

HEALING THE --- HEALERS

Special Edition
Hospital Chaplains on Spiritual
Frontlines during COVID-19

Written Professional Resources - Part 2

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At Odyssey Impact, we believe in the power of personal story to change perspectives, change attitudes, and even to change the world. In responding to the needs of spiritual care providers and faith leaders in COVID-19, we were honored to collaborate with our chaplaincy partner organizations, the Chaplaincy Innovation Lab and the Association for Clinical Pastoral Education (ACPE), to convene conversations and provide resources to spiritual care providers (chaplains) in health care settings.

We are pleased to offer the following topics, reflections, and questions for anyone considering the aspects of providing spiritual care in health care settings during the COVID-19 pandemic. Those exploring the dimensions of pandemic pastoral care in other contexts will find it valuable as well. Uplifted here are spiritual care sub-topics that emerged in David and Shawn's conversation, as well as pandemic-related issues from ongoing national spiritual care dialogues.



For the convenience of chaplaincy educators, students, and residents, all sections are tagged with relevant ACPE Outcomes and APC Competencies. While each of the three filmed zoom conversations is accompanied by a standalone written resource, the content of the three resources do not overlap, and may be considered as a single rich engagement of pandemic chaplaincy topics.

For the creation of this resource, we are grateful to the Rev. Sarah Knoll Sweeney, an ACPE Certified Educator at the Memorial Hermann Health System in Houston, Texas. In terms of pedagogical development, Rev. Sweeney brought to this task her formidable experience as former Chair of the ACPE Curriculum Committee, Founding Convener on Community of Practice for Educators Utilizing Online Options, and Accreditation National Site Team Chair.

Part 2

HOLDING SPACES FOR FEAR, LOSS AND HOPE

Understanding Trauma-Informed Spiritual Caregiving

Both David and Shawn share what they're discovering as they mine their past experiences for wisdom applicable to the here-and-now. In reflecting upon past crises in which they've provided spiritual care, and the collegial communities that supported them through it, they revisit past traumatic moments they hope will guide them in the current moment of communal trauma and anxiety.

There is some debate among chaplains about whether, in this pandemic context, simply showing up to work as a chaplain constitutes trauma. Regardless, trauma-informed spiritual caregiving serves us well in attending to ourselves and those we serve in a time of collective uncertainty, stress, and danger such as this. A review of basic concepts in trauma and brain function is useful: limbic systems, amygdala, fight-flight-freeze. It helps us as chaplains to remember that first responders have override functions; by repetition, they've learned to push past fight-flight-freeze in the same kinds of crises over and over. During chaplaincy education, many students express concern about becoming calloused to suffering and death. However, being ready and capable is not the same as being calloused. Many of us discover that we shift from judging nurses' gallows humor to joining them (out of patient earshot) because we realize this is part of how we were going to get through, too. Things that used to feel like an emergency when we first started have become routine.

But in this pandemic, the contours of "routine" and "emergency" have shifted. "An emergency is a *novel* situation, not something we deal with on a regular basis. Therefore, we don't have a 'mental script' on how to handle it." We're dealing with a *novel* virus, and that means, to various extents for each of us, this is a *novel* emergency. It does not quite feel analogous to our scripts and experiences of previous disasters, crises or emergencies. Shawn recalls his days in CPE during the AIDS crisis, connecting the importance of his peer relationships then to the value he finds in talking with David now. In Houston and other coastal communities, some observed the stockpiling of water and lumber – two major needs for the much more common disaster – a hurricane.

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For New Yorkers, comparisons to September 11th abound, and across media outlets, we hear descriptions of ERs as war zones. But none of these similar experiences quite fit. Being a chaplain to an AIDS patient and to a COVID-19 patient have radically different implications for infection and transmission, and so demand a very different strategy for connection and presence. This lack of a collective memory for how to be a chaplain in a flu pandemic leaves our brains whirring in the background, cycling through fight → flight → freeze, again and again.

Chaplains as Midwives of Death

David and Shawn begin anticipating how they will attend to the religious needs of patients separated from loved ones and community spiritual caregivers in the isolation mandated by the pandemic. As they talk, we can feel their devotion to the importance of the chaplain's role in a patient's death. Many of us who are called to deathbeds — spiritual caregivers, chaplains, religious leader types — have ideas about "dying well." Ira Byock's book and the hospice movement laid a foundation for us. This notion that we can facilitate "the good death" has formed many of us in our approach to blessing, praying, and anointing our people as they lay dying. Some of us see end-of-life care as our most vital function, and it turns out most healthcare staff see us that way, too.

In just September of last year, Byock wrote "When people are competently cared for, many can feel a sense of peace — well within themselves and with others — as they leave this life. Preserving this opportunity is the fullest expression of community. Depriving people of the opportunity to die well seems the final social injustice."

As more of us around the country move to Zero Visitor policies for our COVID-19+ patients, we join our medical colleagues in striving for the good death, working to prevent Byock's final social injustice. We pull beloveds up on ipads for the dying to see. We call them from the other side of the glass to offer their comforting words. Per the traditions of chaplaincy, we make do with what we have, advocating for the sanctification of an otherwise horrifically clinical moment. We hold up the staff as they move on to the next bed. We have learned to communicate with our eyes; the rest is behind a mask.

When David reflects on his apprenticeship moment with a CPE student in the morgue, it becomes clear that the deceased patient's son spontaneously moves into the short list of things chaplains sometimes facilitate loved ones to say to the dying person. Chaplains continue to facilitate grieving, even under some of the most bizarre circumstances of our ministry life.

Adapting to New Tools: Telechaplancy in COVID-19

When David reflects with Shawn on how he navigated using the phone in the morgue with the patient's son, many of us are thrust back into our own experience strategizing creative spiritual caregiving in the midst of the constraints of the pandemic. Perhaps no innovation became more pressing for us than telechaplancy skills. Spurred by some chaplains being removed from their floors, increasingly stringent no visitor policies, uncertainty about the spread of the disease via droplets and aerosols, and a potential or actual shortage of PPE, chaplains have shifted from automatic in-person visits to all patients to strategies utilizing phone and videoconferencing technologies. David's visit to the morgue captures all of this and invites us to reflect on how we navigate these moments for ourselves.

Telechaplancy is not new in the pandemic, but many who had formerly dismissed it have come quickly to learn its usefulness. The phone and iPad not only help us connect with the patient, they help us connect the patient to their beloveds. Like David and Shawn, we mine our colleagues and Facebook groups for best practices and to share what we are learning on a daily basis. [The Chaplaincy Innovation Lab](#) and other organizations are striving to rapidly share and disseminate these best practices for easy access and quick learning. Many, if not most, CPE programs have moved to meeting by videoconference in light of <10 person, 6-foot distance requirements, so Educators are in a parallel scramble to set up and orient to this technology for the education of future chaplains.

Before the pandemic, we often saw our primary role in end-of-life situations as facilitating grief processes among those present. Most chaplains rarely (or sparingly) used technology to connect loved ones otherwise separated. For many of us, the pandemic has invited us to question again the primacy of physical presence in our work. We begin to wonder what relational connections we've neglected to advocate for when a patient faced the end of their life. As the relaxation of HIPAA regulations allowed chaplains to meet these immediate needs with the limited resources at hand, many spiritual care providers have wondered aloud how we've allowed these regulations to needlessly limit us in the past.

For some of us, the new engagement of technology for spiritual care has created fascinating questions (and possibilities), while others hope these questions (and problems) will disappear upon the advent of a COVID-19 vaccine: might some of chaplaincy be more efficient and effective via videoconference, or is this just an exception necessitated by this pandemic? When families can gather on a Zoom from across several states and see the patient's face, what do we learn about our ability to facilitate relational connectivity in the patient's life? Which is better, shouting a prayer from 6 feet away or a phone call that could modulate a less-anxious presence and a soothing tone?

Questions for Reflection:

- 1 How have your knowledge of and experience with trauma informed your work as a spiritual caregiver during the pandemic?
- 2 What have you observed about your brain and body function during the crisis, both while working and in rest? How does this self-awareness inform your work as a chaplain?
- 3 How has the pandemic changed our ideas about “dying well” and the role of the chaplain? How might this inform the future of chaplaincy?
- 4 How has your facilitation of grief changed during the pandemic? What will you bring with you into your spiritual care practice moving forward?
- 5 What technology are you using during the pandemic that you find useful and effective for ongoing spiritual care practice?
- 6 As telechaplaincy becomes the temporary “new normal,” what has been lost that you now hold even more sacred in your role as a spiritual caregiver?
- 7 At a time when chaplains became even more critical surrogates for loved ones at a patient’s end of life, what have you learned about the creative potential of your role?

★ ACPE Outcomes

- 1.2: Identify and discuss major life events, relationships, social location, cultural contexts, and social realities that impact personal identity as expressed in pastoral functioning.
- 1.5: Recognize relational dynamics within group contexts.
- 2.1: Articulate an understanding of the pastoral role that is congruent with one's personal and cultural values, basic assumptions and personhood.
- 1.7: Initiate helping relationships within and across diverse populations.
- 2.4: Assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.
- 2.3: Demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.
- 2.4: Assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.

★ APC Competencies

- ITP2: Incorporate a working knowledge of psychological and sociological disciplines and religious beliefs and practices in the provision of spiritual care.
- PIC2: Articulate ways in which one's feelings, attitudes, values, and assumptions affect professional practice.
- PPS1: Establish, deepen and conclude professional spiritual care relationships with sensitivity, openness, and respect.
- PPS3: Provide spiritual care that respects diversity and differences including, but not limited to culture, gender, sexual orientation and spiritual/religious practices.
- PPS4: Triage and manage crises in the practice of spiritual care.
- PPS5: Provide spiritual care to persons experiencing loss and grief.
- PPS6: Provide religious/spiritual resources appropriate to the care recipients, families, and staff.
- PPS9: Facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups.
- OL1: Promote the integration of spiritual care into the life and service of the institution in which one functions.