Teaching Spiritual Care:
Core or Elective Competence for our Graduates?

Carol Taylor, PhD, MSN, RN
Georgetown University Center for Clinical Bioethics
Washington, DC
taylorcr@georgetown.edu

What does it mean to be a healing presence in today’s society? How many of us as chaplains, pastoral caregivers, educators, health care professionals, office workers or public servants would use the term “healer” to describe ourselves? To what degree do we value our vocations to heal people and cultures? To what degree do our lifestyles support this vocation?

Come to this session and be guided gently into reflection and conversation about the importance of our each being a healing presence. These are hard times for many… are we a positive force oriented to people and their well-being? Are we dedicating time and space to reflect on how we influence others. At the end of the day are people better or worse for having experienced us? Join others as we probe these questions and learn practical strategies for responding to the spiritual needs and hungers of those around us.

Part I – Holistic Health, Healing and Spirituality

There are three universal spiritual needs: meaning and purpose, love and belonging, and forgiveness. Learn how the people we meet every day express these needs and how we can offer helpful spiritual care.

Objectives:
At the conclusion of this session participants will be able to:
1. Identify three universal spiritual needs.
2. Define spirituality, healing, and spiritual care
3. Describe spiritual care and related professional responsibilities.
4. Critique institutional cultures in light of their capacity to promote spiritual care

I. Holistic Health

A. The Theory Practice Gap and the Limits of the Bio-Psycho-Social Model of Health

B. Spirituality
Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. 


In the words of theologian Karl Rahner, spirituality is . . . simply the ultimate depth of everything spiritual creatures do when they realize themselves—when they laugh or cry, accept responsibility, love, live and die, stand up for truth, break out of preoccupation with themselves to help the neighbor, hope against hope, cheerfully refuse to be embittered by the stupidity of daily life, keep silent, not so that evil festers in their hearts, but so that it dies there—when, in a word, they live as they would like to live in opposition to selfishness and to the despair that always assails us (1971, p. 229).

**C. Universal Spiritual Needs**

1. According to Fish and Shelly (1978) there are three spiritual needs underlying all religious traditions and common to all people: (1) need for meaning and purpose, (2) need for love and relatedness, and (3) need for forgiveness

**D. Spirituality and Everyday Living**

Spiritual beliefs and practices are associated with all aspects of a person’s life, including health and illness. According to Quinn the major wisdom traditions address the invisible Spirit—a creative, mysterious, guiding power—by creating principles and practices that:

- Cultivate love of ourselves, our neighbors, of God, and of nature.
- Cultivate wisdom that helps us find meaning in life, be in relationship with others, be true to ourselves, live in uncertainty and mystery, deal with suffering, sickness, and death, honor life’s transitions, like birth, marriage, and death.
- Cultivate awareness of the sacred dimension of life through practices like worship, prayer, meditation, and singing.
- Respect our connectedness as fellow human beings while acknowledging our differences.
- Help us be generous in service to others (2003, pp. 13-14).


**E. Spirituality, Health, and Illness**

Spiritual beliefs are of special importance to clinicians because of the many ways they can influence an individual's state of health and self-care behaviors: (1) daily living habits, (2) source of support, (3) source of strength and healing, (4) source of conflict
II. Spiritual Care

Care that enables individuals to meet basic spiritual needs: (1) need for meaning and purpose, (2) need for love and relatedness, and (3) need for forgiveness.

Spiritual care models offer a framework for health care professionals to connect with their patients; listen to their fears, dreams and pain; collaborate with their patients as partners in their care; and provide, through the therapeutic relationship, an opportunity for healing. Healing is distinguished from cure in this context. It refers to the ability of a person to find solace, comfort, connection, meaning, and purpose in the midst of suffering, disarray, and pain. The care is rooted in spirituality using compassion, hopefulness, and the recognition that, although a person’s life may be limited or no longer socially productive, it remains full of possibility. [Puchalski, C., Ferrell, B., et. al. (2009). Improving the quality of spiritual care as a dimension of palliative care: The report of the consensus conference. *Journal of Palliative Medicine, 12*(10), 890.]

National Guidelines Now Mandate Spiritual Care

Recent research finding: Many advanced cancer patients’ spiritual needs are not supported by religious communities (47%) or the medical system (72%) and spiritual support is associated with better quality of life (Balboni, et al., 2007).

II. Spiritual Care Implementation Model

**ASSESSING SPIRITUAL NEEDS**

**History**

Because a person’s spirituality and religious beliefs have the potential to influence every aspect of being, an assessment of spiritual needs should be included in each comprehensive health history. Numerous assessment guides are now in the literature.

**Maugens’ (1996) SPIRIT mnemonic highlights important areas to be covered.**

**S**—Spiritual belief system

- What is your formal religious affiliation?
- Name and describe your spiritual belief system.

**P**—Personal spirituality

- Describe the beliefs and practices of your religion or personal belief system
- Describe the beliefs or practices you do not accept.
- What does your spirituality mean to you?
- What is the importance of spirituality/religion in daily life?
I—Integration

- Do you belong to a spiritual/religious group or community? What is your role or position?
- What importance does this group have to you? Is it a source of support? In what ways?
- Does or could this group provide help in dealing with health issues?

R—Ritualized practices and restrictions

- Are there specific practices that you carry out as part of your religion/spirituality?
- Are there certain lifestyle activities or practices that your religion/spirituality encourages or forbids? Do you comply? What significance do these practices have for you?
- Are there specific elements of medical care that are forbidden on the basis of religious grounds?

I—Implications for care

- What aspects of your religion/spirituality would you like me to keep in mind as I care for you?
- Would you like to discuss religious or spiritual implications of healthcare?
- What knowledge or understanding would strengthen our relationship as caregiver and client?
- Are there any barriers to our relationship based on religious or spiritual issues?

T—Terminal events planning

- As we plan for end-of-life care, how does your faith affect your decisions?
- Are there particular aspects of care that you wish to forgo or have withheld because of your faith?

A simpler guide is Anandarajah and Hight’s (2001) HOPE acronym:

- **H**—Sources of hope, meaning, comfort, strength, peace, love, and connection
- **O**—Organized religion
- **P**—Personal spirituality and practice
- **E**—Effects on medical care and end-of-life issues

The following questions are from O’Brien’s (1982) Spiritual Assessment Guide:

**Spiritual pain:** Do you ever feel hurt or pain associated with the spiritual or religious beliefs that you hold? Do you feel pain related to uncertainty or nonbelief?

**Spiritual alienation:** Do you frequently feel far away from God? Does it seem that he is remote and far removed from your everyday life?

**Spiritual anxiety:** Are you afraid that God might not take care of your needs? That he might not be there when you need him?

**Spiritual guilt:** Have you ever done things that God would be angry at you for? Are you feeling badly about things that you have done or failed to do in your life?
**Spiritual anger:** Are you angry at God for allowing you to be ill? Do you ever feel like blaming God for your illness? Do you think God is unfair to you?

**Spiritual loss:** Do you ever feel that you have lost God’s love? That you have broken or weakened your relationship with God? Has God turned his back on you?

**Spiritual despair:** Do you ever feel that there is no hope of having God’s love? Of pleasing him? That God does not love you anymore? (p. 102)

If someone shares a spiritual problem, remember to use interview questions to determine the specific nature of the problem, its probable causes, related signs and symptoms, when it first began and how often it occurs, how it affects everyday living, the severity of the problem and whether it can be treated independently by nursing or needs to be referred, and how well the individual/family is coping with the problem.

**DIAGNOSING**

When assessment data point to a spiritual problem, it receives the label **Spiritual Distress**. This may be further specified as spiritual pain, alienation, anxiety, guilt, anger, loss, or despair (O’Brien, 1982). Common etiologies for spiritual distress include inability to reconcile current life situation (e.g., illness, death of loved person, divorce) with spiritual beliefs (“God is all-powerful, all-loving, all-wise and he cares about me”) or separation from or rejection of the religious community or supports.

**PLANNING: EXPECTED OUTCOMES**

**HEALERS** who are sensitive to the role spiritual beliefs play in influencing both a person’s thoughts about self and the world and interactions with the world value **spiritual health**. Their interactions with any patient who values spirituality are supportive of the following goals/outcomes. The patient/family will:

- Identify spiritual beliefs that meet needs for meaning and purpose, love and relatedness, and forgiveness
- Derive from these beliefs strength, hope, and comfort when facing the challenge of illness, injury, or other life crisis
- Develop spiritual practices that nurture communion with inner self, with God, and with the world
- Express satisfaction with the compatibility of spiritual beliefs and everyday living.

Goals/expected outcomes for individuals experiencing spiritual distress need to be individualized and may include some of the following. The patient/family will:

- Explore the origin of spiritual beliefs and practices
- Identify factors in life that challenge spiritual beliefs
- Explore alternatives given these challenges: deny, modify, or reaffirm beliefs; develop new beliefs
- Identify spiritual supports (e.g., spiritual reading, faith, community)
- Report or demonstrate a decrease in spiritual distress following successful
IMPLEMENTING

There are a variety of interventions available to the HEALER who wishes to help others meet spiritual needs. Like other clinical skills, these interventions need to be practiced before the HEALER is able to use them confidently, competently, and at the right moment. Specific interventions include: offering supportive presence, facilitating the practice of religion, nurturing spirituality, praying with patients and others, responding to human suffering and engendering hope, spiritual counseling, contacting a spiritual counselor, and resolving conflicts between treatment and spiritual beliefs.

1. **Offering Supportive Presence.**

   *When you made a cross on my forehead with your thumb, it felt very foreign to me. No one has ever done that before. It felt unfamiliar—but perfect. Like a blessing with no conditions—no strings. How liberating. Affirming. Loving. And to think you did it with just your thumb. And your heart. Thank you.*

   Human Caring Facilitates Healing. We care first and primarily by being present to others in a manner that is compassionate, affirming, and healing.

2. **Person-Centered Communication:** Listening to the individual’s fears, hopes, pain, dreams

3. **Facilitating the Practice of Religion**

   The following are means the HEALER can use to help patients continue normal spiritual practices when homebound or in the unfamiliar environment of the hospital or care center:
   - Familiarize the patient/family with religious services and resources available within the institution—or available to homebound individuals
   - Respect the need for privacy or quiet during periods of prayer (this may entail teaching others about the importance of respecting this need)
   - Assist to obtain devotional objects and protect them from loss or damage.
   - Arrange to receive the sacraments
   - Attempt to meet religious dietary restrictions.
   - Arrange for the local minister, priest, or rabbi to visit if this is desired and possible, or a chaplain or pastoral care worker

   If the patient or family has a conflict between their spiritual beliefs and the proposed medical therapy, the HEALER can assist them in discussing this with the physician. In extreme cases and ethics consultation may be needed to help resolve ethical conflict.

4. **Nurturing Spirituality**

   Some who experience a need to get in touch with their spiritual self and to nurture their spiritual development may look to the HEALER for direction. The person...
who lives life enmeshed in the action and noises of society may feel strangely uncomfortable when illness forces solitude and self-introspection. The HEALER can be helpful in recommending means to develop a relationship with one’s inner world and manifest spiritual energy in one’s outer world. Hill & Smith (1990) identify the following ways to develop one’s inner world and to manifest this energy to the outside world.

Ways to develop a relationship with one’s inner world
- Prayer
- reflection or “quiet listening to one’s essence
- communion with nature through walks in the park, woods, beach
- enjoyment of music, drama, art, dance
- inner dialogue with oneself or with God
- dream analysis
- spiritual direction

Ways to manifest spiritual energy to one’s outer world
- loving relationships with others
- service to others in need
- forgiveness of others
- empathy, compassion, and hope
- laughter, joyous expression
- participation in church services and activities and social gatherings

2. **Praying With Others**

3. **Responding to Human Suffering and Engendering Hope** -- to be addressed after lunch.

III. **Healing vs Curing**

**The difference between “healing” and “curing”**

*Curing*: the alleviation of symptoms or the termination or suppression of a disease process through surgical, chemical or mechanical intervention

*Healing*: may be spontaneous but more often it’s a gradual awakening to a deeper sense of self (and of the self in relation to others) in a way that effects profound change. Healing comes from within and is consistent with a person’s own readiness to grow and to change. A healing attitude is “a belief system that recognizes that all of life’s experiences, including injury, illness, and other setbacks, provides us with opportunities to learn and to grow toward that we are meant to be. Seen in this light, disease is not an enemy but a teacher and motivation. Disease is manifesting, in a physical way, the desire or need of the psyche to reestablish balance and integration through a change of direction in one’s lifestyle, behavior, or attitudes.” [McGlone, M.E. (1990). Healing the spirit. *Holis Nurs Pract*, 4(4), 77-84.]
Healing is the integration of self. People move from a sense of brokenness to a sense of wholeness. C. Puchalski

Healing Testimonies:
Seven years ago I was faced with three life-threatening events in a period of three years. Those life-threatening experiences taught me that it is possible to “heal” and to live fully even when we are in the abyss of suffering. I believe everyone would benefit if we redefined “healing.” Here are elements I now include in my definition.

HEALING IS:

♦ Becoming whole, a life-long journey of becoming fully human, involving the totality of our being: body, mind, emotion, spirit, social and political context, as well as our relationships with others and with the Divine. Healing does not necessarily mean being happy or getting what we think we want out of life; it means growth, often with pain.

♦ Becoming our authentic self, releasing old unreal self-images, discovering who we really are, not what we think we should be, knowing why we are here and what we really value, restoring our ability to heed our aspirations.

♦ Reconnecting lost aspects of ourselves, paying attention to buried feelings and places inside us that are distressed or sick, enabling us to express our self in fullness, both the light and shadow sides.

♦ Being open to change and new possibilities; responding to problems by changing the picture; being willing to let in more life, to open up to what may have been previously closed or destroyed for us and that which holds promise of giving us new life and fulfillment.

♦ Facing our fears and refusing to be injured or wounded; changing our belief systems; breaking unnecessary taboos; letting go of what is familiar, and stepping into the unknown.

♦ Accepting that problems, pain, and suffering are part of life and inseparable from us – not a peripheral relationship, not something isolated and avoidable – enabling us to enter into problems and use suffering, pain, and life-threatening events to enrich our lives.

♦ Being empowered by the Divine; discovering meaning in our defects, disorders, problems, and disease; experiencing new degrees of creativity and life forces that we might never have imagined before our difficulty; finding that our pains and fears are transformed into relief and confidence.

♦ Recognizing the value and preciousness of life, knowing that every moment is unique and significant, which usually leads to greater appreciation of the wonder of our minds, bodies, and spirits and of the Divine.

♦ Having faith and hope – important preconditions for mental and physical health; having a belief in the Divine, the meaning of human life, and the universe; helping us to claim our capacity to create and make something new.

♦ Finding inner peace, contentment, and tranquility amid the realities of daily life, including its problems, changes, and chaos; experiencing a sense of fullness that makes the burdens of pain or illness lighter.
♦ Being forgiving of ourselves and others and being forgiven; giving ourselves and others the freedom to let go of rivalry, strife, anger, hated, fear and limitations.
♦ Feeling connected to one another, a sense of interdependence; knowing we are not isolated or autonomous, giving up the illusions of boundaries in life; taking responsibility, acting justly, and accepting that we share our humanity.
♦ Being loving and loved; loving one’s self and wanting to love and serve others, as well as being capable of receiving love; having an ability to trust, a feeling of aliveness, and a sense of greater participation in life.


**Our vocation to heal people and cultures:**

**Reflection and Discussion**

What are the challenges in being a healing presence in today’s world?
Acknowledging these challenges, what sources of hope and strength do you find most helpful?
What are your “take aways” from this session?

**References**
Part II: Becoming a healing presence

In every human interaction what we offer first is ourselves, our presence. Is the presence we offer healing, neutral, or toxic? Being a healing presence doesn’t just happen because we desire to be healers and it isn’t determined by genetics, like having blue or brown eyes. We have to intend to be healing presences and then cultivate this ability. Learn the steps to becoming a healing presence.

Objectives:
At the conclusion of this session participants will be able to:
1. Define healing presence
2. Describe the process of becoming a healing presence
3. Value self as a healing presence and recommit to the ministry of presence.
4. Evaluate the adequacy of one’s self care and care for one’s team

Healing presence is the condition of being consciously and compassionately in the present moment with another or with others, believing in and affirming their potential for wholeness, wherever they are in life.

Developing Healing Presence

Steps for Being a Healing Presence
Inasmuch as it’s more art than science, you’ll have your own ways of bringing healing presence into your life and the lives of others. Following is a rough order for how you might proceed. (Miller, E.J. & Cutshall, S.C. 2001. The art of being a healing presence. A guide for those in caring relationships. Willogreen Publishing.)

1. Open Yourself

Begin not with the other person but with you. Become present to yourself in a way that is honest, insightful, and accepting. Open to your uniqueness, humanness, prejudices, brokenness, and wholeness. Do this by owning your life story, continually fathoming who you are in a holistic manner, and developing or utilizing a support system to which you hold yourself accountable.

2. Intend to Be a Healing Presence

Aware that healing presence doesn’t just occur out of the blue, you intentionally decide to be such a presence with another. Intend to promote healing in its many forms, while being understanding of yourself as you emerge in the day-to-day intricacies of this practice.

3. Prepare a Space for Healing Presence to Take Place
Clear a space to interact with the other or others, assuring as much privacy as possible and creating an atmosphere of calm. Prepare a space also within by placing yourself out of the way and clearing away your personal expectations for what the other should be or do.

4. **Honor the One in Your Care.**

Approach those you accompany as people with dignity and worth. Show your regard for them by honoring their individuality, equality humanness, separateness, and sacredness. Respect their natural and unique healing capacity.

5. **Offer What You Have to Give**

Freely and simply make available what you have to offer realizing it’s up to the other or others to accept or not. Offer presence, loving acceptance, empathy, dependability, an unselfish focus on them, your firm belief in them, your willingness to follow their lead, and, as much as anything, hope.

6. **Receive the Gifts that Come**

Accept with a grateful heart what is yours to receive. This may include living your life more fully as a result of this practice. Other gifts may include uncovering your genuine self, enjoying wonderful relationships, finding personal satisfaction, realizing you have made a difference, receiving your own healing, and exploring some of life’s most valuable lessons.

7. **Live a Life of Wholeness and Balance**

There is more to life than being a healing presence. So live your days fully, caring for your own needs, setting appropriate boundaries, encouraging your own growth, and nurturing a loving attitude toward life, including the sacred dimension. Affirm and live out the truth of the transforming potential of healing presence. Be grateful for the possibilities.

****************************************

**Living a Lifestyle that Supports Spiritual Care**

We cannot give what we don’t have. Unless our own needs are met we will never be able to be truly present to another. Thus the art of being a healing presence requires a lifestyle that supports this.

*A happy heart is like good medicine. But a broken spirit drains your strength* (A happy heart is like good medicine. But a broken spirit drains your strength (dries your bones).  
*Pr: 17.22*
A personal narrative from a physician chaplain: Preparing One’s Attention and Intention

I now appreciate that the most important thing I bring to each bedside encounter is myself, and how my presence comforts and heals.22,23 Before visiting a patient, I stop to prepare two things, my attention and intention. This is something I teach to all my students. This allows for greater connection and meaning. It also can open us to the sacred. It applies whether one is providing routine medical treatment or spiritual care.

There are many ways different people prepare their attention and intention. I have developed a simple ritual for myself. Before I enter my patient’s room, I stop. While washing (or gelling) my hands, I prepare my attention. I bring my awareness to my feet on the ground, then to my breath, and to the flow of water (or gel) over my hands, as if they are washing aside (evaporating away) my preoccupations, leaving only my best intentions. I make a blessing before I dry my hands (or as my hands are drying): I lift up my hands. May I be of service. Then I take a full breath and remind myself: What matters for you, my patient, is what matters for me. May I meet you in your world as it is for you and accompany you from there. Whatever time I have with you, may I be fully present. May I serve you with all of my life experience as well as my expertise? May I listen fully with a generous heart, without judgment, and without having to fix what cannot be fixed. May my presence allow you to connect with your source of comfort, strength, and guidance as it is for you. May I be well used. Before entering the room, I stop again, take another full breath to keep my focus, and then I knock. When I enter, I scan the room, “touch” the patient with my eyes, then with my voice, and then, as appropriate, with my hand. I cannot know who and what I will encounter when I enter the room. What stories, what emotions, will I even be welcome? I do know that my preparation can facilitate meaningful connection. It also can open the way to what may normally be unseen, which can announce itself to any of us at unexpected times, in unexpected ways, with unexplainable, sometimes extraordinary, moments of awe. Such moments can help sustain one through challenging times.

A plan for personal development that includes spiritual development:

**PISCES Scales (Physical, Intellectual, Spiritual, Emotional, Social)**

After thinking about your life (review the sample behaviors listed), mark X to indicate your place on the continuum.

<table>
<thead>
<tr>
<th>I do nothing for my physical self</th>
<th>I do all I can for my physical self</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples:</strong> exercise regularly; eat healthy diet; maintain appropriate weight; take necessary medications; don’t smoke; get sufficient sleep</td>
<td><strong>One action I will take for my physical self:</strong></td>
</tr>
<tr>
<td>I do nothing for my intellectual self.</td>
<td>I do all I can for my intellectual self</td>
</tr>
</tbody>
</table>
**Examples:** read, attend professional development events; take a class for business or pleasure; develop a new skill; work crossword puzzles play bridge

I do nothing for my spiritual self

One action I will take for my intellectual self:

I do all I can for my spiritual self

**Examples:** attend worship services weekly; pray daily or nightly; meditate, appreciate the beauty of nature; read poetry and inspirational writings; spend time in reflection; keep a journal

I do nothing for my emotional self

One action I will take for my spiritual self:

I do all I can for my emotional self

**Examples:** laugh a lot; share feelings with a loved one, trusted friend, counselor; keep a journal or diary of feelings; allow myself to cry; allow myself to get angry; understand all my feelings as real; use tools that give me information about myself.

I do nothing for my social self.

One action I will take for my emotional self:

I do all I can for my social self

**Examples:** spend time with loved ones and friends; exercise my right to vote; volunteer in my community; contribute money to a worthwhile cause; write a “letter to the editor”; express my opinions; pay taxes

Questions for reflection

1. To what degree do recent recipients of my care experience me as a healing presence?
2. What kind of person must I be to be a “healing presence”?
3. When I am exhausted and “running on empty” how do I renew my spirit and ability to care? What is lifegiving in my life?
4. In what ways might my lifestyle need to change for me to become a better healing presence?
5. What kind of institutional culture, ethos, promotes our being a healing for one another?

Creating a Culture that Mandates and Nourishes the Quality of Healing Presence

Questions for Reflection

1. Are the people better (more “integrated” or “whole”) at the end of the day as a result of experiencing our institutional culture.
2. What specific elements in our culture promote or constrain healing? What should we celebrate and what do we need to change?
3. Who is responsible for healing and spiritual care? Who establishes performance standards, develops requisite competencies, monitors our performance and holds us accountable?
4. Budgets reveal corporate values. What do the institutional resources we commit to healing and spiritual care reveal about the value we attach to promoting a healing culture?

--------------------------------------------------------------------------------------------------

Caring for Self and Colleagues

Gospel care defines and blesses Christians. How do we know we are living lives of Gospel care? I’d suggest two criteria.

- A soft heart: Am I routinely moved by the needs of the most vulnerable to the degree that my spirit is afflicted, I talk about the needs and suffering of others, I grieve, I lament (in a word, I have not made peace with the fact of this need and suffering); ability to be moved by the plight of humans in need
- Caring moves me to action: prayer, donation of time/presence, expertise, money. I go to bed tired each night having tried to “make a difference.”

Authenticity is the hallmark. Do the people who know me well believe that I genuinely care about self and others with special concern for the most vulnerable? Rephrased, is there enough evidence to convict me if I am on trial for being a Christian… or if our facilities were on trial for being faith-based?

Given that we have duties to self, to family and to our “neighbors,” especially the most vulnerable, how can we balance self/family/other care obligations? For those of us in the palliative care community the needs of neighbors suffering with a serious or life-threatening illness can be all consuming. Certainly “compassion fatigue” is a stranger to no one in palliative care—especially given the pace of many of our work environments. Can’t we all recall times when we felt too overwhelmed with the burden of caring for others to really be present with patients, families and colleagues. How do you know when your inner well is dry? And what do you do to refill? When invited by Sr. Karin Dufault to explore these themes for the recent Recovering our Traditions Conference I developed the accompanying tool to assess the adequacy of our self care and care for colleagues. I invite its use for personal or communal reflection and dialogue. While individuals may use it to prompt self-knowledge, healing and growth, professional teams and institutions may also find it helpful in guaging how good a job the institution is doing in caring for its own. Since most of us belong to the “walking wounded” a bit of tender love care can go a long way. See the accompanying strategies for self- and other-care.

<table>
<thead>
<tr>
<th>Self-Care</th>
<th>Fitness activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diet</td>
<td>• Work/Leisure balance</td>
</tr>
<tr>
<td>• Adequate rest</td>
<td>• Spending quality time with</td>
</tr>
</tbody>
</table>
family, friends
• Enjoying nature
• Enjoying the arts
• Mental health days/work
• Sabbath
• Positive Thinking
• Humor
• Prayer
• Retreat
• Spiritual Direction
• Counseling

Care for Colleagues
• Meaningful “How are you?”
• Appropriate use of speech,
touch, gaze
• Knowing when to say, “Take five!”
• Remembering, celebrating birthdays and special occasions
• Get-togethers outside of work
• Beginning of shift “huddles”
• High fives during the day
• Safe times and places to vent
• Planned interventions when teams are stressed
• Holding one another accountable, including formal interventions
Section One: Compassion Fatigue
Compassion fatigue is a state of deep physical, emotional and spiritual exhaustion accompanied by acute emotional pain experienced by those helping people in distress. It is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper.

How would you describe yourself?

Compassion fatigued \hspace{1cm} Energized to heal
1------------2-------------3---------------4---------------5---------------6-----------------7

How would you describe the colleagues/team with whom you work?

Compassion fatigued \hspace{1cm} Energized to heal
1------------2-------------3---------------4---------------5---------------6-----------------7

Section Two: Self-Care

1. Which phrase best describes your beliefs about the need for self-care?

_____ God takes care of me. My responsibility is to care for others.
_____ I would probably benefit from a little self-care but I’m usually too busy.
_____ I have to take care of myself—no one else does!
_____ I’m worth tender loving care—from myself and others!

2. Which phrase best describes the amount of time you spend on self-care?

_____ I almost never spend time on self-care.
_____ I try to make time for self-care, but it’s often a losing battle.
_____ I think I spend an appropriate amount of time on self-care.
_____ I probably spend an excessive amount of time on self-care.

3. What indicators do you rely on to assess the adequacy of your care for your physical self?

• __________________________________________________________
• __________________________________________________________
• __________________________________________________________
4. How would you describe your care of your physical self?

Grossly negligent   Attentive and responsive

1----------2--------3--------4--------5--------6--------7

5. What indicators do you rely on to assess the adequacy of your care for your psychological self?

- 
- 
- 

6. How would you describe your care of your psychological self?

Grossly negligent   Attentive and responsive

1----------2--------3--------4--------5--------6--------7

7. What indicators do you rely on to assess the adequacy of your care for your social self?

- 
- 
- 

8. How would you describe your care of your social self?

Grossly negligent   Attentive and responsive

1----------2--------3--------4--------5--------6--------7

9. What indicators do you rely on to assess the adequacy of your care for your spiritual self?

- 
- 
- 

10. How would you describe your care of your spiritual self?

Grossly negligent   Attentive and responsive

1----------2--------3--------4--------5--------6--------7
11. What self-care practices are most helpful/valuable to you?


12. Which phrase below best describes you?

_____ 1. I am extremely uncomfortable when the recipient of another’s care.. I immediately feel the need to return care and get “out of debt.”
_____ 2. I enjoy the mutuality of care in relationships and accept that this is not a quid pro quo; at times I provide care and at other time I receive care…
_____ 3. I wallow in care and like a sponge soak up whatever is offered without any thought of reciprocating!

Section Three: Care for Colleagues

13. Which phrase best describes your beliefs about your colleagues need for care?

_____ My colleagues are all adults and can take care of themselves.
_____ Everyone is occasionally “fragile” and would benefit from a little tender loving care.
_____ We are all the “walking wounded” and need care.

14. Which phrase best describes your beliefs about colleagues with whom you find it difficult to work?

_____ I’m only human. If someone pisses me off I’ll give it back. I don’t have to take anything from anyone.
_____ Live and let live.
_____ I usually try to understand the behaviors that drive me crazy. Often they are simply a cry for help. Have to admit, ‘though, that some nuts are hard to crack!

15. Which phrase best describes your care for your colleagues?

_____ My job keeps me too busy to worry about my colleagues.
_____ While I know a little tender loving care can go a long way in the workplace I’m usually too frazzled to make it a priority. I’m lucky if I get through the day in one piece myself!
_____ I try to be attentive and responsive to the needs of my colleagues—this is definitely a priority for me.
16. Which phrase would your colleagues most likely use to describe you?

_____ Toxic! Poisons the environment. Bad for your health.
_____ Always knows how to take care of “numero uno”—doesn’t know the rest of us exist!

_____ Genuinely tries to be a team player responsive to others but is too often task-focused.
_____ Always seems to know when someone needs a little tender loving care and can be counted on to be there for everyone.

17. Which phrase best describes your institutional culture?

_____ No one matters here… we are all merely a means to get the work done.
_____ Leadership tries to communicate that everyone matters but the message gets lost in everyday busyness.
_____ Sometimes I’m afraid its all a dream—but people really care here! We know one another and feel like valued members of the team. Best of all everyone matters… the aides and techs, staff, clinicians, leadership!

18. What institutional practices exist in your work environment to create a caring culture?

________________________________________
________________________________________
________________________________________

Reflection:
1. In what ways, if any, has this reflection deepened your self-knowledge?

2. Are there any life changes you would like to make in light of this reflection? Specifically, can you identify at least one take-home action for care of oneself and at least one action to enhance the healing environment for professional caregivers in your work setting?
Role Play Exercise to Develop the Art of Healing Presence:

Invite participants to reflect on how they have experienced another being present to them in a manner that is healing and how they have been present to another

Choose a buddy and then read the brief scenarios which follow. Each of you should select one of the scenarios and enact how you would be present to the individual described. After you have both completed the exercise reflect on and discuss how you each used gaze, speech/silence, and touch to communicate that you cared. Plan to spend three to five minutes being present to the individual(s) described as opposed to doing something for him or her. Evaluate how easy or difficult it is to simply be with the other in a manner that is compassionate, affirming, healing. Talk with one another about why this type of presence matters. It might also be interesting to discuss if different professional roles do presencing differently!

A. Ann is in the breast cancer clinic. She was referred there after a routine mammogram revealed a suspicious lesion.

B. Mildred is the 82 year old wife of a patient in the medical intensive care unit. She has driven herself to the hospital and you find her wandering in the corridor looking lost. When you ask if you can help she cries and tells you that she’s not sure anyone can help.

C. Dawn and Rick belong to your church. They have a 7 year old son who is autistic. He is acting out badly during the church service and you can see that many in the church are annoyed. Dawn and Rick apologize to you as they exit Church.

D. Sylvia/Carl is a co-worker back at work the first day after a leave to grieve the death of a teen-aged daughter killed in a motor vehicle accident. (S)he is standing at the desk just staring and when you approach says, “I don’t know if I’m ready to be back yet.”

E. Sylvia/Carl look exhausted at work and when you comment on this you hear… no one knows what its like to work all day and then go home to a mother with Alzheimer’s disease who needs you round the clock. I don’t know how long I can go on like this… but I don’t see relief in sight.

F. Ten year-old Tommy is sitting outside the principal’s office and looks like he’s ready to burst into tears at the same time he tries to be the “tough guy.” When you ask him what’s wrong he tells you to “Buzz off.” You offer to help and he retorts, “No one cares.”

Thinking about my personal assessment of my commitment to be a healing presence and my competence for healing, I resolve to do the following:

Thinking about my assessment of our institution’s commitment to healing and related competencies, I resolve to work collaboratively to do the following:
Part III: Suffering, hope and human flourishing

To be human is to suffer and we all know that suffering can “make” or “break” people. Learn how we can be present to those who suffer in a way that promotes human transcendence and flourishing.

Objectives:
Upon completion of this session participants will be able to:
1. Relate the concepts of human finitude, suffering, hope and human flourishing
2. Explain different manifestations of human caring when one is present to those who suffer

Hope. 1. desire accompanied by expectation of obtaining what is desired, or belief that it is obtained; often personified. 2 a. trust, reliance, “whose hope is the Lord.” 2 b. expectation merely; prospect. 3. one on whom action or future hopes are centered. 4. ground or source of happy expectation, hence good promise, as “land of hope.” 5. that which is hoped for; an object of hope, “Lavinia is thine elder brother’s hope.” Webster’s New International Dictionary of the English Language, 2nd ed., 1946.

I. Introduction

Extract from a Christmas Card
Dear Mildred,
We have moved to Washington State to live with our daughter. Both of us are sick and cannot take care of ourselves. In July I had back surgery and Steve had a prostate operation. We are 78 and 80 years old, so we are not healing too fast. Both of us have to walk with walkers. Miss my home in New Jersey so much. If ill health won’t kill me depression will. And it’s no picnic living with my daughter. I think all she wanted out of me and pop is the money for the sale of my house. I’m sorry I ever gave her power of attorney. She says I should be glad I have some one to take care of us. And we don’t appreciate what’s being done for us. Hope you’re in good health.
Love and Blessings
Ann and Steve
p.s. new address on envelope

My Starting Assumptions Coming Out of a Christian Orientation:

1. Jesus teaches us by example that being human necessarily entails suffering, dying and death.

2. We can’t be truly human, perfected, REAL, unless we suffer.
3. Christian hope, not merely sunny optimism, is the path through suffering, dying and death to healing and transcendence. But cultivating the virtue hope isn’t for the fainthearted.

Not unique to Christian tradition
Buddha teaches that Life is Suffering….

II. We can’t be truly human, perfected, REAL unless we suffer.

...I could scarcely make out the large sitting Buddha near the entrance of the house. But what caught my attention was the metal circle with spokes resembling a wheel, hanging over the figure of the Buddha. ...I asked our host about the wheel. I was told it represented our eternal journey in this life and continuing into the next. Buddha’s teachings say that life is suffering. We cannot avoid suffering as we move around the rim of the wheel, which represents perpetual change and the transitory nature of life. But the wheel also symbolizes wholeness or completion because the wheel revolves around the center axis that does not move. That center point represents the presence of the divine. If we remain aware of this center point, we are strengthened for whatever lies ahead.

...It is this center point that grounds us in the midst of the many changes in our lives. It is at the center point where we experience the energy and power that turns the wheel. It as at this center point that we connect with the Everywhere Spirit. When we rest in the center point, we find that we have come home again to the place from which we started. But because of the journey, it is as if we had arrived home for the first time. In our journey around the circles of life, we become new persons over and over again.


III. Hope, not merely sunny optimism, is the path through suffering, dying and death to healing and transcendence. But cultivating the virtue hope isn’t for the fainthearted.

Mark’s Story…

Hope: A Definition
Hope: a dynamic inner power that enables transcendence of the present situation and fosters a positive awareness of being [Herth, K. (1993). Hope in the family caregiver of terminally ill people. Journal of Advanced Nursing, 18, 538-548.]

Aquinas writes that hope is a desire characterized by a special type of object. The object of hope must be 1) clearly good, 2) apparent in the future, 3) difficult or arduous to attain, and yet 4) possible to attain.
(I may desire not to die but I cannot hope never to die! This is an impossibility)

Ultimately, hope is not about cure. The source of ultimate hope must be located beyond the limits of our finite, corporal, individual existence. The object of ultimate hope must then be a source of meaning, however this might be construed. For Christians, Muslims, and Jews, this transcendant object of desire is the one, holy, all-loving and almighty God. To reject, or to discover, or to re-cover, or to hold onto an ongoing source of transcendental meaning is one of the major spiritual tasks of the dying. The opposite of hope is called despair, but despair is really just a another name for meaninglessness. To suffer without any sense of meaning abject hopelessness (Sulmasy 2002)
We need the greater and lesser hopes that keep us going day by day. But these are not enough without the great hope, which must surpass everything else. This great hope can only be God, who encompasses the whole of reality and who can bestow upon us what we by ourselves cannot attain. …In this sense it is true that anyone who does not know God, even though he may entertain all kinds of hopes, is ultimately without hope, without the great hope that sustains the whole of life (cf. Eph 2:12). Man’s great, true hope which holds firm in spite of all disappointments can only be God—God who has loved us and who continues to love us “to the end,” until all “is accomplished” (cf. Jn 13:1 and 19:30). [Benedict XVI, Spe Salvi: Encyclical]

Why Hope Matters

Belgian Cardinal Danneels in an address entitled “Where do I find hope” in December 13, 2001 (origins, vol. 31, pp. 445ff) writes:

“How in our fearful times can we remain hopeful? Hope is not located somewhere at the edge of human existence: It is its heart. If it is hit, the person dies.” He offered two ways to exercise hope. First is prayer, which involves “suspending oneself between the past and the future… To pray is to consult one’s memory and to feed it. But prayer is also to look forward with a burning heart to the days to come.” Second is engagement. “Hope never materializes when people do not engage themselves, or do not make decisions or choices.”

Cole Sear in the movie The Sixth Sense was on to something when he said *I see dead people everywhere...And they don't know they're dead.* These are people without hope…

Benedict XVI in Spe Salvi describes three “settings” for learning and practicing hope:

1. **Prayer as a school of hope**
   St. Augustine describes very beautifully the intimate relationship between prayer and hope. He defines prayer as an exercise of desire. Man was created for greatness—for God himself; he was created to be filled by God. But his heart is too small for the greatness to which it is destined. It must be stretched. “By delaying [his gift], God strengthens our desire; through desire he enlarges our soul and by expanding it he increases its capacity [for receiving him].” …”Suppose that God wishes to fill you with honey [a symbol of God’s tenderness and goodness]; but if you are full of vinegar, where will you put the honey? The vessel that is your heart must first be enlarged and then cleaned, freed from vinegar and its taste. This requires hard work and is painful, but in this way alone do we become suited to that for which we are destined.

2. **Action and Suffering as Settings for Learning Hope**
   We can try to limit suffering, to fight against it, but we cannot eliminate it…It is not by sidestepping or fleeing from suffering that we are healed, but rather by our capacity for accepting it, maturing through it and finding meaning through union with Christ, who suffered with infinite love. …A society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through “com-passion” is a cruel and inhuman society.
3. Judgment as a setting for learning and practicing hope

Why hope matters to the individual with a serious and life threatening illness
Erikson’s last developmental stage: ego integrity vs despair

*Hope develops from the basic human need to achieve, to create.* At its root, it embodies the question of the essence of ourselves that will live on after we die, our contribution. The power of this need fuels our will to live: the loss of such a drive leads to feelings of helplessness and despair. … *Hope is the ingredient in life that enables an individual both to consider a future and to actively bring that future into being.* Hope originates in imagination, but must become a valued and realistic possibility for an individual in order to energize action. *Hope has the capacity to embrace the reality of the individual’s suffering without escaping from it (false hope) or being suffocated by it (despair, helplessness, hopelessness).* Hope is unique to each person. During terminal illness, the future being considered will become more focused, yet hope is essential for an individual to transcend despair and complete crucial life tasks. [Ted Creen. Enabling Hope.]

Enabling Hope

1. **Sources of Hope**

When we find life hard we are forced to ask what the source of our hope is.

   This year was a difficult time for me… I sat with people facing hard times and I couldn’t fix their problems… This Advent, season of hope and all I wanted to say was “Bah! Humbug!”… And it was an article in America by Ladislaus Orsy, on the sources of hope that rescued me…
   
   o Scripture
   o Life and witness of Jesus
   o My own inner voice [need to be silent to hear this…, need to be willing to sit patiently in darkness, broken, open… need to be a grain of wheat, pregnant…]

2. “We do not give our patients hope. …Hope is already present as a given in every situation of death. Meaning is already there, awaiting affirmation. *Our task as health care professionals is to show respect and reverence for the dignity that all dying persons have simply because they are human, and to share our hope that meaning transcends the dying process.* We can do nothing more. We must do nothing less. We must create an atmosphere that is conducive to the patient’s own grasping of the hope that is already there to be grasped. We should neither be so naïve nor so arrogant as to think that hope is ours to give. …In the end then, as Vaclav Havel has stated, *hope has nothing whatsoever to do with prognosis. It has everything to do with the human spirit.* …Hope requires imagination. Health care professionals can help patients to hope if they can teach them to imagine the real. Patients on the brink of despair sometimes only need help imagining that their deepest and absolutely ultimate desires can be fulfilled. Hope requires faith, and faith requires imagination: imagination not as fantasy, but imagination as the apprehension of the not-yet-realized real. Health care professionals also need to remember that hope is sustained and nurtured in relationship and in community. …People often build walls around the sick. They project onto the sick their own lack of
faith, lack of hope, and lack of love. People can deny their own death by portraying the dying as essentially different from them (Sulmasy, 2002).

I.V. Meaning in Life Experiences
The concept of suffering in life experience is not new. Nietzsche was one of the first modern philosophers to call attention to this phenomenon: “He who has a ‘why’ to live for can bear almost any ‘how.’” Jaspers confirmed this need of the person to experience meaning: “As soon as an individual wakes he does not merely want to live out the day, but wants to live for something in his life.” Frankl, addressing himself to what he termed today’s “existential vacuum,” developed the conviction that “life holds a meaning for each and every individual, and even more, it retains this meaning literally to his last breath.” “Whenever one is confronted with an inescapable, unavoidable situation…e.g., an incurable disease… just then is one given a last chance to actualize the highest value, to fulfill the deepest meaning… the meaning of suffering.”

Travelbee, one of the first nurse conceptualists to advocate humanistic nursing, explored the nurse’s responsibilities and opportunities to help individuals and their families to meet their need for meaning in the experience of suffering and illness.

The human being is motivated by a search for meaning in life experiences, and that meaning can be found in the experience of illness, suffering and pain. When such meaning is found and the individual is able to use the experience of illness as an enabling life experience, i.e., enabling in the sense that it is possible for the individual to achieve self-actualization and that which lies beyond—self-transcendence.

V. Intimacy [M. Fowler]
That which heals suffering is one thing only: INTIMACY

Yea, though I walk in the valley of darkness I fear no evil for You are with me…

Lamentation: lances the boil of suffering; when spent, it forces you to climb back up the pit!
[See samples…]

VI. Conclusion: Mildred’s Narrative and its Challenges
Suffering and Transformation: Reflection and Discussion

1. The degree to which I hold that suffering is a/the path to integration and transformation

1-2-3-4-5-6-7
Not at all To the highest degree possible

Explanatory Statement:

2. The degree to which my religious tradition holds that suffering is the path to integration and transformation

1-2-3-4-5-6-7
Not at all To the highest degree possible

Explanatory Statement:

3. What help does my religious tradition offer to humans who are suffering. And what does this “help” look like?

4. Suffering can “make or break” us.
   a. What resources can you draw on to ensure that suffering will not “break” you!

   b. What personal resources can you draw on to ensure that suffering will not “break” those you love or those entrusted to your care? How can you be a healing presence for those who are suffering?

5. If you were diagnosed with an incurable illness what would be the source of your hope?
Part IV: *Trying on new healing behaviors*

Today won’t be effective unless we leave newly valuing our ability to be a healing presence and newly confident in the strategies we’ve learned. We’ll walk through some everyday challenges, try to respond, and talk together about best responses.

**Objectives**
At the conclusion of this session participants will be able to:
1. Describe healing presence and its role in integration/healing
2. Assess their ability to be compassionately present to other in personal and professional settings
3. Articulate a plan to enhance presencing skills, including lifestyle modifications

**Exercises and dyad work.**
Take a few minutes to think of a time when you were in need of compassionate presence. Who was there for you in a helpful manner. What was it about this individual’s presence that was healing, affirming? How did it make you feel? Share your experiences with one another and when in the listening posture focus on being compassionately present to the other.

**Practicing Presencing**
Listen to the human experiences being described and if moved volunteer to be compassionately present to the individuals described. Watch how others demonstrate compassionate presence. Conclude with a discussion of which behaviors, gestures, etc. were most helpful.

**Wrap Up**
Remember a recent situation when being a compassionate, healing presence was a challenge. How did you respond? What descriptors best characterize your response? Gentle, supportive, frustrated, angry, empathic?

What needs to happen for you to better demonstrate/live/model compassionate healing presence in your personal and professional life?

What changes need to take place in your institutional culture to facilitate everyone’s being a compassionate healing presence?

Share your plan with a partner… and bless one another for the journey.
Role Play Exercise to Develop the Art of Healing Presence:

Invite participants to reflect on how they have experienced another being present to them in a manner that is healing and how they have been present to another.

Choose a buddy and then read the brief scenarios which follow. Each of you should select one of the scenarios and enact how you would be present to the individual described. After you have both completed the exercise reflect on and discuss how you each used gaze, speech/silence, and touch to communicate that you cared. Plan to spend three to five minutes being present to the individual(s) described as opposed to doing something for him or her. Evaluate how easy or difficult it is to simply be with the other in a manner that is compassionate, affirming, healing. Talk with one another about why this type of presence matters. *It might also be interesting to discuss if different professional roles do presencing differently!*

A. Ann is in the breast cancer clinic. She was referred there after a routine mammogram revealed a suspicious lesion.

B. Mildred is the 82 year old wife of a patient in the medical intensive care unit. She has driven herself to the hospital and you find her wandering in the corridor looking lost. When you ask if you can help she cries and tells you that she’s not sure anyone can help.

C. Dawn and Rick belong to your church. They have a 7 year old son who is autistic. He is acting out badly during the church service and you can see that many in the church are annoyed. Dawn and Rick apologize to you as they exit Church.

D. Sylvia/Carl is a co-worker back at work the first day after a leave to grieve the death of a teen-aged daughter killed in a motor vehicle accident. (S)he is standing at the desk just staring and when you approach says, “I don’t know if I’m ready to be back yet.”

E. Sylvia/Carl look exhausted at work and when you comment on this you hear… no one knows what its like to work all day and then go home to a mother with Alzheimer’s disease who needs you round the clock. I don’t know how long I can go on like this… but I don’t see relief in sight.

F. Ten year-old Tommy is sitting outside the principal’s office and looks like he’s ready to burst into tears at the same time he tries to be the “tough guy.” When you ask him what’s wrong he tells you to “Buzz off.” You offer to help and he retorts, “No one cares.”

Thinking about my personal assessment of my commitment to be a healing presence and my competence for healing, I resolve to do the following:

Thinking about my assessment of our institution’s commitment to healing and related competencies, I resolve to work collaboratively to do the following: