1

Creating a Personal Theology to Do Spiritual / Pastoral Care

Rev. Dr. Martha R. Jacobs, MDiv, DMin, BCC

An eighty-five-year-old man was dying. He seemed to be having a very difficult time with his impending death. The nursing staff asked the chaplain to talk with him, because they sensed that there was something that he needed to deal with and hoped that the chaplain could find out what that was and help him. After establishing a relationship with Sam (not his real name), the chaplain began a life review with him, which took several days, because Sam did not have the stamina for long conversations. Sam talked about his work as a philanthropist and how much pleasure he had found in helping those less fortunate than him. During those conversations, the chaplain was aware (as the staff had indicated) that Sam seemed to want to tell her something but always stopped short of doing so. After several days, and sensing that Sam had come to trust her, the chaplain told him that she thought there was something he wanted to tell her but wasn't. Sam's eyes welled up with tears. He whispered to the chaplain that he thought he was going to go to hell because he had stolen when he was six years old. The chaplain asked him to tell her about it. Sam spent the next ten minutes describing in detail how he stole a candy bar from a store. She asked him why he stole it. He told her that his siblings were very, very hungry (because of the Depression) and that he hoped the candy bar would keep them from starving. He stole the candy bar, went home, and shared it with them. Sam described how much they enjoyed it and

how it seemed to make their world seem a little less hopeless. Then, in almost a whisper, he said that stealing was a sin and that he would have to pay for his sin by going to hell when he died.

The chaplain then asked Sam to tell her about who God was for him. Sam described a God who was loving and open to those who sought to do good in their lives and was always there for them. She asked if he thought that God would forgive someone if they sought that forgiveness from their heart. Sam said, "Absolutely." She asked him if he had sought forgiveness from his heart from God for stealing the candy bar. He hesitated and then said that he had. The chaplain asked if he thought that God had forgiven him. Sam paused for a few seconds and then said quietly, "Yes." She thought for a moment and then asked Sam if he had forgiven himself for stealing the candy bar. He started to cry almost uncontrollably. As she sat there with him, the chaplain thought about how Sam had carried this burden with him all his life. He was a successful businessman who generously gave to those who were most in need of food and shelter. Yet, what was foremost in his mind as he lay dying was the retribution that lay ahead for him for stealing that candy bar.

When his crying subsided, she asked Sam to pray with her. The chaplain prayed that Sam would feel God's love surrounding him, that he would be as loving and accepting of himself as God was, and that he would come to forgive himself for trying to take care of his siblings in the only way a six-year-old could manage. She also prayed that he would come to a deeper understanding of forgiveness.[1]

As a Chaplain—My Theology

This story is an encounter I had with one particular patient. As a chaplain, I could have handled Sam in many different ways. I could have affirmed his belief that he was going to hell. I could have chastised him for stealing but then, since he believed that God was a forgiving God, say that God would forgive him. I could have made light of his stealing (since it was *only* a candy bar) and waived the need to seek forgiveness. I could have left Sam to wonder what would happen to him and not helped him come to "peace" with what was clearly taunting him as he was dying. I am sure that there are other possible outcomes you could suggest as well.

My decision to help him find forgiveness was based on his *own* belief of who God was for him. Since I did not know anything about his belief system, I needed to find out what his theology was before trying to help him deal with his guilt. I could not make any assumptions, even though on the hospital census it said he was "Protestant." It was important to find out what he thought about his God before moving forward with my intervention. If I had not done that, I might have gone down a path that was not in keeping with Sam's own belief system. I might have brought about more confusion and pain for him. I might not have allowed for his own set of beliefs to bring him to a place where he could accept what he had done and also accept the forgiveness he so desperately sought. Sam's theology was different from how he had been raised—since he believed that he would go to "hell" for stealing, which came from his childhood experiences in church. He also believed that God was a forgiving God but could not reconcile his youth image of God with his adult image of God. Later, when I asked Sam why he had not discussed his fear with his own minister, he said that he was afraid to have his fears confirmed. Hence, my need to understand *his* theology before trying to work with him. Affirming Sam in *his* belief system did not in any way affirm or deny *my own* theology.

My theology has to be large enough to accept the theology of those whom I serve, whether they be Christian, Buddhist, Jewish, Muslim, Sikh, Catholic, Humanist, or Atheist. If I cannot support a patient (or family member or staff person) in his or her theology, then I cannot serve as a multifaith professional chaplain. In order to be an effective multifaith chaplain, I need to be secure in my own belief system. I also need to be able to be open to understanding and interpreting Sam's theology and that of any other patient, family member, or staff person with whom I come into contact. I have to be open to other people's theology and help them through using their belief system, not my own.

Dual-Track Mind-Set and Heart-Set

So, how did I get to this place—this ability to put aside my own theology so that I can support the needs of my patients? The development of my theology has taken most of my life and continues to inform how I practice chaplaincy care. I was raised Jewish and became a Christian at the age of seventeen. For many reasons, once I converted, I chose to

"ignore" my Jewish roots—that is, until I was in clinical pastoral education at St. Luke's Roosevelt Hospital and, over the course of an overnight on-call assignment, realized that in order to serve *all* patients, I was going to have to reclaim my Judaic roots. Otherwise, I would not be able to be fully open to Jewish patients.

As God would have it, I was on call one night when I was paged at 10:00 p.m., for a patient who was Jewish and was dying. The patient expressed that he wanted to see his rabbi and gave me his name and the town he lived in, but couldn't tell me the name of his synagogue. Luckily, I was able to find his rabbi (this was in the days before Google). He lived about an hour from the hospital. I was concerned that he would not want to travel so far, so late in the evening, but he showed up about 11:30 p.m. I went with him to the patient's room but stayed outside, allowing private time for the rabbi with his congregant. As I listened, I heard the rabbi begin the *Sh'ma*, the Jewish prayer that every Jewish child learns at a very early age: שְׁמַע יִשְׂרָאֵל יְהוָה אֱלֹהֵינוּ יְהוָה אֶחָד *(Sh'ma Yisra'el Adonai Eloheinu Adonai Echad)*, "Hear, Israel, the Lord is our God, the Lord is One." As he recited it, I could hear the patient's respirator begin to slow down; the patient was clearly soothed by hearing this prayer. After several minutes, the rabbi came out of the room, and I commented that "the *Sh'ma* really made a difference for him." The rabbi looked at me and asked how I knew the *Sh'ma*. I was not sure how he would respond to my story but decided that it was time to face up to my own feelings around my Jewish heritage. So, I told him that I had been raised Jewish but was now a Christian. This rabbi was a real blessing for me. He could have yelled at me or dismissed me. Instead, the rabbi and I spent the night in the waiting room talking while going back and forth to his congregant's room.

At 6:30 a.m., his congregant died. The rabbi and I had spent all night talking and crying and laughing not only about my history but about his as well. As we parted ways, he said to me, "Judaism is clearly the loser. You are going to be an excellent chaplain, able to take care of all of God's people. May God bless you in your work." After he left, I cried as I began the healing of what had been two distinct and separate "lives"—first as a Jew and then as a Christian.

This "chance" encounter allowed me to begin to open the door to my Jewish heritage, which I knew inherently I needed to embrace in order to be the best chaplain I could be. As the rabbi had said to me, he

believed I would "take care of all of God's people," and I knew I needed to do a lot of work in order to fulfill his words.

As I continued to process and integrate my heritage into my Christian beliefs and life, I found that I was able to be more open not only to Jewish patients, but also to patients of all different backgrounds, faiths, and traditions. Being in New York City—a true melting pot of faiths, traditions, cultures, and people—"made" me be more open to the "other."

It also made me face my own racism—of which I was unaware—when I was paged to go to the emergency room to be with a mother whose son had shot himself in the head. The child would survive, but the mother was in need of pastoral care. As I walked into the room, I had to overcome my shock when I saw that the mother was a Caucasian woman and not an African American woman, which is what I assumed I would find. Even though the hospital was located in Harlem and it was more likely that the person would be African American, the fact that I had made an assumption was clearly wrong. This was another way that I had to look at my theology and deal with any racism that was within me so that I could take care of all of God's people.

I was given a chance to do that when paged to the ER on a different overnight (while still in training) when a twenty-eight-year-old man had been killed in a gun battle; he was an innocent bystander. His family was coming in and had to be told that their loved one had died. As I sat with this family, who was African American, I wondered to myself whether I would be able to be of help to this family—our lives were as different as our skin color. As the night wore on and more and more family showed up, I found that not only was I able to be present with them, but I was also able to provide chaplaincy care to them, not because of the color of our skin, but because I had learned about who God was for them and how they lived their theology. My prayers reflected their theology and their God and enabled them to begin their grieving process. I learned that it was not about me and what I believed; it was about them and what their belief system was and who God was for them. And how did I find out? I asked them questions and listened to their conversations as they talked about how they lived their lives. I did not make any assumptions about them—except to initially think that I would not be able to help them because of my own racism. I learned that grief is grief—it doesn't matter one's skin color or culture—the pain of loss is

the pain of loss, especially what seems to be "senseless" loss. Being present to them was what was important and made the difference. Equally important was my being able to be open to who their God was and to help them access their God at a time of such pain and anguish. Again, my theology had to be large enough to take their theology "into" myself for that period of time.

Oddly enough, while being open to their theology, I was silently praying to "my" God, that I would have the wisdom and the patience and the openness to serve them as they needed to be served. So, I had my own theology going in my heart, while I was also using professional chaplaincy skills such as reflective listening to allow them to affirm their theology with honesty and integrity. This dual-track mind-set and heart-set, I believe, is what enables professional chaplains to remain connected to their own theology while also supporting and enabling another's theology.

Prayer

Writing about praying reminded me of the other aspect of my theology that needs to be large enough to provide appropriate chaplaincy care. Prayer is a very personal thing. It is also corporate and different for different people. Patients taught me so much about how they relate to whomever they call God. Some Protestant patients prayed only through Jesus. Many Roman Catholic patients said that they prayed to Mary or to another saint. Jewish patients prayed in their own special way. Some patients followed a pattern that they learned in church, mosque, temple, or synagogue. Some prayed silently, afraid to utter a word. Some offered prayers that flowed from their hearts.

I remember being most concerned about praying in seminary. At the start of each class, students were encouraged to lead the class in prayer. Each student prayed in his or her own way. I began to worry because at least once before leaving seminary, I would be called on to lead prayer. I went through a praying crisis because I thought I was doing it wrong.

The simple truth is that nobody ever taught me how to pray spontaneously. So I wondered if I could have been praying wrong. Was I now in seminary to learn that my praying had been misdirected or misconceived? Was God angry with me for the way I prayed? Also, I often

prayed when walking down the street or traveling to work on the subway. Was this form of praying okay?

Well, my day came in class and I got up to pray. As I was walking to the front of the room, I prayed that what I was going to pray would not be offensive to anyone. When I finished leading the class in prayer, I looked up, and no one was looking at me strangely. Class went on as usual. I breathed a sigh of relief and prayed a quick "thank you" as I sat down. The crisis was over, for the moment.

Then I started training to be a chaplain. Boy, was I scared when I found out that we had to pray with patients—out loud! Again, I wasn't sure what to do. Was I praying right? Would patients feel comforted or confused by my prayers? What if I got tongue-tied or paused for a moment? Would that be okay with the patient and with God?

I was too embarrassed to ask my peers about the right way to pray. I assumed they knew better. Then I encountered the African American family I mentioned above. When paged, I went to be with them armed with the Episcopal *Book of Common Prayer*, which my peers used. I was ready to pray just the right words. I just knew that this book had the right prayers in it. Well, after the first prayer, I realized that this book didn't reflect what was going on for this family. So, I closed the book and began to pray from my heart. God's Spirit guided my words. This felt much better and much more personal.

Conversation as Prayer

One of the things that surprised me when I first started working as a chaplain was the number of patients who felt like our entire conversation had been a prayer. Many patients believed that God had been listening to our conversation, so additional prayer was unnecessary. And that was a powerful lesson to learn; praying really is conversing.

I had not considered this possibility until I met a patient whom I will call Celene. Celene had been in and out of the hospital for nine months. When she had come into the hospital this time, she was frailer than she had been previously. She had advanced lung cancer. She was HIV positive, had a daughter who was HIV positive, and had a grandchild on the way. Our last visit revolved around her concerns for her daughter's and her grandchild's well-being. She was very anxious about them and how they would do without her. We talked about what it

would feel like for her to give her anxieties about her daughter and grandchild over to God. As we talked, it came out that she felt guilty that she had given her daughter the HIV virus and that her grandchild might also be carrying the virus. In the midst of our conversation, it became clear that Celene was seeking forgiveness from God. She was opening her heart to God's Spirit, who was sighing deeply for Celene. Celene believed that God was a forgiving God. She said that it felt like our conversation was an open prayer to God.

I have come to believe that we each have our own idea of who God is for us and we each have a personal relationship with God. Our prayers usually reflect the individual nature of our relationship with God. Therefore, when praying with patients (or family members or staff people), I ask them what they would like me to pray for and offer them the opportunity to offer a prayer in their own words. I pray with them, allowing my own theology to expand, whether I am saying the Hail Mary or the *Sh'ma*.

Final Words

Most books about a "theology of pastoral care" come from the Christian traditions and are, therefore, heavy into Christ and the tenets of Christianity. Therefore, it is difficult to give you a sense of what I mean by a "theology of pastoral care" that encompasses all that we are—and who we are—and whose we are—because theology is an individual and very personal matter. But, since we are also responsible to our faith community, we must maintain this dual-track mind-set and heart-set.

Were I to try to compare my theology with that of another United Church of Christ non-chaplain clergyperson, the other person's would look very different. I believe that to be the case for any chaplain and his or her denominational colleagues, because the work that multifaith chaplains do requires that they be open to hearing another's theology and working with *that* theology to assist the patient (or family member or staff). I have to be actively in touch with my own theology but not actively "use" it (i.e., espouse it) in order to do that. I would expect my non-chaplain colleagues to "use" their theology when counseling or providing pastoral care to one of their own congregants. That is what is expected—a house of worship clergyperson espouses the theology of

the denomination of which he or she is a part. Professional chaplains must be able to move aside their own belief system(s) / theology and support the system of the person to whom they are providing chaplaincy care. We don't forget our own theology. But our theology has to be large enough to enable us to be open to the theology of the "other"—a theology that enables people to function in the situation in which they find themselves.

My job is to help them refind their theology and tap into it to sustain them through this crisis in their life. In the end, my theology has become stronger and firmer as I have come to embrace the other and welcome the other into my heart.

Notes

1. Adapted from Martha R. Jacobs, *A Clergy Guide to End-of-Life Issues* (Cleveland: Pilgrim Press, 2010), 77–78.

About the Contributor

Rev. Dr. Martha R. Jacobs, MDiv, DMin, BCC, is the author of *A Clergy Guide to End-of-Life Issues*. She provides workshops throughout the country for clergy and congregations on end-of-life issues. Martha is an adjunct professor at New York Theological Seminary, where she is the coordinator for the Doctor of Ministry in Pastoral Care and a per diem chaplain at New York Presbyterian Hospital, Columbia Campus. She is the founding managing editor of *PlainViews*.