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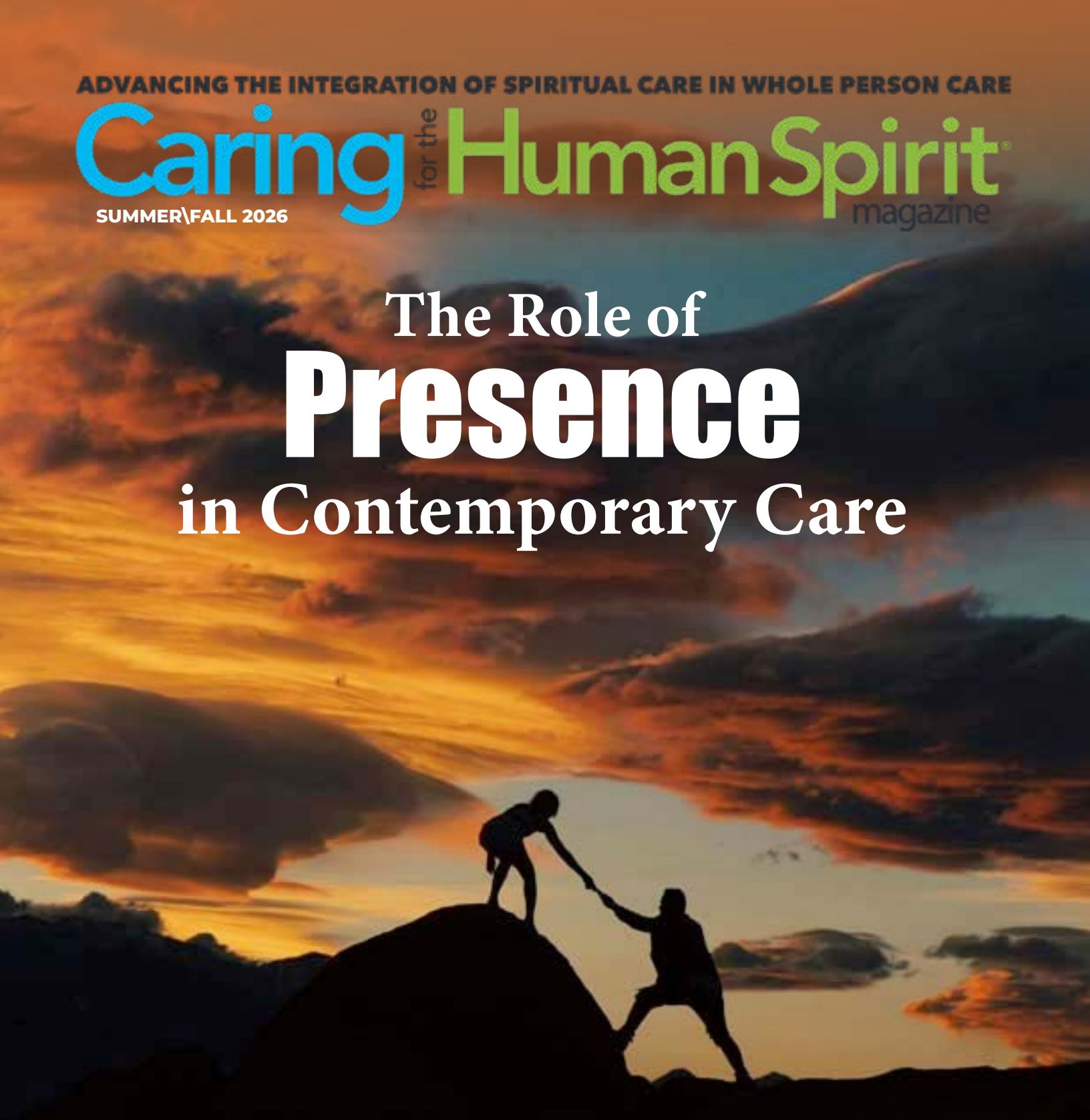
Caring for the Human Spirit magazine

SUMMER\FALL 2026

The Role of Presence in Contemporary Care



Spiritual Care in Behavioral Health

The Future of Chaplaincy Cannot Look Like Its Past

From Presence to Process

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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Dear colleagues,

As 2026 rapidly winds down, our partner organizations – HealthCare Chaplaincy Network, Spiritual Care Association, Capstone University, and Westberg Institute for Faith Community Nursing – are busy with the launch of new programming. We continue our work toward a world where all people have access to compassionate, evidence-based spiritual care, within the healthcare arena and beyond.

Here are some of our current projects:

New Nursing Specialty: Our Nursing Division is completing development of curricula for a new specialty, Spiritual Care Nurse Specialist. With much groundwork and a soon to be published foundational paper defining the role of a Spiritual Care Nurse, we are creating a path to educate and certify nurses interested in becoming leaders in this area. In the coming months we will be launching this new program which will build on nurses' central role in patient care and expand the staff in healthcare settings who are fully prepared to provide high-quality spiritual care.

Hospice and Palliative Care CPE: Capstone University has begun offering clinical pastoral education (CPE) with a specific focus on hospice and palliative care chaplaincy. This CPE center will be the first of its kind on spiritual caregiving in response to aging, serious illness, dying, and bereavement. It is designed to deepen chaplains' ability to provide patient-led spiritual care to individuals and families throughout the end-of-life experience and to collaborate effectively as integral members of multidisciplinary palliative care and hospice teams.

Chaplain Communities: Through our new Boisen Institute of Clinical Pastoral Training, we are providing chaplains around the country the opportunity to take part in online working groups. There are now approximately 15 communities operating in which chaplains provide and receive peer support and counseling to enrich their calling. This is especially helpful for many chaplains who work alone within their organizations, without chaplain colleagues. All members of the Spiritual Care Association are encouraged to participate.

AI: Our AI Advisory Group recently surveyed chaplains in various sectors on their use of AI. The findings revealed that chaplains are encountering AI where they work, but the profession has not developed consistent policies, training, or consensus on boundaries for its use. Strong majorities of chaplains surveyed believed that AI should not be used to conduct spiritual assessments with patients, and that spiritual care leaders should help shape institutional AI policies. Our plan is to publish the survey data and begin developing an AI training protocol.

We are excited and proud to present this new issue of the Caring for the Human Spirit magazine to our valued colleagues who share in this essential work. As you know well, providing the highest quality spiritual care improves patient experience and outcomes, helps professionals feel more connected to their work, and creates an atmosphere of caring in health care, the business world, the military, in emergency and disaster response, and other profoundly challenging areas of life. We are grateful to have your partnership in everything we do.



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- Recognize and illustrate the value of spiritual care in specific care settings
- Differentiate between specialist and generalist spiritual care and the role of each
- Screen and evaluate patients and families to determine who would benefit from specialist spiritual care
- Distinguish unique elements of the spiritual care delivery process
- Conduct a spiritual care conversation.



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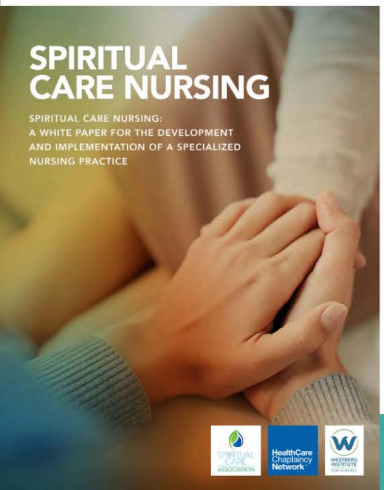

SCA Announces New Foundational Paper

The purpose of this white paper is to establish a conceptual and practice framework for Spiritual Care Nursing as an emerging nursing specialty and to provide recommendations for its implementation within healthcare organizations.

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THE PROPHETIC PARADIGM OF HOLISTIC PATIENT CARE
PSYCHOLOGICAL AND SPIRITUAL DIMENSIONS IN ISLAMIC CHAPLAINCY

By Chaplain Dr. Shady Alshorman

First Published by the Institute for Muslim Mental Health



Introduction

This research examines the Prophet Muhammad, peace be upon him (PBUH)'s direct involvement in what is equivalent to modern chaplaincy and his nuanced interactions with the sick1. The primary objective is to delineate the core tenets of "Prophetic Chaplaincy" and explore the multifaceted nature of his engagement with patients, with a specific focus on psychological and spiritual variables. A key insight of this study is that the Prophetic approach to visitation emphasizes cultivating supportive values, such as emotional empathy. Islam posits a comprehensive framework for human existence, which encompasses the spiritual, physical, and psychological perspectives. This integrated approach is most vividly manifested in the ethic of patient care. In the Islamic worldview, the concept of care includes a critical role for the psychological and spiritual health in the trajectory of healing and in mitigating suffering.

Given these considerations, this study analyzes a fundamental aspect of Prophetic guidance: its transformative impact on patient care through moral and spiritual support. While such practices may appear routine at first glance, the subject matter involves deep theoretical and practical complexities, especially when adapting to diverse cultural and individual patient needs. Therefore, this research aims to analyze the Prophet's compassionate interactions and systematize his practices into a coherent set of values and principles that can be tailored to various contexts, ultimately developing a robust, forward-looking model suitable for contemporary social and clinical institutions facing diverse populations2.

The Definition of Islamic Chaplaincy

Islamic chaplaincy operates through a different theological lens than does chaplaincy within the Christian tradition. Unlike the sacramental role often found in Christian chaplaincy—where the chaplain may act as an intermediary for grace—the Islamic chaplain serves as a mutawalli (caretaker) of the patient's spiritual environment. The Islamic chaplain does not hold a special religious "status" that grants them a closer proximity to God than the patient; rather, they are a supportive peer who facilitates the patient's direct connection to Allah, Subhanahu wa-Ta'ala (praised and exalted; SWT)3.

It is also essential to distinguish between the Prophetic actions of Muhammad (PBUH) and the work of the modern chaplain. The Prophet (PBUH) operated under Wahy (Divine Revelation); his actions were divinely guided and served as the Uswah Hasanah (Perfect Example). While modern chaplains strive to emulate his compassion, they do so as members of the Ummah who lack his unique spiritual station or infallible guidance. Therefore, 'Prophetic Chaplaincy' refers to a model derived from his life, emphasizing ethical and spiritual principles, rather than claiming that the chaplain possesses prophetic authority or infallibility, which may concern some scholars or practitioners seeking theological clarity.

The Islamic Mandate and Prophetic Practice of Visiting the Sick

The human condition is defined by inherent vulnerability. Individuals face psychological, social, and financial challenges that necessitate external support, particularly during illness. Islam recognizes this fundamental need for compassion. This core value is deeply rooted in Islamic theology, as exemplified by the life of the Prophet Muhammad (PBUH). In the Islamic tradition, visiting the sick is classified as an especially significant moral and humanitarian duty rather than a mere social courtesy. Numerous

hadiths emphasize its importance. For instance, Abu Musa al-Ash'ari reported that the Prophet (PBUH) commanded: "Feed the hungry, visit the sick, and free the captive" (Al-Bukhari 1997, hadith 5649).

The Prophet Muhammad (PBUH) consistently modeled this ethic, extending his compassion beyond his immediate companions to include non-believers. This inclusivity was often motivated by a desire for guidance and universal mercy, as evidenced by his sustained concern for a Jewish youth who had served him (Al-Bukhari 1997, hadith 109). His personal visits to individuals such as Sa'd ibn Abi Waqqas further underscore the universal nature of his empathy. Furthermore, records indicate that he often conducted group visits, such as his visit to Jabir ibn Abdullah, which was accompanied by Abu Bakr al-Siddiq (Al-Nasa'i 2007, hadith 139). Uthman and Zayd ibn Arqam both corroborated this dedication, with Uthman noting: "He visited our sick, attended our funerals... and comforted us in both small and large matters" (Ibn Hanbal 2012, hadith 97). Grade: Hasan (Darrusalam).

Scholars emphasize that the primary objective of visiting the sick is to mitigate suffering. The presence of visitors provides psychological relief, assisting patients in managing pain and fostering communal values of brotherhood and harmony.

The divine importance of this practice is further codified in Islamic law. The Prophet (PBUH) identified it as a fundamental "right" (haqq) within the social contract: "A Muslim has six rights over his fellow Muslim... If he falls ill, visit him" (Muslim 2007, hadith 6). He also promised profound spiritual rewards, stating that the visitor remains "in the garden of Paradise" until their return (Al-Tibrizi 1981, hadith 5). Most strikingly, a hadith Qudsi describes Allah (SWT) stating on the Day of Resurrection: "O son of Adam! I fell ill and you did not visit Me... if you had visited [my servant], you would have found Me with him" (Muslim 2007, hadith 18). This theological positioning suggests that showing compassion to the sick is a pathway to Divine proximity.

The Therapeutic Role of Optimism and Verbal Comfort

Islamic tradition emphasizes cultivating hope and positivity, recognizing the symbiotic relationship between mental equilibrium and physical recovery. The discourse employed by a visitor is intended to bolster the patient's resolve and strengthen their psychological character.

When engaging with the sick, it is imperative to inspire optimism through honest, soothing language. Recommended phrases include "May Allah prolong your life" and the Prophetic formula: "No problem, it is a purification, God willing" (La ba'sa tahurun insha'Allah). Ibn Abbas narrated that the Prophet (PBUH) consistently used this phrase to foster patience and hope (Al-Bukhari 1997, hadith 14).

Prominent scholars have elucidated the healing benefits of positive speech. Imam Ibn Battal noted that the sunnah involves reassuring the patient that their suffering serves as an atonement for sins—a concept that provides a redemptive meaning to pain. Sheik Ibn al-Qayyim in Zaad al-Ma'ad asserted that Prophetic comforting speech "boosts the spirit, restores strength, and releases natural warmth," thereby supporting the body's innate resilience (Al-Jawziyah 2009, 4:106–107).

Structural Framework of Prophetic Interventions

To better understand the mechanisms by which the Prophet (PBUH) facilitated healing, the following table synthesizes core Prophetic interventions and their corresponding spiritual and psychological benefits.

Table 1: The Prophetic Paradigm of Holistic Care

Prophetic Action	Spiritual/Theological Basis	Psychological/ Clinical Benefit
Verbal Reassurance	Tahur (Purification)	Cognitive reframing of pain; anxiety reduction via hope.
Compassionate Touch	Physicality of Presence	Sensory grounding lowers cortisol and fosters human connection.
Supplication (Du'a)	Divine Intervention	Transfers the burden of worry to a Higher Power.
Inquiry of Desires	Empathy & Dignity	Restores patient agency and autonomy; boosts morale.
Quranic Recitation	Shifa (Healing)	Induces meditative states; provides tranquility (Sakina).
Theology of Reward	Divine Recognition	Validates suffering; provides redemptive meaning to illness.

Analysis of the Prophetic Paradigm

The data synthesized in Table 1 illustrates a sophisticated multidimensional approach to patient care that prefigures contemporary biopsychosocial models. By integrating verbal reassurance with sensory interventions, such as compassionate touch, the Prophetic paradigm addresses the patient's immediate limbic response to stress, facilitating a transition from a state of physiological "fight or flight" to one of "rest and digest." Furthermore, inquiry into patient desires is a critical intervention in medical ethics, shifting the dynamic from paternalistic care to a patient-centered model that honors individual dignity. Collectively, these interventions provide a "spiritual scaffolding" that allows the patient to find redemptive meaning in their suffering, thereby enhancing overall psychological resilience and clinical outcomes.

The Practice of Supplication and Physical Touch

A central tenet of Prophetic visitation is the offering of du'a (supplication). This practice serves a dual purpose: it seeks divine intervention while providing immediate psychological peace. Knowing that one is the subject of communal prayer significantly reduces anxiety and enhances the patient's sense of belonging.

The Prophet (PBUH) taught specific formulas for healing. Aisha (ra) narrated the comprehensive prayer: "Take away the affliction, O Lord of mankind. Heal, for You are the Healer... a healing that leaves no illness behind" (Ibn Majah 2007, hadith 38). Grade: Sahih (Darussalam). He complemented these words with "compassionate touch," a practice that provides profound sensory reassurance. Narrated 'Aishah, daughter of Sa'd, that her father said: "I was suffering from an illness in Mecca, so the Messenger of Allah (PBUH) came to visit me. He put his hand on my forehead, wiped my chest and belly, and then said: 'O Allah! Heal Sa'd and complete his migration (Hijrah) for him. (Sunan Abi Dawud, Hadith Number: 3104, In-book Reference: Book 21, Hadith 16. Grade: Sahih (Authentic) according to Al-Alban. This physical closeness creates a tangible sense of care, which modern psychological studies have shown correlates with reduced stress levels and improved patient outlook.

In the modern application of the Prophetic paradigm, the use of

"compassionate touch" requires careful boundary-setting to remain consistent with Islamic legal (fiqh) ethics and professional standards. Physical touch (like holding a hand or placing a hand on a shoulder) is generally reserved for patients of the same gender to ensure the comfort and modesty (Haya) of both parties. In visits between different genders, the "Prophetic presence" is maintained through verbal comfort, empathetic listening, and "non-physical touch" (maintaining a respectful distance while offering du'a). While the Prophet (PBUH) touched the sick to provide specific blessings, the modern chaplain prioritizes the patient's autonomy and religious comfort, ensuring all physical contact is consensual and culturally appropriate.

Reciting the Quran for Healing

The recitation of the Quran over the sick is a critical spiritual intervention. As the Quran states: "Verily, in the remembrance of Allah do hearts find rest" (13:28). This practice is believed to facilitate "mercy" and "healing" for the believers (17:82), addressing the spiritual vacuum that often accompanies chronic or acute illness.

Divine Recognition and Fulfilling Patient Desires

The Prophetic paradigm offers comfort through the theology of reward. Abu Burdah cited the Prophet stating that when a servant is ill, they are credited with the same good deeds they performed while healthy (Al-Bukhari 1997, hadith 205). This provides the patient with a sense of spiritual continuity and purpose despite their physical limitations.

A hallmark of "Prophetic Chaplaincy" is the inquiry: "Do you desire anything?" If a patient's wish was harmless, the Prophet (PBUH) would ensure its fulfillment. (Sunan Ibn Majah Hadith Number: 3440. Grade: Da'if (Weak). (Zaad al-Ma'ad.: Volume 4, Page 476). This practice empowers the patient, returning a sense of agency to individuals who often feel they have lost control over their lives. It reflects a deep understanding of the connection between mood, immune function, and recovery.

A Chaplain's Holistic Visit: Embodying the Paradigm

As a hospital chaplain, I strive to manifest this Prophetic mandate. In a recent visit with "Mr. Hassan" (alias), an elderly post-surgical patient, I utilized these principles. Upon observing his fatigue, I inquired if there was anything, even a small comfort, he desired. He expressed a longing for specific dates; after confirming the dietary safety with the clinical team, I facilitated this request.

I employed the visit role of verbal comfort, reassuring him that his illness was a means of purification and divine reward. Following our dialogue, I performed a du'a, placing my hand on his forehead as per the Prophetic tradition. I recited: "Allahumma Rabban-nas, adhhibil-ba's..." and selected verses from the Quran to soothe his spirit. By employing a wholistic approach, this visit was transformed from a formality into an act of faith intended to alleviate his suffering and reinforce the bonds of spiritual brotherhood. [IM7]

Shady Mohammed Alshorman, Ph.D., BCC, is a highly accomplished scholar and Board-Certified Chaplain with over 20 years of experience in academic research, religious leadership, and clinical pastoral care. He holds dual Ph.Ds. in Religious Education from Fordham University and Islamic Studies from the Graduate Theological Foundation. Dr. Alshorman has served as an Imam and Lead Educator for various communities and is currently a Chaplain at Orlando Health, where he provides comprehensive spiritual and emotional support in high-acuity medical environments. A dedicated advocate for community building, he co-founded the Interfaith Committee in Lake County and specializes in interfaith dialogue, curriculum development, and the sociology of Islamic education.



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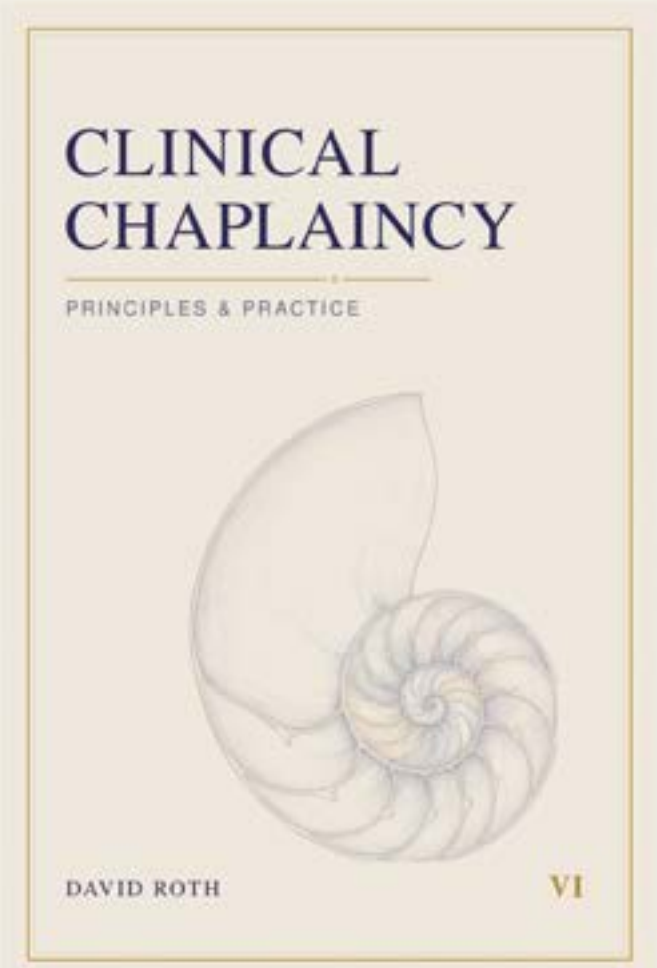

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THE FUTURE OF CHAPLAINCY CANNOT LOOK LIKE ITS PAST

By David Roth



Chaplaincy is approaching a choice it has postponed for too long.

The worlds of medicine, psychology, neuroscience, religion, and healthcare have changed dramatically during the past half century, and the populations we serve have changed with them. Yet much of professional chaplaincy continues to operate from assumptions about training, professional identity, and deployment that would have been recognizable decades ago.

No other clinical discipline could remain so insulated from changes in the knowledge that informs its work and reasonably expect to retain its place at the table. We cannot turn a blind eye to this.

The problem is not that chaplains have failed to care. The problem is that caring alone no longer adequately defines a clinical profession.

A century ago, Anton Boisen understood something revolutionary. He recognized that human experience itself could become a source of theological and clinical knowledge. The "living human document" was not simply someone to whom religious ministry was delivered. The person facing crisis, distress, loss, grief, or perplexity was to be encountered, studied, understood, and cared for with disciplined curiosity. This understanding redefined the training and work of the chaplain.

The revolution Boisen began did not stop with him. During the middle decades of the twentieth century, pastoral care and CPE absorbed much from Carl Rogers and humanistic psychology. Empathy, careful listening, and unconditional positive regard were important advances over more directive approaches to ministry and remain essential to good care. But what represented a groundbreaking development in the 1960s and 1970s cannot by itself provide an adequate clinical foundation for chaplaincy today. Presence is indispensable; it is not, by itself, a clinical method.

A quarter of the way into the twenty-first century, chaplaincy demands a much fuller foundation for practice. Advances in neuroscience and the emerging field of neuropsychoanalysis are reshaping our understanding of consciousness, affect, and emotion. Systems theory and group relations illuminate behavior within institutions and groups. Sociocultural anthropology has transformed our understanding of culture, meaning, and religion. Psychodynamic thought, attachment research, and trauma studies reveal how profoundly human experience is shaped outside conscious awareness.

Boisen was at the cutting edge of his day. Serious care of the soul today must be equally willing to learn from what is now known. These disciplines do not replace theology, but they profoundly change what competent attention to suffering by a chaplain can mean. A frightened patient is not simply expressing "spiritual distress." A family conflict is not merely a pastoral problem. What we encounter may involve attachment, affect regulation, implicit memory, culture, identity, loss, prediction, relational patterns, institutional dynamics, and deeply held meanings operating simultaneously. Clinically trained chaplains should be able to recognize this complexity.

This newfound perspective changes CPE as well. Formation through supervised experience remains indispensable, but reflection on experience cannot be the endpoint of professional education. We need greater theoretical rigor, clearer clinical competencies, stronger diagnostic reasoning grounded in a sophisticated reading of cues and clues, accompanied by a more precise understanding of how chaplains intervene and why.

We must also ask difficult questions about deployment. Not every patient needs a board-certified chaplain. Not every request for spiritual care requires

the same level of expertise. Community clergy, trained spiritual care volunteers, certified generalist chaplains, and more advanced clinical chaplains can each contribute something important. An era of increasingly responsible resource management requires us to match the right resource to the actual level and nature of need rather than assuming that one vaguely defined professional role should provide every form of spiritual support. That is not a diminishment of chaplaincy. It is what mature healthcare professions do.

Chaplains now must demonstrate not merely that people appreciate us, but that we possess distinctive clinical competencies that matter. We must document in ways our colleagues on the care team find meaningful, collaborate fully across disciplines, understand institutional systems, recognize the scope and limits of our competence, and confidently articulate what our work contributes to patient care.

If we honor Boisen, we should remember that he was not preserving an established model. He was disrupting one. He brought theological education into deep conversation with the revolution brought on by Freud, placed students at the bedside, and insisted that human experience could teach us something our inherited systems of ministry did not already know. One hundred years later, faithfulness to that vision requires the same courage. And the need is immediate.

Healthcare institutions are already under enormous pressure to justify the resources they deploy. Professions that cannot demonstrate distinctive competence and meaningful contribution will not be preserved simply because they have traditionally been part of the hospital. Chaplaincy is not exempt. If we remain insufficiently clinical, vaguely defined, and resistant to what a century of new knowledge has taught us about human beings, much of professional chaplaincy may simply disappear. That would be more than the loss of a profession. Human beings will continue to confront illness, suffering, mortality, grief, dislocation, fear, and the collapse of meaning. They will continue to need care directed toward that dimension of human experience we have historically called the soul. Medicine, for all its extraordinary capacities, does not cease to need such care simply because chaplaincy has failed to develop the competence to provide it.

We can defend the profession we inherited until institutions no longer find sufficient reason to support it. Or we can do what Boisen did a century ago: take seriously what is newly known about human beings, rethink how we train, clarify what we uniquely contribute, and build a clinical chaplaincy adequate to the people and institutions we serve.

The future is now. And so is the work.



David Roth, PhD, directs SCA's Clinical Fellowship in Psychodynamic Chaplaincy and heads up ClinicalChaplaincy.org. His book Clinical Chaplaincy: Principles and Practice is published by VerbumIcon.com.





FROM PRESENCE TO PROCESS

BUILDING A CLINICAL SYSTEM FOR HOSPICE SPIRITUAL CARE

By Russell VanHoose, Hospice Chaplain and Spiritual Care Educator

Why Hospice Spiritual Care Needs More Than Individual Presence

I was reading through a previous chaplain's clinical notes when I first understood the problem clearly. She had already left the agency when I arrived. The note itself was weak, but the larger problem was that the organization had no reliable process for recognizing it as weak or requiring something better. A representative entry described a patient lying in bed, mentioned that she was tired and had not slept well, noted that she appreciated the visit, and closed with a plan to return the following week. Yet nothing in it would have helped a nurse, a social worker, an aide, or a physician understand this patient's spiritual condition, not her fears, not her sources of meaning, not her distress, and not what had actually been said or done. She had a name, she had a life, she was dying, and the clinical record reduced that reality to the fact that she was glad someone had stopped by.

What stopped me was not simply the content of the note but the silence that surrounded it, because nobody had flagged it, no supervisor had pushed back, and no one in the interdisciplinary group had asked what the chaplain had actually found. The note moved through care planning cycles and review without generating a corrective response, as if there were no clear standard against which it could be measured. In that absence, spiritual care in that agency, and in many others, sat outside the accountability structures that are clearer and more consistently applied in other parts of care. Visits were logged, but nothing was captured or communicated, nothing that could tell the team what the patient needed or how she was doing. I could not use what she had documented. Neither could the nurses or the social worker. The aide, who spent more time with each patient than anyone, had no framework for understanding what she was seeing or where to send it.

What Is Lost When a System for Hospice Spiritual Care Is Absent

In the settings I have encountered, the spiritual dimension of many patients' experience has remained largely invisible, not because no one cared but because no one had built a reliable system for making it visible. We say that spiritual care is essential to hospice. That expectation shows up in regulation, in philosophy, and in the broader shift toward coordinated, patient-centered care that emphasizes dignity and outcomes at the end of life. Yet hospice spiritual care often lacks the structure required to function consistently as a clinical discipline. In practice, much of what we describe as spiritual care is present but not structured in a way that holds across people and time. Instead, it often depends heavily on the individual chaplain, their training, their instincts, their language, and the culture of the agency where they work. That dependence produces uneven care. It may be deep and attentive in one setting and thin or only partially integrated in another, while remaining loosely connected to the work of the rest of the team.

This is not a critique of chaplains, because hospice chaplains show up, sit with the patients who others cannot reach, and





listen when there is nothing to fix. It is a recognition that commitment alone cannot compensate for the structure in which they are asked to work. We would not consider this kind of variability an acceptable long-term design condition in other parts of care, and we do not build pain management or medication safety around the hope that the right individual will carry the whole burden by instinct. We build systems for those aspects of care, defining expectations, workflows, documentation, and accountability. Spiritual care has not consistently received the same level of operational attention, and the consequences, while often quiet, are not difficult to see once you look for them. A patient declines chaplain services at admission and may effectively disappear from active spiritual care attention even when something is clearly wrong. A nurse documents that a patient has not slept in three days and keeps asking for forgiveness, and the note remains where it was written. An aide notices that a patient who used to talk freely has become withdrawn and restless but has no shared language for what she is seeing and no clear expectation that it belongs in the plan of care. These observations are not spiritual diagnoses. They are possible indicators that warrant broader assessment and, when appropriate, chaplain involvement. The team meets, reviews the plan, adjusts medications, and addresses psychosocial needs, yet spiritual condition often remains thinly represented in the conversation, not because it is absent, but because it has not been structured in a way the team can readily use.

These patterns are not failures of individual clinicians but failures of design. We have treated spiritual care as something that happens in the room between a chaplain and a patient, and while that encounter matters, it is not enough within a clinical setting. If spiritual care cannot be assessed in a reasonably consistent way, documented so others can use it, communicated across a team, and revisited as the patient's condition changes, then clinically meaningful care remains isolated and difficult to sustain across the course of care. Presence matters, and it may be the most human thing we offer. Yet presence without structure does not become consistent, equitable, or visible to the team responsible for the patient's care.

The gap in hospice spiritual care is not a lack of compassion but the absence of an operational framework. No single operational framework appears to have achieved broad adoption across hospice settings for screening spiritual condition at admission, maintaining clinical attention when patients decline chaplain visits, interpreting observations made by nurses and aides, integrating spiritual concerns into care planning, and following spiritual condition across the course of dying. This is the work that has led me to begin developing an operational model for hospice spiritual care, the Hospice Integrated Spiritual Care Model. It is an attempt to define how spiritual care can function as a continuous clinical process rather than an isolated encounter. The model is still in development, but the gap it responds to is already visible.

We have built language, values, and professional roles, but we have not yet built reliable systems everywhere they are needed. Until we do, spiritual care will remain too dependent on who happens to be present rather than on what the patient needs. We may continue documenting that we were there without being able to say clearly what we saw, what it meant, or what we did. Making spiritual condition visible does not mean placing the full pastoral conversation in the record. Documentation should communicate only the clinically relevant strengths, concerns, interventions, responses, and next steps the team needs to support care.

What a System of Hospice Spiritual Care Actually Looks Like

The question is not whether spiritual care matters. Hospice has already answered that. The question is what it would look like for spiritual care to function as part of the system rather than alongside it.

A system does not replace presence. It gives presence a place to go.

It begins at admission, where spiritual care is often framed as a matter of preference. Does the patient want a chaplain? If the answer is yes, a visit is scheduled. If the answer is no, the pathway frequently narrows or closes unless someone later reopens it. What is often missing is a structured way to



understand the patient's spiritual condition at that moment, independent of whether they accept a visit, and a clear path for what happens next.

Separating those two questions, preference and condition, changes what the team is able to see.

From there, spiritual care can follow a pattern that is already familiar in other parts of clinical work. It is observed, interpreted, communicated, and revisited over time. The difference is that these steps are defined rather than assumed, and that the responsibility for recognizing and carrying information forward is shared across the team.

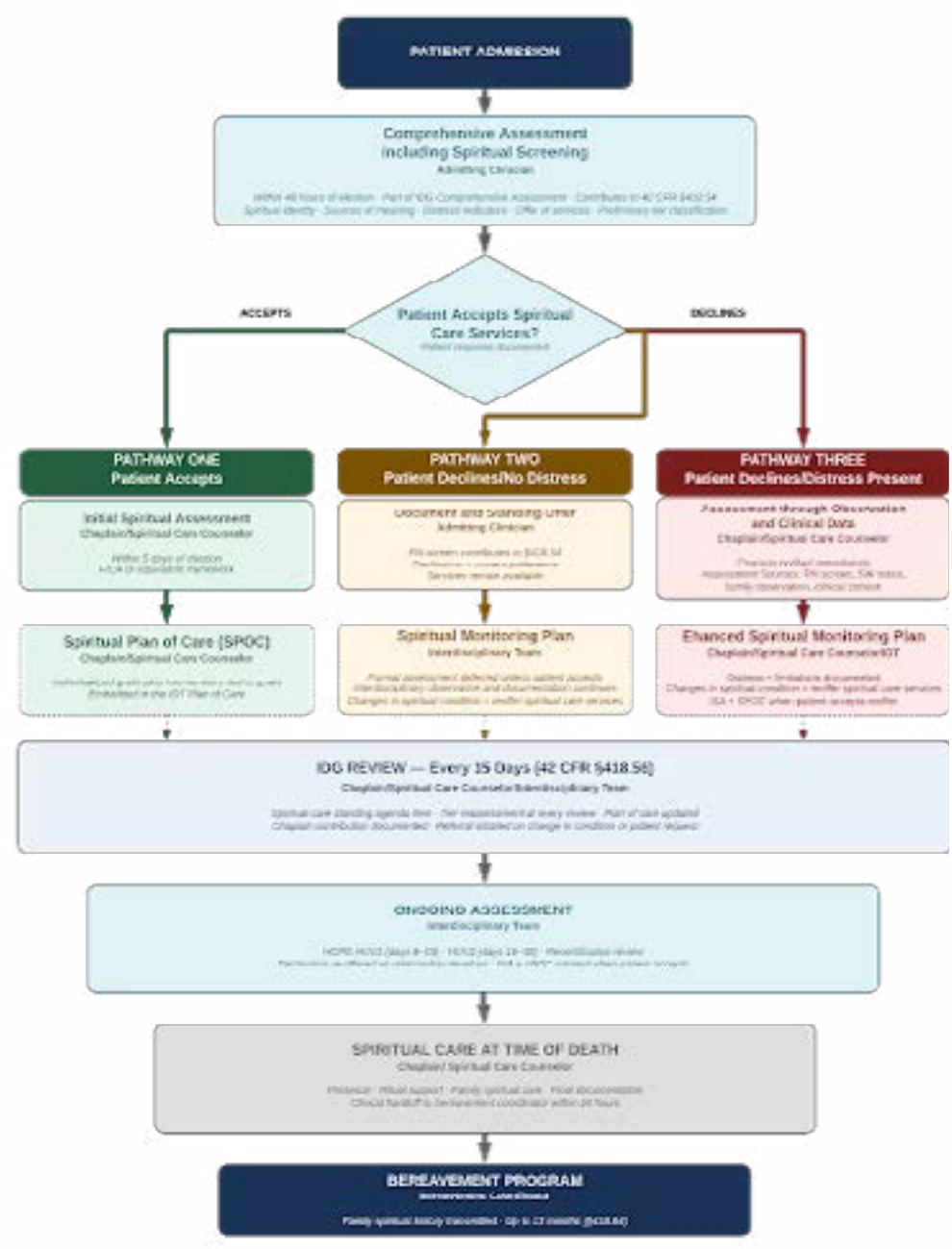
This system does not create an entirely new set of tasks. It makes visible a pattern already present in other domains of care. Nurses, aides, and social workers are already observing patients closely. They notice when someone becomes withdrawn, when sleep patterns change, when a patient expresses fear, guilt, or unresolved conflict. These observations are already being documented. A system approach does not ask those clinicians to become chaplains. It gives them a way to recognize when what they are seeing belongs to the spiritual dimension of care and a clear path for what happens with that information. The chaplain's role becomes more defined, not less. Instead of carrying the entire burden of spiritual care through individual encounters, the chaplain functions as a clinical specialist within a shared process, deepening assessment, naming patterns, and shaping a plan of care that the team can understand and use.

Patients who decline chaplain services are no longer outside the frame. They remain within clinical attention, with the understanding that refusal of a visit does not mean the absence of spiritual need. When indicators of distress appear, there is a pathway for response that does not depend on chance or on whether someone decides to revisit the question.

None of this requires a change in the heart of spiritual care. It does not standardize what happens in the room or reduce the depth of the encounter. What it does is give that encounter a place within the larger structure of care, so that what is seen and heard does not remain isolated.

The Hospice Integrated Spiritual Care Model is still in development and will need to be tested and shaped within different care settings, but the movement itself grows directly out of what is already visible in practice when the system does not yet exist.

Over time, this approach can change interdisciplinary work in subtle but significant ways. Spiritual condition can be named alongside pain, mobility, or caregiver strain, making it visible enough for the team to respond. Hospice has already decided that spiritual care belongs within clinical care. The remaining question is whether hospice organizations are willing to build the structure that allows spiritual care to function consistently within clinical care.



Russell VanHoose, M.Ed., is a hospice chaplain and ordained minister whose background in adult education and curriculum design informs his work in chaplain formation and the clinical integrity of hospice spiritual care. His current focus includes strengthening documentation practices, interdisciplinary integration, and system-level approaches to spiritual care delivery. He is developing the Hospice Integrated Spiritual Care Model (HISCM).

SPIRITUAL CARE IN BEHAVIORAL HEALTH: EMBRACING THE INTERIOR LANDSCAPE

By Dr. DeeAnna Merz Nagel

In my three decades as a psychotherapist, I have come to see each client as a constellation of experiences, identities, longings, and beliefs. They do not arrive in neat categories. They bring with them their ancestors, their symbols, their wounds, and their hopes. And too often, their spiritual selves are left at the threshold of care, unseen and unacknowledged by systems designed to treat physical symptoms alone.

It is precisely in the realm of behavioral health that the integration of spiritual care becomes essential. Whether we're working in clinical, coaching, or chaplaincy roles, our ability to hold space for the spiritual dimensions of mental and emotional well-being is not an optional skill. It is core to treating the whole person.

Beyond the Clinical: A Reframing of Spiritual Care

For too long, spiritual care has been seen as the domain of religious professionals, or a separate discipline altogether. Those of us working in behavioral health understand that psychological suffering is rarely just about biology or cognition. People ache for meaning. They ache for belonging. They ache for transcendence. And that ache often finds expression in spiritual terms, whether articulated through traditional mainstream religion, indigenous practice, New Age exploration, or the personal poetry of one's own soul.

Importantly, spiritual care is not always religious care. It's the honoring of one's beliefs, rituals, cosmology, and connection to something greater. Our ethical codes, slowly but surely, are catching up. While some still omit direct language about spirituality, most now emphasize cultural competence and nondiscrimination regarding religious belief. This is not yet enough. Inclusion has to move beyond policy into practice.

To provide spiritual care within behavioral health, we must embrace a pluralistic view: one that recognizes that spiritual identity is often inextricable from cultural identity. A client from the Caribbean may speak of spiritual attack in terms that seem unfamiliar to a western-trained clinician. An indigenous client may reference dreams, ancestors, or ceremonies as core to their healing. For some clients, especially those raised in rigid religious systems, reclaiming their spiritual self after denying core aspects of identity—such as gender or sexuality—becomes a sacred act of restoration. Spiritual distress can manifest as depression, anxiety, or dissociation—and yet be rooted in a profound loss of connection to self, community, or the sacred.

What changes in our spiritual practice when we acknowledge these invitations for attunement?

In my work, I speak often of the interior landscape—that rich, symbolic terrain where image, emotion, story, and spirit intersect. The interior landscape is where we meet our clients when we step beyond diagnosis and into the deeper waters of their humanity.

I guide practitioners to see this inner world as sacred ground. Here, we do not pathologize the client's language of spirit. We work towards fluency. Whether through archetype, metaphor, oracle, or prayer, we follow the soul's lead.

In this space, spiritual care becomes both explicit and implicit. Explicit in our questions: What gives your life meaning? Who or what do you turn to in times of suffering? And implicit in our presence: the silent, reverent act of holding another's story without rushing to explain or fix.



Practical Ways to Integrate Spiritual Care into Behavioral Health

Spiritual care integration is less about tools and more about stance. Still, here are practices that support this approach:

- **Contemplative presence:** Slow down. Create space for what wants to emerge.
- **Permission-based exploration:** Ask gently if the client would like to bring their spirituality into the conversation.
- **Symbolic language:** Mirror their language—whether they speak of God, universe, ancestors, or intuition.
- **Cultural humility:** Study worldviews that are not your own. Know what you don't know.
- **Use of creative tools**: Journaling, dreamwork, guided imagery, and reflective writing can serve as bridges to the sacred.
- **Supervision and peer dialogue:** Seek support when encountering unfamiliar spiritual themes. You don't have to know everything to be present.

We are living in a time when the need for spiritually integrated behavioral health is more urgent than ever. People are navigating identity, illness, grief, and transformation. They are questioning institutions and seeking meaning on their own terms. As spiritual care providers within behavioral health, we are being asked to widen our lens, to soften our edges, and to honor the soul as central to the healing process. Whether we work in a local community mental health center, employee assistance program, a hospital, or in private practice, we are called to allow the unfolding of spiritual stories that will ultimately aid in healing.

This is not about having all the answers. It is about showing up with reverence. Being willing to learn the dialect of another's sacred story. And trusting that the most powerful care we can offer is presence.

Dr. DeeAnna Merz Nagel is a licensed psychotherapist, certified coach and clinical supervisor specializing in spiritually integrated mentorship. DeeAnna received her doctoral degree in multifaith spiritual direction from SCA's Capstone University.
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LIFELORE:
MINISTERING TO NON-RELIGIOUS PATIENTS OF ALL BACKGROUNDS

By Greg Holden

What do you do after you say hello? This is the universal challenge facing all chaplains. What do you say to someone whose loved one has just died? Who is sick or dying themselves? Who may be of a different faith tradition or background than you, or who has no faith tradition? How do you provide empathy, compassion, and solace to all, regardless of who they are?

Such situations can be aided by what I call Lifelore: meaning-making through life review. It is a way of connecting to anyone regardless of their race, circumstance, religious belief, or lack thereof.

When I worked as a chaplain in palliative care at Cook County Hospital, now known as John H. Stroger Hospital of Cook County, nearly all the patients I saw were different than me in some way. Cook County is the largest hospital in the United States to serve poor and underserved people. The vast majority of patients are African American and/or Latino, and Catholic or another denomination of Christianity. As a Tibetan Buddhist, one-quarter Chinese, and from a comfortable middle-class neighborhood, I naturally wondered whether I would be accepted by the patients I saw.

It turned out that I was accepted, because people were so welcoming of spiritual support. And because, as a reporter and later a nonfiction book author, I knew the value of story.

Phyllis spent most of her adult life caring for her brother William (names changed for anonymity). William had a rare condition which caused him to stop growing. He was only the height of a young boy. He also couldn't speak but could only communicate by tapping in a code only his mother and sister could understand.

Most people with this condition—a long, complicated name I don't remember—only live to their teens or twenties. William survived four decades under his mother's and later Phyllis's devoted care. Phyllis regularly transported him to the barbershop, the store, and doctor's appointments in a toddler's stroller. People would ask if that was her son in the stroller. "No, that's my brother," she would respond.

Finally, having grown to middle age, he fell seriously ill and became our patient. Phyllis was there all the time, interpreting his anxious taps on the bedsheet, talking to the doctors. When our two lead physicians came to examine him, they both came away concerned for Phyllis's own health. In fact, they were sure she had cancer.

It took weeks to convince Phyllis that she should care for herself and get checked out. She was reluctant to leave William's side. Finally, she did go to get tested.

This might seem hard to believe, but it happened: In the morning, Phyllis was told she had cancer. Early that afternoon, William died.

Our doctor assigned me to go with her to tell Phyllis that her brother had died. I had only been on the job a couple of months. Perhaps this was some sort of test.

What to say? I only had a few moments to prepare. Phyllis was definitely not religious. She went to no church. She would not appreciate me quoting from scripture. Music is important to me, so I remembered a line from an old song called "Nature Boy":

The greatest thing you'll ever learn

Is to be loved and love in return.

I told Phyllis that her devotion to William was the highest level of human achievement: service to someone else, compassion for someone in need, and sacrifice without complaint or bitterness.

I recognized that she had likely extended her brother's life by decades. I mentioned that her mother would be proud of her, and (these words just jumped into my head without any planning) I was proud of her as well.

She seemed to have a measure of comfort, of solace, from this. Later, the family invited

me to William's memorial service, and when I arrived, they asked me to say a few words. Another impromptu talk! Once again, this was not a religious service. There was no presiding minister. Because I had been a witness to William's life and Phyllis's story, I was able help the family with a eulogy.

Lifelore is what allowed me to make these connections with Phyllis, to aid her in her grief, and to encourage her and her family.

Lifelore is similar in many ways to Dignity Therapy. Here, the emphasis is on spiritual healing and gaining a sense of self-worth and meaning which constitutes "dignity". It provides for legacies for families—tangible items that families can have to keep, such as a video, a narrative, or a recording.

"Life Review" was something that the doctors, the social worker, and the rest of us on the palliative care team routinely did. The goal is to get some background that will help with difficult discussions and decisions about life support or hospice.

Lifelore is all of the above, with an emphasis on meaning; Positivity; being heard; spiritual health. Lifelore is about story: seeing that your life story has meaning. This is brought out through patterns, critical decisions, and challenges the subject has faced.

The word "lore" in Lifelore has to do with stories that provide meaning and help people make sense of their circumstances. Lore has to do with meaning through story, with a sense of tradition, of facing challenges, much like the Hero's Journey expounded by the mythologist Joseph Campbell.

Connecting to someone through a life story can break the ice. It can comfort those who are non-religious. It is also a means to inclusion, meaning, a sense of healing, and a legacy.

You may not be able to provide legacy through a video recording or interview transcript. But patients gain a legacy when you listen and reflect back their own lives to them. This can be very helpful in times of stress. Their perspective on their own experience can shift.

At the very least, having someone listen to things that they may have kept inside and never told anyone else is valuable to the patient. It can be a load off their mind. It was often a beautiful moment for me.

In order to gather Lifelore, look for clues, such as patterns or recurrent themes in the person's narrative, pay attention to important choices the person made.

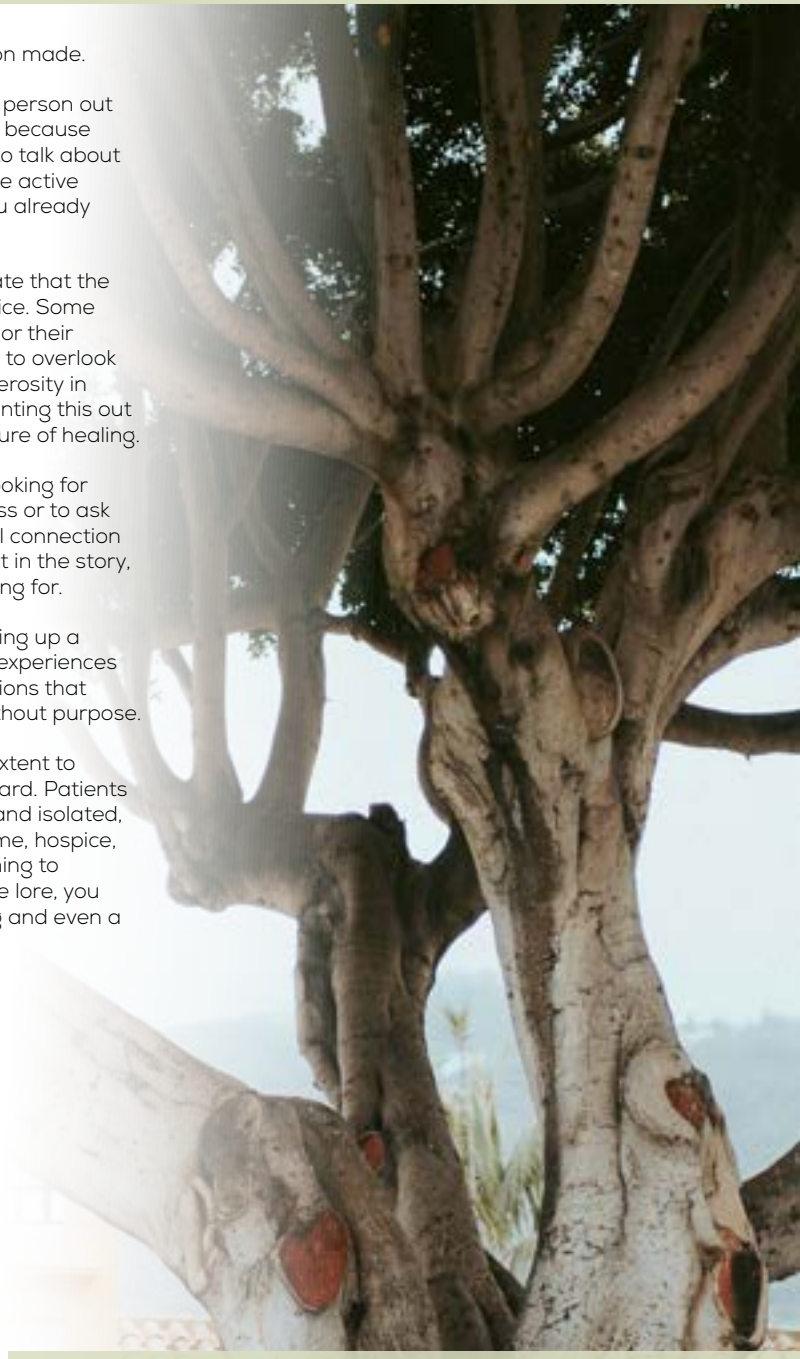
You might have to draw the person out with open-ended questions because some people are reluctant to talk about themselves. This is where the active listening techniques that you already know come in handy.

Look for things you appreciate that the individual may not even notice. Some people devalue themselves or their experiences. They may tend to overlook their own bravery, their generosity in caring for others. Simply pointing this out to people can bring a measure of healing.

Keep in mind that you are looking for story, not for spiritual distress or to ask about the person's personal connection to God. That might come out in the story, but it's not what you're looking for.

Song, poetry, or simply holding up a mirror to an individual's life experiences can bring meaning to situations that seem hopeless and lives without purpose.

Lifelore demonstrates the extent to which people need to be heard. Patients often feel alone, forgotten, and isolated, especially in the nursing home, hospice, or hospital. By actively listening to someone's life story, their life lore, you can help them find meaning and even a measure of healing.



Prior to becoming a chaplain, Greg Holden worked as a reporter, college publications editor, and freelance writer. He is the author of 40+ books on such topics as marketing, website design, and selling online that have sold 300,000+ copies. He worked as a Tibetan Buddhist chaplain in several hospices and hospitals in the Chicago area. He received his board certification in 2019. Before he retired he was the only full-time professional chaplain in John H. Stroger of Cook County, the nation's largest public hospital for the poor and underserved. He and his wife are building a house in Kentucky. You can find out more about Greg and Lifelore at gregholden.com and yourlifelore.com.

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THE ONGOING CHALLENGE OF THE MENTAL HEALTH MODALITIES TO SPIRITUAL CARE: BEHAVIORISM AND BEYOND.

By Sean J. LaBat, Ph.D., BCC-MI

Anton Boisen's first effort in clinical pastoral training started 101 years ago, this summer, in Massachusetts. From the beginning, Sigmund Freud's psychodynamic approach has heavily influenced professional chaplaincy and spiritual care. The fields of spiritual and mental health care owe this approach a great debt. Looking to the future of the field, we need ongoing critical consideration of how psychodynamics continues to inform our fields and how we can continue to learn from it while growing into new directions. How can we best meld spiritual care with the closely allied field of mental health?

HealthCare Chaplaincy Network and Spiritual Care Association (2025) added to this discussion in their recent white paper *Psychodynamic Chaplaincy: Psychological and Spiritual Integration in Healthcare*. Perhaps it is best to start with a basic definition of 'psychodynamics,' a word sometimes misunderstood in chaplaincy circles. Nichols and Davis (2021) define psychodynamics as a means of understanding self and others. Psychodynamics is concerned with one's unconscious impulses, the unconscious's defenses of the self, and how those defenses impact our relationships. Uncovering and understanding these defenses is critical to mental (and spiritual) health (pp. 134-135). Psychodynamic Chaplaincy serves as a helpful reminder of the influence of psychodynamics on the development of professional chaplaincy with its effort to no longer be "uninformed and siloed" in its interactions with patients, clients, and the broader therapeutic team (p. 5).

The incorporation of psychodynamics into professional chaplaincy is part of chaplaincy's effort (especially in health care settings) to be an integrated part of the care team.

Psychodynamic Chaplaincy also implies directions for ongoing development in chaplaincy and spiritual care's dialogue with the mental health modalities. The current challenge is in how to inform and train spiritual care leaders in how to effectively interact with the mental health community – and to use and meld mental health modalities with their own spiritual care skills and practices.

For this dialogue and partnership to be truly effective, however, it will be critical to take seriously Professional Chaplaincy's invitation to the "most current advances" in mental health modalities that are informed by psychodynamics and yet move beyond them (p. 6). Fleenor et al. (2025) points to the need for chaplains to be better trained in counseling patients who are not of their own faith tradition and to be better informed in the methods of the interdisciplinary team. A knowledge of psychodynamics fulfills part of this expectation. Norcross, et al. (2022), however, points to the decreasing influence of psychoanalysis and gestalt (heavily influential upon chaplaincy practice) therapies in the mental health world and the growing influence of multiculturalism, mindfulness, and Cognitive Behavioral modalities.

Likely associated with declining demand for it, a significant problem with psychodynamics resides in its practical application. As Tan (2022) demonstrates, traditional psychoanalysis, while a rich and deep modality, is also lengthy and expensive and does not lend itself to testable hypotheses (p. 55). In other words, how do I do psychodynamically-informed chaplaincy, and how do I know if it works? The application of spiritual care is especially important in the present when chaplain contacts are often brief and our clients often lack the background in a religious tradition or community that created a common point of reference between chaplain and client.

Post World War II, the mental health world turned more pointedly toward the issue of method efficacy. B.F. Skinner's radical behaviorism emerged as one of the first major departures from psychoanalytics. While there is no one single 'founder' of behaviorism, Bowen et al. (2021) assert that behaviorism, and early behaviorism especially, saw human behavior explained through learned associations between a stimulus and a response. Many chaplains, and mental health professionals for that matter, may have a strong (and negative) reaction to images of trained rats and dogs which they associate with classical behaviorist experimentation. However, even the early behaviorists, like Skinner, acknowledged the critical role of verbal, inner, operant behavior on the human condition and that these inner states are formed by external experience and must be subject to objective testing. In other words, we need to try very hard to assess if our methods do indeed 'work' (p. 282).



Thus, a critical difference between psychodynamics and behaviorism (and behaviorism's theoretical offspring) is psychodynamics' trend toward surfacing deeply imbedded inner dynamics with the aim of gaining self-knowledge, versus behaviorism's focus on identifying and modifying external, but often internalized, influences and changing objective behaviors (these behaviors can be either performative or cognitive).

Albert Bandura was an early cultivator of behaviorism as a cognitive, internal event. His study of social learning in the 'Bobo Doll' experiment showed how children learn antisocial as well as prosocial behaviors through observation. As people build expectations from their observations and experiences, they tend to act accordingly. He showed a connection between inner states and external stimuli (Marcelo and Yates, 2020, p. 1005). While the self-knowledge sought in psychodynamics (and in chaplain clinical training) is necessary, it is not sufficient. The behaviorist schools implore us toward building objective, observable experience. If I do not see and experience kindness done, self-knowledge alone will not likely give it to me.

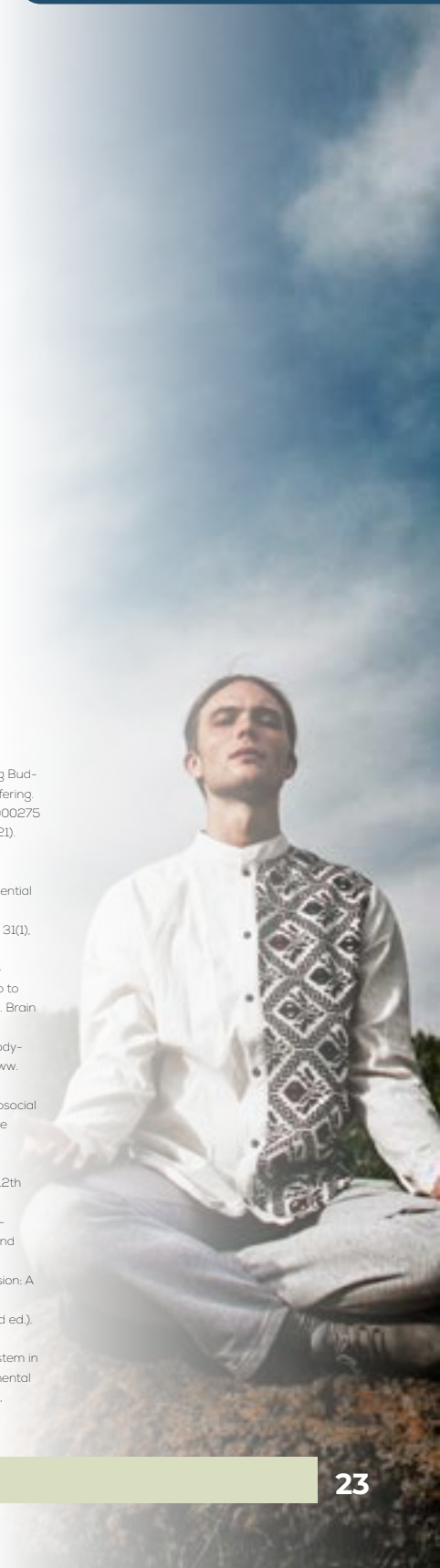
The behaviorist schools have refined their practices since the 1950s and 1960s. Albert Ellis' Rational Emotive Behavior Therapy (REBT) explores the roles of deeply embedded irrational belief (such as catastrophizing, black and white thinking, etc) on our actions and our feelings. Irrational thinking lies behind many miserable feelings and antisocial behaviors (Grove et al., 2024). In this case the behavior to be addressed is dysfunctional thinking. Many of REBT's insights are also incorporated into Aaron Beck's Cognitive Behavioral Therapy (CBT) which incorporates many of Ellis' insights while exploring deeply ingrained core beliefs, usually centering on a person's lovability and self-efficacy (Beck, 2021). Many of CBT's insights have been expanded to incorporate a client's specific spirituality and religious beliefs to build functional and prosocial self-identity and outward behavior (Pearce, 2016).

A likely source of chaplain suspicion of mental health (and especially behaviorist) modalities likely resides in the stereotype of the cold 'lab-coat' clinician running impersonal experiments on clients with whom they have no relationship and toward whom they demonstrate no warmth. However, a critical aspect of behaviorist practice, even as far back as Skinner, is in building of kind regard for one's client. Prior to discussing treatment techniques, Beck (2021), in her CBT manual, spends an entire chapter discussing the client relationship as a foundation and prerequisite for treatment progress (p. 56).

Mental health professions and chaplains are increasingly challenged by limited finances and increasing pressure to show 'results' in limited time. Solution-Focused Brief Therapy (SFBT) is particularly concerned by how to help our client when we may have only a few (perhaps only one) short meetings with them (de Shazer et al., 2021). This should be a concern familiar to almost all chaplains. Without delving into specifics outside the scope of this short article, SFBT focuses us on client strengths and what is going well in our clients' lives, and then building upon that identified progress. An additional helpful perspective offered in SFBT (and at very least implied in CBT) is reframing 'resistances' which are often a major focus of psychodynamics and chaplain training. Aggressively attacking client 'resistance' – a clinical pastoral training staple, usually only reinforces dysfunctional behavior. SFBT and the behaviorist approaches invite us to put ourselves in our client's place. If I do not experience kindness and forbearance coupled with patient, curious, and kind questioning about the practical results of my dysfunctions, how can my behaviors and experiences be expected to change for the better? This does not mean giving dysfunction a 'free pass.' It does propose a change in methods regarding bringing dysfunction to light and inviting the possibility of change in more functional directions (for both chaplain educators and trainee chaplains).

In summation, my intended response to Psychodynamic Chaplaincy is commendation and challenge. The legacy of Sigmund Freud, Carl Jung, Alfred Adler, and the psychodynamic inheritance is an indelible part of both mental health as well as professional chaplaincy practice. We always benefit from a deep and serious exploration of how psychodynamics informs us. Yet, chaplaincy, and especially those of us who work closely with psychiatrists, psychologists, social workers, and mental health counselors, need to be deeply informed in the behaviorist, cognitive, and solution-focused modalities (among others) current in the mental health world.

Sean J. LaBat – Is a clinical chaplain at Central Virginia VA Health Care System in Richmond, Virginia. His main clinical areas are in substance use disorder, mental health, and traumatology chaplaincy. He authored Anton Boisen: Madness, Mysticism, and the Origins of Clinical Pastoral Education, 2021.



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DANTE'S STARS IN THE WILDERNESS:

SPIRITUAL CARE AT THE BEDSIDE

By Hyewon Kim

"I think I've lost my way."

Mr. S, a man in his late 50s hospitalized with advanced pancreatic cancer, spoke these words quietly, almost apologetically. Despite months of aggressive treatment, his illness had progressed. Earlier that week, the medical team had gently shifted care from cure to comfort. Since then, nurses noticed he spoke less, spent long stretches staring at the ceiling, and responded politely but briefly to visitors.

When I introduced myself as the chaplain and asked how he was feeling, he paused before answering.

"It's not fear," he said softly. "It's like… I can't tell where I am. I feel like I'm in the wilderness. I don't know which way to go."

His words did not carry panic but a quiet disorientation. The story he had been living—plans, expectations, the assumed movement of time—had suddenly stopped making sense. Illness disrupted not only his body but also his internal map of life.

After a moment, he added, almost thoughtfully, "Everyone keeps explaining things like the treatments, the next steps… but inside it feels like I missed a turn somewhere."

I nodded. "Like the world is still moving, but you're no longer sure where you stand in it."

He looked relieved at the phrasing. "Yes. Exactly."

We sat together quietly. The hum of monitors and the soft shuffle of nurses outside became the backdrop to our conversation. Afternoon light filtered through the blinds, casting long horizontal shadows across the wall.

After a long pause, I asked gently, "Have you had moments when darkness didn't feel so overwhelming?"

He thought for a while before answering.

"Years ago," he said slowly, "I used to go fishing at night. Just me and a friend." His voice softened as he spoke. "Out there it was completely dark. At first, it felt unsettling. But once your eyes adjusted, you'd start noticing things. The water moving, the wind, and then the stars."

He smiled faintly.

"The stars helped me know where I was."

"What was it like to look up at them?" I asked.

He considered the question. "Peaceful. Like things were bigger than whatever I was worried about. You didn't feel lost anymore."

In that memory, disorientation was temporary; the stars functioned as orientation points. His recollection revealed that even amid uncertainty, humans carry internal maps shaped by moments of meaning.

We spoke for several minutes about those nights: the smell of the lake, the quiet conversations, the rhythm of casting and waiting. As he described them, his breathing slowed. The hospital room seemed less confined, as though memory had opened a wider horizon.

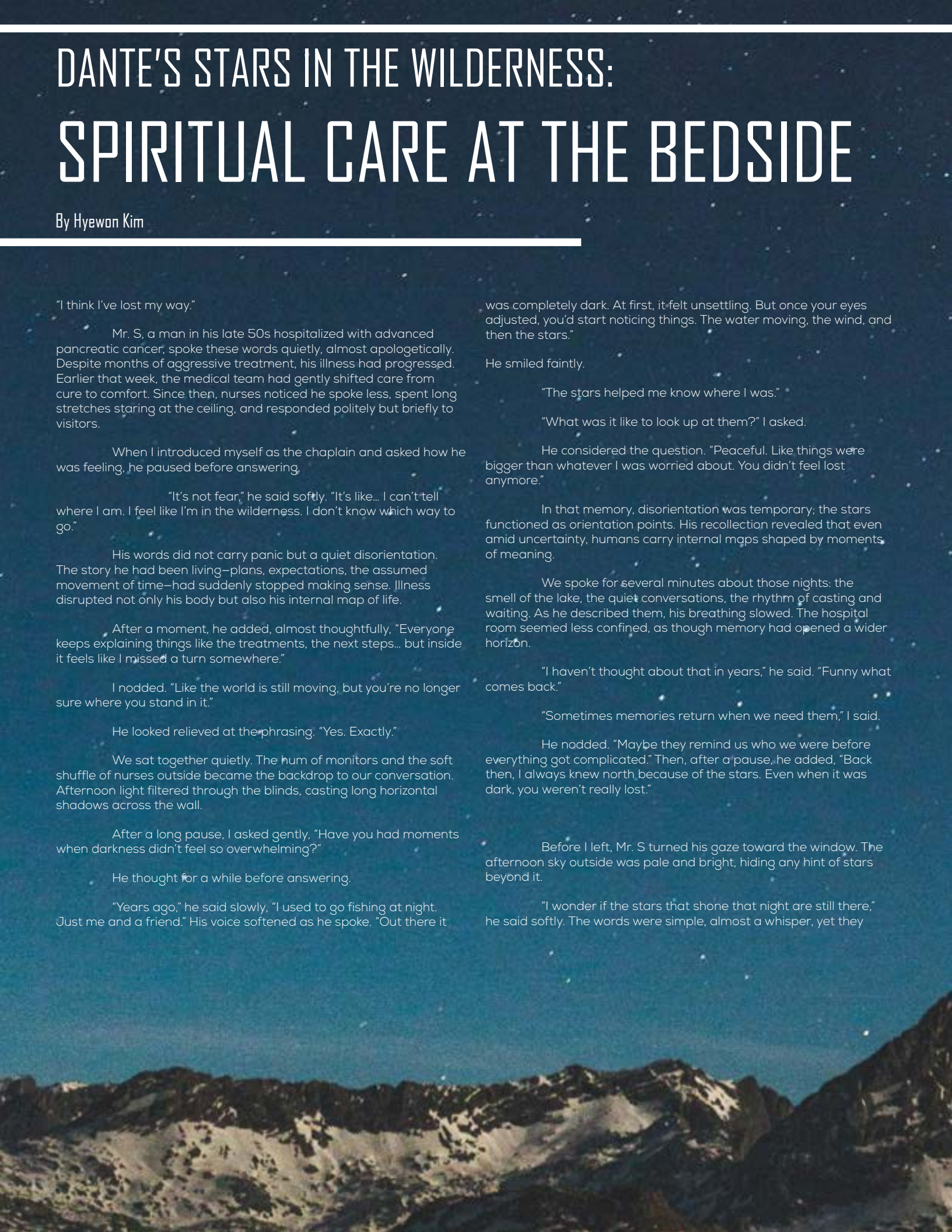
"I haven't thought about that in years," he said. "Funny what comes back."

"Sometimes memories return when we need them," I said.

He nodded. "Maybe they remind us who we were before everything got complicated." Then, after a pause, he added, "Back then, I always knew north because of the stars. Even when it was dark, you weren't really lost."

Before I left, Mr. S turned his gaze toward the window. The afternoon sky outside was pale and bright, hiding any hint of stars beyond it.

"I wonder if the stars that shone that night are still there," he said softly. The words were simple, almost a whisper, yet they



suggested the beginning of a turn towards meaning-making, towards orientation. In spiritual care, hope rarely arrives as certainty.

After our visit, I found myself thinking of Dante Alighieri's Divine Comedy, which begins "in the middle of life's journey" with the poet awakening in a dark forest, having lost the straight path. Like Mr. S, Dante feels confusion and fear in a landscape without familiar markers of direction. Both Mr. S and Dante are travelers who must learn to orient themselves differently.

Korean pastor and writer Kim Gi-seok interprets Dante's forest as a metaphor for modern spiritual life. The forest represents a life that has lost direction, wandering reflects seasons of spiritual silence, guides appear through relationships and grace, and stars symbolize a hope that coexists with darkness. Though the stars cannot escape the darkness surrounding them, the darkness also cannot overwhelm the stars. Dante's journey through hell ultimately ends with a quiet line: emerging once more to see the stars. The stars do not erase suffering. But they can restore direction.

In Mr. S's story, memory itself became such a guide.

Orientation in Spiritual Care

Spiritual distress is often associated with fear, guilt, or theological struggle. Yet in clinical settings it frequently appears as disorientation—the loss of narrative continuity. Serious illness interrupts the assumed future, leaving patients unsure where they stand in their own lives.

Chaplains help restore orientation by accompanying patients as they rediscover meaning already present within them: relationships, memories, values, and spiritual anchors that illness cannot remove. During my conversation with Mr. S, I did very little outwardly. I listened, reflected, and allowed silence to do its work. Yet something shifted. The wilderness of illness remained, but it no longer felt endless. Spiritual care works quietly, often invisibly. Chaplains may not change diagnoses or outcomes, but they create spaces where patients reconnect with identity and meaning.

As I reflected later, Mr. S's question lingered with me:

"I wonder if the stars… are still there."

The question itself became a form of hope. It suggested that even within the wilderness of illness, he sensed the possibility of guidance beyond what he could presently see.

Dante's journey ends beneath the stars, not because darkness vanished, but because vision changed. Likewise, Mr. S remained within the uncertainty of serious illness, yet he had begun to remember that orientation was still possible.

The wilderness remained.

But so did the sky above it.

And sometimes, in the quiet work of chaplaincy, that is enough.

Hyewon Kim is a Board Certified Chaplain (BCCI, an affiliate of the Association of Professional Chaplains) serving patients and families at JPS Health Network. With a focus on bedside spiritual care, she explores the intersections of faith, narrative, and human resilience. She writes about spiritual accompaniment, hope, and orientation in times of illness and uncertainty.

Chaplain Masterclass

Spiritual Care Association

In an effort to assist chaplains to be at their very best, the Spiritual Care Association has started the Chaplain's Masterclass. These classes, presented by experts in the field, address everyday topics and also some extraordinary topics that spiritual care providers see in their everyday roles. Though the focus of these classes is on the chaplain, anyone who is interested in spiritual care and providing the best spiritual care would benefit from attending. All are welcome.

There is no fee for these sessions, but pre-registration is required. Chaplains certified by SCA can claim these sessions as part of their continuing education requirement.

The Spiritual Care Association hopes that together with the curriculum that it has built, these resources will serve as a vehicle to impact patients and staff.



www.ChaplainMasterClass.org

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