'm OK with that.

On those days, I reach out and invite a trusted friend, coworker or family member to show me that same care, and to carry some of my pain.

Russ Myers retired after 18 years as chaplain with Allina Health EMS, St. Paul, Minnesota. He is the author of "Because We Care: A Handbook for Chaplaincy in Emergency Medical Services."

HIDDEN IN THE ORDINARY:
FINDING THE SACRED IN NURSING CARE

By Dr. Antonia van Loon

Hidden in ordinary nursing care are nurse's 'ways of being' and 'ways of doing' which are central tenets of spiritual care in nursing.

On 29th March 2025 central Myanmarwas shaken by a 7.9 earthquake, killing more than 3,500 people and injuring thousands of others. The devastation to infrastructure and housing was huge. Samaritan's Purse responded immediately to this crisis by deploying a multidisciplinary team to support the people of Myanmar with a level 3 Emergency Field Hospital (EFH) set up in Myanmar's capital, Nay-Phi-Taw. I was one nurse in a large team who sought to provide compassionate, holistic, and life-saving care to everyone who entered the EFH.

Our patients' physical wounds were huge and often life-changing, but their emotional struggles of loss, fear and shock were equally difficult for people to process. They would lay in their beds contemplating what had just happened and what their future might look like. It was in this environment that I recalled research I had undertaken decades earlier, noting it remained true and practically useful to consider in acute care situations. Crisis and loss are well recognized causal conditions of spiritual needs. Tha (not her real name) and others on our ward had multiple 'loss' experiences - loss of body function; loss of limbs, loss of lifestyle; loss of houses, loss of friends, family and their significant relationships, loss of self-identity and self-worth, loss of life itself... Let me share Tha's story to illustrate.

Tha was 18 years old. Her mother died next to her in the earthquake. She was admitted with multiple fractures in both legs and her pelvis. She no longer had a house because it had been destroyed in the earthquake. Her final unmarked high school examination papers were destroyed in a fire during the earthquake. That meant Tha had to re-sit her final exams in the near future so she tried to study as she lay in her hospital bed with such serious injuries. Yet throughout our time together, I noted Tha's calm demeanour and her air of quiet resignation at her situation. There was a notable lack of angst in Tha, and indeed in most of the patients on the ward, who were almost all notably calm.

Tha had been learning English via the internet and this meant we were able to have conversations about her life and her situation. We spoke about her injuries and their treatment, her hopes and fears, and how she anticipated coping with what had happened and was continuing to happen

to her. In conversations about faith, Tha said she was Buddhist and expressed her understanding of suffering was that it was inevitable, and she had to process it, and accept it. She asked how I coped when my circumstances led to suffering and fear. I shared with her that my Christian faith gave me strength and promises that gave me hope. I added that through prayer I could have a personal conversation with God and know he would help me and this was integral to restoring my hope. Tha and other patients began to ask if we could pray together. We prayed simply, bringing their unique situations to God and asking for healing and blessing on them, and their nation. As we did this precious bonds began to grow. We talked as we worked on dressings, and helped patients get comfortable, attending to medications, intravenous therapy, health assessments and treatments. In the ordinary nurse/patient relationships something extraordinary had developed. 'Special' relationships were shaped, forged by mutual respect, authentic listening and sharing, whilst providing compassionate, personal, and holistic care. The clinical outcomes were positive and holistic. Those special moments in the therapeutic relationship fostered intimacy and understanding as we shared thoughts, feelings, values, fears, meaning, hopes… It was spiritual care and psycho-social care 'hidden in the ordinary' physical care we delivered each day.

As I reflected on this I was brought way back to my Masters of Nursing grounded theory research that sought to uncover "What constitutes spiritual care in nursing?" (van Loon, 1995). Those findings highlighted that spiritual care was hidden in the context of the ordinary nurse/patient relationship. This 'ordinary' relationship could produce extraordinary results that were seldom appreciated, or possibly even recognised by anyone other than the immediate participants in the nurse/patient relationship. Spiritual care is evident in 'nurse's ways of being' for/with the patient, and in the 'nurse's ways of doing' for/with the patient. I experienced this in the relationship with Tha and with other women in my ward of 12 patients. These ways of being included compassionate presence, careful conversation, empathetic attitudes, and a willingness to connect with interpersonal vulnerability with our patients. Our ways of doing included creating an appropriate safe and healing care environment, providing support for the whole person, encouraging their movement toward independence, and facilitating practices that supported the patient's faith.

In all our interactions we showed love for the people in our care. Our compassionate presence, genuine concern and empathy, helped them feel valued and less isolated. Our patients and their family members frequently commented that they felt safe in the ward and did not feel as if they were suffering alone. They felt respected, accepted, and loved, and comments were made that they had never experienced such care before.

No one can provide hope to another person, but we can ignite hope within the person by our ways of being and our ways of doing. This was achieved by assisting patients to understand their situation through genuine presence and careful conversation. Each day we gave our patients small tasks to do that would move them toward self-care and connect them with other patients who had also experienced loss and grief. We did this by inviting those who could walk to come and sit at a table that we had set up so they could sit together and talk. With gentle encouragement, and celebrating each small success, we could see patients become more hopeful, and this gave them the impetus to keep moving forward.

After 3 weeks the day arrived when I had to leave the EFH. I went to each patient to say goodbye. They asked if I would pray with them. It was at this time that tears began to flow and I knew something precious and spiritual had occurred in our tent. I left with a full heart, knowing I had provided my best care of the whole person – body, mind, spirit and relationships with others, and above all – with God. It reconfirmed to me that caring for the human spirit is the gift that makes nursing such a rewarding profession, and so much of it is hidden in the ordinary nursing care we provide.

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AUTHOR BIO

Dr. Antonia van Loon, deployed as a registered Nurse with the Disaster Assistance Response Team from Samaritan's Purse Australia https://samaritanspurse.org.au/

Dr. van Loon is also the current chairperson of the Australian Faith Community Nurses Association afcna@afcna.org.au.

The images below are official photographs used courtesy of Samaritan's Purse. They are not images of the people discussed in this article.

Samaritan's Purse Emergency Field Hospital in Nay-Phi-Taw , Myanmar, set up to support the local people after the devastating 7.9 magnitude earthquake 29 March 2025

Staff provide holistic care for body, mind and spirit, and prayer was integral to the patients' spiritual care

GRIEF AND THE TROUBLE WITH UNIVERSAL STAGES OF GRIEF

By Dr. Janet Lynn Roseman

Death is the eternal mystery, a mystery that fills our souls with both awe and terror. The consequences of the death of one's mother is not like any other ordeal in life. Daughters are often faced with resurrecting a new life without a road map, catapulted upon the ruins that remain while enduring indescribable emotional pain. Based on my experience of my mother's death, and the shared narratives with other daughters I have spoken with, this journey is both courageous and terrifying.

Grief is often a taboo topic, and many women (and men) in mourning are not only distraught but feel alone and disconnected. Constructing a life with meaning, that is psychologically sound, is empowering, especially when daughters feel abandoned and hopeless after their mother's death. It is a myth that during grief you need to "let go" of your loved one because the unwavering connection crosses the spiritual realms and continues after death.

This eternal bond is boundless, infinite, and everlasting because it is the energy of love, and love cannot be destroyed or lost. Although their physical presence is removed, the bond can never be taken away. When I speak to skeptics, I often cite Dr. Albert Einstein's theory that "energy cannot be created or destroyed; it can only be changed from one form to another."

DR. KÜBLER-ROSS MADE A MISTAKE

Clinicians can offer great comfort, psychological understanding, and support for daughters. When they blindly adopt Dr. Elizabeth Kübler-Ross's stages of grief as the only model, they contribute to the lack of acknowledgment that grief belongs to the griever, and it is a sacred act of love. The respected work of Dr. Kübler-Ross's many stages, although compelling, does not depict the actual stages of grief despite the fact it is universally accepted as the model. Grief, denial, anger, bargaining, depression, and acceptance has been the universal gold standard, but it negates the fact that every person has their own experiences with grief, which may or may not mirror those stages. More importantly, those stages should not be used as a checklist of dictated emotions that grievers should use to judge how they are doing. These stages may bring comfort to those who want validation for their feelings, but I believe it is a false analysis. Reducing the multilayered grief process to five words does a disservice.

Daughters may feel as if they are not experiencing the grief process correctly if they do not travel through these stages or, even worse, they remain stuck in one of those stages. It is insulting because it is formulaic and reductionist. It does not acknowledge my experiences or yours.

Grief is a dance, and we may also feel guilt, sadness, lack of interest in our lives, joy, and celebration. Dr. Kübler-Ross also never mentions any occurrence of visions, dreams, or other signs that the bereaved may experience. The point I am making is that you cannot quantify how you should feel or will feel. The wisdom of suffering that one learns during grief is formidable wisdom, and one learns what truly matters in life when someone you love is taken away.

After the death of her mother, writer Ada McVean wrote in 2019 an insightful article stating that Dr. Kübler-Ross's model "is not science based, does not describe well most people's experiences, and was never meant to apply to the bereaved."[1] According to McVean's research, Dr. Kübler-Ross created this model after she interviewed two hundred dying patients to learn about their psychological beliefs about death and that this model was not based on empirical or systematic investigations but a collection of case studies. What I think is compelling is that her research, although merited, did not consist of interviewing those who had lost loved ones but was based on those who were facing death, and those populations are very different. McVean ends her article with sound advice.

There is not a "right way" to grieve. There is not a "wrong way" to grieve. And I hope that when you experience grief you can take some small comfort in knowing that however you are feeling is just fine.[2]

THE DANGER OF LABELING GRIEF AS A MENTAL ILLNESS

In March of 2022, the newest disorder to be added to the Diagnostic and Statistical Manual of Mental Disorders (DSM), a publication of the American Psychiatric Association, included prolonged grief disorder. They defined this "disorder" as "intense yearning or longing for the deceased (often with intense sorrow and emotional pain)."3 Adding further insult to those in deep grief, clinicians could bill insurance companies for the treatment of this "disorder," and pharmaceutical companies now had further permission to manufacture drugs that grievers would now" need." This addition was not without controversy, and Joanne Cacciatore, an associate professor of

social work who is an expert on the grief experience, stated:"When someone who is a "expert" tells us we are disordered and we are feeling very vulnerable and feeling overwhelmed, we no longer trust ourselves and our emotions. To me, that is an incredibly dangerous move, and short sighted."[4]

When someone is unable to function at all for long periods of time or threatens to harm themselves, they need professional care, and in this case, I am not referring to those circumstances. If you are interested in reading more, there is an abundance of materials on PubMed and in the DSM online.

GRIEF IS NOT PATHOLOGICAL

Daughters who are grieving after one year or "long for" their mothers are at risk of being labeled and medicated. The only boon would be for pharmaceutical companies to help psychiatrists medicate their patients when these daughters are not mentally ill but experiencing deep grief Grief is not a mental illness or a pathology but a natural process. The grief process will include intense longing for your mother and the physical separation from her often creates emotional distress. These are natural human responses and not a mental disorder. Many research papers on grief characterize this normal experience as problematic if grief does not resolve within a year. This is just ridiculous. I wonder if the authors have ever lost a beloved. Find support, allow yourself to mourn, and reach out for help when you need it.

WHO DECIDED THIS DIAGNOSIS AND WHY

The financial conflict that surrounds this diagnosis and the task force that created the initial diagnosis for prolonged grief disorder in 2012 is alarming because 69 percent of the members of the task force reported financial relationships with pharmaceutical companies.[5] There is a justification for prescription drugs when they are needed, and they can be beneficial. I do not believe drugs are an antidote for grief, but I know they can often help some women to ease their distress. Antidepressants and antianxiety medications are the usual pharmaceuticals chosen by clinicians who may not know that natural therapies can also assist. Homeopathy, naturopathy, acupuncture, nutraceutical support, massage, and energetic practices are very valuable. If your clients choose to work with any type of integrative medicine practitioner, naturopath, or energy healer, tell them to seek out those who are clinically trained and have credentials. It is wise for grievers to resist the urge to self-medicate because all medications, including natural remedies, have side effects. It is always prudent to work with someone you trust who also possesses the proper qualifications.

AUTHOR BIO

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Teardrops

i grieve like no one is watching
when i am alone
in the silence
it stares back at me
sometimes
i feel this longing for you to rescue me
from this
sea of vulnerability
with your soothing presence
alone
when there is nothing to say
i don't expect you to carry this load for me
neither close my wounds
or heal my scars
this jarring reality
just hold me through your lens of humanity
if even from a distance
when you don't have the right words
they've been spoken
through the life of my beloved
in my inextricable connection to the fibers of their being
so i continue to write words unexpressed
in this continuum
time alone doesn't heal
but i will continue to write this letter
as i adjust to the empty spaces
if i must weave this letter tear by tear
line upon line
upon the tablets of my heart
until it is written
and somehow i feel
relief
what i long for
what i hope for
as i embrace these tears

- ***Sharondalyn Y. DuPree*** is a certified educator and healthcare chaplain/bereavement coordinator, residing in California. She is the founder of Chaplain Life® Apparel and Gifts and Chaplain Life Books @ www.chaplainlife.org

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