Where Do You Want Me, Lord? The Case of Sandy, a Mid-Sixties CPE Student with a Traumatic Brain Injury

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This case concerns the acceptance of Sandy, a Roman Catholic layman in his mid-sixties with a long-standing traumatic brain injury (TBI), into a summer Level I CPE program at Upstate Medical University Hospital in Syracuse, NY. Traumatic brain injury is defined as an injury to the brain that occurs when an external mechanical force such as a violent blow or jolt to the head or body, or a penetrating object such as a bullet to the skull, causes brain dysfunction. TBIs may cause temporary dysfunction of brain cells. However, more serious TBIs can create bruising, torn tissues, bleeding, and other physical damage to the brain, resulting in long-term complications, or even death.[1] Data for the United States alone reveal the staggering statistic that an estimated 17 million people sustain a TBI annually, resulting in death, hospitalization, and emergency room visits.[2]

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The leading cause of TBI-related deaths is from motor vehicle-traffic injuries, with rates highest for male adults aged twenty to twenty-four years. An estimated 5.3 million Americans are living today with a disability related to a TBI.[3] It is important to understand that having this type of injury is not a static event—it is a lifelong chronic disease with cognitive decline over time.[4] Sandy's TBI matched the above statistics. The heart of this case is the dilemma that is presented when a prospective student applies for CPE who has a significant disability and strong sense of vocation, and the challenge for discernment is whether to accept the applicant for training and under what conditions in order to create a functional learning environment that will benefit both the student, the peer group, and the department, as well as patients, their loved ones, and staff. This article was written by Terry Ruth Culbertson, with contributions by Elizabeth Morey ("Betty") and Sanford Moldenahuer ("Sandy") quoted in the text.

Our CPE program was accredited in 2007 as a freestanding center offering Level I and Level II training, and it received reaccreditation in 2012. We offer both a twelve-week summer intensive unit and an extended thirty-week fall–spring unit. The majority of our learners are Level I unit students from the Central New York area, either fulfilling a requirement for ordination or seminary or exploring an interest in chaplaincy as a vocation (both professionally and as a volunteer). Many of our CPE alumni continue to be affiliated with the Department of Spiritual Care, either as volunteer on-call clergy or volunteer assistant chaplains who supplement our small professional chaplaincy staff. Upstate received further accreditation in 2013 to offer supervisory education and is currently seeking a Supervisory Education Student (SES). The State University of New York (SUNY) Upstate Medical University is an academic medical center located in Syracuse, New York, that is dedicated to education, biomedical research, and healthcare. The downtown campus includes a 409-bed Level I trauma center, adult and pediatric emergency departments, and a number of clinical specialty units. The unit discussed in this case was a twelve-week summer unit held in 2014 with six Level I learners.

Upstate's CPE admissions policy has evolved since our initial accreditation. It includes three key components: a face-to-face conversation with an interview team comprised of a seasoned member of the hospital's CPE Professional Advisory Council and the ACPE supervisor, the utilization of a post-interview five-point Likert scoring system of fifteen assessment criteria, and a 1 to 10 subjective scale that assesses the interviewer's 'gut' re-

sponse as to whether the applicant is suitable for our program. Applicants must be scored at least a '5' to be considered for acceptance.

When he applied for the summer unit, Sandy was a sixty-seven-year-old lay Roman Catholic, married, with two grown children. He had sustained a TBI during college in a motor vehicle accident—perfectly matching the national statistics for type and age of those with TBIs. Raised Lutheran, he completed a BA in 1970 and an MA in 1980 from a Lutheran seminary. During his seminary education, he reported having taken two semesters of CPE at two area hospitals. Although no evaluations could be located, three credits were listed on his seminary transcript.

Following seminary, Sandy worked as an admissions counselor for a local electronics school, in sales for an automotive parts store, and as an automotive salesperson for 3M. He and his wife moved to Syracuse to be closer to her aging parents. Sandy applied for and was accepted in a Level I summer unit at Upstate in 2011 with the goal of exploring hospital chaplaincy as a possible vocation. He acknowledged and was observed to have some cognitive challenges, but he was functioning sufficiently to complete his written assignments, meet his clinical responsibilities in the oncology department, and engage in the group process. His learning issue was how to offer presence and "be with" patients rather than try to "help and fix" patients with the positive-focused approach that had worked for him throughout his extensive rehabilitation. Sandy's love of God, love of his patients, good nature, and desire to be of service were all strengths that endeared him to his peers, our department, and his floor.

Following that summer, Sandy began volunteering once a week in spiritual care at Upstate and several other area hospitals. He especially loved to offer Holy Communion to our Catholic patients, and he regularly carried our trauma/stroke pager and did visits in the emergency department, where he was well received. He had hoped to be hired as a chaplain through the Catholic Diocese, which has no clinical training or educational requirements for their chaplains, and placed on contract at an area institution. When Sandy learned that the diocese was moving towards including the requirement of being an ordained deacon as part of their hiring requirements for their chaplaincy positions, he applied to the diaconal training program. When he was denied admission due to his disability and age, Sandy's question for himself became, *Where do you want me, Lord?* It was this question, more than the desire to be hired as a chaplain, that led Sandy to apply for another CPE unit at Upstate three years later to assist his discernment process.

CASE STUDY

Sandy's History in His Words

My journey began with an extremely bright future. I was in college, the president of my fraternity, started a band that had its first 'gig' in two weeks, with a new car and two girlfriends. Then everything changed. I was hit broadside on a four-lane highway and spun around into the other two lanes, where I was hit again.

My head nearly destroyed the windshield; my left eye was nearly torn from its socket. I sustained a serious brain injury: a brain bruise and bilateral subdural hematoma. I was in a coma for thirty-seven days. Traumatic Brain Injuries differ from individual to individual. When this occurred, there was no rehabilitation therapy as we know it today. My nurses helped me to walk and speak again.

The injury also caused damage to the optical center of my brain causing quadruple vision and the rotation of images. After about a year, my vision gradually improved to double vision that corrective lenses do not help. Dates and names are particularly difficult for me and I live with short-term memory problems. Fortunately, I have developed coping skills to accommodate my limitations.

The easiest way to describe TBI is to think of two circles side by side. Draw a 4" circle on a piece of paper. The center and the entire area around that center point are your interactions and perceptions of the world around you. Draw another circle about 2" in diameter. The new area represents the reality you must work with, live with, and function in. This life-orientation of my TBI is often complicated because the 2" circle can bulge to a 4" reality from time to time. This change has no timetable or schedule; it simply happens from time to time without forewarning.

Because I survived, I felt that God was calling me to a life of service or ministry. I pursued ordination through the Lutheran Church of America, but my internship turned into a disaster. During a retreat assignment, my supervising pastor made sexual advances towards me. While I was trying to decide whom I should contact and what I should do, I was recalled to the seminary. According to my supervising pastor, "Things were just not working out." No recourse, no appeal, no reassignment, just a rental truck to pack up my things and make my way back to St. Paul, Minnesota. This incident wounded my spirit to such an extent that it took almost thirty years before I could even talk about it to anyone.

Liberation came slowly. As a student and graduate of the seminary, I learned to love and embrace the Eucharist as well as the writings of the church fathers. The biblical statement "This is my Body" vexed my soul.

The Lutheran position of "in, with and under" could never be authenticated by Christ's actual words. As I celebrated Communion at my assigned Internship church, I would read the words of Scripture, but I could never embrace the doctrine of my Lutheran faith. For me "This is my body" meant literally "*This is my body*."

My wife was the first to turn to the Catholic Church, and I followed. The more I learned about my Catholic faith, the more I realized that it had always proclaimed a love of the Eucharist. After my interrupted internship, I became part of the 3M automotive sales force, developing several territories and winning several awards. Then, the company downsized and I was released. My wife and I decided to move to Central New York to be with her aging parents.

The move was extremely challenging. I developed heart disease and had to have a quintuple bypass. The rehabilitation seemed to last forever. To help revitalize my spirits, my wife suggested I pursue the calling that nurtured my heart: hospital chaplaincy. I have always wanted to give back because God has given me so much, so often.

Paying it back was not just a great slogan; it became a reality for me. I applied and was accepted to the CPE program at Upstate Hospital in Syracuse in 2011. My first unit was extremely challenging but rewarding. I am blessed by my service to the sick and the dying. I believe that this filled the hole in my soul, which I felt so strongly during my times of trial and sorrow.

At the age of sixty-six, I began to experience more short-term memory loss. In late 2013 I talked to my doctor about this, and he suggested magnetic imagery of the brain. This indicated that I have pre-Alzheimer's disease. Earlier that year, I was diagnosed with cancer. Although I was assured that this was the least aggressive and most curable kind, it was still *cancer*. My faith was shaken, but only for a short time.

A friend of mine once described this time by saying it was as if I went into my "cave" to retreat into stillness and quiet as I healed. This time of healing motivated me to pursue another unit of CPE. I love being a chaplain. I love being able to be with the sick and the dying. I am not simply ministering to them, I am one of them. Being a chaplain blesses me beyond measure.

Sandy's CPE Interview

Betty Morey, an experienced CPE applicant interviewer and long-time Professional Advisory Council member, met with Sandy and me for his admissions interview. We experienced Sandy's caring nature and sense of call while observing that self-reflecting, processing feelings, and objectively as-

sessing training demands were more challenging for him compared to his previous unit of training. As we sat with him that day and encouraged him to go deeper, Sandy was able to access some of his deep well of sorrow and pain related to his disability. His genuineness and desire to serve, combined with our sense of the challenges and benefits of accepting him for the unit as a person who was familiar to our institution and department, compelled us to create a plan offering accommodation for his TBI by appointing Betty as a mentor to help Sandy stay on task with CPE requirements so that I could hold my role as his clinical supervisor.

Educational Challenge

The Office of Federal Contract Compliance Programs of the U.S. Department of Labor describes reasonable accommodation as "an adjustment or modification made to a job, or the workplace, or the usual manner or circumstances of performing the job that allows an applicant or employee with a disability to successfully apply for the job, perform the duties of the job, or enjoy the benefits and privileges of employment. Reasonable accommodation also applies to the application process."[5] Examples of reasonable accommodation depend upon the nature of the disability and the type of work but may not be unduly costly or disruptive for the employer. They may include providing written materials in an accessible format, adjusting or modifying work schedules, or changing the work environment in ways that improve accessibility.

Although it is outside the scope of this article to go into detail about the Americans with Disabilities Act (ADA), what is important for CPE supervisors to know is that the ADA prohibits discrimination on the basis of disability in employment in state and local government, public accommodations, commercial facilities, telecommunications, and transportation. To be protected by the ADA, one must have a disability or have a relationship or association with an individual with a disability. An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such an impairment. The ADA does not specifically name all of the impairments that are covered—however, it was clear that Sandy fit these criteria. [6] The challenge was how to best provide a reasonable accommodation that would be tailored to Sandy's specific issues with learning.

I had sought consultation prior to Sandy's interview from Upstate psychologist Dr. Brian Rieger, a specialist in brain injury and rehabilitation, and learned some significant issues related to adult learning and TBI. As a progressive chronic condition, poor insight and memory cognition and also a tendency towards the concrete are behavioral traits to watch for. People with TBIs find their own ways to function and naturally adapt over time to their limitations. Brain injuries unnaturally age the brain, and there is diminished resilience to overall aging.

If the frontal lobe is injured, higher abstract thinking, empathy, insight, and nuance in 'reading' social situations are challenged. Persons with brain injuries function best in highly structured and routine environments. Dr. Rieger made it clear that one cannot expect a brain-injured person to fit in where they can't function. Thus, it would be important to shape the position to Sandy rather than try to shape Sandy to the position. The question that emerged was, Could we find a place for him in the program if we accepted him?[7]

Assessment and Interventions

Betty has been a member of the CPE Professional Advisory Council for over ten years and has participated in numerous applicant interviews. As both a county nurse for twenty-five years and an inner-city pastor for seventeen years who served on the ordination board of her denomination, she brings a unique blend of experience in understanding and relating to our prospective students. Betty's contribution to assessing the efficacy of Sandy's application was valuable in our decision-making process. She writes:

> Interviewing potential candidates for the CPE program is one of the joys of serving on the Professional Advisory Committee. So when Rev. Culbertson asked me to assist with Sandy's interview and I had the opportunity to read his application and biographical information, I knew that this would be different from the usual interview. As a former registered nurse, I was aware of the subtle and not-so-subtle deficits that can come with a traumatic brain injury. This candidate had been living with the results of a TBI for many years and had adapted his life to it. He also noted in the application that he was a candidate for the deacon's ministry in the Roman Catholic Church.
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> It was evident from everything he wrote that Sandy's call to ministry and his motivation for continuing with a second unit of CPE came from his personal experience of recovery and his desire to share his experience and be a source of encouragement for those going through similar experiences

> in their own lives. That was substantiated during the hour-long interview. What impressed me most were his passion for, and his commitment to, helping people through ministry and his desire to offer the Eucharist as a part of that. He was honest and up front about his limitations regarding his memory—"Three things max!"—which was a concern for us, along with his ability to do the in-depth work required as a part of the CPE process.
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> In our discussion following the interview, Rev. Culbertson and I discussed at length the feasibility of Sandy's participation—including the fact that he noted in the interview that he had recently been denied entry into the educational program to become an ordained deacon. Because of his passion for ministry and my own background as a second-career pastor and member of my denomination's Board of Ordained Ministry, I offered to mentor him through the first few weeks of the unit if we assessed that he could be accepted again for training.

Sandy was aware of the progression of his disability. He was open to having a mentor work with him as a condition of acceptance into training. In addition to his short-term memory difficulties, Sandy knew he did not completely understand subtle inferences of questions or statements. At first, our plan was for the mentor relationship to be confined to the first few weeks of the unit.

Betty's reflections reveal the ongoing learning process that evolved in her role with Sandy. She wrote:

> It was soon evident that there were too many distractions and not enough time [when the two met face-to-face]. The third week, I was ill, so we met by phone, which Sandy thought worked better since he could work from his computer as we spoke. We had more time without the distractions and worked about an hour and a half each week.
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> From that time on, Sandy would send me his weekly reports and reflections based on his CPE goals and strategies. On reviewing his work, I noted that he often missed the point—providing lists of tasks and visits without much, if any, feedback or reflection. We worked each week on the questions "How did that make you feel?" and "Why?" These were not easy concepts for him to grasp, but over time—and with some coaching—he began to make the connections based on his pastoral visits.
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> Most of our time together involved reframing the questions so he could better understand what was being asked of him. Because he often forgot key issues shortly after making his pastoral visits, we decided that it would be better if he took notes after each visit. He chose to do this on his computer (using a flash drive), which led to a significant improvement in content.

> What was intended initially to be short-term mentoring extended over the twelve weeks of the unit. My experience of Sandy was of a man who was passionate about his ministry and caring for all persons, especially those who had had experiences similar to his own. He was a great "encourager" for those who were struggling on the road to recovery. He used humor and laughter in his ministry, sometimes to "buy time" when he was asked to explain complex topics, and given the time he usually could do it. He was both a joy and a challenge to work with throughout the unit, but it was if there were a "hole" in his ability to process and hold on to his thoughts. One could work around it, but not fix it—only accommodate the deficit.

As Sandy's CPE supervisor, I utilized our first supervision session to discuss the issues related to Sandy's TBI that impacted his learning process—specifically, the reality that "my memory shelf can only hold so much"—in relation to keeping dates and assignments straight. The mentor relationship became an important contribution to Sandy's ability to utilize clinical pastoral supervision to focus on clinical and intrapersonal dynamics. Although we kept the boundary of receiving practical support from Betty in clarifying the intent of tasks and ways to compensate for the limits of Sandy's memory, as a pastor she also offered pastoral care in the context of her mentorship.

Sandy continually stated to me that he wanted to "take in everything" I was teaching and was concerned about how much he could absorb. Together we worked on developing appropriate goals for Sandy for this Level I unit: (1) *Pastoral Competence*: To grow in understanding of the culture of current rehabilitation, gaining competency in the role of the rehab chaplain; (2) *Pastoral Reflection*: In light of my traumatic brain injury, how is my chaplaincy being formed and altered in God's plan? (3) *Pastoral Formation*: To work on self-understanding and individual feelings in order to be more attuned to the feelings of the patient and family and develop an empathic exchange.

Discussion and Evaluation

Sandy used a flash drive on a daily basis to record his experiences and feelings, which was a driving force in his doing more in-depth self-reflection. His reflection papers grew in length and depth. He disciplined himself to write chart notes immediately after each patient visit. I co-sign all student chart notes and was able to edit his notes when his narrative or choice of interventions and outcomes were unclear. I was intentional in promoting understanding and retention of specific pastoral skills, offering feedback and ongoing evaluation by rounding on patients with Sandy to continually as-

sess goal process and by focusing on creating a learning climate that encouraged the development of the supervisory relationship in the context of each of our limits. Because I had received a college education through the federal vocational rehabilitation program for a physical disability, I was especially mindful of my countertransference and identification with the dynamics of perseverance and determination required in living beyond the limits of an identified disability.

Sandy was appreciated by his peer group, and as he grew in comfort, he was able to use our systems-centered theory orientation to initiate a subgroup that joined around the feeling that at times their ministry didn't make any difference. His humble demeanor, ability to laugh at himself, and belief in our learning process were all assets for the group as it developed from simpler to more complex relationships throughout the training. Sandy modeled for his peers the ability to be in the "here and now," especially his emotions but also his experiences of a strong sense of God's presence.

Sandy was faithful in his patient visitation and began to modify his tendency to want to be useful and replace it with the ability to be present more in the here and now. Sandy's strength with his rehab patients was his embodiment of hope in the face of great challenge. This was also his limitation, notably when he encountered severely injured patients who were unable to complete the demands of their rehabilitation. He was especially effective with anxious patients seeking spiritual support. One night an older woman was in the emergency department with a breathing problem. Sandy suggested that she allow the Holy Spirit to fill her lungs with healing and hope and press her lips together to blow away any fear or doubt that arose. Later that week, she specifically requested another visit by Sandy.

Attending daily physician rounds on rehab served as a key way for Sandy to build his relationship with staff. Feedback was received from a number of staff that described him as a great addition to the care team, noting that he put patients at ease by respecting their dignity and that he helped staff in any way possible. He was especially appreciated for his smiling face, cheerful greetings, and kind words. One Emergency Department nurse commented, "You were always attentive to any and all (both patients as well as staff) . . . there were times that the day seemed unbearable and you managed to turn that around." Department of Spiritual Care chaplains learned from Sandy's humbleness and non-defensiveness in asking for help when he was confused, which allowed them to become more vulnerable and request assistance when needed without shame.

Sandy evaluated the efficacy of having a mentor work with him during this unit. He wrote:

> Betty helped me on numerous occasions to more fully comprehend the assignments and work my way through to the most appropriate and accurate responses. We began by meeting over lunch. This proved to be cumbersome. Because of illness, we started phone meetings, which were most satisfactory. It took the tension away from my being able to take notes or compile papers. Again, the reason for this collaboration is quite simple, "Two heads are better than one," especially when TBI is involved. There was one particular assignment that I did not totally comprehend. It was through Betty's support and coaching that I was able to modify and resurrect it into something much more acceptable. Without her assistance I do not believe I could have survived this class.

Theological Considerations

As neuropsychologist Kirsten Dams-O'Connor states, "I am often amazed by the creative and graceful ways people reinvent their lives. . . . I cannot promise all my patients that things will turn out as they wish, but I can tell them that the human spirit is amazingly resilient. People can (and do) thrive in the face of devastating loss."[8] In his mid-unit theological integration paper, Sandy identified with Brother André, a monastic who lived in the 1800s. Brother André was drawn to the life of a religious, but his superiors had doubts concerning his abilities due to his disability and made him a porter at Notre Dame instead. Tongue in cheek, Brother André wrote, "When I entered the community, my superiors showed me the door, and I remained there forty years without leaving."[9]

Like Brother André, Sandy also desired to serve God wherever God placed him. Our CPE program values the theology of hospitality, of welcoming the stranger, of learning from our weakness and using it as strength, and of the wholeness that grows out of our shared brokenness. My theology of supervision connects with Bonhoeffer's framework for a "genuine community" that is not based on human illusion of unity or perfection but instead is set in the context of our relationship with God.[10] By our experience of God's mercy, we in turn can choose to be in relationship and grow in understanding of one another in the process. Bonhoeffer makes it clear that community requires respect, freedom and trust from its members if it is to

exist in a healthy fashion. Hauerwas takes this a step further by elaborating on diversity in relationships:

"If we are to be a good community, we must be one that has convictions substantive enough not to fear our differences, and indeed, to see that we would not be whole without the other being different from us."[11] As Nancy Eiesland writes in her book *The Disabled God*, there is an emancipating presence when persons with disabilities are part of a community. Eiesland believes that especially in the Christian Eucharist, so central to Sandy's theology as a devout Catholic, the "disabled God" is encountered in such a way as to open up new possibilities of wholeness and embodiments of justice.[12]

Conclusion

Our relationship with Sandy over several years was a unique factor in our decision to accept him for this summer unit. He was known to our hospital and our department. His personality and sense of God's call in his life was an inspiration to those of us who also struggle with disabilities. For a student just beginning CPE at an unfamiliar center, the challenges of accommodation might be too much without a great deal more mentoring than was provided. This arrangement took more time and energy than is usual for our program, but I close with these words Sandy wrote for this article in the hope that you may sense how meaningful our experience together has been for our CPE program:

> My hope is that everyone reading this will consider allowing those with TBI to grow from and participate in CPE training. For me, being a volunteer chaplain and Eucharistic minister is something with unbelievable rewards. I am so blessed and so fulfilled each day I check into the floors. By allowing those with TBI to participate in CPE training, you will be allowing and training those with disabilities to "walk with Jesus on this journey."

NOTES

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7. Phone conversation with Brian P. Rieger, Ph.D, Director, Concussion Management Program, Upstate Medical University, Syracuse, New York, February 7, 2014.

8. Kristen Dams-O'Connor, "Dig Deep: A Rehabilitation Neuropsychologist Reflects on the Strength and Resilience of People Reinventing Their Lives after a Traumatic Brain Injury," *Neurology Now* 11, no. 5 (October/November 2015): 70. Dr. Dams-O'Connor is an associate professor in the department of rehabilitation medicine and co-director of the Brain Injury Research Center at the Icahn School of Medicine at Mount Sinai in New York.

9. "A Brief Biography of Saint Andrew Bessette of Montreal," Salt of the Earth, March 16, 2011, accessed March 25, 2016, solzemli.wordpress.com/2011/03/16/a-brief-biography-of-saint-andrew-bessette-of-montreal/.

10. Dietrick Bonhoeffer, *Life Together,* trans. John W. Doberstein (New York: Harper and Row, 1954). See chapter 1, "Community," pp. 17–39, for a thorough description of Bonhoeffer's notion of community.

11. Stanley Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped and the Church* (Notre Dame, IN: University of Notre Dame Press, 1986), 214 (in the section entitled "Community and Diversity: The Tyranny of Normality").

12. Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville: Abingdon Press, 1994).