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CHAPLAINS' NETWORK

Caring Connections

An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling

Caring for Mental Health

The Purpose of Caring Connections

Caring Connections: An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling is written by and for Lutheran practitioners and educators in the fields of pastoral care, counseling, and education. Seeking to promote both breadth and depth of reflection on the theology and practice of ministry in the Lutheran tradition, *Caring Connections* intends to be academically informed, yet readable; solidly grounded in the practice of ministry; and theologically probing. *Caring Connections* seeks to reach a broad readership, including chaplains, pastoral counselors, seminary faculty and other teachers in academic settings, clinical educators, synod and district leaders, others in specialized ministries and — not least — concerned congregational pastors and laity.

Caring Connections also provides news and information about activities, events and opportunities of interest to diverse constituencies in specialized ministries.

Scholarships

When the Inter Lutheran Coordinating Committee disbanded a few years ago, the money from the "Give Something Back" Scholarship Fund was divided between the ELCA and the LCMS. The ELCA has retained the name "Give Something Back" for their fund, and the LCMS calls theirs "The SPM Scholarship Endowment Fund." These endowments make a limited number of financial awards available to individuals seeking ecclesiastical endorsement and certification/credentialing in ministries of chaplaincy, pastoral counseling, and clinical education.

Applicants must:

- have completed one [1] unit of CPE.
- be rostered or eligible for active roster status in the ELCA or the LCMS.
- not already be receiving funds from either the ELCA or LCMS national offices.
- submit an application, along with a financial data form, for committee review.

Applicants must complete the Scholarship Application forms that are available from Judy Simonson [ELCA] or Joel Hempel [LCMS]. Consideration is given to scholarship requests after each application deadline. LCMS deadlines are April 1, July 1 and November 1, with awards generally made by the end of the month. ELCA deadline is December 31. Email items to Judith Simonson at *jsimonson@aol.com* and to Joel Hempel at *Joel.Hempel@lcms.org*.

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News, Announcements, Events: E-mail items to Judith Simonson at *jsimonson@aol.com* or Joel Hempel at *Joel.Hempel@lcms.org*

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Call for Articles

Caring Connections seeks to provide Lutheran Pastoral Care Providers the opportunity to share expertise and insight with the wider community. We want to invite anyone interested in writing an article to please contact one of the co-editors, Diane Greve at *dkgreve@gmail.com* or Lee Joesten at *lee.joesten@gmail.com*. Specifically, we invite articles for the upcoming issue on the following themes:

2019.1 Ministry and Suicide;
2019.2 Best Practices/Evidence Based Spiritual Care

Have you dealt with any of these issues? Please consider writing an article for us. We sincerely want to hear from you! And, as always, if you haven't already done so, we hope you will subscribe online to *Caring Connections*. Remember, a subscription is free! By subscribing, you are assured that you will receive prompt notification when each issue of the journal appears on the *Caring Connections* website. This also helps the editors and the editorial board to get a sense of how much interest is being generated by each issue. We are delighted that the numbers of those who check in is increasing with each new issue. Please visit *www.lutheranservices.org/newsletters#cc* and click on "Click here to subscribe to the *Caring Connections Journal*." to receive automatic notification of new issues.

Editorial

Diane Greve

Caring for Mental Health takes many forms and foci.

"Minneapolis police responding to a mental health crisis call shot and killed a man they say was suicidal and armed on the city's North Side Friday afternoon."[1] Everyday my newspaper seems to have a reference to mental health needs and to untreated mental illness as a possible cause for violence. Those who live with mental health challenges have often told me how hard it is to hear this in the news since these assessments only add to the stigma of mental illness. It suggests those with mental illness are dangerous people. We know that many of the homeless and incarcerated could be better served with adequate mental health services and appropriate care.

I began my public ministry in institutions dedicated to treating mental illness. My one-year deaconess internship over 45 years ago was with Chaplain Ken Siess at St Louis State Hospital, an urban psychiatric facility. Coincidently, this issue of *Caring Connections* also remembers Ken upon his recent death. And, curiously, I completed my public ministry as a chaplain and CPE supervisor at University of Minnesota Health where Ken had a vested interest and where Fairview Health Services continues to operate a large behavioral health program. Clearly, mental health ministry has become central to my own life and ministry. Thankfully, treatment methodologies have changed considerably over those years.

While there are many, many more resources and approaches we could have illuminated in this issue, we have a diverse group of ten writers whose theory and practice can inform the ministries of chaplains, pastoral counselors and certified, clinical educators in practice and in self-care. They are thoughtful, provocative and insightful. Mutuality is a common theme as we are all in this together.

- **Scott Davis** uses story to engage people in an almost weekly behavioral health group at Wellspan-Ephrata Community Hospital in Lancaster, Pennsylvania.
- **Diane Ott-Hager** provides regular spirituality groups and individual visits in an inpatient treatment program at University of Minnesota Health in Minneapolis, Minnesota.
- **Ed Neiderhiser**, having served 26 years at the maximum security Graterford prison in the Pennsylvania state system, writes of the mental health needs of the incarcerated.

1 *Star-Tribune,* Minneapolis (Section B-1*)* Saturday, November 10, 2018

- **Diane Waavick** tells of a faith community approach to connecting individuals and their families with needed, but often hard to find, mental health resources in the Minneapolis area.
- **Deb Haynes** provides services to the homeless and incarcerated who live with mental health challenges in the community of Fairfax, Virginia.
- **Heidi Goehmann**, a many-faceted deaconess who lives in Norfolk, Nebraska, reminds us all of the benefits of connections for caregivers and care receivers.
- **Stacey Tasler Crosson** writes about a parish she currently serves as the Minister of Care and Outreach in Springfield, Virginia with embedded mental health services.
- **Joseph Kim Paxton**, doctoral student at Claremont School of Theology, offers his thoughts and theory around secondary trauma in our society today.
- **Paul Shoup**, a retired AAPC therapist living in Stanford, Washington, is learning to enjoy doing what *he* wants to do while discovering the conative aspects of the human being.
- **Fred Schramm,** now retired from full time pastoral counseling, draws on family systems theory and his own professional experience to offer direction for those serving in caregiving professions in this time of polarization and high anxiety.
- **Zion 2019,** the next triennial gathering of Lutheran chaplains, pastoral counselors and certified educators, is described. Hope to see many of our readers there. Keep watching for more information.

In addition to above named contributors to this issue of *Caring Connections*, I want to direct the reader to a podcast on the topic of mental health and treating mental illness. Dr Katharine "Kaz" Nelson, assistant professor of psychiatry at the University of Minnesota, and her brother George have developed a way to talk about mental health diagnoses and treatment that speaks to the average listener. Check them out at *www.theminddeconstructed.org*

Of behalf of the editorial board and of past editors, I want to extend deepest appreciation to Dave McCurdy who was on the ground floor in the creation of *Caring Connection* in 2004 and who edited two of the earliest issues. Since then, he has served on the editorial board intermittently for 15 years. Due to term limits on service, Dave is moving off the editorial board. Lee Joesten and I met him for lunch recently and agreed we want to continue to use him as a consultant and resource into the future. He served at Advocate for 12 years as the Senior Ethics Consultant and the Director of Organizational Ethics. Now, into his retirement, he is an adjunct professor in religious studies at Elmhurst College.

May you as care providers find this issue to be a helpful resource for your own mental well-being and in your ministries of caring for the mental health of others.

A Story-Formed Spirituality Group

Scott Davis

AFTER ELEVEN MONTHS, the appointment to facilitate the weekly spirituality group in the 18-bed Behavioral Health Unit at a local community acute-care hospital remains tinged with irony. A few months before the appointment, the spouse of a congregant-client in the same mental health system took umbrage at an observation which I made in a Sunday sermon. His words still reverberate: "You know nothing about mental illness!" This rebuke came from the man who called me three times in the prior year to do pastoral interventions with his wife during her cyclical mental illness crises—and to his satisfaction! A second irony is noted: in my last clinical position (as pastoral educator in a quaternary care hospital), I vigorously advocated for greater accountability in what chaplains were doing in behavior health unit spirituality groups. I advocated for written objectives to be part of the documentation of treatment. Move the calendar ahead, and now I am in a system with a free-standing behavioral health facility that expects such documentation in its acute-care behavioral health units. "Won't be too difficult," I thought, "In three months, I can repeat the modules!" Well, here I am in month eleven, and I have a few of the same patients in spirituality group I had in month one—and have been compelled to create a new lesson-module every week.

Christians are a story-formed people in and through Holy Scripture.

I don't begrudge the challenge of creating anew each week—I often find links with my weekly sermon and children's message preparation in my primary ministry in the congregation. In month nine, one of the longer-term patients told a newly admitted patient, "This guy teaches us every week with a different story!" He was accurate in his assessment: I choose stories because of my work with narrative in my theory papers for endorsement and certification, and in my doctoral thesis in homiletics (preaching from bedside encounters), where I have quoted Henri Nouwen's observation many times: "One of the remarkable qualities of story is that it creates space. We can dwell in a story, walk around, find our own place. The story confronts but does not oppress; the story inspires but does not manipulate. The story invites us to an encounter, a dialogue, a mutual sharing." [1] The other voice upon which this ministry is grounded is that of Stanley Hauerwas' earlier books through which I came to appreciate how we are a story-formed people in general, and Christians are a story-formed people in and through Holy Scripture. Weekly, I continue to find the wisdom of these observations of Nouwen and Hauerwas as patients and staff have been willing to discover their own stories nestled in the midst of the stories I have chosen,

1 *The Living Reminder: Service and Prayer in Memory of Jesus Christ* [Seabury, 1977], 65–66

and use the given story as a springboard to share and explore their own self-forming stories through the behavioral/mental health sojourn and life in general.

I choose to use (mostly) children's stories as the core of the voluntarily attended spirituality group so as to sidestep the issue of being too sectarian or Christian in my selection, and seek supporting spiritual stories that are inter-faith. And yet, this caution has proven to be too extreme, I can't remember a participant or staff member (who monitors the group time) that has not told me at the end of the group time that they espouse the Christian faith. Being Pop-Pop to four grandchildren (two four-year olds and two six-year olds), I had a basic library of stories sitting in the family room to complement my own more adult spiritual stories. I have found the suggested children's books for the weekly Revised Common Lectionary put out by *Storypath* and Union Presbyterian Seminary[2] a good place to explore new books. Recently, I shared Emily Jenkins' *Love You When You Whine* paired with the RCL First Reading from Exodus 16-17 where God's people complain and whine about their hunger and thirst, ending with a responsive prayer based on Psalm 136: "God's love never quits." Although I distribute objectives along with portions of the resources to be used in each session, I am often surprised by the directions which develop as the patients find their place in the stories presented. One week, a particularly animated patient—within appropriate behavioral boundaries set forth by the group—began raucously acting out the animal sounds in the Grimm Fairy Tale "The Bremen Town Musicians," with the result that by the end of the story, each of the participants had chosen an animal voice to share, to identify with, and to discuss around the topic of being neighbor to the other. Another surprise occurred when the group was sharing "It's You I Like" from *Mister Rogers' Neighborhood* TV show on the week of the anniversary of his death: a safe, benign subject, or so I thought. A long-time patient and occasional spirituality group participant accurately remembered the *Mister Rogers'* show that dealt with the theme of war. The passion of the participant turned the group from talking about self-worth to being victims of violence in their lives, which was intensely and unexpectedly cathartic with mutual support attending the sharing. The reading of Robert Munsch's *Love You Forever* on the Wednesday before Mother's Day was intended to speak about one's relationship with mothers. Instead, it evoked the tear-filled memories and enduring grief of a mother whose cyclical behavior-health admissions resulted in her now-adult sons having forgotten her: how she longed for a reconciliation in which she would be rocked back and forth by her sons. Again, the group that night found their stories in their peer's pain and found mutual support. A group favorite, which had been cited often in subsequent weeks was Margaret Wise Brown's *The Runaway Bunny*¸ which I

I am often surprised by the directions which develop as the patients find their place in the stories presented.

2 *storypath.upsem.edu*

paired with the lost-and-found stories in Luke 15 and Psalm 139 accompanied by my white rabbit puppet.

Once a month, I move to more adult-oriented stories. I've used Francis Dorff's The Rabbi's Gift" found in the beginning of Scott Peck's *The Different Drum* as a way to explore the possibilities of reframed visions and becoming community. In the midst of frustrations of not progressing quickly enough, I have shared David Juniper's story, "Walking with the Lord," paired with

Wilfred Arlan Peterson's "Slow Me Down Lord." Walter Wangerin, Jr.'s classic tale of "The Ragman" gave opportunity to name what old rag each of us dearly wanted to discard and how that might transform our being in the present. Oh, even Dr. Seuss has found space in the adult line-up as I paired *The Butter-Battle Book* with a touching cliff-hanging tale of reconciliation entitled *The Forgiveness Garden* by Lauren Thompson. When I finished the two stories, the participants started quoting Matthew's Jesus' teachings on forgiveness without any prompting from me—one of the very objectives intended!

It's month eleven (I do all but one week each month—church council takes priority), and every Monday as I am in prayer and study for sermon and worship preparation, my wife hears the same assertion: "It's time to start repeating the topics!" And each Wednesday afternoon she discovers I've prepared yet another new spirituality group topic with another new story. In the stories shared, I share; and as I share, the participants in the behavioral health unit spirituality group find their space and share their stories. And hearing their stories of struggle and triumph, of questions and connections, I am privileged to share new stories of spiritual discovery and formation with my congregation who will never meet or know this storied-formed people in whom I have come to delight as an anticipated weekly ministry.

The Rev. Dr. Scott K. Davis is a former certified ACPE educator. Now a retired APC Board Certified Chaplain, he is called as Pastor of Brickerville United Lutheran Church (ELCA) in Lititz, PA. He has been maintaining his passion in hospital pastoral care by serving as prn chaplain for Wellspan-Ephrata Community Hospital in addition to his full-time congregational ministry.

Spirituality, Breath, Connection and Peace

Diane L. Ott-Hager

O Lord, I ain't what I ought to be,
And I ain't what I want to be,
And, I ain't what I'm going to be,
But, O Lord, I thank you
That I ain't what I used to be.[1]

"WE'VE ALL GOT S*!** [Insert your scatological verbiage of choice here.]" This abrupt wisdom is regularly in my thoughts – and sometimes is spoken aloud – as I facilitate spirituality groups among clients in an inpatient hospital-based, Behavioral Health treatment program.

Accompanying individuals and groups who are working to reconnect with spirituality in the midst of mental health treatment is a privilege and responsibility that evokes a complexity of emotions for the client/patient and for the chaplain!

In reality, we're in the same boat; it's our common humanity. We are fearfully and wonderfully made – breathed into life in the image of a loving, life-giving God. We can make connections to life mediated through bodily senses; precious relationships formed; lessons learned; truths held; traumas lived – we're connected to the essence of self, others, and Higher Power simply through the process of living life.

And we are fearfully and wonderfully complex! We've all got stories – the little anecdotes we share to connect with others – and, the expansive incredible story of life that is carried from ancestors, to family of origin, to the most intimate and private aspects of mind and heart and spirit. The dignity of life is breathed into individual and shared truths; and, the actuality of life forms us into the very people we are.

When medical interventions actually level one to powerlessness, what can be precipitated is a spiritual transformation for the client and for me.

I've grown through several units of clinical pastoral education (CPE). With each unit, great practical skill building and research challenged me to find those growth edges that had been untouched. However, in the winter/spring of 2016, I found myself simultaneously stretched and inspired in unimagined ways by persons I met in adult chemical dependency programs. Whether meeting one-to-one in an inpatient detox unit or co-facilitating spirituality groups in residential treatment, I have marveled at the authenticity – and sometimes the painful honesty – of the persons encountered. When medical interventions actually level one to powerlessness, what can be precipitated is a spiritual transformation for the client and for me.

1 (Recovery wisdom from *The 12-Step Prayer Book)*

I find it helpful to consider the connection between the complexities of life and spirituality – the link between breath and spirit. For me, the presupposition and metaphor are supported by consideration of three ancient words which point to air ... breath ... wind ... spirit:

- Hebrew – *ruach*
- Greek – *pneuma*
- Latin – *spiritus*

Once the heart and mind open to the idea of breath and spirituality being intertwined, a new understanding of life can be rediscovered or re-imagined.

The presupposition, *"If you're breathing, you're spiritual..."* usually fosters attention and curiosity when spoken in spirituality groups. Many mental health clients are familiar with diaphragmatic breathing to reduce anxiety; yet, little or no consideration is given to the nonphysical benefits of pneumatological link between God's gift of life and one's soul. The biological truth can cause one to consider spirituality in new ways:

- breath and spirituality are gifts given by a Power that is beyond/outside of human intellect, skill, or will.
- respiration – the inhale and exhale of the body animates us with vitality and life.
- aspiration and inspiration – a Source beyond the self who brings wisdom to life.
- Transcendent Love and breath are present – even when no one is paying attention.
- Creator conceived connections for life occur in the symbiosis of vegetation offering oxygen and humans exhaling carbon dioxide.
- spirituality is experienced and expressed individually *and* corporately; i.e., it's singular *and* shared.
- breath and spirit are organic or organizational, accessible and portable.
- breath-work and spirituality are transformative.
- breath and spirituality **are** at all times, everywhere!

When we pay attention to our breath as a spiritual practice, we attend to our spirit; when we pay attention to our spirit, we attend to our physical breath and health. It's that simple!

Once the heart and mind open to the idea of breath and spirituality being intertwined, a new understanding of life can be rediscovered or re-imagined. The opportunity to practice healthy spirituality fosters a connection to/with Higher Power, with others and with oneself; and, this connectivity provides a framework to explore the meaning/purpose of life. Even for the one who has not struggled with chemical dependency or mental health issues, there are "addictions" that can impede an open heart and mind. Impediments might include anger, judgmentalism,

overeating, perfectionism, workaholic behavior, etc. Spirituality – i.e., a focus/mindfulness/attention on a Higher Power beyond the self – is the connection that fosters openness and health.

Thinking of spirituality as a way to attend to one's Higher Power – and to frame life events with a sense of meaning/purpose – encourages an openness/appreciation to Wisdom that transcends all that is human.

And yet, we mediate life through both our singular and corporate human experience(s). Hence, spiritual skills and practices can help facilitate an integration of the body with the mind and with the spirit; skills and practices can develop into healthy habits. Spiritual practices are ways to live out skills learned and developed in treatment. Spirituality is as singular as the personal piety of a person; and, spirituality is as expansive as *every* culture throughout *all* time. To explore one's spirituality in the midst of the Wisdom of the Ancient of Days takes the courage of an open heart and mind. The faith truths breathed into us from the very moment of life allows for self-compassion, love of others, and the understanding that Transcendent Love is omnipresent.

Spiritual skills and practices can help facilitate an integration of the body with the mind and with the spirit; skills and practices can develop into healthy habits.

The ambiguity of life teaches us to be suspicious of our own thoughts and to be skeptical of others. In a cause-and-effect [fallen] world, innocent, idealistic, and inspired notions can turn into harsh realities. Sacred, universal, and individually-held truths can harden to form suffering of heart and mind. That suffering can lead to less-than-healthy behaviors in order to cope. Suffering can cause us to lose sight – or, to even forget – that the God of Love knows the full depth (i.e., delight and/or despair) of human experience. When the unimaginable becomes a crisis-point, spirituality provides the opportunity to be a pivot-point. Spirituality points us to Truth – to Transcendent Love.

The True Source of the dignity of the human condition has breathed into each individual. Spirituality integrates that Breath and breadth into a healthy body, an open mind, and spirit of love for self and others. The essence of spirituality is life-giving, heart-rending work for the one willing to be spiritually courageous and vulnerable.

Charles Suhor offers a *Connectedness Meditation* – a litany – that elegantly expresses the mutuality of life:

I am open to my connectedness with all things.

I am connected with my body and spirit.
May I be at peace.

I am connected with the most beloved in my life.
May we be at peace.

I am connected with friends and colleagues.
May we be at peace.

I am connected with those I see casually and in passing.
May we be at peace.

I am connected with those who have angered me and I have angered.
May we be at peace.

I am connected with all humanity, dead and living and unborn.
May we be at peace.

I am connected with visible animals in the world.
May we be at peace.

I am connected with animal life microscopic and unseen,
teeming in the natural world.
May we be at peace.

I am connected with animal life, dead, living, and unborn.
May we be at peace.

I am connected with living plants of the world.
May we be at peace.

I am connected with plant life microscopic and unseen,
teeming in the natural world.
May we be at peace.

I am connected with all plant life, dead and living and unborn.
I am connected with all inanimate things, from the clothing closest to my body
to the stars in farthest galaxies.
May we be at peace.

I am connected with unknown forms of matter and life and spirit.
May we be at peace.

I accept my connections with all things, and I am open to oneness with All.

Spirituality invites us to remember, to be mindful and to pay attention to the One who is constantly reaching out to us in Love. May the Transcendent transform your life-breath and spirit. Thanks be to God!

For more than forty years, Diane L. Ott-Hager served Lutheran congregations, taught in classrooms, and currently serves as a chaplain at University of Minnesota Health in Minneapolis. In January 2016, she came under the clinical guidance of Anna Kendig, MDiv, BCC, who has become her mentor and guide. Diane's experience over these past two years points to the fact that as client/patient and chaplain regard one another in a climate of mutuality – in life, in spirituality, in shared ministry – the Love of God is made manifest. She is grateful to the individuals in the inter-faith residential treatment spirituality groups who remind her of a God who loves us all into life, gives us the breath of life in every temporal moment and assures us of the promise of eternal life to come. Thanks be to God!

Mental Health and Correctional Chaplaincy

Chaplain Edward A. Neiderhiser, Ph.D., retired

INMATES WITH MENTAL HEALTH NEEDS often make up a disproportionate presence in prison populations and provide unique opportunities for ministry in a correctional context.

The high percentage of mental health inmates in the Pennsylvania State prison population (the system with which I am most familiar) has frequently been linked to the closing of state administered hospitals for the mentally ill thus removing the availability of care for those unable to afford private facilities. Without adequate resources or supervision, many individuals with mental health issues too often engage in behaviors deemed by the community at large as "criminal" and find themselves sentenced to lengthy prison terms.

Prisons are primarily designed to provide secure confinement and treatment for those adjudicated by the courts for varying degrees of offense to the community. They have not always included a program component geared specifically for those suffering from mental illness. With the influx of substantial numbers of inmates exhibiting such issues and in light of litigation concerning their treatment in correctional settings, there has been much movement in recent years to provide programming particularly targeted to this segment of the incarcerated population.

The intent is to incorporate such individuals as fully as possible into a more mainstream participation in the life of the incarcerated community as well as to provide regular therapeutic counsel and activities for those requiring more restricted accommodations due to the inability to function in general population. Restricted housing can become counterproductive to these goals as the experience of being isolated in lock-up twenty-three hours a day can lead to deterioration rather than improvement for those in such fragile conditions. Developing and executing effective treatment plans for those so identified can be a complex process.

Without adequate resources or supervision, many individuals with mental health issues too often engage in behaviors deemed by the community at large as "criminal" and find themselves sentenced to lengthy prison terms.

The presence of chaplaincy staff seeking to address these concerns and actively participating in such programs can be a valuable and constructive part of the treatment process.

Prior to my retirement in 2015, I served for 26 years as Chaplain and Director of Chaplaincy and Religious Services at SCI-Graterford, the largest maximum security prison in the Pennsylvania State Correctional System. Over the years the population at Graterford, with a designed capacity of less than 3000, frequently ranged from 3800 to 4200 inmates. The facility's mental health roster regularly encompassed

20 – 25% of the population, meaning at any given time 800 to 1100 individuals with such therapeutic needs were confined in substantially over crowed conditions.

Graterford has subsequently been replaced by the newly constructed SCI-Phoenix, but concerns for mental health inmates remain. This is indeed a significant piece of the prison chaplain's ministry involvements.

The incarcerated mental health roster includes inmates identified by several categories of need:

- those with minimal needs who are able to function in the general population but may be assigned to regular contact with a psychologist
- those requiring psychiatric attention and varying applications of psychotropic medications
- those whose functioning level necessitates housing in restricted units for their own protection and the protection of others
- those meeting the standards for a full commitment to a licensed mental health facility which may or may not be available within the facility's structure

While these concerns are common to the myriad of prison facilities that dot the landscape across our country, I can only speak to the attempts to address them at my facility. I do believe programs laid out by the Pennsylvania Department of Corrections and executed by local professionals are dedicated to the best interests of those incarcerated with mental illness while remaining aware of and compliant with the security concerns of a maximum security prison. This can be a complex balance, but the effectiveness of those so tasked is often impressive.

Chaplaincy staff very much seeks to partner with these professionals as part of a team effort to address effectively the needs of such a large portion of the inmate population.

To address these needs, the Department of Corrections wisely employs a substantial staff of psychologists, psychiatrists, mental health nurses, mental health therapists and counselors, as well as providing special training for COs (Correctional Officers) who would be assigned to sensitive security responsibilities in mental health units. Chaplaincy staff very much seeks to partner with these professionals as part of a team effort to address effectively the needs of such a large portion of the inmate population.

In the course of their duties, chaplains may pursue ministry opportunities for mental health inmates in a variety of ways.

One-on-one counsel is readily available, often in the chaplain's office either at the request of the inmate or initiated by the chaplain. More frequently chaplains visit such inmates during the course of regular rounds on housing units including the restricted areas. Chaplains are in fact assigned to rounds in all the special units on a rotating schedule. Every inmate classified as mentally ill has direct personal access

to a chaplain a minimum of five days a week. This also includes official holidays when chaplains take their turn visiting all restricted units on the day off for regularly scheduled staff and activities.

To ameliorate the effects of long-term isolation, Chaplains also provide *routinely scheduled out-of-cell activities* for mental health inmates in restricted units. Inmates wishing to participate are removed from their cells to gather as a group to meet with the chaplain. Such activities may consist of open conversations, viewing of select videos, interactive readings of stories, listening to and discussing music, or other group involvements.

Out-of-cell activities may sometimes attempt to have a worship content. Because of the broad array of religious traditions represented in prison populations, this can, however, become more divisive than unifying. Many mental health inmates may not be familiar or comfortable with liturgical formats, traditional language, sacred text references, or prayer practices not their own. However, *generic "God" discussions* can be fruitful. Likewise inviting everyone to offer some prayerful expression out of their own sense of spiritual self can be effective in encouraging personal focus, communication, and a positive group dynamic.

Inviting everyone to offer some prayerful expression out of their own sense of spiritual self can be effective in encouraging personal focus, communication, and a positive group dynamic.

For mental health inmates in general population, chaplains often make an intentional effort to *include them in the regular worship services* of their tradition. It is not uncommon to invite someone to read a lesson, give a testimony, serve as usher, sing with a group, et al. In addition, regular attendees at Catholic Mass, Jumah prayer, Sabbath services, Native prayer circle, Protestant services, Jehovah's Witness Meeting and others are often remarkably compassionate in welcoming and assisting the appropriate participation of the mentally ill. Such active concern often extends to the housing units where members of the various congregations see it as part of their personal ministry to care for and protect those who are vulnerable.

For many years, as an example, the worship life of Graterford's Church-Behind-the-Wall (Protestant Congregation) included a choir whose membership was made up primarily of these vulnerable ones. Their pride of participation and joy of achievement was remarkable, encouraging behavioral and social growth as well as personal responsibility and communal interactions.

It is important that chaplains do not seek to evangelize any vulnerable population. Chaplains should be aware of and conversant with a broad range of spiritual traditions so as to be prepared to inspire growth within the context of that which is familiar to the inmate. Demonstrating a spiritual multilingual ability encourages everyone to explore and embrace the sense of grace, peace, comfort offered by their own traditional language and teachings. While such informed

understanding and conversance with multiple faith traditions is the responsibility of chaplains across the board, not just for mental health populations, success in correctional chaplaincy depends on conscious exercise of this sensitivity.

Ministries of the grace, love, and compassion that are common to all significant religious expressions continue in the efforts of correctional chaplains seeking to address the needs of the least of these our brethren. The coordinated and integrated presence of such chaplains can be a significant part of the effort to incorporate mental health inmates as fully as possible into the everyday life of the human community.

Ed Neiderhiser is an ordained Lutheran minister with forty-five years of professional experience. He holds a Ph.D. in Hebrew Scriptures, Cognate Languages, and Arabic studies, and has served parishes in the Urban and Suburban areas of Philadelphia. For twenty-six years, until his retirement in 2015, he served as Protestant Chaplain and Facility Chaplaincy Program Director at the maximum security Graterford prison in the Pennsylvania state system. He returned to the prison for several months in 2018 to assist with high stress levels and anxieties surrounding the closing of Graterford and the transition to the newly constructed SCI-Phoenix. He was named Chaplain of the Year in 2015 by the Pennsylvania Prison Chaplains Association. With wife Sally (artist and mental health worker with behavior problem and autistic children), he remains active in his local community and performs regularly as a Jazz trumpeter.

Faith Communities and Mental Health: A New Perspective

Diane Waarvik

"God has shown you, O mortal, what is good; and what does the Lord require of you but to do justice and to love kindness and to walk humbly with your God." Micah 6:8

WE ARE HAVING A MENTAL HEALTH CRISIS in the USA! According to Mental Health America, one in five adults will have a mental health condition. Depression and anxiety are the most frequently seen illnesses in our youth; there is an extreme shortage of mental health practitioners; and, 56% of all adults do not get the treatment they need.

What does this mean for our faith communities? Congregations are often aware of the mental health needs and barriers in their community contexts, but they do not have the ministries or partnerships that can offer holistic support to their members and neighbors. Faith communities have a history of outsourcing mental health support at the crisis level without making theological, spiritual, relational connections within the church, synagogue or mosque. When mental health is only discussed within the context of a crisis or threat (mass shooting, completed suicide, demon-possessed Bible characters, etc.), the stigma persists that mental health is isolating, embarrassing, or evil.

Many faith communities have integrated health into their congregational life. Health ministry is a lived faith that is intimately connected to the core of what Jesus did. When Jesus sent his first followers out to do the work for which he had prepared them, he sent them to "proclaim the kingdom of God and to heal."[1]

Health ministry is a lived faith that is intimately connected to the core of what Jesus did.

How do we reach out to our community in order to help heal those in need? Why would the churches want to have leaders learn more about how to minister to individuals with mental health conditions such as depression, suicide ideation, anxiety, schizophrenia?

- According to a post September 11, 2001 Red Cross Survey, 60% of people in emotional distress turn first to clergy for help before going to a psychologist or psychiatrist. Clergy are often on the front lines of mental and emotional crisis, but few feel well prepared to respond effectively to troubled people experiencing a psychiatric disturbance.

1 Luke 9:2

- There are far more churches, temples and mosques than mental health care providers in our rural and urban communities, and they are more evenly distributed geographically.
- Faith groups are already committed to social justice issues and advocacy for the marginalized, poor and oppressed in society.
- Faith groups already provide educational settings so, by interacting with them, the National Alliance on Mental Illness (NAMI) can educate a larger percentage of Americans.
- Not only do faith communities play a unique role in society and benefit from NAMI outreach, but NAMI affiliates also gain a great deal from connecting with religious bodies (NAMI FaithNet).

A gracious, loving, welcoming and accepting community can be a salutary refuge from the rigors and isolation accompanying depression (or other mental illnesses). It is imperative that the community be educated, sensitive and aware of the importance and impact of its ministry to those afflicted and affected by depression (or other mental illnesses).[2]

A gracious, loving, welcoming and accepting community can be a salutary refuge from the rigors and isolation accompanying depression (or other mental illnesses).

In 2014, Bethlehem Lutheran Church Twin Cities (BLCTC) studied our neighborhood through a grant from the Epiphany Legacy Fund. After reviewing and assessing our community, we discovered that the greatest need for those living with mental illness was to break through the barriers they face: barriers of stigma, lack of resources, housing, jobs, insurance, and a lack of understanding of what mental illnesses and related conditions are and what to do about them. From this discovery, Mental Health Connect was created as a ministry of BLCTC.

Mental Health Connect (MHC) is an interfaith outreach ministry working to provide community-based resources, support and education to improve *access* to mental health services and to *connect* individuals and families with the services they need.

MHC started in 2015 with the development of a navigation and education model that addresses barriers to mental health. MHC confronts the inequality of access to affordable mental health services and social supports. In this effort, the stigma of mental illness is recognized and addressed through education and outreach to the communities across the socio-economic spectrum. The foundation of the MHC model is based on a key personnel role: the Mental Health Navigator (MHN). This position provides a novel and unique faith community approach to mental health through personalized assistance with referrals, education, and support.

2 Albers, Robert, et.al, editors. *Ministry with Persons with Mental Illness and their Families*, Fortress Press, 2012

The Navigator has preparation and experience in social services to assess client resource needs, to identify barriers to mental health care, and to develop a plan to meet desired outcomes. If extended support is indicated, a MHN who has certified peer specialist qualifications may be engaged. The certified peer specialist (CPS) is an individual in recovery with a diagnosis of mental illness who has completed CPS training. She/he assists clients who could benefit from someone who may have experienced similar obstacles to care.

The MHC team is mobile and can meet clients at their homes, community sites, their congregations, etc. The Navigators work together to promote the MHC service through community presentations, congregational site contacts and neighborhood distribution of program materials. The MHC team engages with an array of community resources to meet the needs of their clients. Their services are free of charge and open to the community.

Churches can step up to speak to the world with God's message of healing -beginning with the people in their own midst who badly need to hear this good news.

Congregations can be powerhouses of life-giving community. Churches can step up to speak to the world with God's message of healing -beginning with the people in their own midst who badly need to hear this good news. Health ministry is not about filling the pews with doctors and nurses. The roots are not in science and medicine but in being faithful to the gospel's call.

Faith communities play an important role in the health of their neighborhoods. MHC aims to enhance that capability and expand the program across low income/ underserved communities in Minneapolis and surrounding areas through a growing network of congregations and community service sites. Therefore, various faith communities in the Twin Cities have joined together with Bethlehem Lutheran to create a *Mental Health Connect Collaborative*.[3] Each faith community member of the collaborative appoints one or more *ambassadors* to help implement MHC services.

The role of the Mental Health Connect ambassador is to assist with program planning and evaluation, implement the MHC tool kit of educational resources within their congregations, schedule on-site Navigator presentations, and meet with other MHC Ambassadors to share experiences and expand resources. The interfaith community collaborative identifies and participates in scheduled events to share outcomes of the MHC model to the broader community. In these ways, MHC seeks to equip congregations to effectively address issues of mental health resource access.

3 Mental Health Connect Collaborative members are: St Joan of Arc Catholic Church, Mt. Olivet Lutheran Church, Zion Lutheran, Bethlehem Lutheran Church Twin Cities, Shepherd of the Hills Lutheran Church, First Universalist Society, First Unitarian Church, Basilica of St. Mary Catholic Church, Redeemer Lutheran Church and Living Table United Church of Christ. In addition to the churches, MHC works in partnership with Fairview Health Community Services and Vail Place.

Impact on the community served

The MHC model supports the client and family with timely interventions in community settings versus in an emergency room or inpatient hospital program. This approach engages them in the appropriate level of care and supports client follow-through. It empowers persons to make healthy changes in the recovery process, while encouraging communities of faith to address the stigma around mental illness. MHC offers a low-cost approach with savings to personal and medical resources through education and support at a natural point of community contact.

One client reflected on their experience. "You have begun to change a gaping wound. So many others are not so lucky. I am so blessed to be getting your help. You are doing a service no one offers anywhere. It is life-saving!"

When engaged, the MHC model directly supports the interfaith community with timely and effective response to mental health concerns. We invite congregations to join in this model because they are connected to the communities and they want to serve their neighbors. And, in doing so, families, individuals and faith communities are transformed.

Diane Waarvik, BSN, MSN is the Director of Congregational Care at Bethlehem Lutheran Church Twin Cities. Diane oversees all of the Care Ministries at Bethlehem which includes Mental Health Connect. She serves on the board of Total Health Africa, a non-profit serving in Bukoba, Tanzania where she travels once a year to offer training and supervision to the Community Health Workers. Diane also serves on the boards of the Westminster Counseling Center and the Fairview Interfaith Network in the Twin Cities.

Homelessness, Incarceration and Mental Illness

Deacon Deb Haynes

SERIOUS MENTAL ILLNESS, HOMELESSNESS AND INCARCERATION are close companions today. Since deinstitutionalization, the shelters, prisons and jails serve the mentally ill as much or more than behavioral health supports or housing. In Fairfax County, VA, 44% of homeless single adults enumerated by Housing and Urban Development's Point In Time Count in January, 2018, self-identified as suffering from serious mental illness and/or substance abuse.[1] Many of these individuals are treatment-resistant and shelter-averse, and so they come to the Lamb Center, an ecumenical Christian daytime drop-in for the poor and homeless. Here they may shower, eat, have their laundry done, attend Bible study and AA meetings, work with our case managers, see a dentist or a nurse practitioner, choose clothing and be known as a beloved child of God. Many experience delusions or paranoia that do not allow them to use the county shelters (even if there were miraculously enough beds), but they feel safe here.

We serve 1,700 people a year at the Lamb Center, not all of them homeless, averaging 102 per day. The county mental health team who comes to do outreach estimates that on any given day, 75% of our guests suffer from serious mental illness. We also receive outreach from the Jail Diversion Team, a special team dedicated to justice-involved individuals whose root issue is untreated mental illness. According to the Bureau of Justice Statistics, 37% of state and federal prisoners and 44% of jail inmates had been told by a mental health professional in the past that they had a mental health disorder.[2] Many communities, including my own, tout that they are ending homelessness. From my office, it appears that our social services have made great strides toward that goal with the unintended consequence of concentrating the most ill and difficult to serve in unsheltered homelessness.

It is extremely difficult to engage with a provider, acknowledge a diagnosis and/or addiction, take medication and continue engagement while homeless, incarcerated or cycling between the two.

Shelters, prisons and jails are not ideal places for behavioral health treatment. It is extremely difficult to engage with a provider, acknowledge a diagnosis and/or

1 From Fairfax County 2018 Point In Time Count: *www.fairfaxcounty.gov/homeless/point-in-time-count* Forty-four percent of single adults (221) who were experiencing homelessness suffered from serious mental illness and/or substance abuse, identical to last year.

2 *www.bjs.gov/content/pub/pdf/imhprpji1112_sum.pdf*

- More than a third (37%) of prisoners had been told by a mental health professional in the past that they had a mental health disorder. Prisoners were most commonly told they had a major depressive disorder (24%), a bipolar disorder (18%), post-traumatic stress disorder (PTSD) or personality disorder (13%), and schizophrenia or another psychotic disorder (9%).
- Forty-four percent of jail inmates had been told by a mental health professional in the past that they had a mental health disorder. Nearly a third (31%) of jail inmates had previously been told that they had major depressive disorder and a quarter (25%) had been told they had a bipolar disorder. About 18% of jail inmates had been told they had an anxiety disorder, 16% had been told they had PTSD, and 14% had been told they had a personality disorder.

addiction, take medication and continue engagement while homeless, incarcerated or cycling between the two. Instability and trauma are endemic to homelessness and incarceration, and the enemy of keeping appointments, staying on a medication regimen, and complying with assessments. A major emphasis of our work at the Lamb Center is to meet our guests where they are. We get to know them, show them love and build their trust. We create an island of stability in their life. Only then is it possible to introduce them to mental health outreach. Sometimes even the inducements of applying for housing or disability are insufficient to engage them with treatment.

We create an island of stability in their life. Only then is it possible to introduce them to mental health outreach.

We see successes: the long-timer who finally enters a dual-diagnosis residential treatment program, the seriously mentally ill young woman exploited for sex work that we connected to law enforcement and inpatient treatment, the angry young man with a violent criminal history who accepted treatment and is now in stable housing. We also see tragedies: the 33-year-old man who was run over and killed while prostrate in the road after not meeting the legal criteria for an involuntary commitment, the dual-diagnosis mom who loses parental rights to all four of her children, the 62-year-old woman who believes imposters replaced her family and refuses their help.

One of the most challenging and painful aspects of ministry here is the wellness checks from the parents of mentally ill young adults. I have several mothers who check in with me regularly, and all I can tell them is what anyone could observe on the street: "Yes, I saw her, she's alive. She was dressed for the weather and looks like she's eating." I cannot tell them what they really want to know – is she in treatment, has he applied for housing or a job, is she being trafficked or abused, is he using drugs or in trouble with the police. The agony of these parents haunts me. Most of them I have never met in person. They call or e-mail for fear that encountering their ill child at the Lamb Center would drive their child away from the resources here. I listen to them, sharing love, reassurance and prayer. I hate to say, "I'm sorry, I can't tell you that" when their questions would violate their adult child's legal right to privacy.

One mother emailed to inform me that she changed the locks after her young adult child became too dangerous to allow in the family home. Her heartbreak was breathtaking, but she has to protect the lives of the others in the home. It was a brutal choice to make. I assured her that she had done everything in her power, asked her not to punish herself when her child's mental illness punishes both of them already, and prayed that the peace which passes understanding would be in her heart and mind. She replied with trust in God and hope for a future in which God answers her prayers.

The Lamb Center's theme verse is Jeremiah 29:11, and we rely on the hope and future that God has promised. Trusting in that promise, we love our most seriously mentally ill guests, and lavish God's grace on them.

Deacon Deb Haynes is called by the Metropolitan Washington DC Synod of the ELCA to the Lamb Center, where she is Assistant Director for Case Management. The Lamb Center is an ecumenical Christian ministry that serves the poor, the homeless and the marginalized in Fairfax, VA. Deacon Deb is a volunteer worship leader and preacher for the Community of St. Dysmas, an ELCA congregation inside the Maryland Department of Corrections.

The Place of Connections and Relationships in Treatment and Care

Heidi Goehmann

LIKE MOST OF THE WORLD, I have only so much tolerance for human interaction. Give me a book and a bathtub and I am set for my idea of a perfect evening. I like kayaking over canoeing, because there is only one seat. As a writer, I could squirrel myself away in my upstairs office for days and only come out for food and the occasional visit to the restroom.

All of this is true, and I am a person who likes people! I highly value sitting across from someone and hearing their story. I feel all warm inside when my table is covered in good food and surrounded by joy and laughter. I like it when my neighbor stops me in the grocery store to tell me about their recent family shenanigans.

We usually look at our relationships, and even our relationship with our inner selves, as something to balance…a little time with our spouse here, time with our children over here, workplace relationships in this slot here, maybe some time for friendship on the weekend, and a little selfcare here and there.

Our relationships roll out *according to* our schedule more often than they roll out *in relationship* to those lovely faces we have the opportunity to connect, learn and grow, or share joy and sorrow with on any given day.

Our schedule essentially ends up driving our relationships, rather than the other way around.

Most people let relationships happen to them and believe they have very little agency over the relationships in their lives.

Then, we turn around at the end of the week, the month, the year, anytime we settle down long enough, and we find ourselves feeling isolated, a little sad or lonely, at the very least dissatisfied with this life, wondering if the path we are forging is the one we were meant for. Each of you likely know all this rooting around and meta-analysis of our own inner worlds and *relationship with relationship* is useful and good for growth because of your chosen profession and life vantage point. What comes to mind for me, however, is all the people we interact with regularly who do not understand the value of relationship, or more importantly: the value of genuine connection.

After working in ministry and mental health for over fifteen years, I have noticed a shocking theme: most people let relationships happen to them and believe they have very little agency over the relationships in their lives. Many will not stop to consider their relationships or their need for relationship, unless a crisis comes, and some not even then. The question begs, *what is the value of connection? More directly, how can we, as those who enter into people's lives in places of crisis, treatment, or care,*

offer support and connection, however momentary. How can we also help those in our care find the support and connection they need through the longer haul of life - in the ups, the downs, and the in-betweens.

Why connection matters

We come from a Connected God. We understand that even those people we serve with zero connection to Jesus have been created by this Connected God. God shows us the importance of connection by His very existence in the Trinity, three persons, One God. Then, He connects Himself to people continually. In the Garden of Eden, He created man and woman to connect with and connect together. He created marriage and family, the pièce-de-résistance of connection, but in creating Adam and Eve, He also created community and connection, one person to another.[1] Sin entered into that connection. It was devastating and continues to be devastating. Sin pokes at all our relationships, making them imperfect and sometimes just plain heartbreaking. Sin breaks connection.[2] Sin makes relationships a lot of work, hard work, constant effort, and people spend a lot of time disconnecting to avoid the heartbreak and the work. But God, in His connectivity, walked into our sin, in the person of Jesus Christ and connects us with grace, which makes the connection stronger than when it started. In the weakness of our imperfection, He is strong.[3] Relationships and connection grow through reconciliation, rather than wither in stagnation. This doesn't make sin good, but it does tell us that while Satan would wound us, wound our relationships, and distance us from God and one another in our sin, God uses even sin to strengthen connection and grow relationships.

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Systems theory reminds us that we are all working cogs in a giant wheel.[4] We are not islands and our relationships are not vacuums. We know people are deeply impacted by their social environments and interactions with those around them. While western culture is slower to understand and make peace with this fact,[5] many other cultures highly value and understand the interconnectedness of people in families, workspaces, neighborhoods, towns, nations, and more, as well as their impact on one another. Because of this, many cultures have adopted longer maternity and paternity leaves for attachment and bonding, adjustments to educational policy, and addiction treatment norms which highly engage existing and expanding

1 Genesis 2:15-25
2 Genesis 3:1-24
3 2 Corinthians 12:9-11
4 *www.academia.edu/4130515/Systems_Theory_and_Interpersonal_Relationships*
5 *www.scientificamerican.com/article/why-we-are-wired-to-connect*

a person's social support. We also know from research that connection improves physical, emotional, mental, and relational health outcomes.[6]

Helping those in treatment and care find and build connection

Connection happens spontaneously of course, in those "I'm not alone!" moments of interaction with a person. However, because of our culture, and the reality of a broken world, it is useful for connection to be taught. Particularly when working within mental health fields, crisis care, or any ministry which touches on moments of brokenness, grief, and despair, people tend to turtle themselves in, building an armor of protection against more harm, the pain of trauma, in an attempt to shield themselves from shame. The human nature response to sin is to hide, after all. How can we help those in our care reach out for connection, rather than fig leaves and armor?

How can we help those in our care reach out for connection, rather than fig leaves and armor?

Connect to them ourselves:

This is one of the great gifts of ministry and helper professions. We stand as a lighthouse of connection for people in dark moments. In my own Biblical and social research, I have found that God's version of community and connection does not always match up with dictionaries and data bases. Rather, God's definition of community is usually one plus one plus Him. Including and inviting starts with one person, sharing One God, who wants to connect with one individual. I am continuously surprised by the amount of people walking this planet who have known so little care and concern. Noticing another's pain, reaching out a hand for prayer together, sharing a snippet of time begins a link to positive connection and can rewrite pathways so used to disconnection and disappointment.

Teach connection:

When we connect with someone ourselves, a side benefit is that we end up offering a model of connection for that person. Research also identifies the benefits of teaching connection strategically. Studies identify the greater gains made in treatment when individuals or groups are taught help-seeking behaviors, connecting to social and emotional supports around them.[7] Again, pushing against putting on fig leaves and armors that we foolishly believe will make us impenetrable is in our DNA at this point and then reinforced environmentally. We can dismantle that with the help of our connecting Savior's message and tools from the therapeutic toolbox. Teach Genesis 2 and 3 to help people see the connectedness of God to His people and His connecting of people to other people. Teach the unique position of the Body of Christ to continue

6 *www.psychologytoday.com/us/blog/feeling-it/201208/connect-thrive*

7 *www.ncbi.nlm.nih.gov/pmc/articles/PMC2729718*

connection in a world that seems ever increasingly disconnected. Teach the gifts of The Five Love Languages[8] for connecting to those around us in ways they can receive it. Teach saying the word "Help," out loud. Even saying it can be hard for some people. Build on this exercise by adding one need, one desire, or one hope to it. Make a relationship web with someone to help them see all the possible people available to them and how they can connect to them, reach out for help, and also give it, which can be an empowering realization.

Connection is natural and necessary, but brokenness masks our intrinsic knowledge of what is natural and necessary. Instead God sent His Son, and His servants – you and me, His people – to share with the world His connecting work, His healing work and the intersection of the two. May you connect today with those around you, those you serve, and be connected by His light and life in the Spirit.

Deaconess Heidi Goehmann is a licensed independent social worker and mental health care provider, a writer, speaker, wife, mom, forgiven and loved child of God. She received her deaconess certification, as well as her bachelor's degree in theology and psychology from Concordia University Chicago, and her master's degree in social work from the University of Toledo with an emphasis on children, families, and social justice.

Heidi has worked in a variety of clinical settings including trauma treatment for abuse and sexual assault, cross-cultural research, Eye Movement Desensitization and Reprocessing, and home-based therapy. She has also served in various ministry capacities including college student ministry, women's and children's ministry, and missionary work in Haiti. Heidi is the founder of ilovemyshepherd.com which provides resources and advocacy for women, mental health, and genuine relationships.

She lives with her family in Norfolk, Nebraska.

8 *www.5lovelanguages.com*

Embedded Mental Health Care in the Congregation Breaks Down Barriers to Care

Stacey Crosson, DCE, LMFT

IMAGINE A FAITH COMMUNITY learning to embrace the health of the whole person, where those who struggle emotionally and mentally have easy access to care and pastors co-labor with mental health professionals to foster healing and restoration. Where the stereotypes surrounding mental health are decreasing and are replaced with empathy and care. Where congregation members acknowledge human brokenness, see hurting people, offer friendship, and are learning to talk openly about mental health issues. Where those who are suffering are referred to mental resources on their campus and in their community. Sound too good to be true? For many churches and mental health professionals on the east coast this is our new reality.

Four years ago, I took a position with a Lutheran church in Virginia to serve as the Minister of Care and Outreach. It was a new position for my church. There were several reasons the congregation decided to think outside the box and create this new position. First, there is a pastoral shortage in our synod and the days of multiple pastors on staff are coming to an end. With church attendance and financial giving decreasing nationwide, it was also more cost effective. Ordained ministers tend to cost the church about twice as much as a nonordained professional. The church recognized the increasing need to care for the whole person, however, and decided to consider a non-traditional church worker who might fit the need.

I was trained at one of our synodical universities in the early 1990s as a Director of Christian Education. In my first call to Florida, I went back to college to pursue a Master's degree in Marriage and Family Therapy. This strong foundation in the social sciences and theology, in addition to the twenty-plus years of experience in the people helping business, made me a good candidate to be embedded in a congregation to provide pastoral care and mental health support.

The church recognized the increasing need to care for the whole person, however, and decided to consider a non-traditional church worker who might fit the need.

In this new position I provide short-term counseling, teach psychoeducational classes, and create partnerships in the community that minister to the whole person: physical, mental, spiritual, and relational. We address topics like healthy boundaries in relationships, separation and divorce, loss and grief, how to have crucial conversations with loved ones, and understanding and helping people with mental health issues. To be honest, it was awkward at first, to address these issues so candidly in the church. In the therapist office, it's more natural since people expect to share openly about what is plaguing them. But in the church, it's not as easy to be

vulnerable. Members who struggle with mental illness and relationship issues often feel alienated from the church and distanced from God.

Upon my arrival, one of my immediate goals was to build a network for mental health referrals who took insurance and who were well vetted. I wanted to be confident that when our ministry staff made a counseling referral, it would be a good one. The worst thing a pastor can do is make a referral to a counselor or therapist who isn't taking new patients or doesn't accept insurance. When someone has finally decided to make the step to get help, it's important the referral is a solid one.

Over the course of several weeks, I visited with and interviewed forty mental health professionals who were personally recommended by our church members. I met some amazing professionals but was shocked to learn that most of them did not take insurance. The high cost of leasing office space and people's ability to pay the out of pocket session rate in the Washington, DC area made taking insurance cost prohibitive due to the lower reimbursable rate that most insurances provide. In addition, there is an administrative burden for mental health professionals that makes taking insurance less appealing. This was somewhat discouraging. Fortunately, I stumbled upon Safe Harbor Christian Counseling.

When someone has finally decided to make the step to get help, it's important the referral is a solid one.

In 1996, Eric Sundquist, founder of Safe Harbor Christian Counseling, observed the trends occurring in mental health. Having served as a parish pastor for three years, his eyes were opened to the plethora of mental health needs in his community. He became convinced of the power of the local church and mental health practitioners to transform lives. He heard the call to go back to graduate school and become a mental health clinician. Soon after receiving his license as a social worker, Eric founded Safe Harbor Christian Counseling.

"I saw the church as uniquely positioned for collaboration with mental health practitioners; specifically, a complementary relationship where the church provides the space to impact the broader community with mental health clinicians providing a specific targeted expertise related to treating mental health disorders," says Eric.

The ministry model of Safe Harbor is to partner with local churches and non-profits to use free office space at their location and embed mental health professionals on their campus. This model allows for Safe Harbor to take most insurances, assume the administrative work, and offer a reduced out of pocket rate. Having a trusted mental health provider on campus also provides pastors a soft hand-off when he or she realizes the parishioner needs more support than basic pastoral care can provide.

Pastor Chad Simpkins, pastor at The Journey Church in Springfield, Virginia has been partnering with Safe Harbor for six years and recognizes the gift of embedded therapists. "It seems like in the church, people are expected to 'get better'

only through their belief in God. You may hear people say, "God will fix all of your problems, it just takes faith." As a pastor, I do believe God can heal us; however, I also believe there are many times we need trained mental health professionals to help us walk through the 'dark nights of the soul.' Our partnership with Safe Harbor Christian Counseling provides a healing space for our church. I let people know as their pastor, I am not a trained counselor. I may not know the best step forward for them so enlisting the help from someone who is gifted to help them take the next steps on the journey is important. We not only encourage people from our church to get counseling, we help pay for it too when needed. God heals, but sometimes that healing begins through counseling. We are excited we get to experience those healings because of organizations like Safe Harbor."

Safe Harbor has more than 125 offices throughout Washington, DC, Maryland, Delaware, Virginia, Pennsylvania, Connecticut, Indiana, and Georgia. The majority of these are on the campuses of local churches. This direct access decreases stigma and challenges stereotypes in the church. It also allows for early intervention and decreases the inpatient admission rate for acute behavioral health issues, saving insurance companies money and keeping insurance rates low. "When issues can be handled at the local level and interventions are made earlier before a crisis occurs, it helps everyone: the family, the church, and the local hospital resources," says Pastor Chad. Safe Harbor's model has been so successful that it's embedding therapists in medical practices as well.

I let people know as their pastor, I am not a trained counselor. I may not know the best step forward for them so enlisting the help from someone who is gifted to help them take the next steps on the journey is important.

As I work up close with mental health issues in the church every day, I am seeing it more and more through a stewardship lens. As the church, we have the message of grace which is incredibly therapeutic and healing. We also recognize a variety of helping vocations that, when leveraged, can provide coordinated care for the whole person with sensitivity to people's time, their unique callings, and financial resources.

It's been almost four years since I started my position and I can see momentum in how we approach mental health as a faith community. By learning how to talk openly about mental health care, offering forums and special classes on mental health topics, and partnering with Safe Harbor to host an office on our campus, a gradual shift is occurring. I remind myself every day that just as individuals are growing and in process so is our church, as the living, present body of Christ. Members and staff are becoming more comfortable with the topic of mental health. Whereas before, members were scared to see a homeless person with mental health issues walk through the doors or felt unprepared in helping a depressed youth, they are now friendlier, less anxious, and know to whom and where to turn for help. Our pastors value having the referral source right inside our church so a smooth and coordinated

handoff can occur if the member needs more support than regular pastoral care can provide.

As with so many issues the church faces today, mental health concerns will continue to require leaders and lay members to be open to new approaches. One proven technique is the concept of embedding caring and professional mental health providers in the church and on their campus. Yes, it requires the church to provide a space for the care to happen, but the trade-off is well worth the investment. I have seen firsthand the positive change and impact this type of partnership can have a faith community. I encourage any church struggling with how to provide effective Christian care and counseling to consider partnering with an organization like Safe Harbor Christian Counseling.

"If you and your church are interested in meeting the mental health needs in your community, consider becoming a partner with safe harbor or another counseling agency in your area," Eric offers. "We are ready to help you help others."

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Secondary Trauma, Countertransference, and an Epistemology of the Cross

Joseph Kim Paxton

EVERY DAY, IT SEEMS, we are bombarded with social, political, and (un)natural traumas. Recently, there was a week of tragedy where two African-Americans were shot and killed in Kentucky, bombs were sent to members of a specific political party, and the Jewish community was ravished by the murder of 11 members of the Tree of Life Synagogue in Pittsburgh, PA. In the last fourteen months we, in the United States, have faced mass shootings in Las Vegas, NV, Parkland, FL, Santa Fe, TX, and Pittsburgh, PA. Over and over we are repeatedly exposed to and relive these traumatic events through media and social media outlets. These events affect us more than we think, and possibly, in ways that we are unaware of. Specifically, care providers might experience various forms of countertransference. Growing in an awareness of how these events may affect us as care givers, is an ethical duty and responsibility in the practice of care. To learn more about the effects of (secondary) trauma, we will engage the works of Judith Herman, Jeff Greenberg and Michael Hogg, Mary Solberg, and Duane Bidwell.

Judith Herman, in her work, *Trauma and Recovery,* says that "trauma is contagious."[1] This *contagion,* identifies the nature of secondary trauma. Through repeated or prolonged exposure to trauma, people can begin to experience symptoms of post-traumatic stress disorder. This *vicarious traumatization* can also take on another form of secondary trauma called *compassion fatigue*. Compassion fatigue reduces a caregiver's interest or capacity for empathy. In turn, this decreases their ability to hold space for the suffering of others.[2] This leads me to question, "How does vicarious traumatization and compassion fatigue affect how care providers think, feel, and act in care situations?"

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Before we answer this question, I would like to identify two types of exposure that may lead to secondary trauma: digital and local. Digitally-based secondary trauma can happen through media and, especially, social media channels. On the other hand, locally-based secondary trauma occurs through direct or repeated

1 Judith Lewis Herman, *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror* (New York: Basic-Books, 1992), 140.

2 Richard E. Adams, Joseph A. Boscarino, and Charles R. Figley, "Compassion Fatigue and Psychological Distress Among Social Workers: A Validation Study," *American Journal of Orthopsychiatry, 76* no. 1 (January 2006): 103-108.

exposure to traumatized care-seekers. Care providers may experience symptoms of trauma through (repeated) exposure to one or both types of secondary trauma.

A primary dilemma of vicarious traumatization and compassion fatigue is that they may influence the way a care provider thinks, feels, and acts in relationship to themselves and/or their care-seekers. Psychologically, this may be seen as a *countertransference* process.[3] Social psychologically, however, countertransference is caught up in *Terror Management Theory*[4] and *Uncertainty Identity Theory*.[5] Together, these theories can help care providers become more aware of the ways in which traumatic and every day events may affect the way they think and/or feel and how this may affect their care practices.

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Terror Management Theory suggests that people want to strive after beliefs in a just and safe world where they are immune to or at least protected against death and vulnerability. Death triggers *mortality salience,* which increases feelings of vulnerability and mortality. To defend against these feelings, individuals may seek thoughts and beliefs that produce and reinforce closed, structured, and certain worldviews. Here, the individual is able to defend against feelings of vulnerability and mortality by shaping their thoughts and attitudes to conform to a particular worldview, one bereft of vulnerability, complexity, paradox, and uncertainty.

In a similar way, Michael Hogg suggests, in his *Uncertainty Identity Theory,* that people and events may generate feelings of uncertainty about themselves, others, God, and/or the world around them. He has shown that people are psychologically motivated to reduce feelings of uncertainty. To do this, an individual can focus on particular thoughts or attitudes that provide structured, closed, and certain worldviews. Here, an individual is able to defend against feelings of uncertainty by changing their thoughts, attitudes, or beliefs about self, others, God, or the world. Again, this social-cognitive strategy reduces or eliminates complexity, paradox, and uncertainty.

Theologically this is significant because a person who is defending against vulnerability, mortality, and/or uncertainty could quickly become a theologian of glory, instead of a theologian of the cross. These social-cognitive defensive maneuvers can lead to *victim blaming, defensive theology usage,* and reduce people to stereotypes or digital documents instead of *living human documents*. Combined, these processes implicate the practices of care. To resist these psychosocial

3 Pamela Cooper-White, *Shared Wisdom: Use of the Self in Pastoral Care and Counseling* (Minneapolis: Fortress Press, 2004).

4 Jeff Greenberg, Tom Pyszczynski, and Sheldon Solomon, "The Causes and Consequences of a Need for Self-Esteem: A Terror Management Theory," in *Public Self and Private Self,* ed. Roy F. Baumeister (New York: Springer-Verlag, 1986): 189-206.

5 Michael A. Hogg, "Uncertainty-Identity Theory," in *Advances in Experimental Social Psychology,* ed. Mark P. Zanna (San Diego: Academic Press, 2007): 69-126.

processes, we will engage Mary Solberg's epistemology of the cross in order to become theologians of the cross and responsively address thoughts and feelings of vulnerability, mortality, and uncertainty in our care practices.

In *Cross Examinations*, Solberg suggests that an epistemology of the cross seeks to *know*. In her definition, she pushes against the psychosocial processes of mortality salience and uncertainty by suggesting that knowing does not happen in structured, and I would add, comfortable, safe, and certain, ways.[6] She suggests that an individual, to be a theologian of the cross, must first overcome *disillusionment*. Here, I argue that two fruits of disillusionment arise as an uncritical response to mortality salience and uncertainty. We can overcome this *disillusionment* through what she calls *epistemological conversion*. This requires a "shift in consciousness," that requires caregivers to become aware of and trace the ways that feelings of vulnerability, mortality, and uncertainty manifest urges and impulses towards glory – ways of knowing that produce comfort, safety, and certainty. To do this, a caregiver is called to *responsive solidarity,* that requires not only self-reflective but also self-reflexive practices in order to explore the interior world of one's thoughts, feelings, and motivations for acting.[7]

The process and practice of self-awareness and self-reflexivity can be difficult. And in the throes of trauma there may not be enough time to practice self-reflection or self-reflexivity and increase one's consciousness.

We come to a point where we might ask, "What can I do?" Duane Bidwell offers three recommendations that look to and are congruent with an epistemology of the cross. In his book, *Short-Term Spiritual Guidance,* he suggests that the tools of *curiosity, learned ignorance,* and *a stance of unknowing* are ways to avoid misuses of power, which can occur as an unconscious reaction to *disillusionment*. Bidwell's tools can produce what Solberg calls *epistemologically conversion* through a shift in consciousness.[8]

The process and practice of self-awareness and self-reflexivity can be difficult. And in the throes of trauma there may not be enough time to practice self-reflection or self-reflexivity and increase one's consciousness. However, the mere practice of *curiosity, learned ignorance,* and *a stance of unknowing* shift consciousness, resist disillusionment, and lead to epistemic conversion. In the moment, *curiosity* suspends heuristic processes that would otherwise label and/or oversimplify a person or situation (seeking certainty), as in the case of morality salience and uncertainty. *Learned ignorance* invites the care provider to "empty themselves" of what they know so that they can be present and open to the person and experience(s) of the

6 Mary M. Solberg, "All That Matters: What an Epistemology of the Cross is Good For," in *Cross Examinations: Readings on the Meaning of the Cross Today,* ed. Marit Trelstad (Minneapolis: Augsburg Fortress, 2006): 150.

7 Ibid., 150-153.

8 Duane R. Bidwell, *Short-Term Spiritual Guidance*, Creative Pastoral Care and Counseling Series (Minneapolis: Fortress Press, 2004), 16-19.

other (vulnerability and uncertainty). *A stance of unknowing* resists the colonial, Western-Eurocentric idea of "expert," and instead bears with the other in their suffering, refusing to name and label their experiences (uncertainty). Instead, they draw near to listen, be present, and resist the psychosocial urge to curve inward towards comfort, security, and certainty.[9] Here, the care provider and the care-seeker join together at the cross.

The challenge of care in the face of trauma, according to *Terror Management Theory and Uncertainty Identity Theory,* are our own feelings and awareness of vulnerability, mortality, and uncertainty. These can be triggered through vicarious traumatization and compassion. If acted upon, they can produce psychosocial practices that can lead to misuses of power and curve the care provider in towards *disillusionment*. An epistemology of the cross invites the care provider into spaces of curiosity, unknowing, and learned ignorance so that they can resist glories of care and be present with their care-seeker at the foot of the cross.

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9 Ibid., 11.

Reawakening the Conative Process

Paul Shoup

ABOUT A MONTH AFTER MY WIFE DIED, my eldest daughter said to me, "Dad, it's time for you to do what you want to do." My immediate thought was, yes, but what does that mean. That started me on a journey that is still unfolding.

My first stop was back to my training to become a pastoral counselor where the young psychiatrist had a handout simplifying how what we Think, Feel and Want drive our behavior. I went to the part on Want and reacquainted myself with the term Conative process.

I found out that this is one of the thousand least known words in the English language. In the handout it refers to striving for and avoidance of…impulses, needs, likes and dislikes.

The more I thought about this handout, the more I saw the parallel of Cognitive, Affective, and Conative with Body, Mind and Spirit. I went back to the creation story in Genesis 2. There, I believe, is a very strong connection between Conative and Spirit: "God breathed into man the breath of life and he became a living soul."

If we are going to have good mental health, these three aspects of our brain functions need to be well integrated with each other. They need to be both separate and connected with each other.

I believe that over the years the spiritual has become dis-integrated from the other two functions. As we have to blocked out memory and feelings from our current experience, the Conative has been very much reduced in its value and functioning in our lives.

The leadership of AAPC has been articulating the importance of the integration of the spiritual into human life. I think it is interesting that the spiritual has been so dis-integrated over the centuries.

For me, the asking of the question about "what I want" has been much more about "am I listening? Am I paying attention to the impulses, the intuitions, to the dreams that I am having?"

I am thinking that it is our task as chaplains and pastoral counselors to reawaken and reconnect people with this somewhat dormant part of our brain functioning. This is very much what good mental health is all about.

For me, the asking of the question about "what I want" has been much more about "am I listening? Am I paying attention to the impulses, the intuitions, to the dreams that I am having?" It is asking whether and how these are instances of how God is leading me day by day.

At the same time, I am needing to pay attention to the fears that arise, get in the way and block me from moving in those directions. Paying attention becomes part

of the brain health that I need to exercise. This is where all three parts of my brain need to work together. My fears (affective) and my thoughts (cognitive) are actually responsive to the spiritual (conative) within me.

As Chaplains and Pastoral Counselors, it is important that we exercise all of these aspects of ourselves in our work and in our personal lives. It is important that as we interface with our patients and clients, that we help them to engage in all three of these functions.

I am finding that I am doing much more of what I want to do. It has also been couched in the discovery of how often I have needed to stop and ask the question, "*what is it that I do want*?"

Paul Shoup, M. Div., AAPC Fellow, serves as the Northwest Regional Chair of AAPC. Paul lives with his wife in Stanwood, Washington, where he is learning to enjoy doing what he wants to do. He recently retired from his ministry as a pastoral counselor/ therapist.

Help for Caregivers in an Age of Polarization

Fred Schramm

THOSE OF US IN THE HEALING PROFESSIONS face an increased challenge in this age of extreme political, social, and societal polarization. Providing care giving in this highly anxious and polarized society takes a confident, self- differentiated, non-anxious caregiver who is not looking for quick fixes but is willing to be a healing presence in a chronically anxious system.

Thinking back to the beginning of my ministry, I realize how unprepared I was to provide counseling. I graduated from Concordia Seminary, St Louis in 1970 and served a dual parish across the Missouri - Iowa line. The seminary introductory counseling courses proved inadequate for me to become a confident and effective counselor. In 1973 I accepted a call to Hope Lutheran in Milledgeville, Georgia. I soon learned of the extended quarter CPE program at nearby Central State Hospital. With the blessing of the parish I completed several CPE units with the large staff of supervisors. With this training, I began my counseling journey in earnest. My position as the part time chaplain at Colony Farm Correctional Institute in Hardwick, Georgia also helped me gain experience.

In 1979 I accepted a call to a church in Orlando, Florida. As pastor, counselor and volunteer Lutheran chaplain at University of Central Florida, I soon discovered that something was still missing. For many years, I counseled people in my pastoral ministry but I was not exactly sure of the best approach. However, through the pain of being attacked by a small group of parishioners who mounted a campaign to remove me as their pastor, I learned the vital importance of "emotional process." In 1989, a month before the eruption of the conflict, God blessed me with a seminar by Dr. Peter Steinke about congregational emotional process. With Dr. Steinke's permission I recorded the entire presentation for my personal use. These recordings became my saving grace through ten months of conflict. Daily I would listen to my recordings of the presentation. The understanding of the triune brain, emotional process, triangulation, and self-definition kept me calm and functioning. After the resolution of the ten-month conflict, I continued my ministry at that parish for another nine years.

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As a result of this experience, my approach to counseling changed and my preaching became richer and more effective. Nevertheless, I still wanted to learn more; therefore, I studied with Dr. Steinke's mentor, Dr. Edwin Friedman in Bethesda, Maryland. Studying with him I learned that knowing myself and managing

my own emotional process was of primary importance in ministry. The powerful book he was writing when I studied with him was published after his death: *A Failure of Nerve: Leadership in the Age of the Quick Fix* (Friedman, 1999).[1]

Each day with Dr. Friedman had two parts. In the morning he would listen to our case studies and teach important points about emotional process. In the afternoon, we would process our own personal history through genograms in small groups followed by a debriefing with Dr. Friedman. This training and practice built my confidence in providing pastoral counseling and consultation. I grew in my understanding of human functioning and of the everyday dynamics of ministry.[2]

I believe that self-understanding, supervision, training and practice are necessary for a caregiver to facilitate effective and lasting healing in relationships, marriages, family systems, and organizations.

I believe that self-understanding, supervision, training and practice are necessary for a caregiver to facilitate effective and lasting healing in relationships, marriages, family systems, and organizations. Here are some of the important insights that have helped me be a more confident and effective caregiver for individuals, couples, families, churches and organizations.

The Being of the caregiver is most important

- It is important to be a *non-anxious, differentiated presence*. The human brain immediately senses the anxiety that is carried by a person. Somehow, we know that something is not right, even without the person speaking a word. Maybe something about the body language gives it away. If a caregiver radiates anxiety, it is hard to establish a safe encounter.
- Understanding the *cutoffs of your present and generational family systems* is critical. Cutoffs in families damage those involved and, potentially, the children for many generations. A cutoff binds the anxiety within the person, doing the cutting off, which then prevents healing. In class Dr. Friedman often said "a person will know if you stop thinking about them." The opposite is also true. I had prayed for a client couple (silently) in the Sunday service. When they came into the office on Monday they asked if I had prayed for them on Sunday morning. After I responded in the affirmative, they said they both felt a positive change in their relationship around 10 AM. Their observation confirmed for me the power of praying for those who are receiving care.

1 Many of the quotes and reference to Dr. Friedman come from my personal library of recordings he permitted me to make. A list of resources is found at the end of this article.

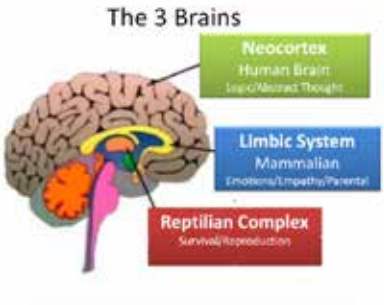
2 I not only credit Peter Steinke, Dr. Edwin Friedman, and my CPE supervisors but also the conflict in the parish for giving me the motivation to learn more. Credit also goes to my long-time mentor and AAPC supervisor, Dr. Richard Erikson, who had practiced in Winter Park, Florida, and of course to the Holy Spirit who continually helps me gain deeper insight.

- Do not try to care for others when you know the issue presented will trigger *your own unresolved issues*. This is how so many pastors, counselors, therapists and chaplains find themselves violating the ethical codes of their professions. Just think of all the professionals who have gotten into sexual relationships through a care giving relationship when their personal home relationships were not going well.
- Make sure you *have a supervisor* to review your cases. Trained supervisors not only help with difficult situations but also will help you interrogate your methods and boundaries. Supervision is expensive, but it is worth every penny. Some supervisors in AAPC and ACPE do distant supervision through secure communication for those in distant locations.
- Also, it is important to *review the ethical codes* of your profession often.

Training & Perspective

Having those items in place helps make it possible for the caregiver to be a safe provider and create a safe place for a healing encounter. Next, let's look at a few tips about how to go about the healing process, what to look for, and how to listen.

1. The Function of the Triune Brain



Dr. Friedman based his systems approach upon the work of psychiatrist Murray Bowen, who founded the Georgetown Family Center at Georgetown University, and upon the scientific discoveries of how the total body functions.[3] Understanding the dynamics of the triune brain has helped me in managing my own functioning in care giving. Many books have been written about the triune brain since an American physician and neuroscientist Paul D. MacLean originally formulated his model in the 1960s. Peter Steinke's book, *How Your Church Family Works* (Alban Institute, 2012), especially pages 16 through 20, gives a quick summary of the triune brain.

The *reptilian brain stem* keeps a person alive, regulating the autonomic nervous system. This is the fight-or-flight portion of the brain. Once a person's functioning moves down into the brain stem, which is triggered by epinephrine and norepinephrine, it is impossible to reason with them.

The *limbic system (or the mammalian brain)*, above the stem, is the part of the brain that handles emotion, connection, memory of extreme events, and an early warning system—the amygdala. Without emotional connections for which the limbic system is responsible, I doubt that humans would marry each other.

3 The class asked Dr. Friedman what reading the class should do going forward. He said, "subscribe to Scientific American and read the medical journals that bring new insights into the functioning of the brain and the body."

The *cerebral or neocortex* (the grey matter) surrounds the limbic system and deals with higher-level functions: thinking and learning, the senses, creativity, problem solving, decisions, and memory. In the front of the cerebral cortex are the frontal lobes which are involved in motor function, problem solving, spontaneity, memory, language, judgment, impulse control, and social and sexual behavior. The frontal lobes are critical to self-control, strategy, and morality.

The higher the level of anxiety the lower the functioning of the brain. Under extreme stress most people will regress to functioning out of the brain stem. I am sure that the phrase "alligators in the pews" is a description of persons who, due to emotional reactivity, have compromised frontal lobes and therefore are in the fight-or-flight mode. Dr. Friedman described it this way: "Chronically anxious families (including organizations and whole societies) tend to mimic the reptilian response: Lacking the capacity to be playful, their perspective is narrow... Neither apology nor forgiveness is within their ken."[4]

I learned that chronically anxious families will seek a target to blame so that the family can function peacefully. In organizations, they often recruit other dissatisfied people to join their cause. This is very important to remember in working with congregations or organizational systems.

If one finds oneself getting reactive, angry or raising one's voice, a person can train oneself to be self-aware and to manage these brain reactions. The frontal lobe can be brought back on line to stop the process of functioning out of the lower brain. Early self-regulation is important to prevent the brain from being flooded with fighting hormones. Once that happens, only time will allow the body to metabolize the fighting hormones and bring the person back to a reasonable state. I have seen the process take from a half an hour to two hours. This is why it makes no sense to try to reason with someone who has regressed into brain stem function, it only makes them angrier.

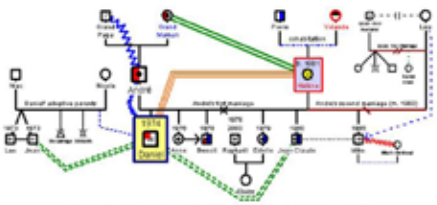
All the parts of the triune brain are important, just like the three persons of the Godhead. The Athanasian Creed goes into great detail about how one person of the Trinity is not more important than the other. Often, I think of the brain stem as being like God the Father, the creator, the one who keeps all things running, and the reactive part of the Godhead. I imagine the Holy Spirit to be like the limbic system with the emotions and feelings that connect people to God. Lastly, the cerebral cortex and the frontal lobes must be like Jesus, the Word of God, the Teacher, the one who went to the cross without reactivity. If there is any truth to my imaging then our brains are truly made in the image of God.

A self-regulated caregiver can be present, non-triggered, listening, understanding, and thinking all at the same time. True care giving is defeated if the caregiver gets reactive and shuts down the recourses of the upper brain. God has

4 Dr. Friedman 1999, Family Edition, p. 84.

given us three major parts of the brain for very important reasons. If one of those parts is malfunctioning then the brain is compromised. It is very important that the caregiver have awareness of all three parts for effective care giving.

2. Genograms



Sample Genogram with the Emotional Relationships

When care giving, one way to reduce reactivity and bring greater understanding, if time permits, is to listen through diagramming a systemic genogram. A genogram is a graphic drawing of family connections that displays detailed data on relationships among individuals and the emotional process. Doing this slows down the emotional process, the blaming, the extreme emotional baggage, that many people bring into the hospital room, counseling session or parish. With a family in a hospital room, sometimes the information comes very quickly as family members come in and out of the room. I have found that asking permission to diagram the relationships helps me and the family gain insight. In as little as thirty minutes, both the family and the caregiver can learn a great deal using this method.

Dr. Friedman had small groups do self-reflection using family genograms (including the present triangulations) going back three and four generations. That material was then brought into a safe small group process where colleagues discussed what arose out of the material presented. This process helped me to clearly identify and understand many of the dynamics of my family of origin that were directly affecting my ministry. Working on resolving those conflicts and cutoffs, and being aware of my internal tendencies to see things in a particular way, greatly improved my preaching, my parish ministry and my counseling.

I have used genograms ever since. With practice, a caregiver can identify family problems in the process of writing down the information. This is a great tool in healing problems that have been transmitted over the generations. Sometimes I would have three or four generations of the family in the session doing a genogram. I have been amazed how some issues were resolved just in the intake process. I seemingly had not done anything, other than let the family describe their emotional and generational process and diagram it for them.

3. Self-definition

The workshop that was given by Peter Steinke in January of 1989 had a profound effect on my life and ministry. At the end of the workshop someone asked Dr. Steinke if he would go back into full-time parish ministry. If I remember his response correctly, he said, “If I did, I would spend most of my time on self-definition.”

Remembering to be self-defined helped me in the first week of my counseling ministry in Fairbanks, Alaska. A client came in who had fired many other counselors. After an intake during which she spoke for fifty minutes, she was insistent that I call her previous psychiatrist and tell him that he was all wrong. When I calmly defined my role with her, she left very dissatisfied. She had fired me.

Defining self also means that it is not useful for the client to define your role. After many hours with Dr. Edwin Friedman, I asked him, "Why do you always deflect the praise that the group offers to you." Summarizing his answer, he said, "If you let people put you on a pedestal, it is a long way down and easy to be knocked off." Defusing unrealistic expectations is an important process in care giving.

That concept was very helpful for me in Fairbanks, Alaska, where I had developed a reputation for helping families and couples in conflict. Couples would come in and say they chose me because I had saved the marriage of one of their friends. I would try to defuse the high expectations by saying something like, "Yes, that went very well with them; however, last week I lost all my skills." Then after a pause I would say: "Let's see what we can do together."

None of us has the healing touch of Jesus, but we can be his representatives—bringing understanding, calmness, and self-definition (instead of defining the other) into our care giving, our society and the world.

Or at the door of the church, a congregant says, "Pastor, that was the greatest sermon I have ever heard," at which I might respond, "Thank you, but just wait til next week. I am going to really mess up."

Care giving in this age of polarization, and extreme emotional reactions, requires the caregiver to be the safe place where people can unload their preconceived notions and go deeper into the healing process. None of us has the healing touch of Jesus, but we can be his representatives—bringing understanding, calmness, and self-definition (instead of defining the other) into our care giving, our society and the world.

Dr. Friedman kept on pointing out that is important to define what you are going to do instead of trying to define the other person. As he said, "No one enjoys being told what to do." It is very important that the caregiver not be directive, not over-promise, and not be triangulated into the problem.

4. Focus on Strength

A final key teaching of Dr. Friedman is that a caregiver can make more progress by focusing on strengths rather than pathology.[5] In systems work, he taught that working with the more differentiated person or persons in the system will produce the best results. My thanks go to Rev. Dr. Eldon Olson, ELCA pastor, pastoral counselor and former Director of Consultation to Clergy, for sharing with me his system of dealing

5 Dr. Friedman 1999, Family Edition, p. 44.

with congregational conflict. This system focuses on the those in the congregation who are the non-reactive and are accepted as leaders by people on all sides of the issue.

5. Use of Scripture

I found it amazing that I was able to lead more people to God and into active participation in a church during twelve years of pastoral counseling ministry in Fairbanks, Alaska, than in twenty-eight years of pulpit ministry. Many of the people who were changed had rejected God and the church. Atheists, agnostics, lapsed religionists of many different religions, were helped to discover God in their lives through the caring process. I never forced religion on any of those in my care; however, I always had my Bible on the coffee table. I did not bring up scripture unless a client asked and it clearly spoke to the situation. Asking permission to quote scripture is important. The Holy Spirit works in mysterious ways.

Once a caregiver has gone through the process of resolving issues in his or her own life, they can be a more effective healing presence.

In summary

- Do the work necessary to resolve your own family of origin issues. Once a caregiver has gone through the process of resolving issues in his or her own life, they can be a more effective healing presence. However, a self-awareness checklist is useful to keep yourself and others safe.
- Provide safety in the care giving process. Safety allows the person involved with the caregiver to open up to the hidden dynamics and deeper issues. I have found that my clients in therapy slowly built trust after a number of sessions. However, I have personally experienced a few counselors that created the safe space in a few minutes.
- Continually be aware of your own emotional reactivity. Emotional reactivity can be overcome by keeping the pre-frontal cortex online. Non-awareness in the caregiver of his or her own emotional reactivity can preclude any healing encounters taking place.
- Look for and keep in mind the system forces that are binding or separating people and causing problems. Understanding the family, societal, and systemic issues can ultimately help the person, couple, family or group move forward into healing.
- Finally, prayer helps. If you can, set the stage, take a minute or so to do some slow breathing during an opening quiet time. Say a silent prayer asking the Holy Spirit to give wisdom in the care giving. This helps me and helps those coming for help.

May God bless you in your care giving. Often the Holy Spirit gave me the right words to say that made all the difference. May the Holy Spirit do the same for you. May you become the non-anxious presence of Christ that helps heal our polarized world.

Resources:

Friedman, Edwin H. 1999. *A Failure of Nerve: Leadership in the Age of the Quick Fix*. New York, New York: Seabury Books.

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The Rev. Dr. Fred Schramm, while retired from full time pastoral counseling, continues doing family systems work, with pastors, congregations, and coaching for persons and families with ADD. Fred is a Fellow in AAPC and is licensed in Florida as a Mental Health Counselor and MFT. A retired LCMS pastor, he has served parishes in Memphis, MO, Bloomfield, IA, Milledgeville, GA, Orlando, FL, and Fairbanks, AK. In Fairbanks, he was the executive director of Samaritan Counseling Center. He currently lives in Broomall, PA, where he enjoys life and is celebrating sixty years as an Amateur Radio Operator with the call of K2HA The Happy Amateur.

News, Announcements, Events

Remembrances: Well done, good and faithful servants!

The **Rev Dr Kenneth J Siess**, age 86, died on August 24, 2018 at his home in Edina, Minnesota. Ken obtained his MDiv. from Concordia Seminary and his DMin. from Eden Seminary, both in St Louis. He also served in St Louis as a chaplain and CPE supervisor through the Lutheran Mission Association and on the faculty of Concordia Seminary. For many years he was a deaconess internship supervisor for numerous deaconess students from the LDA. He then moved to the University of Minnesota Hospital and Clinics, Minneapolis in 1976 where he developed the Chaplain's Department and stayed until 1994. He continued on staff at Lutheran Social Services of Minnesota and later contracted as a CPE supervisor at various sites well into his retirement. He received the Distinguished Service Award from the North Central Region, ACPE and guided both ACPE and APC in developing a Professional Code of Ethics and building accountability into their professional standards of practice. Late in his career, he served as the National Chair for the ACPE Professional Ethics Commission, and after retiring served as Chair of the APC Commission on Professional Ethics. In 2007 Ken received the Christus in Mundo Award. He was supportive of women in ministry, assisting two Lutheran women in becoming ACPE supervisors. He was a faithful caregiver for his wife, Ellie, until her death in 2014.

The **Rev. David R. Tuff**, age 95 died at Good Samaritan Specialty Care in Robbinsdale, Minnesota, on October 25, 2018. He served in the Marines during World War II during which time he flew over 60 missions and was awarded the Air Medal. He and his wife, Florence, were ranchers in Montana and Wyoming before David felt a call to ministry in 1958. He graduated from Luther College, Decorah, Iowa, and then from Luther Seminary in St Paul, graduating in 1961. He then served as a missionary for 13 years in Papua New Guinea. Upon returning, he enrolled in clinical pastoral education and served as a chaplain in hospitals and care facilities in Oshkosh, WI for the rest of his career. Upon retirement, he lived with his wife in Menominee, Wisconsin and Robbinsdale, Minnesota. Florence died in 2014.

If you know of other chaplains, pastoral counselors or certified educators who have died, please let us know: Diane Greve (dkgreve@gmail.com) or Lee Joesten (lee.joesten@gmail.com).

In Times Such as These Zion 2019

ZION 2019 will gather on the beautifully wooded campus of University of St. Mary of the Lake in Mundelein, a north suburb of Chicago. The dates for Zion are September 26 through 29. The theme around which we gather is "IN TIMES SUCH AS THESE."

We find ourselves in troubling and uncertain times.

The national healthcare system in which many of us serve does not work well, is extraordinarily expensive, and the certainty of reimbursement is tenuous. Healthcare corporations are realigning in anticipation of a future not clearly seen, leaving their employees anxious about their roles, responsibilities, accountability, and job security.

Our society has been shaken by the dramatic demise of the myth of a post-racial America. We are newly aware of two Americas – one black and one white. We have experience greater suspicion toward the "other" who has made a home among us and greater hostility toward the "stranger" outside our borders.

The open secret of sexual abuse, exploitation, and devaluation has exploded and the shock waves continue to reverberate in politics, arts, sports, health care, entertainment, business, and religion. The "#MeToo" movement confronts not only overt behaviors, but also long-standing biases.

The many societal issues which impact us in times such as these are compounded by a loss of safe space for and civility in our public discourse. There is little consensus on facts, less on truth. That which is repeated most often and most loudly is accepted as normative. Social media serves as an echo chamber which confirms already held prejudices. Families, friendships, and even congregations are divided as people are no longer able to dialogue with one another.

It is in times such as these that we as chaplains, pastoral counselors, and certified educators are called to serve. We are "front-line Church" impacted through the people to whom we minister, through the institutions we are called to serve, and personally as members of this society. How shall we understand the issues which trouble us? Where do we see Christ at work in these uncertain times? Are there unique insights we might gain from our own Reformation tradition, born and nurtured in equally troubling and uncertain times? How might we best serve clients, patients, students, and families in this context? What can we teach the Church about the world we are encountering on the front line?

In light of the theme there will be three keynote speakers this year addressing Woman and Justice, Racism and Reaction, and Healthcare and Health. The Rev Kathie Bender Schwich, the senior officer for Mission and Spiritual Care in the newly-formed Advocate-Aurora health care system will address healthcare. The other keynotes will be confirmed shortly. The Reverend Peter Nafzger, Assistant Professor of Practical Theology at Concordia Seminary, will serve as the Bible Study leader. The Reverend Lee Joesten, retired CPE supervisor, will serve as liturgist and the Reverend Elizabeth Palmer, book editor for *Christian Century*, will serve as

homilist for the Saturday evening service which will follow the banquet and Christus in Mundo presentations. The possibility of a visit to the Illinois Holocaust Museum in Skokie is being explored and there will be quiet time to take in the serenity of the St. Mary of the Lake campus.

Please put a hold on these dates, **September 26 – 29, 2019,** and watch for further information.