Seventh-day Adventist Theological Seminary

DOCTOR OF MINISTRY

Andrews University

CHMN787 Theory & Research in Chaplaincy
(5 credits)

2009 Healthcare Chaplaincy Cohort

Professor

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February 20-28 2010

LOMA LINDA UNIVERSITY
School of Religion

Loma Linda, CA.

Table of Contents

Module (or Course) Description

This module covers instruction in theory and research skills within the context of spiritual care in the chaplaincy setting. It provides education in the following specialty areas: practical theology, qualitative research, cultural psychology and theology.

The course is prepared especially for chaplains of hospital, community, and healthcare organizations.

Each course participant will integrate essential research skills and approaches into their context of healthcare practice and demonstrate competencies in a portfolio of experiences. Participants will share accountability for their development in peer groups that meet outside of the two-week intensive.

Participants in the healthcare chaplaincy cohort take the following modules as part of a sequence of CHMN 786, GSEM 730, GSEM 706, GSEM790, CHMN 787 (February 20-28, 2011), GSEM 796, CHMN788 and GSEM 796 to form a healthcare chaplaincy concentration.

Concentration Outcomes / Program Competencies

The Doctor of Ministry program seeks to develop the person, knowledge, and practice of its students. While the program is structured around certain areas of concentration, there are competencies we feel are important to evaluate as outcomes for all students. The following are those program competencies.

Being:

Self-reflection: to help participants become aware of their strengths and limitations (background, emotional state) and to realize the impact self-awareness and self-understanding may have on ministry.

Knowing:

Academic: to help participants acquire knowledge of current issues and research related to the field of spirituality and health, engage the discipline through sociological and psychological perspectives, reflect theologically on the lived experience of patients, and learn basic research skills relating to the field of healthcare.

Professional: to help participants gain knowledge of the professional field including spiritual leadership, consultation, networking, and ethical conduct.

Doing:

Clinical: to help participants acquire clinical skills pertinent to their practice in the field of chaplaincy and spiritual care within the context of healthcare.

Spiritual and Theological Formation: to help participants integrate their spiritual and theological

perspectives into the practice of ministry.

Course Module Content

The description of content for this module is not meant to represent the learning design or form a contract for the content.

Participants will receive an orientation and practice to the overall qualitative research and practical theology.

Specific competencies for the current course include the following:

1. History of practical theology and qualitative research as a theoretical framework for healthcare chaplaincy work.

2. Qualitative research methods and approaches as they relate to healthcare chaplaincy approaches.

3. Practical theology as a way of interpreting life and ministry in healthcare chaplaincy.

4. Broad understanding of various qualitative research theories as they relate to healthcare chaplaincy.

5. In-depth understanding of specific interview techniques (narrative, listening, reflection, analysis, model building, theory/theology development) as applied in healthcare chaplaincy.

6. Seeing healthcare chaplaincy ministry from practical theology/qualitative research approaches.

7. Self-Reflection: identify personal issues as a healthcare chaplain.

The Cohort

This module or course is open to members of this cohort, who take the sequence of modules and courses together as listed in the **Description**. Cohort members will meet in groups between intensives and pursue projects that advance their competencies. On completion, they will have completed a healthcare chaplaincy concentration in their DMin program.

Always consult the Doctor of Ministry program planner at www.doctorofministry.com for possible adjustments to the date and locations of future teaching intensives.

Module (or Course) Requirements

NOTE: "Books can be purchased in any manner convenient to the participant. They can be ordered through the Andrews University Bookstore - 800-385-2001. Some books are available used at the Amazon online book store."

I. Pre-Intensive

ALL STUDENTS READ THIS BOOK--Swinton, John and Harriet Mowatt. Practical theology and qualitative research. London: SCM, 2006

> **NOTE**: Swinton's book will provide the theoretical framework for research in chaplaincy. All will learn about practical theology as a way to do theology for today's society in an engaging manner where the church is as central to theology as the traditions of the past. This book is in harmony with EGW's perspectives on "present truth" and on "inspiration" and "revelation".
>
> **READ**: Ellen G. White writings excerpts attached to learn / review EGW's perspectives on "present truth" and on "inspiration" and "revelation".
>
> White, Ellen G. (1958). Selected Messages Book 1. Mountain View, CA: Pacific Press Publishing Association. Read: Chapter 1, "The Inspiration of the Prophetic Writers" pages 15-23. Chapter 55, "Presented as Old Truth in New Framework" and Chapter 56 "A Truth Bearing the Divine Credentials", pages 355-364. A Pdf of the whole book is available through the class website at Andrews University D2L Portal <https://d2l.andrews.edu/index.asp>. For an online reading go to <http://wordoftruth.seedoftruth.net/downloads/selected_messages_book_1>.
>
> White, Ellen G. (1888, 1907). The Great Controversy Between Christ and Satan. Mountain View, CA: Pacific Press Publishing Association. Read: A Pdf of the chapter is available through the class website at Andrews University D2L Portal <https://d2l.andrews.edu/index.asp>. For an online reading go to <http://www.whiteestate.org/books/gc/gcintroduction.html>

a) read the book carefully

b) take notes on each chapter—a summary of the arguments

c) for each chapter—answer the question-how does this information define my ministry as a chaplain (or pastor)?

d) think of a topic you can deal with from this perspective (we will all write a small research paper for this class)—keep a running list of possible topics.

STUDENT SELECTED TWO BOOKS FROM THIS LIST—

Journaling of the literature:

a) read the book carefully

b) take notes on each chapter—a summary of the arguments

      c)   for each chapter—answer the question-how does this information define my ministry as a chaplain (or pastor)?

      d)   think of a topic you can deal with from this perspective (we will all write a small research paper for this class)—keep a running list of possible topics.

Page On Attached Document

Books   1

Review the whole list before selecting which books you will review, select books according to your personal and professional goals and interests. It is your responsibility to purchase the books, to secure them with interlibrary loans or to check them out from a library.

"Books can be purchased in any manner convenient to the participant. They can be ordered through the Andrews University Bookstore - 800-385-2001. Some books are available used at the Amazon online book store."

1. Pennington, Robert John (AKA M. Basil Pennington). (2007). The Christ chaplain; the way to a deeper, more effective hospital ministry. Haworth Press.   132

2. Handzo, George. (Editor) (ca. 2010). By Its Fruits: The Science of Health Care Chaplaincy and Practice. New York, New York: HealthCare Chaplaincy. (See provided Pdf) <http://www.healthcarechaplaincy.org/userimages/pb-by-its-fruits.pdf>   1

3. VandeCreek, L., & Lucas, A. (2001). The Discipline for Pastoral Care Giving. Binghamton: Haworth Press.   2

4. Frampton, S., Charmel, P., & Gilpin, L. (2003). Putting Patients First: Designing and Practicing Patient-Centered Care. San Francisco: Jossey-Bass.   2

5. Providing Culturally and Linguistically Competent Healthcare (2006). Oakbrook, IL: Joint Commission Resources.   3

6. Fitchett, G. (1993) Assessing Spiritual Need: A Guide for Caregivers. Minneapolis, Minnesota: Augsburg/Fortress Press.   4

7. VandeCreek, L. (2002). Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No. Binghamton: Haworth Press.   4

8. Nursing: Scope and Standard of Practice (2004). Silver Spring, MD: American Nurses Association.   5

9. George, M.L. (2002). Lean Six Sigma: Combining Six Sigma Qualities with Lean Speed. New York: McGraw Hill.   5

10. Studer, Q. (2003). Hardwiring Excellence: Purpose, Wothwhile Work, Making a Difference. Gulf Breeze, FL: Fire Starter Publishing.   5

11. Bowker, J. (1975). Problems of Suffering in Religions of the World. Cambridge: Cambridge University Press.   5

12. Kuhn, T. (1962). The Structure of Scientific Revolutions. Chicago, IL: University of Chicago Press.   6

13. Schön, D. A. (1987). Educating the Reflective Practitioner. (San Francisco: Jossey-Bass).   15

14. Hinchey, P. H. (1998). Finding Freedom in the Classroom: A Practical Introduction to Critical Theory. (New York: Peter Lang).   17

15. Palmer, P. J. (1998). The Courage to Teach: Exploring the Inner Landscape of a Teacher's Life. (San Francisco: Jossey-Bass, 1998).   17

16. Mezirow, J. and Associates (2000). Learning as Transformation: Critical Perspectives on a Theory in Progress. (San Francisco: Jossey-Bass).   18

17. Frawley-O'Dea, M. G., and J. Sarnat (2001). The Supervisory Relationship: A Contemporary Psychodynamic Approach. (New York: The Guilford Press).   19

18. Hawkins, P. and R. Shohet (2006). Supervision in the Helping Professions, 3rd ed. (Berkshire, England: Open University Press).   20

19. Bandura, Albert. (1997). Self-Efficacy. New York: Freeman and Company.   21

20. Baumeister, Roy & Vohs, Kathleen. (2006). Handbook of Self-Regulation. New York: Guilford Press.   21

21. Seligman, Martin. (2002). Authentic Happiness. New York: Free Press.   21

22. Haidt, Jonathan. (2006). The Happiness Hypothesis: Finding Modern Truth in Ancient Wisdom. New York: Basic Books.   21

23. Frawley-O'Dea and Sarnat (2001). The Teaching and Learning of Psychotherapy. Madison, CT: International Universities Press.   21

24. Ekstein, R., & Wallerstein, R. (1958). The Teaching of Psychotherapy. New York: Basic Books.   21

25. Dewey, John. (1938). Experience and Education. (1938, 1998). Indianapolis, Indiana: Kappa delta Pi.   22

26. Greene, Maxine. (1995). Releasing the Imagination. San Francisco: Jossey-Bass.   22

27. Grefe, Dagmar. (2009). Edition 3 of a Series, 'Meeting the Other: Interreligious Encounters in the Provision and Supervision of Spiritual Care'. N.P.: John Templeton Foundation. (see attached Pdf pp. 23-35).   23

17. Knitter, Paul F. (2007). Introducing Theologies of Religions. Maryknoll, NY: Orbis Books.   24

18. Knitter, Paul F. (1995). One Earth, Many Religions: Multifaith Dialogue and Global Responsibility. Maryknoll: Orbis Book.   24

19. Stephan, Walter G., & Stephan, Cookie W. (1996). Intergroup Relations. Social Psychology Series. Madison: Brown & Benchmark Publishers.   25

20. Irish, Donald P., Kathleen F. Lundquist, and Vivian Jenkins Nelsen (Editors), (1993). Ethnic Variations in Dying, Death, and Grief: Diversity in Universality. Philadelphia: Taylor & Francis.   27

21. Lartey, Emmanuel Y. (2003). In Living Color: An Intercultural Approach to Pastoral Care and Counseling. 2nd ed. London: Jessica Kingsley Publishers.   28

22. Griffin, David Ray, (Editor), (2005). Deep Religious Pluralism. Louisville, KY: Westminster John Knox Press.   29

23. Friedman, Dayle A. (Editor), (2005). Jewish Pastoral Care: A Practical Handbook from Traditional and Contemporary Sources. 2nd ed. Woodstock, VT: Jewish Lights Publishing.   30

24. Ariarajah, S. Wesley. (2006). Not Without My Neighbor: Issues in Interfaith Relations. Geneva: WCC Publications.   32

25. Richards, P Scott. (Series Editor), (ca. 2010). 'Edition 4 of a Series: Discerning Patient Needs: Spiritual Assessment Perspectives for Health Care Chaplains' (see attached Pdf pp. 36-50).   36

26. Kristeller, J. L., & Hummel, L. M. (2006). 'Spiritual engagement and transformation in cancer patients: The experience of the patient, the role of the physician'. In Joan Koss-Chioino and Philip Hefner (eds.), Spiritual Transformation and Healing: Anthropological, Theological, Neuroscientific, and Clinical Perspectives, Lanham, MD: Rowan and Littlefield Press.   39

27. Richards, P. Scott, & Bergin, A. E. (2005). Religious and spiritual assessment (pp. 219 – 247). In P. S. Richards & A. E. Bergin (Eds.), A spiritual strategy for counseling and psychotherapy (2nd ed.). Washington, DC: American Psychological Association.   43

28. Gorsuch, Richard L., & Miller, William R. (1999). Assessing spirituality (pp. 47 – 64). In W. R. Miller (Ed.), Integrating spirituality into treatment: Resources for practitioners. Washington, DC: American Psychological Association.   44

29. Cooper-White, Michael, (Contributing Editor) & Montonye Martin, (Editor), (ca. 2010). 'Edition 5 of a Series: The Management of Care: Literature on Leadership and Organizational Development. New York, NY: Education, HealthCare Chaplaincy (see attached Pdf pp. 51-59).   51

30. Burns, James MacGregor. (2003). Transforming Leadership. New York: Grove Press.   53

31. Friedman, Edwin H. (2007). A Failure of Nerve: Leadership in the Age of the Quick Fix New York: Seabury.   53

32. Hawley, Jack. (1993). Reawakening the Spirit in Work: The Power of Dharmic Management. San Francisco: Berrett-Koehler.   54

33. Lama, Dalai, & Van Den Muyzenberg, Laurens. (2009). The Leader's Way: The Art of Making the Right Decisions in Our Careers, Our Companies, and the World at Large. New York: Broadway Books.   54

34. Northouse, Peter G. (2007). Leadership: Theory and Practice - 4th ed. Thousand Oaks, CA: Sage.   55

35. Bolman, Lee G., & Deal, Terrence E. (1997). Reframing Organizations: Artistry, Choice, and Leadership. San Francisco: Jossey-Bass.   56

36. Sample, Steven B. (2002). The Contrarian's Guide to Leadership. San Francisco: Jossey-Bass.   56

37. Badaracco, Jr, Joseph L. (2002). Leading Quietly: An Unorthodox Guide to Doing the Right Thing. Boston: Harvard Business School Press.   58

38. Hackman. J. Richard. (2002). Leading Teams: Setting the Stage for Great Performances. Boston: Harvard Business School Press.   58

STUDENT SELECTED THREE ARTICLES FROM THIS LIST—

Review the whole list before selecting which articles you will review, select articles according to your personal and professional goals and interests.

Journaling of the literature:

a) read the article carefully

b) take notes on the article—a summary of the arguments

c) for each argument—answer the question-how does this information define my ministry as a chaplain (or pastor)?

d) think of a topic you can deal with from this perspective (we will all write a small research paper for this class)—keep a running list of possible topics.

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Articles   1

Review the whole list before selecting which articles you will review, select articles according to your personal and professional goals and interests. You have to secure the articles from their published sources either through the web, through Ebsco Host or via a library interlibrary loan or from the stacks. It is your responsibility to secure the selected articles as assigned.

1. VandeCreek, L., & Burton, L. (2001). Professional Chaplaincy: Its Role and Importance in Healthcare. Journal of Pastoral Care & Counseling, 55(1), 81-98.   6

2. Iler, W., Obershain, D., & Camac, M., (2001). The Impact of Daily Visits from Chaplains on Patients with Chronic Obstructive Pulmonary Disease (COPD): A Pilot Study. Chaplaincy Today, 17 (1), 5-11.   6

3. PowerPoint Presentation-- Wintz, S, "Outcome Oriented Chaplaincy- An Overview" (see provided Pdf pp. 63-128).   63

4. Fitchett, G., et al. (2004). Religious Struggle: Prevalence, Correlates and Mental Health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients. International Journal of Psychiatry in Medicine. 34(2), 179-196.   7

5. Fitchett, G. & Risk, J. L. (2009). Screening for spiritual struggle. Journal of Pastoral Care and Counseling, 63 (1,2). Available online at http://journals.sfu.ca/jpcp/index.php/jpcp/article/view/71/57.   8

6. Balboni, T. A. et al. (2007). Religiousness and Spiritual Support among Advanced Cancer Patients and Associations with End-of-Life Treatment Preferences and Quality of Life. Journal of Clinical Oncology, 25(5), 555-560.   8

7. Handzo, G., & Koenig, H. (2004). 'Spiritual care: whose job is it anyway?' Southern Medical Journal, 97(12), 1242-1244.   9

8. Puchalski, C., Lunsford, B., Harris, M., & Miller, R. (2006).) Interdisciplinary Spiritual Care for Seriously Ill and Dying Patients: A Collaborative Model. The Cancer Journal, 1295, 398-416.   9

9. Cadge, W., PhD, Freese, J., PhD, & Christakis, N. A., PhD. (2008). The Provision of Hospital Chaplaincy in the United States: A National Overview. Southern Medical Journal, 101(6), 626-630.   10

10. Flannelly, K., Handzo, G., Smith, W., & Weaver, A. (2005). A National Survey of Health Care Administrators' Views on the Importance of Various Chaplain Roles. The Journal of Pastoral Care & Counseling, 59(1-2), 87-96.   10

11. Hummel, Leonard M. (ca. 2010). Critical Analysis 'By Its Fruits: The Science of Health Care Chaplaincy' (see attached Pdf pp. 11-13).   11

12. Kytle, Ph.D., Jackson. (ca. 2010). Edition 2 of a Series 'TO WANT TO LEARN'. New York, New York: HealthCare Chaplaincy (see attached Pdf pp. 14-22).   14

13. Fredrickson, Barbara. (2003) "The value of positive emotions." American Scientist 91, 330-335.   21

14. Grant, H., & Dweck, C. S. (2003). Clarifying achievement goals and their impact. *Journal of Personality and Social Psychology, 85*, 541-553.   21

15. Jones, Alum. (1998). "Some reflections on clinical supervision: An existential phenomenological paradigm." European Journal of Cancer Care 7, 56-62.   22

16. Toback, Phyllis Brooks. (1993). "A Theological Reflection on Baptism by a Jewish Chaplain." Journal of Pastoral Care 47, no. 3: 315-317.   30

17. Monnett, Mike. (2005). "Developing a Buddhist Approach to Pastoral Care: A Peacemaker's View." Journal of Pastoral Care and Counseling 59, nos. 1-2: 57-62.   31

18. Pettigrew, Thomas F. (1998). "Intergroup Contact Theory." Annual Review of Psychology 49: 65-84.   32

19. Taylor, Bonita E., and David J. Zucker. (2002). "What We Wished Our Non-Jewish Supervisors Knew About Us As Jewish Supervisees." Journal of Pastoral Care and Counseling 56, no. 4: 317-327.   33

20. Nagda, Biren (Ratnesh), & Amelia Seraphia Derr. (2004). "Intergroup Dialogue: Embracing Difference, Conflict, Engendering Community." In Education Programs for Improving Intergroup Relations: Theory, Research, and Practice, ed. Walter G. Stephan, and W. Paul Vogt, 133-51. Multicultural Education Series. New York: Teachers College Press.   34

21. Cameron W. Byrd. (1992/1993). "Inclusiveness in a Basic Unit of Clinical Pastoral Education: A Story of Struggle, Risk and Commitment." Journal of Supervision and Training in Ministry 14:201-11.   34

22. Ledbetter, Timothy J. (2008). Screening for pastoral visitations using the Clinical + Coping Score. The Journal of Pastoral Care and Counseling, 62 (4), 367-373.   38

23. Puchalski, C. (2006). Spiritual assessment in clinical practice. Psychiatric Annals, 36 (3), 150-155.   40

24. Hodge, David R. (2006). A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. Social Work, 51(4), 317-326.   42

25. Hathaway, William L. (2003). Clinically significant religious impairment. Mental Health, Religion and Culture, 6 (2), 113- 129.   42

26. Millspaugh, D. (2005). 'Assessment and response to spiritual pain: Part I'. Journal of Palliative Medicine, 8(5), 919-923.   45

27. Millspaugh, D. (2005). 'Assessment and response to spiritual pain: Part II'. Journal of Palliative Medicine, 8(6), 1110-1117.   46

II. The Intensive

1) Expectations for attendance: You will attend each lecture, come prepare with knowledge of assigned reading materials, bring assigned written assignments, and engage in discussion.

2) Participation in discussion, exercises, and field experience as assigned during intensive.

3) Beginning the Ministry Development Plan per assigned groups.

4) Journaling of the intensive experience as per MDP.

5) Beginning their project chapter as per MDP.

6) Participation and completion of the following learning, graded activities: Interview One, Interview Two; Paper Draft; Paper Final; Reflection Quizzes and Oral Reports.

III. Post Intensive

Include in the assignments:

1) Literature (three other books and three other articles from given lists of books and articles provided)

2) Journaling of the selected books:
   a) read the book carefully

b) take notes on each chapter—a summary of the arguments

c) for each chapter—answer the question-how does this information define my ministry as a chaplain (or pastor)?

d) think of how this reading contributes to the selected research topic.

3) Journaling of the selected articles:

a) read the article carefully

b) take notes on the article—a summary of the arguments

c) for each argument—answer the question-how does this information define my ministry as a chaplain (or pastor)?

d) think of how this reading contributes to the selected research topic.

3) A Ministry Development Plan of 5 – 6 pages (this is assigned in the first module and a revision is assigned in the third module)

4) Students will form a context support group of five to seven persons from their specific ministry context who will meet face-to face annually with them to review their MDP.

The meetings will center on personal and professional progress. The first meeting must occur on or before (the end of March, 2011). The group will review the MDP and its role with materials provided during the intensive.

5) Students will participate in a minimum of two sessions of a work group for peer support and sharing of experience.

a) A journal and attendance record of the group meetings will be required from a secretary for each group by (date).

b) The first group meeting must occur on or before (date), and review the work of each student on their chapter (name the appropriate chapter).

c) The second group meeting must occur on or before (date), and review the (state the assignment to be reviewed) done by each student.

d) Groups may meet by phone conference, face-to-face, or via electronic conference.

6) The appropriate project chapter will be written: "*The Andrews University Standards for Written Work, 129*[th] *Edition* will provide the standards for the project chapter."

7) A 5-7 pages reflection paper based on the narrative analysis of the selected topic will be write.

Assessment

Assessment is accomplished by evaluating participation and assignments around the outcomes of the concentration. The chart below describes the process of judging the integration of those outcomes. Distinctions become vague when the contribution of all experience to the cyclical process of true learning in the areas of being, knowing, and doing are considered.

Grading –

Pre Intensive	600 points
Intensive	800 points
Post Intensive	600 points
Total	**2000 points**

Grading Scale

96 - 100% - A
93 - 95% - A-
90 - 92% -
B+ 85 - 89% - B
82 - 84% - B-
79 - 81% - C+
75 - 78% - C
72 - 74% - C-

Journals Pre Intensive Readings--Assignment submission deadlines will be applied as follows:		**Points**
Book One: Swinton, John and Harriet Mowatt, Practical Theology & Qual		100
Book Two: _____		100
Book Three: _____		100
Article One: _____		100
Article Two: _____		100
Article Three: _____		100
All Pre Intensive Readings are Due On the First Day of the Intensive *February 20, 2011* Six Journals to be deposited on D2L on the class website <https://d2l.andrews.edu/index.asp>		**TOTAL 600**
Assignment due date:	02/20/2011 (possible A grade)	
Delay up to 60 days:	04/20/2011 (no more than A- grade)	
Delay up to 90 days:	05/20/2011 (no more than B+ grade)	
Delay up to 120 days:	06/20/2011 (no more than B grade)	
Delay up to 150 days	07/20/2011 (no more than C grade)	

Intensive--Assignment submission ONLY accepted on required days during intensive and no latter than the last day of the intensive:	**Points**
Interview One: _____	100
Interview Two: _____	100
Paper Draft: _____	100
Paper Final: _____	100
Reflection Quizzes: _____	200
Oral Reports: _____	200
All Intensive Assignments are Due On the Last Day of the Intensive *July 28, 2011* to be deposited on D2L on the class website or handed in class as requested <https://d2l.andrews.edu/index.asp>	**Total 800**

Journals Post Intensive Readings--Assignment submission deadlines will be applied as follows:		Points
Book One: _____		100
Book Two: _____		100
Book Three: _____		100
Article One: _____		100
Article Two: _____		100
Article Three: _____		100
All Post Intensive Readings are Due On the First Day of the Intensive *July 20, 2011* Six Journals to be deposited on D2L on the class website <https://d2l.andrews.edu/index.asp>		**Total** **600**
Assignment due date:	07/20/2011 (possible A grade)	
Delay up to 60 days:	08/20/2011 (no more than A- grade)	
Delay up to 90 days:	09/20/2011 (no more than B+ grade)	
Delay up to 120 days:	10/20/2011 (no more than B grade)	
Delay up to 150 days	11/20/2011 (no more than C grade)	

Graduation requires a 3.0 or better program GPA. Students who receive a DN must seek permission from the DMin office to restart with another cohort and seek a new program time limit. Such requests are considered by the DMin program committee and not guaranteed. No tuition refunds are considered.

Academic honesty is required as published in the Andrews bulletin.

Accommodations are made for disabilities. Students with diagnosed disabilities should request accommodation. If you qualify for accommodation under the American Disabilities Act, please see the instructor as soon as possible for referral and assistance in arranging such accommodations.

Bibliography

Anderson, Ray S. (2001). The shape of practical theology: Empowering ministry with theological praxis. Downers Grove: InterVarsity Press.

Benson, Herbert. (1999). Timeless Healing. N.Y.: Scribner, p. 305.

Berg, Gary E., Fonss, N., Reed, A. J. & VandeCreek, L. (1995). The Impact of Religious Faith and Practice on Patients Suffering From a Major Affective Disorder: A Cost Analysis. Journal of Pastoral Care, 49(4), pp. 359-363.

Berry, Wendell. (1994). A Parting. Entries: Poems by Wendell Berry. New York: Pantheon Books, 11.

Brady, Marianne J., Peterman, A. H., Fitchett, G., Mo, M., & Cella, D. (1999). A Case for Including Spirituality in Quality of Life Measurement in Oncology. Psycho-Oncology, 8(5), 417-428.

Browning, Don S (ed.). (1983). Practical theology: The emerging field in theology, church and world. San Francisco: Harper and Row.

Burgener, Sandy C. (1999) Predicting Quality of Life in Caregivers of Alzheimer's Patients: The Role of Support from and Involvement with the Religious Community. Journal of Pastoral Care, 53(4), 433-446.

Canadian Council on Health Services Accreditation. (1999). Achieving Improved Measurement (AIM) Program . 430-1730 St Laurent Blvd, Ottawa, Ontario, Canada, K1G 5L1. Sections 13.3 & 14.9.

Carey, Raymond D. (1985). Change in Perceived Need, Value and Role of Hospital Chaplains. In Lawrence E. Holst (Ed.) Hospital Ministry: The Role of the Chaplain To d a y (New York: Crossroad Publishing Company), pp. 28-41.

Carey, Raymond G. (1973). Chaplaincy, Component of Total Patient Care? Hospitals: Journal of the American Hospital Association, 47(14), 166-172.

Daly, G. (2000). Ethics and Economics. Nursing Economics, 18(4), 194-201.

Feher, S. & Maly, C. (1999). Coping With Breast Cancer in Later Life: The Role of Religious Faith. Psycho-Oncology, 8(5), 408-416.

Fehring, Richard J., Miller, J.F., & Shaw, C. (1997). Spiritual Well-Being, Religiosity, Hope, Depression , and Other Mood States in Elderly People Coping With Cancer. Oncology Nursing Forum , 24(4), 663-671.

Fitchett, George, Burton, L. A.., & Sivan, A. B. (1997). The Religious Needs and Resources of Psychiatric In-Patients. Journal of Nervous and Mental Disease, 185(5) 320-326.

Fitchett, George, Meyer, P. & Burton, L. A. (2000). Spiritual Care: Who Requests It? Who Needs It? Journal of Pastoral Care, 54(2), 173-186.

Fitchett, George, Rybarczyk, B. D., DeMarco, G. A., & Nicholas, J. J. (1999). The Role of Religion in Medical Rehabilitation Outcomes: A Longitudinal Study. Rehabilitation Psychology, 44,(4), 333-353.

Fitchett, George. (1999a). Screening for Spiritual Risk. Chaplaincy Today, 15(1), 2-12.

Fitchett, George. (1999b). Selected Resources for Screening for Spiritual Risk. Chaplaincy Today, 15(1), 13-26.

Gibbons, James L. & Miller, S.L. (1989). An Image of Contemporary Hospital Chaplaincy. Journal of Pastoral Care, 43(4), 355-361.

Gibbons, James L., Thomas, J., VandeCreek, L., & Jessen A. K. (1991). The Value of Hospital Chaplains: Patient Perspectives. Journal of Pastoral Care, 45(2), 117-125.

Henry, L.G. & Henry, J.D. (1999). Reclaiming Soul in Health Care. Chicago: Health Form, Inc. 52.

Hover, Margot, Travis, J. L. III, Koenig, H. G., & Bearon, L. B. (1992). Pastoral Research in a Hospital Setting: A Case Study. Journal of Pastoral Care, 46(3), 283-290.

Johnson, Sarah C. & Spilka, B. (1991). Coping with Breast Cancer: The Roles of Clergy and Faith. Journal of Religion and Health, 30(1), 21-33.

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The Science of Health Care Chaplaincy

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Books

Review the whole list before selecting which books you will review, select books according to your personal and professional goals and interests. It is your responsibility to purchase the books, to secure them with interlibrary loans or to check them out from a library.

"Books can be purchased in any manner convenient to the participant. They can be ordered through the Andrews University Bookstore - 800-385-2001. Some books are available used at the Amazon online book store."

1. Pennington, Robert John (AKA M. Basil Pennington). (2007). The Christ chaplain; the way to a deeper, more effective hospital ministry. Haworth Press. 132

2. Handzo, George. (Editor) (ca. 2010). By Its Fruits: The Science of Health Care Chaplaincy and Practice. New York, New York: HealthCare Chaplaincy. (See provided Pdf) <http://www.healthcarechaplaincy.org/userimages/pb-by-its-fruits.pdf> 1

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5. Providing Culturally and Linguistically Competent Healthcare (2006). Oakbrook, IL: Joint Commission Resources. 3

6. Fitchett, G. (1993) Assessing Spiritual Need: A Guide for Caregivers. Minneapolis, Minnesota: Augsburg/Fortress Press. 4

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8. Nursing: Scope and Standard of Practice (2004). Silver Spring, MD: American Nurses Association. 5

9. George, M.L. (2002). Lean Six Sigma: Combining Six Sigma Qualities with Lean Speed. New York: McGraw Hill. 5

10. Studer, Q. (2003). Hardwiring Excellence: Purpose, Wothwhile Work, Making a Difference. Gulf Breeze, FL: Fire Starter Publishing. 5

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13. Schön, D. A. (1987). Educating the Reflective Practitioner. (San Francisco: Jossey-Bass). 15

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Articles

Review the whole list before selecting which articles you will review, select articles according to your personal and professional goals and interests. You have to secure the articles from their published sources either through the web, through Ebsco Host or via a library interlibrary loan or from the stacks. It is your responsibility to secure the selected articles as assigned.

1. VandeCreek, L., & Burton, L. (2001). Professional Chaplaincy: Its Role and Importance in Healthcare. Journal of Pastoral Care & Counseling, 55(1), 81-98.   6

2. Iler, W., Obershain, D., & Camac, M., (2001). The Impact of Daily Visits from Chaplains on Patients with Chronic Obstructive Pulmonary Disease (COPD): A Pilot Study. Chaplaincy Today, 17 (1), 5-11.   6

3. PowerPoint Presentation-- Wintz, S, "Outcome Oriented Chaplaincy- An Overview" (see provided Pdf pp. 63-128).   63

4. Fitchett, G., et al. (2004). Religious Struggle: Prevalence, Correlates and Mental Health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients. International Journal of Psychiatry in Medicine. 34(2), 179-196.   7

5. Fitchett, G. & Risk, J. L. (2009). Screening for spiritual struggle. Journal of Pastoral Care and Counseling, 63 (1,2). Available online at http://journals.sfu.ca/jpcp/index.php/jpcp/article/view/71/57.   8

6. Balboni, T. A. et al. (2007). Religiousness and Spiritual Support among Advanced Cancer Patients and Associations with End-of-Life Treatment Preferences and Quality of Life. Journal of Clinical Oncology, 25(5), 555-560.   8

7. Handzo, G., & Koenig, H. (2004). 'Spiritual care: whose job is it anyway?' Southern Medical Journal, 97(12), 1242-1244.   9

8. Puchalski, C., Lunsford, B., Harris, M., & Miller, R. (2006).) Interdisciplinary Spiritual Care for Seriously Ill and Dying Patients: A Collaborative Model. The Cancer Journal, 1295, 398-416.   9

9. Cadge, W., PhD, Freese, J., PhD, & Christakis, N. A., PhD. (2008). The Provision of Hospital Chaplaincy in the United States: A National Overview. Southern Medical Journal, 101(6), 626-630.   10

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12. Kytle, Ph.D., Jackson. (ca. 2010). Edition 2 of a Series 'TO WANT TO LEARN'. New York, New York: HealthCare Chaplaincy (see attached Pdf pp. 14-22).   14

13. Fredrickson, Barbara. (2003) "The value of positive emotions." American Scientist 91, 330-335.   21

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Edition 1 of a Series

By Its Fruits: The Science of Health Care Chaplaincy
Editor: Reverend George Handzo, Vice President, Pastoral Care Leadership and Practice, HealthCare Chaplaincy, New York, New York.

HealthCare Chaplaincy, with the generous support of the John Templeton Foundation, introduces *Practical Bearings*, a series of bibliographies and critical reviews of the important books, articles and other publications on the theory and practice of pastoral care.

To learn more about Practical Bearings and read other editions when they're published, please go to www.healthcarechaplaincy.org/practicalbearings

I.   Rationale

This series will present a variety of current thought and suggested practice bearing on what might be broadly characterized as the science of modern health care chaplaincy. A basic premise underlying this series is that pastoral care in health care can, and should, and needs to make increasingly predictable and evidence based contributions to the holistic care of those who are suffering, and their care givers. Because the published thought in pastoral care pertaining to these issues is limited, material will be drawn from sources outside the profession. While the relevance of some of the titles may seem questionable, we will attempt to make the relevance clear in each review. Finally, this series is emphatically not an attempt to remove the art or mystery from professional pastoral care or in any way minimize their importance. However, it does posit that pastoral care must adopt and adapt relevant scientific thought and method to maximize its benefit to those it serves.

II.   3-5 Best Books

As aforementioned, the overall literature in this field is in its infancy. With the exception of VandeCreek & Lucas, the books presented here are not directly about outcome based chaplaincy; rather, they present important components of what should go into the thinking about, and the planning for, that practice.

1

VandeCreek, L., & Lucas, A. (2001). *The Discipline for Pastoral Care Giving*. Binghamton: Haworth Press.

Summary

Co-author Chaplain Arthur Lucas, the former Director of Pastoral Care and CPE Supervisor at Barnes-Jewish Hospital in St. Louis, is credited with developing this system for the delivery of pastoral care to patients. As documented in the book, the system is characterized by an assessment, a patient profile and a plan of care with expected outcomes, interventions and measurement of how well the outcomes were achieved. The idea of outcomes that are measurable and for which the chaplain is accountable probably represents the most dramatic departure from the traditional delivery models for pastoral care, in which structure of this kind is considered problematic, if not heretical. However, this system almost mirrors the outlines of nursing standards of practice insomuch that communications and referrals are improved across interdisciplinary lines. The book, itself, is composed of an introductory chapter, which outlines the system followed by different Barnes chaplains, thus demonstrating how the system plays out within their particular clinical specialty, or within the teaching of clinical pastoral education.

Comment

This volume is the only book to date devoted entirely to presenting a system for "outcome oriented chaplaincy." It is a must-read book for anyone practicing, or in training to practice, pastoral care in a health care setting today. The material is clear and straight forward. Chaplain Lucas' system summation in the introductory chapter is done nicely, while the following chapters vary somewhat in quality, as expected from a book of different authors. They generally present good case material, which allows the reader to see the system in action. A couple chapters on the use of the system in CPE highlight the usefulness of this system as a training method and a patient care delivery model. This system is not as prescriptive as it may first appear. While it proposes an outline for service delivery; when done well, it actually enables creativity in the pastoral relationship rather than constricting it. This system also enables monitoring of service delivery for quality improvement purposes as more and more institutions are requiring.

Frampton, S., Charmel, P., & Gilpin, L. (2003). *Putting Patients First: Designing and Practicing Patient-Centered Care*. San Francisco: Jossey-Bass.

Summary

Patient-centered care has now become a central outcome of health care in the United States; emphasizing respect, collaboration and holistic care. It is the philosophical approach behind the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which every general hospital is now required to administer and publicly report its results. Since 1978, the Planetree Group has been applying it to every aspect of its care, from how doctors talk to patients, to how the lobby is designed. Planetree is a non-profit membership organization working with hospitals and health centers to develop and implement patient-centered care in healing environments. Edited

by three of Planetree's principle architects, this volume lays out a vision for patient-centered care that is actually alive and functioning throughout the country. All chapter authors have practical experience in their particular area. The book is divided into two basic sections: *Nine Elements of Patient-Centered Care* and *Future Directions for Patient-Centered Care*. The pervasive influence and presence of spirituality in this care model is quite apparent and quite consonant with the practice of pastoral care.

Comment

Arguably, no one does patient-centered care better than Planetree. They have proven that a hospital can fully involve patients and families in their own care, while making staff happy, and making money. For pastoral care providers, this model demonstrates that focusing on the care of the spirits of patients, family members and staff, does not have to be an afterthought; rather, it can be the centerpiece of a care model. In that vein, the chapter on religious and spiritual care may be the least interesting to chaplains because it tells them what they already know. This book presents, not guesses about what might be done, but results of what has been done, and done successfully. It is filled with ideas that chaplains can advocate for in their institutions, ideas that embody the values of pastoral care. While spirituality is everywhere in this model, it is sometimes so ubiquitous that it is hard to define and take hold of. That is, it is often everywhere, and no where, which is a valuable example for chaplains engaged in discussion of the role of spirituality in their own institutions.

Providing Culturally and Linguistically Competent Healthcare (2006). Oakbrook, IL: Joint Commission Resources.

Summary

This volume is the output of a research process at the Joint Commission that reviews the benefits, business case and barriers associated with cultural competence. Cultural and linguistic competence is "the ability of healthcare providers and institutions to deliver effective services to racially, ethnically, and culturally diverse patient populations. It is one of the primary drivers of quality in health care today.

A large part of the book is devoted to the provision of language and translation services to patients in hospitals, which while interesting, is not directly relevant to the practice of pastoral care. However, it should be noted that "Culturally" coming before "Linguistically" in the title is intentional. Cultural sensitivity and competence should be a major skill set of the professional chaplain. These are areas in which the professional chaplain can make significant contributions. Since Joint Commission Resources is a subsidiary of the Joint Commission and not the Joint Commission itself, this volume does not have the force of regulation. However, it still carries significant weight with healthcare administrators. Due to the involvement of the Rev. Sue Wintz, BCC as an editor of this volume, there is specific and significant mention of chaplains and their role in this important outcome of care.

Comment

Cultural competence, because of its tie to patient safety, has gone from a "nice to have" to a "must have" for every healthcare institution. The Joint Commission will also soon come out with a standard for this area of care on which there has been professional pastoral care input. As this volume advocates, chaplains are often looked to as the "culture brokers" for the institution. They become the subject matter experts in both staff training, formation of institutional policy, and care of individual patients and families. Given this role, chaplains become familiar with the issues involved and have a plan for how they might contribute to these important outcomes in the context of the cultural mix of their particular institution. This volume provides significant help with that task. One important caution is to pay attention, not only to the cultural mix of the patient population, but to the cultures of the staff as well and any cultural interactions between the two groups

Fitchett, G. (1993) *Assessing Spiritual Need: A Guide for Caregivers*. Minneapolis, Minnesota: Augsburg/Fortress Press.

Summary

George Fitchett presents a model for spiritual assessment that he and his colleagues developed, as illustrated with case studies. This "7X7" model has become a classic from which many other models are derived. He reviews three other models and provides a framework for evaluating them. The framework includes the model's concept of spirituality, norms and authority, and assessment context and process. The models include Paul Pruyser's *The Minister as Diagnostician,* Elizabeth McSherry's work at the Veterans Administration, and the model of the North American Nursing Diagnostic Association. This book addresses many of the questions pastoral caregivers have raised about this timely and enduring topic and provides an informed and balanced approach for making decisions about spiritual assessment models and tools.

Comment

Good assessment needs to be the cornerstone on which all of pastoral care delivery is built. It drives the plan of care, interventions, and outcomes. It surfaces the facts that communicate to other disciplines what chaplaincy does. As a side note, it is important to distinguish spiritual screening, which any staff person can do, and spiritual assessment, which should be the prerogative of the professional chaplain. Many chaplains have avoided doing assessment because professional pastoral care does not have a standard method. All chaplains need to realize that what is most important is to have a system that becomes standard for them and for their colleagues in a given institution so that other disciplines come to understand what they are doing.

III.   Other books

VandeCreek, L. (2002). *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No*. Binghamton: Haworth Press.

One of the many services that Larry VandeCreek rendered for professional chaplaincy was to gather a group of thought leaders to write about the pros and cons of chaplaincy becoming more scientific. Since outcome oriented chaplaincy is by its nature, scientific. Additionally, very chaplain needs to understand what "scientific" means in the context of chaplaincy, what it will do for us, and some of the down sides we need to recognize and avoid.

Nursing: Scope and Standard of Practice (2004). Silver Spring, MD: American Nurses Association.

As chaplains move toward standards of practice as a mechanism for demonstrating outcomes, spending even one hour reading the comparable documents for the profession of nursing gives us a template for how this is done, and how simple the process actually is.

George, M.L. (2002). *Lean Six Sigma: Combining Six Sigma Qualities with Lean Speed*. New York: McGraw Hill.

Continuous Quality Improvement is here to stay, and with the Joint Commission firmly in the lead, Lean Six Sigma as presented in this volume, is the Cadillac of quality improvement systems. While it is not necessary for chaplains to understand all of the intricacies of Six Sigma as presented here, or be able to implement it, many of the terms and much of the process is part of the environment in most healthcare institutions. Chaplains would do well to understand this approach to management, if they are to fully participate in the life of their institutions and to contribute to the desired outcomes rather than being further marginalized.

Studer, Q. (2003). *Hardwiring Excellence: Purpose, Wothwhile Work, Making a Difference*. Gulf Breeze, FL: Fire Starter Publishing.

Quint Studer, an important management consultant, presents a system that has successfully helped institutions consistently attain virtually perfect patient satisfaction ratings and retain virtually all of their employees. Although the system will likely seem "routine-ized" and therefore stilted to chaplains, understanding a program whose influence is being felt throughout US health care as a solution to one of the primary desired outcomes- patient satisfaction, will assist chaplains.

Bowker, J. (1975). *Problems of Suffering in Religions of the World*. Cambridge: Cambridge University Press.

The author's primary thesis is that explaining suffering and integrating it into a given belief system is the greatest challenge to all of the religious belief systems in the world. Suffering challenges the believer who needs and wants to have an all-powerful deity or higher power and one who, at the same time, is all powerful. All religions spend a great deal of effort explaining how suffering can exist in this context. This is a very dense and

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challenging book, but one that explores in depth a central challenge and desired outcomes for professional chaplains.

Kuhn, T. (1962). *The Structure of Scientific Revolutions*. Chicago, IL: University of Chicago Press.

"Paradigm shift" is a vastly overused and misunderstood concept. Long ago, Thomas Kuhn gave us the classic text that explains in clear language how ideas and paradigms change in a scientific environment like the one we all live in. This text will help anyone understand how and why change happens and why it does not happen.

Articles

The articles below describe different aspects of the science of pastoral care today including evidence for its efficacy, methods, demonstration of need and delivery models.

VandeCreek, L., & Burton, L. (2001). Professional Chaplaincy: Its Role and Importance in Healthcare. *Journal of Pastoral Care & Counseling, 55(1)*, 81-98.

Summary

This paper describes the role and significance of spiritual care and is the first joint statement on this subject prepared by five of the major healthcare chaplaincy organizations in North America representing over 10,000 members. As a consensus paper, it represents the perspectives of these bodies on the spiritual care they provide for the benefit of individuals, healthcare organizations and communities. Throughout this paper, *spirituality* is inclusive of *religion; spiritual care* includes *pastoral care.*

[Click to read the articles](#)   (Read pages 61-62, open the links read the articles and linked documents)

Comment

This article, known in professional chaplaincy as the "White Paper' remains the only official description of professional chaplaincy ever authored by the profession, itself. While now in need of updating, it remains an essential teaching tool to help explain to health care administrators and others what professional chaplains do and how they are trained. It should be read by any administrator who supervises pastoral care or is thinking about starting pastoral care services.

Iler, W., Obershain, D., & Camac, M., (2001). The Impact of Daily Visits from Chaplains on Patients with Chronic Obstructive Pulmonary Disease (COPD): A Pilot Study. *Chaplaincy Today, 17 (1)*, 5-11.

Summary

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This study presents empirical data showing the relationship between daily visits from the chaplain and several variables including anxiety, length of stay, and willingness to recommend the hospital to others. Generally, the chaplain visits seemed to influence these variables in desirable directions when compared to a group of patients who did not receive a visit from a chaplain. In sum, this study demonstrates qualitatively some possible benefits of visits from a chaplain.

Comment

The article is unique on several fronts. First, it is arguably the only published example of a controlled trial of chaplaincy interventions that demonstrates how pastoral care visits can affect some significant outcomes, including anxiety and length of stay. Further, the outcomes are demonstrated without resorting to a rigid protocol of interventions suggesting that it is only necessary for a chaplain to "do their thing" in order to get results. Second, this is a testament to the fact that a single chaplain, alone in a community hospital, without a lot of support, can plan, carry out and publish significant research.

Wintz, S, Outcome Oriented Chaplaincy- An Overview

Summary

In her Power Point Presentation, Sue Wintz, one of the principle trainers in Outcome Oriented Chaplaincy (The Discipline), presents a set of training slides that spell out in some detail the steps in actualizing the practice of OOC. Included are two extended case examples, suggestions for interacting with the multidisciplinary team and hints for "getting going." Wintz's intent is to give a starting point for individual chaplains or groups who wish to adopt some variant of this system.

Click to download presentation (Read Ppt presentation from pages 63-128)

Comment

Sue Wintz is the most experienced trainer in Outcome Oriented Chaplaincy active today. She outlines a very logical and clear process for adopting this method. An essential caveat to bear in mind is that this system does not need to be swallowed whole. That is, it is not essential to know it completely before beginning to use it. The experience of others is that the best way is simply to start and work into the system through periodic case review.

Fitchett, G., et al. (2004). Religious Struggle: Prevalence, Correlates and Mental Health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients. *International Journal of Psychiatry in Medicine. 34(2)*, 179-196.

Summary

The aim of this study was to examine the prevalence of religious struggle in three groups of medical patients- diabetic outpatients, congestive heart failure outpatients and oncology inpatients. Half of the total sample reported no religious struggle, while 15% reported moderate or high levels. Younger patients, CHF patients, and patients with positive religious coping tended to have higher levels of religious struggle. Religious struggle was also associated with emotional distress in all groups.

Comment

As chaplains begin to contemplate outcomes for chaplaincy, one of the first questions is, Which outcome? Certainly, some of the frequently used outcomes like patient satisfaction apply. However, what outcomes are unique to pastoral care? George Fitchett and his group present us with "religious struggle," which is roughly defined as the combination of heavy reliance on religious coping resources and failure of those resources to function in a given situation. Their paper begins to explore the prevalence of this issue in several medical populations.

Fitchett, G. & Risk, J. L. (2009). Screening for spiritual struggle. Journal of Pastoral Care and Counseling, 63 (1,2). Available online at http://journals.sfu.ca/jpcp/index.php/jpcp/article/view/71/57.

Summary

For years George Fitchett has been the leading authority on spiritual assessment and screening. The article describes a brief screening protocol for use identifying patients who may be experiencing religious/spiritual struggle, as well as patients who would like a visit from a chaplain. They describe the results of a pilot study in which non-chaplain healthcare colleagues administered the screening protocol to patients on admission. The protocol identified 7% of the patients as possibly experiencing struggle. The protocol generated a very low rate of false positives and a somewhat higher rater of false negatives.

Comment

Increasingly, pastoral care in healthcare settings is focused on need for care rather than desire for care. For chaplains to demonstrate outcomes that contribute to healing, they have to demonstrate need. Until now, there has been no screening protocol for pastoral care. The screening protocol from Fitchett and colleagues provides an extremely simple, effective and easily taught method to identify patients with religious struggle. It can easily be inserted into any nursing or admitting assessment.

Balboni, T. A. et al. (2007). Religiousness and Spiritual Support among Advanced Cancer Patients and Associations with End-of-Life Treatment Preferences and Quality of Life. *Journal of Clinical Oncology, 25(5)*, 555-560.

Summary

In a sample of 230 advanced cancer patients, 88% considered religion to be a least somewhat important in their coping. Nearly half (47%) reported that their spiritual needs

were minimally or not at all supported by the religious community, and 72% reported that their spiritual needs were supported minimally or not at all by the medical system. Spiritual support by religious communities or the medical system was significantly associated with patient quality of life (p=.0003).

Comment

In building the case to administrators and others that tending to spiritual and religious need is not just a nice thing to do but a necessary part of holistic care, it is essential to demonstrate need. This well documented study by a highly reputable team of researchers demonstrates that religious/spiritual needs are central to the coping of this population and that those needs are not being met- even by the religious community. Thus, this study provides crucial evidence for the presence of professional chaplains.

Handzo, G., & Koenig, H. (2004). "Spiritual care: whose job is it anyway?" *Southern Medical Journal, 97(12)*, 1242-1244.

Summary

The authors, a chaplain and a physician, respectively, set out a description of the relative roles of chaplains and physicians in providing spiritual care. The physician's role is defined as the spiritual care specialist whose job is to screen for spiritual/religious need and attend to those that may be within the physician's training. The chaplain's role is defined as the spiritual care specialists, whom like all other specialists in the medical system, is tasked to respond to referrals in cases where religious/spiritual need is considered significant.

Click to read the Article

Comment

One of the major questions for professional pastoral care is how its role interrelates with, but is different from, the roles of other professions. Significant concern exists in the pastoral care community that other disciplines are hijacking the role of chaplain. At the same time, it is acknowledged that all disciplines have some role in spiritual care. Using a generalist-specialist model familiar to every health care professional, this article clearly deals with some of the important issues in this area in a way that would apply to other disciplines as well.

Puchalski, C., Lunsford, B., Harris, M., & Miller, R. (2006).) Interdisciplinary Spiritual Care for Seriously Ill and Dying Patients: A Collaborative Model. *The Cancer Journal, 1295*, 398-416.

Summary

This article by an interdisciplinary team of care givers describes a system for spiritual care in which each member of the team has partial responsibility for that care. The role of each discipline is carefully documented in the context of a case study. A system for

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taking a spiritual history is also described in detail along with barriers to providing spiritual care.

Comment

Dr. Puchalski continues to be one of the leading proponents of the inclusion of spiritual care in health care and the chaplain as the spiritual care professional. This article represents a well written and thorough example of how a health care team that includes a chaplain can work together to provide spiritual care to patients and families. The article would be an effective teaching tool for teams who are working to enhance their assessment and treatment of spiritual/religious issues.

Cadge, W., PhD, Freese, J., PhD, & Christakis, N. A., PhD. (2008). The Provision of Hospital Chaplaincy in the United States: A National Overview. *Southern Medical Journal, 101(6)*, 626-630.

Summary

This study investigates (1) the extent of chaplaincy service availability in US hospitals between 1980 and 2003; (2) the predictors of having chaplaincy services in 1993 and 2003; and (3) the change in the magnitude of these predictors between years. Between 54% and 64% of hospitals had chaplaincy services between 1980 and 2003, with no systematic trend over that period. Hospital size, location and church affiliation were central factors influencing the presence of chaplaincy services.

Comment

Another question often asked chaplains advocating for pastoral care is what do others do? Cadge and her colleagues have given us a rough parameter to measure the market penetration of chaplaincy. While this is a helpful study representing new knowledge, please note the measurement question asked is somewhat non-specific and open to interpretation. Also, while the study measures the presence or absence of pastoral care, it cannot account for increase or decrease in the quantity or quality of pastoral care within a given institution. Therefore, one needs to be careful in describing what this data actually means.

Flannelly, K., Handzo, G., Smith, W., & Weaver, A. (2005). A National Survey of Health Care Administrators' Views on the Importance of Various Chaplain Roles. *The Journal of Pastoral Care & Counseling, 59(1-2)*, 87-96.

Summary

A random sample of hospital administrators throughout the United States was surveyed about their views on the importance of eleven chaplain roles and functions. All eleven roles were considered relatively important, although administrators of hospitals that do not have pastoral care departments gave lower ratings, overall. Meeting the emotional needs of patients and relatives were seen as chaplains' most important roles, whereas

performing religious rituals and conducting religious services were seen as least important.

Comment

Again, as chaplains are choosing outcomes as part of their planning, they should be choosing outcomes that are consonant with the goals and objectives their administrators have for them. Too often, chaplains do not align their goals with the goals of their institutions and then wonder why they are not supported. This large random survey that elicited responses from all fifty states gives support to eleven roles for chaplains. Notably, emotional care of patients and families, particularly care of the dying, were endorsed as important by an overwhelming majority of administrators while religious services were not nearly as well supported.

Critical Analysis
By Its Fruits: The Science of Health Care Chaplaincy

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The recommendations by Handzo and Wintz to assess chaplaincy outcomes are part of a larger endeavor by other health care professionals to evaluate the effects of their protocols and practices.[1] Handzo's own advocacy for outcome based chaplaincy is clearly connected to his ongoing support for social scientific research--and of scientific inquiry itself--as a means to the end of a better chaplaincy: "Science can work in the service of ministry, especially in the current era of healthcare in which numbers drive administrative decision making."[2] Along with the late Dr. Andrew Weaver, Handzo holds that scientific study of religion may reveal its practical bearings: "The effect of faith or religious practice on people's lives can be described by science, irrespective of one's faith claims."[3]

In its striving to measure the effects of chaplaincy, Handzo's endeavor bears a family resemblance to the earlier efforts of the American pragmatists to assess things religious by their fruits.[4] Their call for outcome based chaplaincy is commensurable with the

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[1] E.g., Paul Fenn and Alistair McGuire, "Valuation as measurement: an economist's approach to rendering health care outcomes commensurable," in *Health Outcomes: Biological, Social, and Economic Perspectives,* ed. Helen Macbeth (Oxford: Oxford University Press, 1996).

[2] George Handzo and Kevin Flannelly, **"**An Opportunity to Participate in Chaplaincy Research," **PlainViews** 2, no. 2 (1995). See also George Handzo, "Bridging diversity: President's address to the 2004 APC conference," *Chaplaincy Today* 20, no. 2 (2004): 31-35 and George Handzo, "Science and ministry: Confusion and reality," *Journal of HealthCare Chaplaincy* 12, no. 1, 2 (2002): 73-79.

[3] Andrew J. Weaver and George Handzo, "Research, Cancer, and God," *Lutheran Partners* 18, no. 4 (July/August 2002).

[4] William James, *The Variety of Religious Experience* (New York: Viking/Penguin Press, 1982); see also *A Pluralistic Universe* (Cambridge, MA: Harvard University Press, 1977) wherein James lays a rationale for the social scientific study of all religious beliefs and practices: "Let empiricism become associated with religion, as hitherto, through some misunderstanding, it has been associated with irreligion" (142).

broader pragmatic inquiry into the practical bearings of all ideas[5] and for the purposive nature of all inquiry.[6] That is, like those calling for structuring assessments of chaplaincy practices around the ways in which they achieve particular goals, these pragmatists also focused on the "so what" question of a variety of ideas and practices.

In *Pragmatic Theology: Negotiating the Intersection of an American Philosophy of Religion and Public Theology,* Victor Anderson describes the particularly religious bearings of American pragmatism.[7] Throughout this work, Anderson examines a wide variety of understandings for the ways in which religious belief may and must be translated into publically understandable, if not empirically verifiable, argument. In describing the Chicago School of Theology that held some sway in the 1920s and 30s,

Anderson asserts: "For these thinkers, in order for religion to be intelligible . . . the study of religion must be congruent with the criteria of intelligibility . . . operative in other fields of study."[8] In a like manner, proponents of outcome based chaplaincy maintain those outcomes must be intelligible to other health care professionals.

Again, Anderson notes the strong response of theologians such as H. Richard Niebuhr that, "[the Chicago School's] use of value in religion [its utility in securing human well-being and the justification of human values] was methodologically disastrous for theology. For the justification of theological claims proceeds as inferences from knowledge claims in other disciplines and not as an inference of religious insight or religious life itself."[9] In a like manner, there may be those who aver that the valuation of chaplaincy outcomes by any criteria outside the worldview of chaplains themselves may be beyond the pale of chaplaincy.

On the other hand, the work of practical theologians such as Johannes van der Ven,[10] and the ongoing research reported in *The Journal of Empirical Theology,*[11] exemplify how the effects of religious practices such as those of chaplains may be measured without violating their integrity or purposes.

Throughout his career as a neo-pragmatic philosopher, Richard J. Bernstein has proposed ways that social-scientific research may be reconceived so that it serves human needs;[12] ways to resolve tensions around the objectivity and relativity of such research;[13] and problems and possibilities of common meanings in differing human

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[5] See William James, "Pragmatism: Lecture Two," in *The Writings of William James: A Comprehensive Edition,* ed. John C. McDermott, (Chicago.: University of Chicago Press, 1977), 379, and Charles Sanders Peirce, "How to Make our Ideas Clear" in ed. James Hoopes, *Peirce on Signs: Writings on the Semiotic* (Chapel Hill: University of North Carolina Press, 1991), 169.

[6] John E. Smith, *Purpose and Thought: The Meaning of Pragmatism* (New Haven, CT: Yale University Press, 1978).

[7] Victor Anderson, *Pragmatic Theology: Negotiating the Intersection of an American Philosophy of Religion and Public Theology* (Albany: SUNY Press, 1999).

[8] Ibid., 59.

[9] Ibid., 84.

[10] E.g., Johannes van der Ven, *Practical Theology: An Empirical Approach* (Leuven, Belgium: Peeters, 1993).

[11] *The Journal of Empirical Theology* (Nijmegen, the Netherlands: Brill) at http: //www.brill.nl/jet.

[12] Richard J. Bernstein, *The Restructuring of Social and Political Theory* (Philadelphia: University of Pennsylvania Press, 1978).

[13] Richard J. Bernstein, *Beyond Objectivism and Relativism: Science, Hermeneutics, and Praxis* (Philadelphia: University of Pennsylvania Press, 1983).

endeavors.[14] In *The Restructuring of Social and Political Theory,* Bernstein cites Max Weber's referencing Leo Tolstoy's question: "What is the meaning of science?"

> Tolstoy has given the simplest answer with the words: "Science is meaningless because it gives no answer to our question, the only question important for us, 'What shall we do and how shall we live?'"

That is to ask: can social scientific studies that measure the outcomes of chaplaincy answer questions about what practices chaplains should engage in and what protocols they should establish? Some may think not. However, the citation continues, "That science does not give an answer to this is indisputable. The only question that remains is the sense in which science gives 'no' answer, and whether or not science might yet be of some use to the one who puts the question correctly."[15]

The corpus of Bernstein's works suggest that there are, indeed, good ways to put science to use to help all persons--including health care professionals such as chaplains--discern what to do and how to orient themselves. Accordingly, there is reason to suggest that the enterprise of Handzo, Wintz--and others--to employ social scientific reasoning for the sake of profession of chaplaincy may produce good fruits.

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[14] Richard J. Bernstein, "Incommensurability and Otherness Revisited" in *The New Constellation: The Ethical-Political Horizons of Modernity/Post-Modernity* (Cambridge, MA: MIT Press, 1992).

[15] Max Weber, "Science as a Vocation," from *Max Weber: Essays in Sociology*, ed. H. H. Gerth and C. Wright Mills (New York: Oxford University Press, 1946), 143 in *The Restructuring of Social and Political Theory* (Philadelphia: University of Pennsylvania Press, 1978), 47.
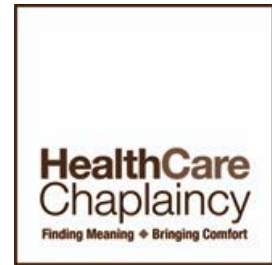
Edition 2 of a Series

TO WANT TO LEARN
Jackson Kytle, Ph.D., HealthCare Chaplaincy

Through the generous support of the John Templeton Foundation and HealthCare Chaplaincy, Practical Bearings: The Critical Bibliography for Health Care Chaplains continues to offer the most thorough and current resources for pastoral educators and pastoral practitioners to guide them in their work. In this second contribution to the series, To Want to Learn: Educational Theory for Supervision and Training, Dr. Jackson Kytle, Vice President for Academic Affairs for HealthCare Chaplaincy, provides a rationale and concluding commentary for considering key texts that address motivation and learning. Along with Kytle's reflections on salient works in the field, this series includes commentaries by several leading pastoral educators on eight highly-recommended books. "*What* do chaplains in health care need to know about motivation and learning? *Why* do they need these ideas and theories?" These are the questions Kytle and the other reviewers in this series address. These are the questions to which this series invites its readers to respond by commenting on the series itself and by recommending other texts to assist health care chaplains in their professional activities.

Rationale

What do chaplains in health care need to know about motivation and learning? *Why* do they need these ideas and theories? I believe that everyone is an educator, having been a student or teacher so many times over in life. Certainly, chaplains and supervisors or pastoral faculty are educators. Having a working knowledge of motivation and learning will help chaplains work with patients, families, and staff. Also, we humans face the daily task of self-motivation, which can surprise us with its difficulty, not to mention learning to adapt to the demanding environs of where we live and work. If chaplains understand their *personal* motivation and learning styles, it will help them manage the stress of their ministries. Pastoral faculty or supervisors have the special responsibility of mentoring students. Faculty need theory, lots of it, to share with students and ideas, too, about best practices. Alas, motivation and learning

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have large, sprawling literatures, mostly in psychology and education, which cannot be easily summarized. In the annotated bibliography that follows, we start with basic books and theories before discussing new and advanced reading.   Finally, I invite my readers to submit new entries for books important to them by which to deepen and diversify this resource for multi-faith, professional chaplains.

Daloz, L. (1986). *Effective Teaching and Mentoring: Realizing the Transformational Power of Adult Learning Experiences*. (San Francisco: Jossey-Bass). Review by the Rev. Elizabeth BJ Larson, M.Div., Spiritual Health Services Director, ACPE Supervisor, Youth Grief Services Director, Fairview Ridges Hospital.

Summary

Effective Teaching and Mentoring is a second edition of an award-winning classic. Daloz focuses on the role of the mentor and the process of mentoring by which to transform learning. He has an eye for vivid vignettes and this book will demonstrate how anyone who is a teacher can become an effective mentor.

Comment

The strength of Daloz's book is the guidance his approach provides for mentors in the context of the learning relationship. Mentors who listen well build trust and hear the whole of students' lives impacting their educational journey. Readers of Daloz's book who serve as guides will find this text helpful in understanding students' developmental dance with authority and systemic forces impacting the learning journey. Daloz quite effectively draws on a range of theoretical approaches to increase mentors' understanding of their task and suggest more effective approaches to working with students' developmental journeys. This text is particularly applicable for educators engaged in the journey of Clinical Pastoral Education (CPE).

Schön, D. A. (1987). *Educating the Reflective Practitioner.* (San Francisco: Jossey-Bass). Review by the Rev. Peter Kuhn, ACPE Supervisor and Manager, Pastoral Care & Education, Gettysburg Hospital Wellspan Health, Gettysburg, PA.

Summary

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Donald Alan Schön (1930-1997) was professor for Urban Studies and Education at MIT when he wrote this book. It is based on an earlier volume, *The Reflective Practitioner* (1983) and was first published in 1987, subtitled *Towards a New Design for Teaching and Learning in the Professions.* Schön takes architectural design as a prototype for reflection-in–action (thinking on our feet) and education for artistry in other fields of practice. He describes the setting as a reflective practicum in which *students learn by doing with the help of coaching*. He then goes on to describe the reflective practicum in other contexts. Schön points out how learning and coaching are similar, and how they vary in different contexts. He applies double loop learning and demonstrates its applications for improving professional education.

Comment

The appeal of Schön's book is its description of the learning experience in different professional fields. His three ways of meaning making—"knowing in action," "reflection in action" and "reflection on action"—help us understand how students learn. His models of single loop and double loop learning demonstrate *what* students learn. Schön does not stop with the individual student, but applies his theory to systems of education and artistry. He leaves the pastoral care provider with the responsibility to apply his methods to supervision, which can be sobering and invigorating, as it leaves a creative space in which both failure to learn and learning have a place. It challenges the teacher to become a coach and to find authority in the facilitation of creating new meaning.

Shor, I. (1992). *Empowering Education: Critical Teaching for Social Change*. (Chicago: The University of Chicago Press). Review by the Rev. Dr. Barbara Blodgett, Director of Supervised Ministries, Yale Divinity School.

Summary

Ira Shor teaches Rhetoric/Composition in the Graduate Center of the City University of New York and English at the College of Staten Island. His mentor was Paulo Freire, the well-known Brazilian popular educator, and he has written several books honoring Freire. *Empowering Education* "offers a broad theory and practice linking critical pedagogy to democracy and empowerment." The book begins: "Like many kids, I loved learning but not schooling" (1) and proceeds to examine not only why traditional educational methods alienate students but also how new ones can emancipate them. Shor emphasizes participatory problem-posing, shared student-teacher authority, and less teacher-talk in favor of collaborative dialogue.

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Comment

A useful book for classroom teachers, it will also speak to those in supervision and training who, after all, often create alternatives to traditional educational forms. Further, it will support those hoping to resist the habit of speaking "first, most, loudest, last, and always" (263), thereby helping students find their own voices.

Hinchey, P. H. (1998). *Finding Freedom in the Classroom: A Practical Introduction to Critical Theory.* (New York: Peter Lang). Review by the Rev. Dr. Barbara Blodgett, Director of Supervised Ministries, Yale Divinity School.

Summary

Patricia Hinchey is Associate Professor of Education at Penn State University. Hinchey's opening disclaimer belies the book's substance but previews its style: "If you expect crisp definitions and recipes for classroom activities, you will be disappointed. And you won't find exhaustive analysis and fine distinctions, either. I haven't tried to transform readers into experts on critical theory. Instead, I've simply tried to provide food for thought to nourish readers' thinking about their own classrooms and what happens there." The editor's preface makes clear that "[W]hile the book is reader-friendly and sensitive to the reader's background, it does not seek to protect the fragile reader. Hinchey unabashedly takes on the central concepts of critical theory in all their power and controversiality."

Comment

Indeed, each chapter presents a major concept in critical thought—e.g., constructed consciousness, hegemony, social reproduction and resistance, *conscientization*—accessibly explaining each using analogies and anecdotes. While written for classroom teachers, this book will help supervisors and trainers move their students beyond personal reflection and received assumptions toward thinking critically and politically about their practice.

Palmer, P. J. (1998). *The Courage to Teach: Exploring the Inner Landscape of a Teacher's Life.* (San Francisco: Jossey-Bass, 1998). Review by the Rev. Paula Teague, M.B.A., ACPE Supervisor, Johns Hopkins University Hospital, Baltimore.

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Summary

Parker Palmer's book, *The Courage to Teach: Exploring the Inner Landscape of a Teacher's Life,* is a cornerstone of any educator or service provider's book shelf. Palmer establishes his thesis in the first few pages by saying that "good teaching requires self-knowledge." (3) Palmer's passion for teaching and his human experience of it are evident in the pages that follow. The ability to teach from "the place where intellect and emotion and spirit and will converge in the human self" (11) is the underpinning of the book's chapters. Each educator needs community, models of teaching that include a student centered approach, and a spiritual perspective. The book is simultaneously a philosophy, a methodology, and a narrative of experiences and examples.

Comment

The Courage to Teach has a broader reach in the professional life of chaplains, clinical pastoral education supervisors and others in ministry than Palmer was probably initially intending. With the current focus in hospitals on patient-centered medicine, the book provides ideas about personal reflection, the ability to listen and attend to the needs of others and the community, and partnership needed for good health care to take place. Palmer's thoughts can be applied to ethics consultation and spiritual care and counseling, as well as the more sacramental acts of ministry such as preaching or performing rituals. There is no substitute for doing the work one loves, that resonates with one's gifts, and which contributes to the broader life of humanity. The reading of *The Courage to Teach* models what it means to do this because Palmer embodies the theory he espouses.

Mezirow, J. and Associates (2000). *Learning as Transformation: Critical Perspectives on a Theory in Progress.* (San Francisco: Jossey-Bass). Review by the Rev. Sheryl Lyndes Stowman, ACPE Supervisor, University of Minnesota Medical Center.

Summary

This book grew out of presentations from the First Conference on Transformative Learning in 1998. That conference marked the twenty-year development by adult educators of the concept of transformative learning, as first introduced by Jack Mezirow. Joining Mezirow in this volume are fifteen of the field's top scholars and practitioners. Together, they review the core principles of *transformation theory*, analyze the process of transformation learning, describe different types of learning and learners, suggest key conditions for socially

responsible learning, explore group and organizational learning, and present revelations from the latest research.

Comment

A highlight of this volume is its emphasis the authors place on critically reviewing how this theory of adult learning has evolved and what pieces are missing. Key critiques are raised in the areas of affective learning, power dynamics, developmental issues, and a need for coordinated research in chapters by Kegan, Brookfield, Belenky, Daloz, Cranton, and Taylor. Because transformative learning has become a central constructivist theory being utilized in CPE/pastoral supervision, this work provides an important overview and discussion from multiple perspectives. While the book attempts to give "real world examples" drawn from the author's experiences, it serves best as a theoretical exploration.

Frawley-O'Dea, M. G., and J. Sarnat (2001). *The Supervisory Relationship: A Contemporary Psychodynamic Approach.* (New York: The Guilford Press). Review by the Rev. Sheryl Lyndes Stowman, University of Minnesota Medical Center.

Summary

This groundbreaking volume is the first to elaborate a comprehensive contemporary model of supervision. The authors, both noted practitioners and clinical supervisors, found a lack of congruence between more contemporary relational psychoanalytic thought and models of supervision being utilized. The volume begins by discussing the history of psychodynamic supervision. An innovative typology is delineated to facilitate comparison among models and to enable readers to think more systematically about their own supervisory practice. Key themes from the author's own relational model explore power and authority, regression in the supervisory relationship, rethinking the "therapy/education" question, parallel process, and working with group process and organizations.

Comment

By looking at the dimensions of supervisory authority, focus and modes of participation, distinctions in approaches are made visible. This is particularly helpful for supervisors developing a clinical supervisory model that builds on, but goes beyond, the classic work of Eckstein and Wallerstein. The author's Supervisory-Matrix Centered approach acknowledges the supervisor as an embedded participant. Her authority and skills are related to her capacity

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to participate in, reflect upon, and process relational dynamics/themes in the supervision and in supervisory relationship, itself. From a "use of self" perspective, this volume is a significant contribution to pastoral supervision from a relational, post-modern perspective.

Hawkins, P. and R. Shohet (2006). *Supervision in the Helping Professions*, 3rd ed. (Berkshire, England: Open University Press). Review by Jane S. Litzinger, Chaplain Supervisor, Wake Forest University Baptist Medical Center, Winston Salem, NC.

Summary

The latest edition of this best selling book on supervision updates and expands the previous two editions. New content is added in the areas of group supervision, transcultural supervision, and supervision in systems and networks. The first edition, written with supervision of counseling/psychotherapy in mind, emphasized facing and using one's own shadow and struggles to engage with others more fully. As the author's work has spread into the fields of education and organizational change, they claim in this new edition a developmental focus for supervision. This includes, by their account, a greater emphasis on learning and building on positives in order to flourish at work.

Comment

This is an exceptionally fine book on supervision. It is comprehensive, dealing with supervision at individual, group and organizational levels. The "seven-eyed process model of supervision" at the heart of the book has theoretical clarity, honors the place of relationship and skill in supervision, and stresses the importance of experiential learning. The book will serve as a valued resource for those beginning ACPE supervisory education. It will also provide particular assistance for ACPE supervisors charged with building curriculum for supervisory education. The maps and models chapter will assist pastoral care coaches as they negotiate learning contracts and individual supervisory sessions. Reading the book again was renewing for me and a reminder of why I have such passion for pastoral supervision.

General Commentary

The twin projects of understanding human motivation and learning are entangled and never finished, which is why I titled my 2004 book *To Want to Learn* (New York: Palgrave Macmillan). My review with the help of colleagues has covered several sources used by contemporary

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chaplains. Each one of this small group is worth consulting, but no one volume is broad or deep enough for the work of chaplains and pastoral faculty. Sadly, we find no modern sources written *by chaplains for chaplains.* Thus we turn to psychology, education, psychiatry and nursing, each field having valuable insights but also blind spots when it comes to the needs of the profession.

Understanding motivation and learning is important for becoming a self-directed learner and for helping others toward that goal. This literature in psychology comes under different names: "self-efficacy" by Albert Bandura (1997, *Self-Efficacy.* New York: Freeman and Company) and "self-regulation" by Roy Baumeister and Kathleen Vohs (2006, *Handbook of Self-Regulation.* New York: Guilford Press).

Other sources we have not considered come from the relatively new movement in psychology founded by Martin Seligman (2002) called "positive psychology" (*Authentic Happiness.* New York: Free Press). Barbara Fredrickson (2003) theorized about a "broaden-and-build model" where positive emotions and states, deliberately cultivated, lead to better learning ("The value of positive emotions." *American Scientist 91*, 330-335). Recently, Carol Dweck (2003) has written about motivating students by tailoring the material to their life experiences and by helping them form goals, stretch goals being the best. (Grant, H. and Dweck, C. *Journal of Personality and Social Psychology 85,* No. 3, 541-553).

Chaplains should enjoy a provocative new book by Jonathan Haidt (2006) with an odd title (*The Happiness Hypothesis: Finding Modern Truth in Ancient Wisdom.* New York: Basic Books). Haidt, a social psychologist, investigates ten ideas discovered by the world's religions and civilizations, and uses contemporary research in social and cognitive psychology to illumine them. He has a lovely way with language and you'll enjoy the Buddhist-inspired image of the hapless rider (human reason) trying to steer the elephant (the unconscious and emotional elements of our being).

Chaplains may want to study motivation and learning in the special circumstances of chaplaincy as a profession, in general, and the supervisory relationship, in particular. Frawley-O'Dea and Sarnat (2001) is an important contribution, representing a modern version of the classic by Ekstein and Wallerstein (1971, first published in 1958), *The Teaching and Learning of Psychotherapy.* Madison, CT: International Universities Press.

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While working on my own book, I looked far and wide to find pithy principles I could pass on to my readers. Ten principles to motivate my students, or something. I learned—slowly—that reductive principles lined up in a row do not exist because we do not know enough yet about the basic mechanisms of motivation and learning, and those concepts we *think* we know (such as "learning that lasts is connected learning") have to be evaluated in context.

One of the many intellectual streams that have fed pastoral education is American progressive education from the 1930s forward. John Dewey's (1938) slim book, *Experience and Education,* has much to say about traditional and progressive education and could be read once a year for its many insights about experiential learning (New York: Collier Macmillan). In that intellectual tradition, chaplains also might consult the probing books and provocative language of existentialist educator Maxine Greene of Teachers College Columbia. A recent book by her is *Releasing the Imagination*. San Francisco: Jossey-Bass, 1995. If, like me, you are drawn to existentialist literature and philosophy, please read Alum Jones (1998) "Some reflections on clinical supervision: An existential-phenomenological paradigm." *European Journal of Cancer Care 7*, 56-62.

Motivation and learning, like most academic topics, have to be seen in context. We have not yet considered voices from the left such as bel hooks (1994) *Teaching to Transgress.* Hers is a passionate voice for progress! Because the processes and expressions of motivation and learning are powerfully shaped by race, social class, and culture, we also have not yet looked here for insights. In a recent class for supervisory education students at HCC, for instance, I asked my students to read two recent, but thin, articles on the Asian experience in America. If we educators are to be culturally competent, we need to understand motivation and learning in the cultures of our patients and their families. Finally, political ecological concerns of the world find expression in the work of Edmund O'Sullivan and his colleagues (2002) *Expanding the Boundaries of Transformative Learning*. New York: Palgrave Macmillan.

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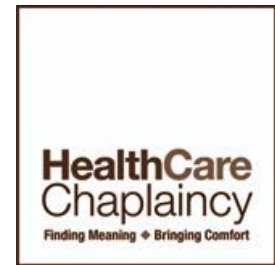
Edition 3 of a Series

Meeting the Other: Interreligious Encounters
in the Provision and Supervision of Spiritual Care
Dagmar Grefe, Ph.D., 4/1/09

I.   Rationale

The development of a theory of interreligious spiritual care is just beginning. The literature listed in this series represents three avenues to the understanding of what is going on when persons meet the religiously other at the bedside or in supervision.

First is the *theological* avenue: effective interreligious pastoral care cannot superficially rely on knowledge of resources alone. Chaplains need to work through what motivates them to reach out to others, how their religious way compels them to meet the other or keeps them from the other. S*econd* is the *socio-psychological* avenue: effective interreligious spiritual care involves an understanding and personal exploration of stereotype, prejudice, and unequal power-relationships. Addressing these issues, as well as how to manage intergroup relations and reduce prejudice, intergroup relations theory offers contributions and possibilities for supervision and the teaching of spiritual care. The *third* avenue is *spiritual care* through an interreligious and intercultural lens.

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II.   5 Best Books

Knitter, Paul F. <u>Introducing Theologies of Religions</u>. Maryknoll, NY: Orbis Books, 2007.

Summary

In the global village people of diverse cultural, racial, and religious backgrounds live closer to each other than ever before. The emergence of a theology of religions has been one of the major developments in Christian theology in recent years. This book lays out the major theological positions on the relation of Christianity to other religious ways. The author gives an impartial and systematic introduction to the theology of religions for those who are new to the topic. He sorts through the diversity and controversy of numerous Christian approaches to religious pluralism and organizes them in four models: replacement, fulfillment, mutuality, and acceptance. His overview includes theological positions from the early 20th to the early 21st century. The author's intent is to have "the reader not only understand each of the theological models but also to feel and be attracted by their insights and power." The publication describes the intra-Christian conversation about other religious ways, which at times can be just as challenging as inter-faith dialogue.

Comment

The book has two very obvious strengths. 1. The description and organization of the models are clear and accessible for the student of interfaith dialogue. 2. The author models dialogue through the way he portrays the different positions. He succeeds in his intent to really listen to the strengths of each model and understand its perspective. The reader can take away a systematic understanding and knowledge of different theological positions as well as experience an example of *how* to respectfully listen to and seek to understand perspectives which are opposed to his or her convictions. Chaplains and clinical pastoral educators will have to draw conclusions and applications to their clinical practice. While the book is of theoretical nature, it still provides an important contribution to clinicians as they articulate their own theological approach to people of other faiths, whom they support through presence and counseling, as well as diverse ritual and spiritual practices.

Knitter, Paul F. <u>One Earth, Many Religions: Multifaith Dialogue and Global Responsibility.</u>
Maryknoll: Orbis Books, 1995.

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Summary

This book represents Knitter's unique approach to religious pluralism, a "globally responsible, correlational dialogue of religions." For Knitter interfaith encounters are incomplete if they do not include an attempt to resolve the human and ecological suffering prevalent through the world. Interfaith dialogue begins with praxis. The immediacy of suffering, such as poverty, violence, victimization, and the ecological crisis, calls for a collaborative response and presents a terrain in which religions can discover common ground. The author addresses possible pitfalls of his approach as well as the critique that his approach has a tendency to homogenize or to overlook the differences of the ways in which diverse religions understand the world. Knitter gives priority to those otherwise excluded by weaving together the efforts of theologians from the North and the South to respond to the religious other *and* to the suffering other. He concludes with suggestions and examples of interreligious cooperation on behalf of social justice and peace.

Comment

This was selected as one of the top books because Knitter's approach to religious pluralism provides a basis for a practical theology of interreligious encounters. The transformation of suffering provides a strong motivation to work and dialogue with each other, in the wider social and global context, which Knitter describes, as well as in the care for patients and families. Often it is the immediate experience of suffering that compels chaplains to move into the spiritual world of patients from various faiths in order to strengthen their resources. Knitter's work can remind readers in the field of health care chaplaincy of the social component of their work. It is a part of spiritual counseling to assist patients uncover social ills that cause their suffering, such as the disparity in the access to resources and poverty. In their institutions chaplains often empower the voices of those who have less power, which frequently are persons of ethnic and religious minorities. Chaplains can advocate for minority faiths through education in health care settings as well as through the development of relationships with local diverse religious communities. Active engagement for the diversity of faiths can create living examples in health care institutions that persons of different religious ways can work together, enrich each other, and learn from each other.

Stephan, Walter G., and Cookie W. Stephan. <u>Intergroup Relations</u>. Social Psychology Series. Madison: Brown & Benchmark Publishers, 1996.

Summary

Our multicultural society offers many opportunities and at the same time is a source of racial, cultural, and religious conflicts. One of the lenses through which these intercultural relationships can be examined is social psychology. In this textbook the Stephans provide an introduction to the research of intergroup relations theory. The socio-psychological lens, represented in this book, focuses on the experience of individuals and how belonging to groups and attitudes toward other groups influences perceptions, affect, and behavior. The authors also describe solutions to manage intergroup relations, and improve them by reducing stereotypes. 'Group' does not only refer to a cohesive group in the narrow sense, but also to membership of a category. Intergroup relations include conflictual, and non-conflictual attitudes, emotions, behavior and ways of interaction.[1] The first two chapters examine the nature of stereotype and prejudice. The third chapter describes the 'contact hypothesis', looking at conditions under which face-to-face encounters in small groups can reduce stereotype. Other chapters address social identity theory, intercultural relations, and conflict resolution.

Comment

Much detailed information is presented in form of research data, theory, and illustrative examples. The book is structured clearly with definitions and summaries in each chapter. This basic introduction was incorporated into this bibliography because intergroup relations can contribute greatly to the understanding of interreligious relationships.

Spiritual care and counseling and clinical pastoral education in the U.S. have primarily been shaped by psychodynamic theory focusing on the individual. Outcomes in the standards of the Association of Clinical Pastoral Education have concentrated on the development of pastoral and personal identity. In recent years more attention has been given to cultural issues. The training of spiritual caregivers can benefit from attention to social identity, the part of a person's self-concept, which derives from their membership of social groups. Meeting the culturally and religiously other involves a reflection on psychological factors, such as stereotype, prejudice, and fear. Intergroup contact theory can be applied to group supervision in clinical pastoral education and can inform supervisors about leadership tools assisting them to work through religious conflict. The chapters on stereotype and prejudice can be used as reading materials in level II and supervisory CPE,

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[1] Donald M.Taylor and Fathali M. Moghaddam. Theories of Intergroup Relations: International Social Psychological Perspectives, 2nd ed. (Westport, CT: Praeger 1994), 6.

contributing to the development of cultural competency for chaplains and clinical pastoral educators.

Irish, Donald P., Kathleen F. Lundquist, and Vivian Jenkins Nelsen, eds. <u>Ethnic Variations in Dying, Death, and Grief: Diversity in Universality</u>. Philadelphia:
Taylor & Francis, 1993.

Summary
The book's intended audience consists of health care professionals, such as doctors, nurses, social workers, chaplains, whose personal reflections are included in one chapter. This essay collection discusses beliefs and customs of dying and bereavement in ethnic groups about which health care professionals in the majority Caucasian Christian North American culture are less informed. The authors encourage readers to reflect on their own beliefs about death as well as their cultural assumptions. The different essays provide extended information about different, at times contrasting, ethnic patterns of dealing with death. Attention is given to beliefs and practices just prior to death, following death and later on during bereavement. The book includes numerous clinical examples of the handling of ethnic diversity by health care professionals. Several essays describe traditions in the African American, Mexican American, Hmong, Native American, Jewish, Muslim, Buddhist, and Quaker/Unitarian communities and are authored by representatives of those minority cultures. Closing, the editors draw conclusions about policies, practices, and education regarding death and culture in health care institutions.

Comment
This essay collection has a number of strengths. The authors "practice what they preach:" the book includes a multitude of voices and perspectives. It is not only *about* ethnic variations in health care but also authored *by* diverse ethnic representatives and healthcare professionals. Readers get to know reflections of nurses, social workers, and chaplains. Authors from diverse ethnic communities describe the beliefs and customs of their group on their own terms. Applications to health care chaplaincy are at hand: The book is helpful to chaplains as they accompany patients and families from different traditions in the dying and grieving process. Chaplains increasingly take on active roles in education about death and cultural diversity in health care institutions. The book provides helpful data to advocate for and initiate more appropriate

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policies in institutions, such as creating grieving spaces that accommodate the practice of death rituals or organizing outreach to representatives from the ethnic groups within the local community that can be contacted for consultation and support. Understandably, the ethnic traditions addressed in the book are not assumed to be all encompassing and readers need to be aware of variations of practices and beliefs within ethnic groups. This book is helpful resource in any spiritual care department.

Lartey, Emmanuel Y. In Living Color: An Intercultural Approach to Pastoral Care and Counseling. 2nd ed. London: Jessica Kingsley Publishers, 2003.

Summary

Lartey offers a holistic approach to pastoral care and counseling in the global context. He distinguishes his concept from a cross-cultural perspective that tends to essentialize difference, and a multicultural perspective that emphasizes information *about* culture and is prone to oversimplification. His *inter*cultural approach envisions the whole web of relations between people who are interconnected to their ethnicity, geography, social, and cultural location. The first part reviews the history and core concepts of pastoral care and counseling. The second edition includes a discussion of postmodernism and postcolonialism as the context for intercultural spiritual care. It addresses pastoral care concepts and practices from different parts of the world and through the lens of marginalized people. Lartey's examination of the understanding of spirituality takes into account a few insights from different religious traditions. He develops his intercultural concept of spiritual care by reliance on liberation theology. Moving beyond a Western primarily psychodynamic and individualistic orientation, liberation theology contributes to pastoral care the attention to social context and expands its 'toolbox' to incorporate social analysis. Lartey's broadened intercultural concept of pastoral care includes the empowerment of persons to define their experiences on their own terms for empowerment and liberation.

Comment

Lartey is a Ghanaian theologian teaching in the United States. His clinical and teaching practice integrates both contexts. His holistic perspective with attention to social context, intercultural relations, and their power dynamics is essential for the practice of pastoral care in a global and intercultural context. Some case examples from the pastoral care context in Ghana help readers understand the worldview of persons who are deeply influenced by different cultural systems, by

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traditionalist and modernist worldviews at the same time. Health care chaplains and clinical pastoral educators who work with immigrants and persons from diverse cultures will find impulses for reflection as well as concrete tools for their clinical practice work in this book. Lartey's definition of spirituality is one of the few in the Christian context that leaves room for different religious traditions and cultural systems. The reader is introduced to African Traditional Religions (ATR), and Lartey demonstrates how a Christian counselor might integrate rituals of ATR into spiritual care when appropriate. While interreligious encounters do not take center stage in this book and are brought up rather sporadically, Lartey's intercultural approach is a fruitful ground on which a theology of interreligious spiritual care may emerge.

III.   Other Books and Articles

Books and articles in the following section add to and deepen the three fields addressed by books listed in the first section: The first book provides another theological perspective on religious pluralism. The following four publications address interreligious spiritual care. The last four articles discuss issues of clinical pastoral supervision with students from diverse backgrounds. Two of them introduce intergroup contact dialogue as a tool with potential for application in Clinical Pastoral Education.

Griffin, David Ray, ed. <u>Deep Religious Pluralism</u>. Louisville, KY: Westminster John Knox Press, 2005.

Summary

This book uses a Whiteheadian process lens to understand religious pluralism. The frame, the first two and the last chapters, discuss John Cobb's 'deep, complementary pluralism' acknowledging real differences in religious ways, which will undergo mutual transformation in the encounter with each other. The center of the book contains nine essays of authors from diverse religious ways presenting approaches to religious pluralism in their traditions. Contributions include Buddhist, Jewish, Muslim, Hindu, and Chinese philosophical perspectives.

Comment

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Readers who primarily are looking for practical applications will be disappointed. This publication is clearly of philosophical and theoretical nature. It has been incorporated in this bibliography for two reasons. First, the encounter with other religious ways is primarily seen through the lens of process philosophy, which engages religious pluralism differently than Knitter. Second, it provides insights into approaches to religious pluralism in other traditions. The essays can be helpful for chaplains and those who educate them to gain an understanding of how the diversity of faiths can be understood in non-Christian traditions.

Toback, Phyllis Brooks, "A Theological Reflection on Baptism by a Jewish Chaplain." Journal of Pastoral Care 47, no. 3 (1993): 315-317.

Summary
Toback is a Jewish chaplain and CPE supervisor who works in a predominantly Christian setting. She offers a reflection on the possibility of facilitating a baptism, a distinctly Christian ritual, by a non-Christian chaplain. The article represents a case example of interreligious care across religious boundaries and addresses the question how far to move into the terrain of a different faith in order to support a patient or family while maintaining one's own integrity.

Comment
This short and personal article has become a standard reading in my ACPE center. It assists Jewish students to find clarity about how they will handle requests for emergency baptisms. By addressing how the history of the persecution of Jews by Christians may surface for a Jewish chaplain, it teaches chaplains of all faiths about the role of social and historical issues in interreligious encounters.

Friedman, Dayle A., ed. Jewish Pastoral Care: A Practical Handbook from Traditional and Contemporary Sources. 2nd ed. Woodstock, VT: Jewish Lights Publishing, 2005.

Summary
The book provides a Jewish spiritual perspective on the theory of spiritual care as well as its practical applications. It describes the needs of Jewish persons in crisis and transition and represents voices from the Orthodox, Renewal, Conservative, Reform, and Reconstructionist

Jewish movements. It consists of three parts, which discuss foundational concepts, specific skills and Jewish resources, and tools for Jewish spiritual care in specific settings.

Comment

The intended audience for this handbook consists of rabbis, cantors, trained volunteers as well as non-Jewish chaplains who seek to understand the specific needs of Jewish patients. It is an excellent resource for non-Jewish clinical pastoral educators in their teaching of pastoral care as it provides information about needs regarding religious observance and central elements of pastoral care with Jewish patients in the health care setting. For example, the practice of custom-made prayers, the healing prayer, the viddui, and the use of psalms are discussed. The handbook can be consulted when working in particular care situations and can serve as a helpful resource in the library of every Clinical Pastoral Education center.

Monnett, Mike, "Developing a Buddhist Approach to Pastoral Care: A Peacemaker's View." Journal of Pastoral Care and Counseling 59, nos. 1-2 (2005): 57-62.

Summary

Monnett describes a Buddhist concept of pastoral care and how it shapes his practice as a hospital chaplain. His concept is rooted in Thich Nhat Hanh's "Engaged Buddhism" and the Three Tenets of the Peacemaker Order: not knowing, bearing witness, and healing action. Health care and hospice are suitable settings for Buddhism that aims at a practice engaging the suffering of sentient beings. The role of the chaplain is presence and accompaniment of patients in crisis where they are and to assist them to utilize *their* spiritual resources, which is consistent with the Three Tenets.

Comment

Monnett gives examples of his spiritual care as a Buddhist chaplain with persons from various religious traditions: supporting the patient through presence, empathic listening as well as crossing religious boundaries by using particular spiritual resources that are meaningful for the patient, such as prayer, or the reading of sacred texts. Besides describing his practice of interreligious spiritual

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care, Monnett demonstrates in his brief introduction of engaged Buddhism how some Buddhist principles can contribute to the development of a theory of interreligious spiritual care.

Ariarajah, S. Wesley. <u>Not Without My Neighbor: Issues in Interfaith Relations</u>. Geneva: WCC Publications, 2006.

Summary

Ariarajah's book is full of examples from his rich experience growing up as a Christian in a predominantly Hindu neighborhood, as a local pastor in Sri Lanka and the director of the interfaith dialogue program of the World Council of Churches. He addresses a number of practical issues in interfaith relations: confronting religious extremism, the possibilities of shared interreligious spirituality, interreligious relations in social conflict, the role of women in interfaith dialogue, interfaith marriage, mission and dialogue.

Comment

Ariarajah's reflections on interfaith worship (chapter 3) and interreligious marriage (chapter 6) have direct practical implications for chaplains as they facilitate interfaith services in their health care settings or counsel with families uniting different faith traditions that guide their health care decisions. The book illustrates how issues of interfaith relations are interwoven with the struggles of daily life. The chapter on interfaith spirituality can serve as a text for level I and level II CPE assisting students to reflect on the facilitation of interfaith services in their institutions and in their peer groups.

Pettigrew, Thomas F., "Intergroup Contact Theory." <u>Annual Review of Psychology</u> 49 (1998): 65-84.

Summary

The author reviews Gordon Allport's Intergroup Contact Hypothesis because it has proven influential in policy and useful in applied settings, in other words, because it works. Allport established that prejudice in persons of different groups (groups of different ethnic, cultural

backgrounds, gender, sexual orientation) can be reduced when they encounter each other under certain facilitating conditions: they meet face-to-face with equal status cooperating toward common goals, with support of authorities, such as law or custom.

Comment

Allport's theory has been expanded by research that analyzes how intergroup contact can reduce prejudice not just for the participants but also for other members of the outgroup. Many of the conditions of intergroup contact hypothesis can be found in CPE group settings. Supervisors who familiarize themselves with this theory can utilize their diverse group settings to help students meet the religiously other peer in a safe environment, work beyond stereotype and learn about the other through personal contact.

Taylor, Bonita E., and David J. Zucker, "What We Wished Our Non-Jewish Supervisors Knew About Us As Jewish Supervisees." Journal of Pastoral Care and Counseling 56, no. 4 (2002): 317-27.

Summary

Since CPE originated in a Protestant context, Christianity heavily influences much of its underlying values. Thus, Jewish CPE students often feel like strangers in a strange land. The authors offer 12 Jewish values that explain some of the differences of Jewish and Christian identity. The article helps Jewish students to articulate their position in their relationship with non-Jewish supervisors and peers. It helps non-Jewish CPE supervisors to become more sensitive to the values and ways of thinking and communicating of their Jewish students.

Comment

This article is a must-read for Christian clinical pastoral educators. In a culture where Christianity is the majority, Christians are tempted to assume that everyone shares their ways of being and of thinking and - without knowing it - may impose their values onto others. Besides helping non-Jewish supervisors to become more sensitive to their Jewish students, this article in a broader sense raises the issue of the assumed normativity of the values of the majority and, thus, can be helpful as supervisors encounter students of other faiths, be it Jewish, Buddhist, Hindu, or Muslim.

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Nagda, Biren (Ratnesh), and Amelia Seraphia Derr. "Intergroup Dialogue: Embracing Difference, Conflict, Engendering Community." In Education Programs for Improving Intergroup Relations: Theory, Research, and Practice, ed. Walter G. Stephan, and W. Paul Vogt, 133-51. Multicultural Education Series. New York: Teachers College Press, 2004.

Summary

Intergroup dialogues are facilitated face-to-face encounters between two or more persons of diverse social identity groups with a history or potential of conflict. The Intergroup Contact Theory has been applied in intergroup dialogue groups on college campuses. The authors portray the history, curriculum, and group development stages of such dialogue groups. They depict prominent issues of organization and leadership, give examples of exercises that enhance the facilitation, and make suggestions for further outcome studies regarding the effectiveness of such groups.

Comment

Chaplain interns in Clinical Pastoral Education groups come together representing social identity groups of diverse ethnicities, races, cultures, and religions. CPE group facilitation may benefit from impulses from the theory and practice of intergroup dialogue groups. Such dialogue groups connect individual and interpersonal with structural issues, and foster respect for differing views, listening, supporting, challenging, and questioning as well as the exploration of feelings and expansion of understanding. The congruence of these values with principles of CPE group supervision and standards of the Association of Clinical Pastoral Education, Inc. (ACPE) support the contention that the Intergroup Contact Theory can provide a constructive contribution to the clinical supervision of interreligious encounters of clergy and students from diverse religious traditions.

Cameron W. Byrd, "Inclusiveness in a Basic Unit of Clinical Pastoral Education: A Story of Struggle, Risk and Commitment." Journal of Supervision and Training in Ministry 14 (1992/1993): 201-11.

Summary

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The author, a CPE supervisor and pastoral care department director, describes the development of and evaluation of an inclusiveness curriculum in his CPE program. Inclusiveness is defined as respect and appreciation for diversity. Racism, sexism and heterosexism are addressed in the curriculum because these "isms" impair excellence in ministry. The inclusiveness curriculum increasingly developed a collegial style and consists of didactic seminars, sharing of personal perspectives in order to own the issues, and sharing of family histories, and memories.

Comment

Although the inclusiveness program at Washington Hospital Center does not use the form of intergroup dialogue per se, it can serve as an example of how elements of it can be integrated into a CPE curriculum. Through seminars the curriculum brings to consciousness issues of prejudice and –isms, focusing on personal stories of participants who have experienced racism, sexism, and heterosexism or painfully have become aware of it. The article clearly describes program elements and the process of refining the curriculum. This type of program design shows potential of application to issues of prejudice in interreligious relationships.

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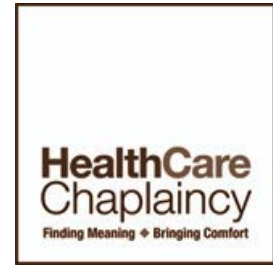
Edition 4 of a Series

Discerning Patient Needs: Spiritual Assessment Perspectives for Health Care Chaplains

Series Editor: P Scott Richards
Counseling Psychology and Special Education, Department of Education, Brigham Young University

I.   Rationale

Despite growing professional awareness of the importance of religion and spirituality in health and human welfare, patients' religious backgrounds and spirituality may be overlooked by physicians, nurses, psychologists, and other health care professionals. Chaplains can fulfill a crucial role in health care settings by making sure that patients' spiritual beliefs and needs are carefully assessed and fully understood. This information may prove valuable for all members of the health care team. By understanding patients' spiritual worldviews, health care professionals are better able to empathically understand them. Spiritual assessment can also help health care professionals determine if clients have unresolved spiritual concerns or needs. Physical healing and psychological coping may be complicated if patients are experiencing spiritual distress. Appropriately addressing patients' spiritual concerns and needs can contribute to more rapid recovery and better prognosis. A spiritual assessment can also help health care professionals identify patients' whose spiritual and psychological distress is sufficiently severe and persistent as to warrant referral for longer-term professional help after hospital discharge. A number of potentially useful religious-spiritual assessment strategies and methods have been described in the professional literature. This bibliographic series introduces chaplains to this literature. Ultimately, for health care professionals who believe that human beings may receive enlightenment and inspiration from the divine, a spiritual assessment may be more than just conceptualizing information that has been gathered in intake questionnaires, clinical interviews, and objective or projective assessment measures. A spiritual assessment may also include prayerful or meditative efforts to seek spiritual impressions and insights about patients and their problems and how to assist them.

II. Three-Five of the Best Books or Articles The first entry summary and commentary on Fitchett and the second on Fitchett and Risk are reprints from Reverend George Handzo's "By Its Fruits: The Science of Health Care Chaplaincy" in *Practical Bearings: The Critical Bibliography for Health Care Chaplains*, Vol. 1, No. 1, (February, 2009). The first three books/articles in this section were written by pastoral professionals for pastoral professionals and have direct relevance to the work of chaplains. The second two chapters/articles were written for primarily for physicians, but they are included because they provide much insight that is of importance to health care chaplains.

Fitchett, G. (1993) *Assessing Spiritual Need: A Guide for Caregivers*. Minneapolis, Minnesota: Augsburg/Fortress Press.

Summary

George Fitchett presents a model for spiritual assessment that he and his colleagues developed, as illustrated with case studies. This "7X7" model has become a classic from which many other models are derived. He reviews three other models and provides a framework for evaluating them. The framework includes the model's concept of spirituality, norms and authority, and assessment context and process. The models include Paul Pruyser's *The Minister as Diagnostician,* Elizabeth McSherry's work at the Veterans Administration, and the model of the North American Nursing Diagnostic Association. This book addresses many of the questions pastoral caregivers have raised about this timely and enduring topic and provides an informed and balanced approach for making decisions about spiritual assessment models and tools.

Comment

Good assessment needs to be the cornerstone on which all of pastoral care delivery is built. It drives the plan of care, interventions, and outcomes. It surfaces the facts that communicate to other disciplines what chaplaincy does. As a side note, it is important to distinguish spiritual screening, which any staff person can do, and spiritual assessment, which should be the prerogative of the professional chaplain. Many chaplains have avoided doing assessment because professional pastoral care does not have a standard method. All chaplains need to realize that what is most important is to have a system that becomes standard for them and for their colleagues in a given institution so that other disciplines come to understand what they are doing.

Fitchett, G., & Risk, J. Screening for Spiritual Risk. *Journal of Pastoral Care & Counseling. In Press.*

Summary

For years George Fitchett has been the leading authority on spiritual assessment and screening. The article describes a brief screening protocol for use identifying patients who may be experiencing religious/spiritual struggle, as well as patients who would like a visit from a chaplain. They describe the results of a pilot study in which non-chaplain healthcare colleagues administered the screening protocol to patients on admission. The protocol identified 7% of the patients as possibly experiencing struggle. The protocol generated a very low rate of false positives and a somewhat higher rate of false negatives.

Comment

Increasingly, pastoral care in healthcare settings is focused on need for care rather than desire for care. For chaplains to demonstrate outcomes that contribute to healing, they have to demonstrate need. Until now, there has been no screening protocol for pastoral care. The screening protocol from Fitchett and colleagues provides an extremely simple, effective and easily taught method to identify patients with religious struggle. It can easily be inserted into any nursing or admitting assessment.

Ledbetter, Timothy J. (2008). Screening for pastoral visitations using the Clinical + Coping Score. *The Journal of Pastoral Care and Counseling, 62 (4)*, 367-373.

Abstract

Hospital chaplains struggle to know which patients most likely need pastoral care and why. The author presents a computerized model to screen and document indicated patients. A new screening tool is introduced, the Clinical + Coping Score, which can check with greater precision for patients who show evidence of insufficient coping. This screening model informs the subsequent assessment and intervention opportunities, though they are not discussed. The model's format enables chaplains to efficiently and effectively document pastoral screening using the hospital's electronic charting program. Two levels of visitation priority are suggested. In so doing, the chaplains are able to identify the indicators for pastoral care contacts and interventions, as well as the number of patients whose recognized needs have yet to be addressed (Ledbetter, 2008, p. 367).

Comment

This is a practical, applied article that describes a model for assisting hospital chaplains in deciding which patient are in greatest need of pastoral care. The model is simple, and yet practical, and provides a framework in which chaplains consider patients' medical status (stable, serious, or critical) and coping resources (full, adequate, marginal, and deficient) as they screen patients for potential pastoral visits. Chaplains in training would benefit from reading and discussing this article before their first hospital placement.

Kristeller, J. L., & Hummel, L. M. (2006). Spiritual engagement and transformation in cancer patients: The experience of the patient, the role of the physician. In Joan Koss-Chioino and Philip Hefner (eds.), *Spiritual Transformation and Healing: Anthropological, Theological, Neuroscientific, and Clinical Perspectives*, Lanham, MD: Rowan and Littlefield Press.

Summary

This chapter addresses the general question of the quality of the spiritual experience of the patient and the related question of how such issues might be appropriately explored within the medical setting by the physician. It also addresses the question of whether there is an appropriate and effective way for oncologists to explore the issue of spiritual or religious concerns with their patients, and it explores how patients may experience both that type of inquiry and their own experiences in drawing on spiritual or religious resources. The authors describe a brief, patient centered approach that oncologists can use in assessing and addressing patients' spiritual concerns, which they call the OASIS inquiry (Oncologist Assisted Spirituality Intervention Study). The authors' research suggests that not only does a brief, patient-centered inquiry, such as the OASIS approach, appear to be acceptable to most patients and relatively comfortable for physicians, but there is an increase in patients' satisfaction with care and at least preliminary evidence of improved quality of life for some patients. Whether it is appropriate for physicians to explore the spiritual or religious concerns of their patients remains a matter of legitimate debate and physician choice.

Comment

This book chapter explores many issues that are important for health care professionals, including chaplains who work in health care settings. It builds a strong rationale for why it is important for physicians to assess and address patients' spiritual needs during medical treatment, particularly oncology patients. The authors respectfully acknowledge both philosophical and practical reasons why physicians might resist doing any sort of a spiritual assessment of their patients. However, they argue effectively that a brief, patient-centered assessment is both possible and desirable. One of the outstanding things about this chapter is that it reports the findings of two research studies which provide empirical support for the hypothesis that a brief, patient-centered spiritual assessment approach can be effectively used by physicians and benefits patients. Thus, this chapter not only provides a spiritual assessment approach for physicians, but it also models how health care professionals, including chaplains, can empirically evaluate spiritual assessment approaches for health care settings. The authors' OASIS spiritual assessment approach is one of the very few that has been empirically evaluated and supported. Hopefully, chaplains and other health care professionals will "go and do likewise" with spiritual assessment approaches they may develop. This chapter may also help chaplains more fully understand spiritual assessment from the perspective of physicians and increase their ability to collaborate effectively with physicians in patient care.

Puchalski, C. (2006). Spiritual assessment in clinical practice. Psychiatric Annals, 36 (3), 150-155.

Summary

Spiritual needs are important to many patients. There is institutional support for the inclusion of spiritual care in the holistic care of patients. There is also data that patients want their spiritual beliefs integrated into the care of their patients and that spiritual beliefs may benefit patients in some healthcare outcomes, resiliency to stress and adverse situations, and coping with suffering. A spiritual history provides an opportunity in the clinical encounter for the patient to share spiritual beliefs if that is what he or she chooses to do. It also helps the clinician to identify spiritual distress, as well as spiritual resources of strength, and to provide the appropriate therapy and referrals needed to give the patient the best care from a bio-psycho-social-spiritual framework (Puchalski, 2006, pp. 154-155). The author describes her spiritual history "FICA" model as follows (Puchalski, 2006, p. 153):

F — Faith and Belief

"Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds "no," the physician might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

I — Importance

"What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"

C — Community

"Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples, and mosques, or a group of likeminded friends, can serve as strong support systems for some patients.

A — Address in Care

"How would you like me, your healthcare provider, to address these issues in your healthcare?" Often it is not necessary to ask this question but to think about what spiritual issues need to be addressed in the treatment plan. Examples include referral to chaplains, pastoral counselors, or spiritual directors, journaling, and music or art therapy. Sometimes the plan may be simply to listen and support the person in their journey.

Comment

This article provides a strong rationale for why it is important to assess spiritual issues in health care settings. It offers suggestions to help health care professionals recognize spiritual issues in the clinical setting. It provides concrete suggestions about how to take a spiritual history in medical settings. Although the article is directed primarily to physicians, chaplains may also find the rationale and spiritual history approach useful for their own practices. When chaplains are given opportunities to provide training about spirituality to physicians, nurses, psychologists, and social workers, this article may be useful for helping these members of the health care team more fully understand the importance of conducting spiritual assessments.

II.   Five to Ten other Books or Articles

A number of the articles and book chapters in this section were written by psychologists or social workers for mental health professionals, but are included because they have considerable relevance to the work of health care chaplains. Several of the articles in this section were written by chaplains and provide valuable perspectives, but in my view did not fall into the category of the "five best" on the topic of spiritual assessment.

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Hodge, David R. (2006). A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. Social Work, 51(4), 317-326.

Abstract

Growing consensus exists regarding the importance of spiritual assessment. For instance, the largest health care accrediting body in the United States, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), now requires the administration of a spiritual assessment. Although most practitioners endorse the concept of spiritual assessment, studies suggest that social workers have received little training in spiritual assessment. To address this gap, the current article reviews the JCAHO requirements for conducting a spiritual assessment and provides practitioners with guidelines for its proper implementation. In addition to helping equip practitioners in JCAHO-accredited settings who may be required to perform such an assessment, the spiritual assessment template profiled in this article may also be of use to practitioners in other settings (Hodge, 2006, p. 317).

Comment

The target audience for this article is social workers and treatment facilities, but chaplains working in health care settings may find the discussion of JCAHO recommendations about spiritual assessment very relevant. The author offers his views about how the JCAHO recommendations can be effectively implemented in clinical practice. For example, he recommends fewer assessment questions, but questions that are more open-ended in nature. He also suggests that a brief spiritual assessment may reveal the need to transition into a deeper second level assessment. The author's discussion of cautions and caveats about performing more in-depth spiritual assessments are valuable, but will hopefully not discourage social workers and other clinicians to perform more in-depth spiritual assessments when indicated.

Hathaway, William L. (2003). Clinically significant religious impairment. Mental Health, Religion and Culture, 6 (2), 113- 129.

Abstract

Recent psychodiagnostic practice, as embodied in the DSM IV, requires that psychopathological features result in a ''clinically significant impairment'' to qualify as a ''mental disorder'' in many cases. The impairment must be in social, occupational, or other

important areas of functioning. The current proposal is that clinicians should consider the potential impairment in religious functioning arising from mental disorders in diagnostic process. It is suggested that psychopathology may result in a clinically significant religious impairment that is defined as a reduced ability to perform religious activities, achieve religious goals, or to experience religious states, due to a psychological disorder. Various existing approaches to studying the relationship between religious functioning and psychopathology are briefly reviewed and roughly categorized as either focused on 'symptomatic religiosity' or reflecting a 'religiously sympathetic' posture. Yet, in both of these approaches, religion has predominantly been construed as an exogenous variable contributing to mental health in some fashion (for good, for ill, or for both). The current proposal suggests that clinicians should also consider religion in endogenous perspective. So construed, religion is a significant domain of adaptive functioning, which may be adversely impacted by psychopathology. A discussion of various clinical, research and ethical issues involved in realizing the proposal is provided (Hathaway, 2003, p. 113).

Comment

This article explores the idea that mental disorders can cause impairment in religious functioning, or in other words, result in a reduced ability for patients to perform religious activities, achieve religious goals, and to experience religious states, due to a psychological disorder. Chaplains in medical settings may frequently observe situations where patients' physical disorders are causing impairment in their religious functioning. The author's article provides a rationale for the importance of chaplaincy services in the sense that when religion and spirituality are viewed as adaptive areas of human functioning that can be impaired by psychological or physical disorders the need to intervene pastorally to help patients who are in spiritual distress may be more readily understood by all members of the health care team.

Richards, P. Scott, & Bergin, A. E. (2005). Religious and spiritual assessment (pp. 219 – 247). In P. S. Richards & A. E. Bergin (Eds.), *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: American Psychological Association.

Summary

In this chapter, the authors' discuss a number of reasons why it is important for counselors and psychotherapists to assess clients' religious and spiritual backgrounds and status along with the other aspects of their lives. They identify and describe dimensions of religiosity and spirituality that are clinically relevant from a psychological perspective. They then describe a multilevel, multi-systemic psychological assessment strategy and discuss how a religious-

spiritual assessment fits into such a strategy. The authors also discuss how intake questionnaires, clinical interviews, and standardized tests can be used to facilitate a religious-spiritual assessment. They discuss meta-empathy, or the idea that psychotherapists may on occasion experience intuitive insights and inspiration that assist them in understanding their clients. They also discuss the importance of assessing the spiritual outcomes of treatment.

Comment

This book chapter was written by psychologists for psychologists and has received positive reviews within the mainstream psychology profession. Its primary value for chaplains may be in the psychological perspective it provides about religious and spiritual assessment and in the validation it gives concerning the importance of spirituality in a comprehensive treatment approach. Understanding why a religious and spiritual assessment is important from the perspective of psychologists and other mental health professionals may help chaplains more effectively interface with them on the health care team. This chapter may give chaplains some additional insight into dimensions of spirituality that may be important in clinical settings. Chaplains may also find that the authors' brief discussion of meta-empathy affirming of the non-quantifiable aspect of their role as spiritual caregivers and of the importance of the spiritual presence in chaplaincy care.

Gorsuch, Richard L., & Miller, William R. (1999). Assessing spirituality (pp. 47 – 64). In W. R. Miller (Ed.), Integrating spirituality into treatment: Resources for practitioners. Washington, DC: American Psychological Association.

Summary

This practically focused chapter begins with a brief consideration of why mental health professionals should assess clients' spirituality. The main body of the chapter is devoted to recommendations on how to assess spirituality in ways that are relevant to treatment. The authors start with broader approaches and proceed to more specific measures organized around the three broad assessment domains—cognitive, behavioral, and experiential. Finally, they offer a few general cautionary notes about this area of assessment.

Comment

This book chapter provides some strong rationales for why it is important for psychologists and other mental health professionals to assess the religious and spiritual dimensions of their clients' lives. It provides useful suggestions about assessing clients' religious beliefs,

behaviors, and experiences. Its primary value for chaplains may lie in helping broaden their understanding of religious and spiritual assessment from a psychological perspective.

Millspaugh, D. (2005). Assessment and response to spiritual pain: Part I. *Journal of Palliative Medicine, 8(5)*, 919-923.

Abstract

Spiritual pain or suffering is common. Cicely Saunders described persons with "total pain" including the physical, psychological, social, and spiritual dimensions. Yet, a construct for what it is, and how to respond, is not so common. In this paper, I hypothesize that the components of spiritual pain can be summarized in the following manner.

Spiritual pain or Suffering =
(Awareness of death + Loss of Relationships + Loss of Self) (Loss of Purpose + Loss of Control)/Life affirming and transcending Purpose + Internal Sense of Control

Thus, an assessment of spiritual pain or suffering should examine the degree to which the individual is experiencing each of these components and their relationship to each other. Further, each of these components is dynamic, always in process, both within and between the components. A second paper will examine the sufferer's religious responses and suggested pastoral responses (Millspaugh, 2005, p. 919).

Comment

This article provides a useful exploration of some potential causes of spiritual pain and suffering (e.g., awareness of death, loss of relationships, etc.). The article seems to derive primarily from the author's clinical experience as a chaplain and so it provides a valuable, but perhaps limited perspective in this regard. I did not find the author's algebraic formula of spiritual suffering helpful in the sense that I think it oversimplifies something that is much more complex. Simplifying complex ideas can often be helpful, but in this case I think the mathematical formula so distorts the relationships between various life experiences and personal characteristics that can cause and ameliorate spiritual pain and suffering that it is not helpful. Nevertheless, despite its limitations, I think this article provides some useful food for thought about the types and causes of spiritual pain and suffering patients may be experiencing. I think it may be especially useful for those who are early in their training as chaplains.

Millspaugh, D. (2005). Assessment and response to spiritual pain: Part II. *Journal of Palliative Medicine, 8(6)*, 1110-1117.

Abstract

In Part I of this article, published in October 2005, I hypothesized that the components of spiritual pain can be summarized in the following manner.

Spiritual pain or Suffering =
(Awareness of death + Loss of Relationships + Loss of Self) (Loss of Purpose + Loss of Control)/Life affirming and transcending Purpose + Internal Sense of Control

Thus, an assessment of spiritual pain or suffering should examine the degree to which the individual is experiencing each of these components and their relationship to each other. Now in Part II I examine the Christian sufferer's religious responses and suggest pastoral interventions (Millspaugh, 2005, p. 1110).

Comment

Millspaugh details several general categories of patient responses to spiritual pain—eight, to be specific. He then presents a section on "pastoral response" which discusses a number of issues, including self-assessment, pastoral presence, pastoral assessment, and spiritual care planning. Each of these provides detailed questions that chaplains may want to consider concerning the person suffering spiritual pain. I thought that this article had many helpful insights; however, in the latter half of the article was unfocused and suffered from repetitiveness and a lack of clarity and organization. There were various lists and the numbering was not consistent. One numbered list had a numbered list within it that was also numbered with plain, ordinal Arabic numerals. Later a different numbering structure was used. I once had a clinical supervisor who was fond of saying that when it comes to clinical practice, "It is better to be simple-minded than muddle-headed." I think this article may leave readers feeling muddle-headed because of its lack of clarity, conciseness, and organization. Nevertheless, I think this article has value if readers are willing to make the effort to sort through the muddle-headedness and find the gems of clinical insight offered within it.

Austin, Larry J. (2006). Spiritual assessment: A Chaplain's perspective. *Explore, 2(6)*, 540-542.

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Summary

Austin's brief article identifies a lack of collaboration between healthcare professionals and a lack of understanding and specificity of professional functions and concepts. He provides a set of categories for spiritual assessment as a "starting place for dialogue and collaboration among disciplines; sense of the Holy, actions of the Holy, beliefs and practices, affective responses, personal responsibility, community, meaning, vocation, hope, grief, humor, forgiveness, courage, and virtue and beauty" (Austin, 2006, p. 540). He then briefly explains each category, implying that each of these categories may be important to assess with patients.

Comment

This is a brief and basic article and may be most useful to those early in their training as chaplains to stimulate their thinking about possible ways to think about patients' spirituality. To someone not yet familiar with chaplaincy or basic pastoral care, it may offer some new and helpful information.

Gordon, Tom, & Mitchell, David (2004). A competency model for the assessment and delivery of spiritual care. Palliative Medicine, 18, 646-651.

Abstract

The delivery of spiritual and religious care has received a high profile in national reports, guidelines and standards since the start of the millennium, yet there is, to date, no recognized definition of spirituality or spiritual care nor a validated assessment tool. This article suggests an alternative to the search for a definition and assessment tool, and seeks to set spiritual care in a practical context by offering a model for spiritual assessment and care based on the individual competence of all healthcare professionals to deliver spiritual and religious care. Through the evaluation of a pilot study to familiarize staff with the Spiritual and Religious Care Competencies for Specialist Palliative Care developed by Marie Curie Cancer Care, the authors conclude that competencies are a viable and crucial first step in 'earthing' spiritual care in practice, and evidencing this illusive area of care (Gordon & Mitchell, 2004, p. 646).

Comment

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This article provides some valuable perspectives about the challenges of assessing patients' religious and spiritual beliefs and background in hospital settings. The four-level religious and spiritual competence model also provides a useful way to think about religious-spiritual competency expectations in health care settings. The authors' description of the pilot study they did among staff members in the Marie Curie Hospices was useful in the sense that it provides some food for thought about how religious-spiritual competencies might be encouraged among health care staff—and about the role chaplains might take in promoting such competencies. The weakness of the article may be that the authors remained rather vague about what specific religious-spiritual competencies they regard as important.

Scott, Stacey, Garver, Stacy, Richards, Julie, & Hathaway, William R. (2003). Religious issues in diagnosis: The V-Code and beyond. Mental Health, Religion and Culture, 6, 161-173.

Abstract

This paper addresses the issues around considering clients' religious and spiritual functioning as a matter of client diversity. Such issues may be under appreciated by many clinicians. The introduction of a religious and spiritual problem V-Code (V62.89) into the DSM-IV provided a significant accommodation of client religious and spiritual functioning in contemporary psychodiagnostics. The V-Code allows for explicit identification of a nonpathological religious or spiritual focus in treatment. The nature of and history of the V-Code's inclusion in DSM-IV is briefly reviewed. The strengths and limitations of the V-Code for raising clinician awareness of the religious and spiritual domain of client functioning is discussed and illustrated by a number of case examples. The V-Code approach is contrasted with Hathaway's (2003) clinically significant religious impairment concept. Both are viewed as making complementary contributions to a religiously and spiritually sensitive clinical practice (Scott et al., 2003, p. 161).

Comment

Perhaps the primary value of this article for chaplains is that it may raise their awareness about the potential influence of the American Psychiatric Association's Diagnostic and Statistical Manual's (DSM) religious and spiritual problem V-Code on how psychiatrists and other mental health professionals think about religious and spiritual diagnosis and assessment. Overall, the authors express concerns that the DSM V-Code is a poor tool in the assessment of religious and spiritual issues and that it needs to be revised to be more helpful to clinicians.

Gleason, John J. (1999). The four worlds of spiritual assessment and care. Journal of Religion and Health, 38(4), 305-317.

Abstract

From the dawn of human consciousness, religious and spiritual expressions have been inexorably intertwined with some degree of assessment toward more effective care—whether such care is offered by shaman, imam, rabbi, shirpa, prophet, priest, pastor, physician, nurse, or lay minister. Currently, two major forces have brought spiritual assessment and care into sharp focus regarding the delivery of health care in the U.S. The first is the advent of managed care. The shift in emphasis from sickness-based to wellness-based reimbursement, spurred by spiraling costs, has brought close scrutiny to provider effects on patient outcomes. The second major force, related to the first, has been increased attention to alternative medicine and to previously unacknowledged adjuncts to traditional health-care delivery, most often understood by the terms "holistic health" or "wellness." One of the sub-areas within holistic health is spiritual care. A measure of the increasing importance of spiritual care within the delivery of U.S. health care is the fact that the Joint Commission on Accreditation of Health Organizations (JCAHO) is gradually upgrading the place of chaplaincy services in the Standards. Thus, a clear, simple, user-friendly, inclusive, valid, reliable, useful diagnostic, care-anticipating, and outcomes-measurable spiritual-care model is becoming more a necessity in the increasingly demanding discipline of clinical chaplaincy (Gleason, 1999, p. 305).

Comment

This article describes a "four world" model for conceptualizing patients' spiritual development along literal-mythical and open-closed dimensions. It also presents case examples of people in these "four worlds" with implications for chaplains. Findings from a study where the reliability and validity of an assessment approach based on the four-world model are also presented. Although the practical value of this spiritual assessment approach for chaplains in healthcare settings can be questioned, the article provides food for thought and debate as chaplains in training seek to clarify their own views about how they can most effectively conduct spiritual assessments with their patients.

Flannelly, Kevin J., Galek, Kathleen, Tannenbaum, Helen P., Handzo, George F. (2007). A preliminary proposal for a scale to measure the effectiveness of pastoral care with family members of hospitalized patients. Journal of Pastoral Care and Counseling, 61, 19-29.

Abstract

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The authors conducted an electronic search of the Medline database for articles measuring family satisfaction. Content analysis was then performed on the relevant studies to determine the types of themes included in scales measuring family satisfaction in healthcare settings. The authors used these themes to develop a scale for measuring the effectiveness of pastoral care with family members. A convenience sample of chaplains that was asked to judge the usefulness of each of the scale items, rated them all, on average, to be "somewhat useful" to "very useful" for evaluating chaplains' effectiveness. The value of the scale is discussed in terms of its being a more outcome-oriented measure of effectiveness compared to typical family satisfaction instruments (Flannelly et al, 2007, p. 19).

Comment

The focus of this article is not about assessing patients' religious-spiritual issues, but on describing the development of a scale for assessing the outcomes of the pastoral services chaplains provide to the family members of hospitalized patients. This article may be valuable for chaplains who are concerned about assessing the outcomes of their pastoral care for a couple of reasons. First, the process of scale development it describes may assist chaplains who wish to develop their own outcome assessment measures. Second, the scale the authors developed for measuring the effectiveness of pastoral care with family members may prove useful for chaplains who wish to assess the effectiveness of this aspect of their work.

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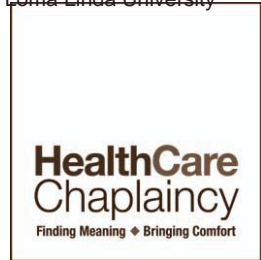
Edition 5 of a Series

The Management of Care: Literature on Leadership and Organizational Development

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Contributing Editor: The Rev. Michael Cooper-White, D.D. is President of the Lutheran Theological Seminary at Gettysburg, Gettysburg, PA.

This Series is made possible through the generous support of the John Templeton Foundations and HealthCare Chaplaincy. *Practical Bearings* is a series of bibliographies and critical reviews of important books, articles and other publications on the theory and practice of pastoral care.

Editor-in-Chief: The Reverend Leonard M. Hummel, Ph. D. is Associate Professor of Pastoral Theology at the Lutheran Theological Seminary at Gettysburg, Gettysburg, PA.

To learn more about *Practical Bearings* and read other editions, please go to www.healthcarechaplaincy.org/practicalbearings

Rationale

The primary goal of this series is to introduce pastoral care professionals to literature that 1) enhances leadership competency and 2) prepares pastoral professionals to better serve as leaders in organizations. Our aim is to encourage reflection, personal and professional exploration, and skill enhancement to the end that readers become more effective at accomplishing personal and professional goals within their ministry setting.

In this series we offer reviews on several topics of interest to pastoral leaders: empowerment and the struggle for change; organizations and leadership as emotional processes; integrating one's Spirit and mindfulness in the workplace; the importance of having a theory of leadership; viewing organizations as frames and system maps; breaking free of conventional thinking; becoming more inclusive; stories about quiet leaders and how they serve; and leadership in the context of team work.

The area of Pastoral Management and Leadership as a multifaith and intercultural area of study is relatively new field of study. We hope these resources will generate dialogue among pastoral care professionals and contribute to this field.

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General Comments

I still recall what a shock it was to discover, just as I was completing my graduate training to be a high school instructor, that I still needed to learn how to teach and "manage" (read: control) a classroom of teenagers. The moment of truth came for me the first day the students arrived. As I stood in the front of the class and they took their seats, I suddenly realized that the art of teaching was not an automatic gift that came with my faculties as a student or with my new job and degree. Teaching – as an exercise in "leading" students to where they can learn – was something I still needed to learn.

This same realization process has repeated itself several times throughout my professional life when it came to exercising leadership: when I became ordained and began to pastor a congregation; when I became a pastoral educator and began teaching clinical pastoral education; and when I began to manage pastoral care departments in healthcare settings. Each of these occasions challenged me to explore my assumptions about leadership, acquire skills and competencies, and demonstrate the appropriate behavior depending on the scope and level of my responsibility.

For several years I have wrestled with how to teach students to become leaders and acquire roles in leadership. Out of frustration over the seemingly lack of leadership materials aimed toward pastoral professionals, I began to study many of the popular books and articles on leadership. I have found – to paraphrase W. Somerset Maugham's remarks about writing a novel – there are three rules for creating good leaders: Unfortunately, no one knows what they are. The more I read, the more I am convinced that much of what is written on leadership is a blend of personal philosophy, professional experience and pop-psychology. If Whitehead is correct in asserting that the proper solution to any critical inquiry is an adequate synthesis of ultimacy and immediacy, of universality and individuality, then most of this material has lost one pole or another.

Since the dawn of human civilization, a great deal has been written on the subject of leadership, but definitions and explanations vary widely. How exactly does one become a leader? Are we gifted with special traits when we are born? Can we learn to become a leader? Do good leaders need to have a prescribed set of values? Does the opportunity to lead present itself depending upon the situation and predisposition of participants? Can leaders promote organizational change, or do organizations change leaders? Is leadership distinct from authority and power or only a synonym for them? Given the world events of our times, advances in new technology and research to understand human behavior, is there a new model of leadership critical to the success of our enterprise as pastoral professionals?

As you ponder these and other questions, I hope you enjoy reading these reviews. I invite your comments, suggestions and additional resources on leadership. In particular, I am interested in learning what you believe are some of the strengths and challenges pastoral professionals face as leaders. In light of the unique preparation and role of pastoral professionals, is there a distinct developmental process pastoral professionals must engage in to move from the bedside to the boardroom? Please let me know by completing the short evaluation form accessible at the end of these reviews.

Reviews by Martin Montonye, D. Min.

James MacGregor Burns, <u>Transforming Leadership</u> (New York: Grove Press, 2003).

Summary

Burns examines the process of leadership structures across history. He shows not only how leaders have shaped history but moves beyond the biographies of leaders to demonstrate how great leaders respond to followers' deep wants and needs. For Burns, this is the source of power for leaders who wish to create change. Part I begins with a discussion on the mysteries of leadership (beginning with Cleopatra's Nose) and ends with causality, leadership and vision. Parts II and III provides several examples of historical leaders and how they have impacted history and the role of crisis. Parts IV and V describes the origins of motivation, the power of values and the role of transforming leaders.

Comment

Burns most relevant topics for pastoral care professionals are his discussions on leaders and followers' motivation, crisis, values and change. For Burns, the principle task of a leader is to respond to follower's wants and needs. Followers become frustrated when they cannot reconcile to the ascribed meanings and actual meaning of important experiences. This "gap" is a moral judgment that the transformational leader reframes. "The creative insight is, in short, transforming. . . .Reframing means the transformation of values" (p. 167). The power for change is in the "truth" and the leader's ability to "strike a deep chord." This form of leadership is liberating for those isolated through fear and moves them "into the realm of new and shared meanings, to become 'reflective participants'"(p. 169) .Burns assessment of leadership includes the common elements of ministry that pastoral care providers engage at the bedside or in board meetings - empowerment and the process and struggle for meaningful change.

Edwin H. Friedman, <u>A Failure of Nerve: Leadership in the Age of the Quick Fix</u> (New York: Seabury, 2007).

Summary

This book was unfinished at the time of Friedman's untimely death in 1996, and originally published in a limited edition a year later. The new edition adds unfinished chapter notes to the original manuscript. Freidman describes our society as in a state of regression toward safety rather than adventure. The survival of society depends less on the selection of leaders who rely on data, technique and empathy, but rather more on maturity, stamina and personal responsibility. Readers familiar with Friedman's Generation to Generation will find many of the same ideas in this book: organizational personalities, emotional triangles, sabotage, self-differentiation and anxiety.

Comment

In A Failure of Nerve, Friedman extends his analytic framework to developing an approach to leadership as "essentially an emotional process rather than a cognitive phenomenon" (p. 13).

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For Friedman, the world as it currently exists is in a state of chronic anxiety. Effective leaders are "well-differentiated" leaders: they have clarity about defining themselves; they are secure in how they connect and differ from those they lead; they remain separate enough to be objective while remaining engaged enough to make valuable contributions; they are less likely to be reactive and lose themselves in anxious emotional processes. However, while many pastoral types resonate with Friedman's sometimes abstract theories, in reality what may make them uneasy is his list of necessary attributes to function as leaders when it is time to risk changing the world around them. The call for "persistence in the face of resistance and downright rejection...stamina in the face of sabotage along the way...being headstrong and ruthless" may be just too much to ask of some (p. 189-190).

Jack Hawley, Reawakening the Spirit in Work: The Power of Dharmic Management (San Francisco: Berrett-Koehler, 1993).

Summary

Jack Hawley wrote this book to counter today's "erosion of Spirit and the pattern of thoughtless dishonesty." He aims to "feed the roots of integrity and nudge toward Spirit" (p. 1). This book is divided into five sections. In Part I, the author delineates the importance of Spirit in work and life. Part II focuses on reverence, defined as deep caring for others or intense respect. The author calls this the "loving secret sauce" of the new management agenda. Part III is devoted to defining the five key realities of work and life: belief as a basic foundation, thought power, already-thereness, instantaneousness, and untethering. Part IV is devoted to the idea of character and living by one's inner truth. Here the author develops the concept of dharma - an Eastern concept defined in the West as integrity. Part V explores the spiritual core of leadership. The author concludes that all leadership is spiritual.

Comment

Hawley's thesis is that connection with "Spirit" is essential to organizational success and individual satisfaction. To the degree leaders and managers are able to connect their "state of mind" to Spirit is directly proportional to the level of "aliveness, energy and zest" of any organization. "State of mind is more important than...well-knit strategies and perfectly laid plans" (p. 174). Contentment, capacity, equanimity, detachment and connectedness are the five mood ingredients included in the leaders' state of mind. An important question weaved throughout this text is, Why is the connection to Spirit essential to success at the individual or organizational level? The author explains three benefits: 1) To get in step with oneself; 2) Bring health; 3) To attune to life's purpose. For the author, the leader's role is to define reality through following one's inner truth. In the end, what is true for the individual is also true for the organization. If you are looking for a book on the connection between spirituality and work, start here.

Dalai Lama and Laurens Van Den Muyzenberg, The Leader's Way: The Art of Making the Right Decisions in Our Careers, Our Companies, and the World at Large (New York: Broadway Books, 2009).

Summary

Describing how best business practices and Buddhist principles commonly hold "making rational, holistic decisions and turning them into responsible, effective actions," the authors proceed to demonstrate how business fits into society and the true meaning of corporate responsibility. (cover) Part One entitled "Leading Yourself," outlines some basic Buddhist principles and illustrates the relevance of these principles to daily life. Part Two "Leading Your Organization," is designed to apply key Buddhist principles to the business world. Part Three "Leading in an Interconnected World," the authors show how to apply Buddhist values to the global economy. The "ultimate wish" of the authors is "that by improving the quality of our leaders' decision, we will find ourselves in a better world for everyone" (p. 9).

Comment

The Leader's Way is written to show the importance of mindfulness at all levels of leadership. It illustrates the relevance of an ancient eastern philosophy to contemporary global leadership and management. The Buddhist principles of "Right View" and "Right Conduct" can help pastoral leaders accept and thrive within the ever-changing business world where every goal is a moving target and the permanent satisfactory state is impossible. Perhaps the most important and useful aspect of the book is that it provides readers with practical strategies to develop the capability of "mindfulness" in order to achieve "Right View" which can lead to the achievement of positive change. This is a useful skill for pastoral care leaders and managers at any level of an organization.

Peter G. Northouse, Leadership: Theory and Practice - 4th ed. (Thousand Oaks, CA: Sage, 2007).

Summary

In its fourth edition, Leadership: Theory and Practice offers a structured account of several leadership theories with a special attention toward how "theory can inform and direct the way leadership is practiced." The book is divided into fourteen chapters, which cover key areas in the field of leadership: defining and describing leadership; trait approach; skills approach; style approach; situational approach; contingency theory; path-goal theory; leader-member exchange theory; transformational leadership; team leadership; psychodynamic approach; women and leadership; culture and leadership, and leadership ethics. Each chapter follows a similar format and includes the strengths and weaknesses of each leadership theory and style, case study material and a reader-assessment questionnaire. A fifth edition is soon to be released and includes a chapter on authentic leadership.

Comment

Readers will enjoy this book because the author accomplishes what he set out to do: to write an edition that bridges the gap between the simplistic and overly abstract. Northhouse's book offers pastoral educators a resource that can be easily distilled into a brief didactic format and assessment tools for students to gain immediate insight in to their leadership styles. Professional chaplains will find the chapters on transformational and team leadership informative as they struggle with strategic choices to improve their professional functioning. The chapters on culture and ethics contain particularly helpful information for chaplains interested in learning more about how cultural differences and values influence the leadership

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process and organizational development. The author's discussions include concepts familiar to readers such as uncertainty avoidance, holding environments, and ethics of caring.

Reviews by Michael Cooper-White, D. D.

Lee G. Bolman and Terrence E. Deal, <u>Reframing Organizations: Artistry, Choice, and Leadership</u>
(San Francisco: Jossey-Bass, 1997).

Summary

A consistent best-seller, Reframing Organizations explores powerful, imaginative leadership in a variety of venues. With their stated purpose to "inspire both inventive management and wise leadership," (p. 377) Bolman and Deal offer practical ways of thinking about today's organizational challenges. The authors recognize that effecting change in any organization, regardless of its context and culture, requires paying attention to and acting wisely in four "frames": Structural, Human Resources, Political and Symbolic. Specific topics covered include organizing teams, navigating power dynamics, coping with inevitable conflicts, and acting in the "organization as theater." A concluding section sets forth key tasks for improving leadership practice.

Comment

Reframing Organizations' ability to embrace colliding cultures of for-profit "business" and compassionate "service" gives it particular relevance to institutional chaplains, who serve at the intersection of faith communities and health care conglomerates. A primary text in Harvard programs for senior institutional leaders, the book recognizes that "the proliferation of complex organizations has made almost every human activity a collective one." (p.7) To serve successfully amidst such complexity, and to lead a care team to new levels of excellence, one must be a savvy navigator of organizational politics, achieve candor and clarity in communication, forge mental "system maps" toward desired future states, and marshal the courage to overcome inevitable resistance.

A Note by Series Editor, Martin Montonye: How chaplains understand and practice "service" is often heavily influenced by their professional identity. Theologically, is it possible for chaplains to offer compassionate service within the business world?

Steven B. Sample, <u>The Contrarian's Guide to Leadership</u> (San Francisco: Jossey-Bass, 2002).

Summary

Electrical engineer, musician, outdoorsman, professor, inventor, and currently president of the University of Southern California, Steve Sample writes what David Gergen describes as "an

intoxicating read, a bushwhacker's delight" which "cuts down a lot of bad ideas about leadership and opens a new path for the next generation . . ." (cover) The book's counter-intuitive assertions set it apart from the current "leadership" genre and shock the reader to consider radical notions like giving up daily newspapers in favor of enduring "supertexts." USC's growth under Sample's leadership (it's currently the largest employer in Los Angeles) is testimony that contrarian leadership works!

Comment

This reviewer has been amazed how seminarians "get it" when they read and discuss a major university president's reflections on leadership. Of particular relevance to those who lead care teams in complex clinical settings will be chapters like "Know Which Hill You're Willing to Die On." Serving amidst ethical ambiguities, one will find a kindred spirit in Sample when he encourages "Thinking Gray and Free." And to those who must lead by listening, the chapter on "Artful Listening" will find a helpful hearing. Breaking free from conventional thinking, one may invent a new dishwasher digital control system, as did Sample, or a whole new approach to Seelsorge (care of souls)!

Lynn N. Rhodes, "Leadership From a Feminist Perspective," Word & World, Vol. XIII, No. 1 (Winter 1993): 13-18.

Summary

Rhodes begins with a feminist critique of deeply embedded traditional leadership modalities, noting how many seminarians are challenged and frustrated in attempting to utilize a more collaborative, collegial style of leadership. Observing that "feminism is not one coherent theory," (p. 14) she nevertheless calls for giving greater value to women's experiences and well-being. Lifting up "a feminist vision" by pointing to Letty Russell and others, Rhodes lays a solid theological foundation for "partnership," decries stereotypical notions of who are the "best and brightest," and concludes with some specific suggestions for implementing more inclusive leadership styles and stances.

Comment

This brief article is a "must read" for my students early in semester-long courses on leadership. Both women and men will be challenged to recognize that women "have a history of difference" (p. 14) and such difference matters in all arenas, particularly in ministry. Concluding on the basis of extensive research that "the clergy role is not healthy for the development of human beings," (p. 15), Rhodes points to new possibilities for exercising religious leadership in any setting. This piece is like old familiar hymns or prayers—it is brief and it merits frequent repetition until its concepts and convictions are woven into the fabric of servant leadership.

A Note by the Series Editor, Martin Montonye: This is an excellent article for a classroom theological discussion, valuable and thought-provoking. This editor is left longing for some attention in this valuable and thought-provoking article for the resistance and sacrifice one would must endure in the hopes of changing a system to reflect the kind of leadership model Rhode's advocates.

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Joseph L. Badaracco, Jr., <u>Leading Quietly: An Unorthodox Guide to Doing the Right Thing</u> (Boston: Harvard Business School Press, 2002).

Summary

David Gergen, who has worked with corporate CEO's, politicians and others typically described as "high-powered," praises Badaracco's lifting up "the quiet leaders—unsung men and women who actually keep most of the world going from one day to the next." While a few leaders emerge on the world stage and appear in headlines, most of those who truly make a difference work far from the limelight. Badaracco examines what makes quiet leaders tick, and in nine chapters points to their habits and inclinations. Eschewing the simplistic, he asserts, "Quiet leaders drill down into complex problems," (p. 92), and often must act amidst ambiguity.

Comment

A "case study" approach is familiar to lawyers, and increasingly to ministry practitioners, especially those in clinical and chaplaincy settings. In contrast with the common approach of studying heroic leaders on the world stage, leadership detective Badaracco finds lesser known but highly influential leaders and shares their stories. In a profession where it is hard to measure "progress," his assurances that true leaders' efforts "resemble a long guerilla war rather than a glorious cavalry charge" (p. 177) ought to be reassuring for us clergy types. This book will encourage and guide, whether one is a lonely solo practitioner or heads a huge department.

J. Richard Hackman, <u>Leading Teams: Setting the Stage for Great Performances</u> (Boston: Harvard Business School Press, 2002).

Summary

Hackman and his associates studied effective leaders in a variety of contexts—from airliners to orchestras—where sustained teamwork is crucial. Convinced that "teams have more talent and experience, more diverse resources, and greater operating flexibility than individual performers," (jacket cover), Hackman et. al. are nevertheless realistic about the considerable costs of teamwork—in time, psychic energy and financial resources. They identify five critical "enabling conditions" for effective teams: having a real purpose; pursuing a compelling direction; functioning within an enabling structure; undergirded within a supportive context; and having readily available expert coaching.

Comment

While the "lone ranger" ministry modality worked many places in the past, most who try to go it alone today end up discouraged or in trouble. While teamwork, networking, and collegiality are in vogue, they are never easy. Hackman and his research team went out and found exemplary working teams, from which we who serve in congregations, clinical settings or institutions can learn much. Frequent air travelers might note the conclusion that it's not

optimal to fly with a cockpit crew on the initial leg of their first trip together. "Go team!" should not be a strange cheer for those who see ourselves serving a God who made humankind in order not to go it alone!

Martin Montonye's Closing Comments:

I'm not certain leadership can ever be taught in a classroom. Perhaps the most we can hope for is to learn what others have done, challenge our assumptions and see the world differently. Learning to be a leader seems to be more a product of experience of living in the tension between taking decisive action and being compassionate. When the two intersect - as in deciding whether or not to offer a prayer during a pastoral visit - there is little discomfort or struggle to act decisively and compassionately. But when called upon to make uncomfortable or unpopular decisions - as in challenging authority or terminating an employee - it is difficult to feel, and to be perceived, as compassionate.

The image we have of ourselves in the course of our emergence into personhood controls profoundly our capacities to be and do. To a large degree, our behavior is a manifestation of the self image we have been taught – and learned – to feel we are. Perhaps self image and avoiding discomfort more than external reality help to explain why some pastoral professionals choose not to serve in leadership roles beyond the scope of their identity as educators, clinicians and therapists.

Your feedback on Practical Bearings is important.

Please click here and fill out the short evaluation form.

If you are interested in joining Rev. Montonye and others in an online group for pastoral care professionals, click on the link below for the Pastoral Care Leadership & Management Linked In Group
http://www.linkedin.com/e/vgh/2423971/

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Practical Bearings: **The Critical Bibliography Series for Health Care Chaplains**

HealthCare Chaplaincy, with the generous support of the John Templeton Foundation, is pleased to offer *Practical Bearings,* a series of bibliographies and critical reviews of the important books, articles and other publications on the theory and practice of pastoral care.

The series name *Practical Bearings* derives from the Pragmatic Maxim of the great philosophers Charles Sanders Peirce and William James who contended that all important ideas have consequences for life and living—that is, "practical bearings."

"*Practical Bearings* will point professional chaplains to resources that will help them fulfill their mission in the evolving and complex world of health care," says Rev. Dr. Leonard Hummel, editor-in-chief and director of supervised clinical ministry at Gettysburg Seminary in Gettysburg, Pennsylvania. He is a visiting scholar at HealthCare Chaplaincy.

HealthCare Chaplaincy plans at least six issues, each on a single topic. Each issue will contain:

- The rationale behind the key role that the topic plays in the profession of pastoral care
- A list of the three to five publications on that topic that are either most essential or most representative with a summary and comments on each
- Other publications of value

Click on the title to download each edition in an easy-to-print PDF file:

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- **Edition 3: Meeting the Other: Interreligious Encounters in the Provision and Supervision of Spiritual Care**
- **Edition 4: Discerning Patient Needs: Spiritual Assessment**
- **Edition 5: The Management of Care: Literature on Leadership and Organizational Development**

(Above you will find links to web articles click on them when connected to the web and read the linked articles.)

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http://www.healthcarechaplaincy.org/chaplaincy-research-resources/practical-bearings.html[12/21/10 9:03:38 PM]

Professional Chaplaincy
Its Role and Importance In Healthcare

PROFESSIONAL CHAPLAINCY

Its Role and Importance In Healthcare

Editors
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Laurel Burton Th.D.

Design
ZGroupinc NYC

Contents

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EXECUTIVE SUMMARY
This paper describes the role and significance of spiritual care and is the first joint statement on this subject prepared by the five largest healthcare chaplaincy organizations in North America representing over 10,000 members. As a consensus paper, it presents the perspectives of these bodies on the spiritual care they provide for the benefit of individuals, healthcare organizations and communities. Throughout this paper, the word spirituality is inclusive of religion; spiritual care includes pastoral care.

Spiritual caregivers in healthcare institutions are often known as chaplains although they may have different designations in some settings, i.e. spiritual care providers. The paper contains four sections.

SECTION I
The Meaning and Practice of Spiritual Care

(When connected to the web click on this link and read the linked articles.)

This first section describes *spirit* as a natural dimension of all persons and defines the nature of spiritual care. With the basic premise that attention to spirituality is intrinsic to healthcare, the paper establishes their relationship and outlines the various environments in which care is provided.

SECTION II
Who Provides Spiritual Care?

(When connected to the web click on this link and read the linked articles.)

Professional chaplains provide spiritual care. This section describes their education, skill and certification.

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https://secure.healthcarechaplaincy.org/publications/publications/white_paper_05.22.01/index.html[12/21/10 9:02:22 PM]

SECTION III
The Functions and Activities of Professional Chaplains

This section delineates the typical activities of professional chaplains within healthcare settings, focusing on their care of persons and their participation in healthcare teams.

(When connected to the web click on this link and read the linked articles.)

SECTION IV
The Benefits of Spiritual Care Provided by Professional Chaplains

The materials here describe how professional chaplains benefit healthcare patients and their families, staff members, employing organizations, and communities.

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 1998) in the U.S. states, "Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values." A Canadian accreditation agency makes similar statements. Such regulations, and efforts to meet them, flow from the belief that attention to the human spirit, including mind, heart and soul, contributes to the goals of healthcare organizations.

(When connected to the web click on this link and read the linked articles.)

THE HEALTHCARE CHAPLAINCY

Outcome Oriented Chaplaincy

Overview

Sue Wintz, BCC

9/08

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Case Example: Mary

Received referral from nursing

- ◆ Clinical: Newly diagnosed brain tumor; scheduled for surgery <24 hours after admission
- ◆ Social: No identified support system
- ◆ Spiritual: Pt facing major surgery complicated by issues of social isolation and aphasia

Updated by RN:

- ◆ 73 yo female found in an unclean apartment lying on a soiled mattress on the floor
- ◆ Family: one cousin in Minnesota she had not spoken to in 3 years; had been located by RN and had spoken to pt
- ◆ Right sided weakness, expressive aphasia
- ◆ Initial diagnosis: lesion on right frontal lobe, scheduled for neurosurgery that afternoon
- ◆ RN concern that patient's wishes be identified and documented

Reviewed chart

Case Example: Mary

Response to chaplain self-introduction

- ◆ "I…don't…want"
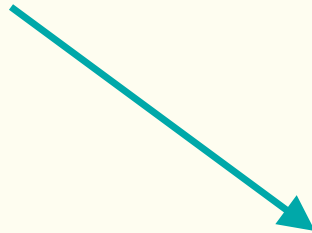
Chaplain response?

Case Example: Mary

Chaplain conversation revealed:

- Receiving no community adult services
- No friends or neighbors she socialized with
- No religious tradition, community, or practices
- Income: monthly social security check
- "…What's…wrong…with…me?"
- "…I…don't…want…."
  - "CPR…shock…"
  - "Machines…breathe"

⟶ Chaplain response?

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Case Example: Mary

HealthCare Chaplaincy
Finding Meaning ◆ Bringing Comfort

Simple intervention and documentation, right?

- Pastoral presence and listening
- Completion of Advance Directives: Healthcare Power of Attorney and Living Will
- Blessing/hopeful words before surgery

⟶ Or maybe not…

Case Example: Mary

Talked to (the new) neurosurgery resident

- Reintroduced the role of the chaplain on the unit (month previously had presented an in-service as part of their orientation)
- Made aware of Living Will and patient's question "What's wrong with me?"
- Asked about pt's neuro diagnosis
- Asked about hoped-for-outcomes of surgery
- Asked about plan of care following surgery
  - What about the chest x-ray?
  - Would a palliative care consult be appropriate?

Case Example: Mary

Spoke with attending intensivist/pulmonary critical care MD who:

- Reviewed chest x-ray
- Talked to patient
- Called neurosurgery resident and attending to delay surgery until
- Ordered chest CT and full body scan
- Ordered palliative care consult
- *"This is why I am glad you are on our team."*

Case Example: Mary

Outcomes:

- Diagnosis of metastatic cancer

- In consultation with palliative care team, patient and her cousin/ HPOA made decision for comfort care only – "No…treatment"

- Patient's beliefs, values, and preferences were respected "Die…my…way."

- Needless pain/suffering avoided "No…surgery"

- Discharged to inpatient hospice for end of life care

- Shorter length of hospital stay

- Improved use of healthcare resources

- Effective communication within the multidisciplinary team and additional education with neurosurgery residents

Components of Outcome Oriented Chaplaincy
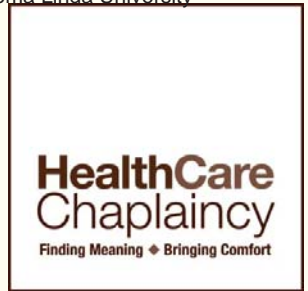
Spiritual Assessment

- ◆ Needs, hopes and resources
- ◆ Profile ("Snapshot")
- ◆ Identify desired contributing outcomes

Care planning

- ◆ Co-ownership
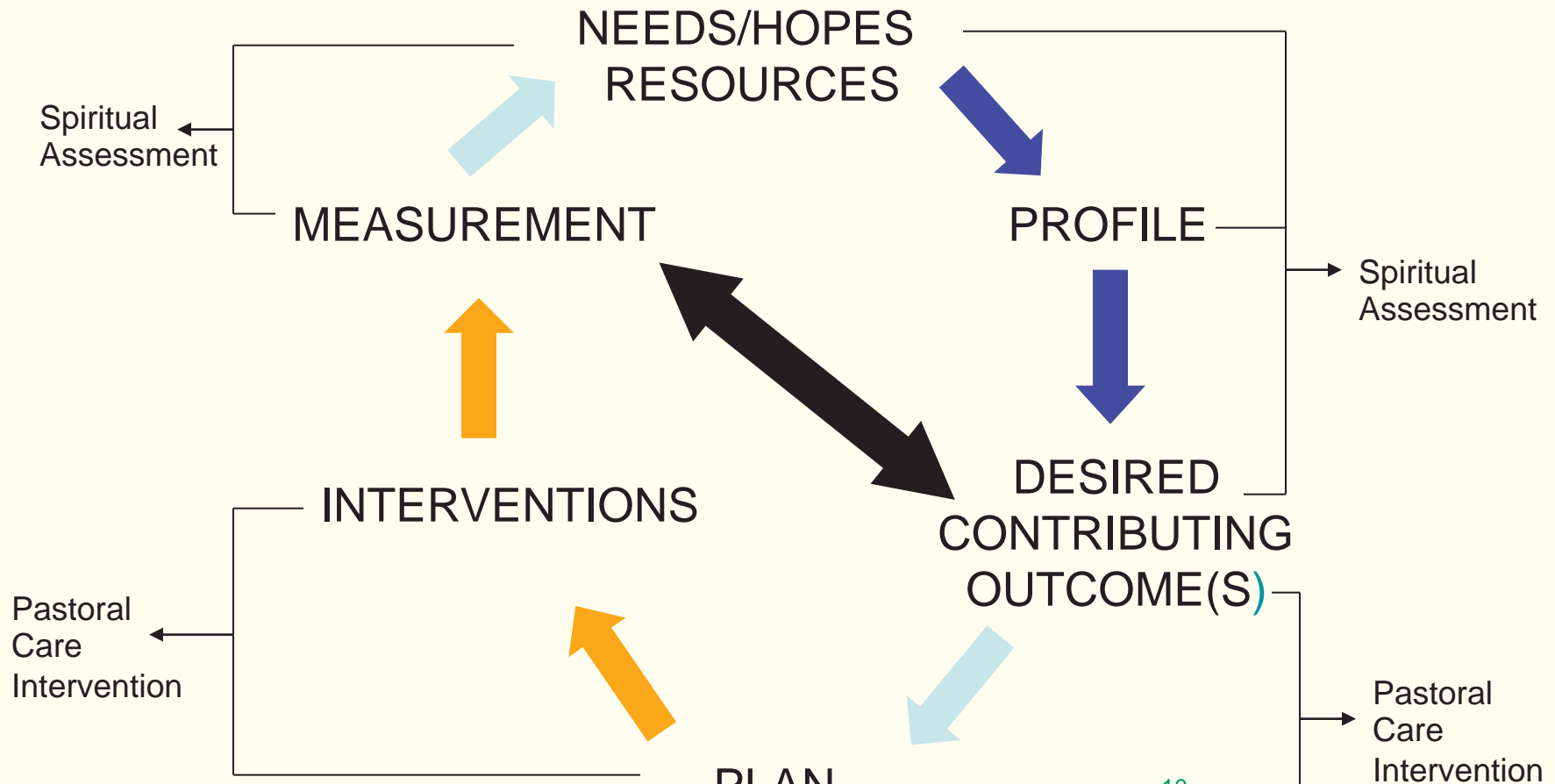- ◆ Integrated

Pastoral care interventions

Measurement

Re-assessment

Outcome Oriented Chaplaincy Lucas: Discipline for Pastoral Care Giving

HealthCare Chaplaincy
Finding Meaning ♦ Bringing Comfort

Spiritual Assessment

Process of discerning the spiritual and religious needs and resources of persons

Summarizes the religious and spiritual needs and resources in ways that are applicable to the persons' immediate situation and future coping

Requires understanding of the spiritual and religious dimensions

Requires training and competency

Normally done by a professional chaplain

Spiritual Assessment

"Demonstrate ability" in spiritual assessment means to:

- ◆ Have a professional model based on updated theory and accepted professional practice

- ◆ Be able to articulate it in professional language congruent with spiritual care.

- ◆ Be able to demonstrate how one uses the information in a variety of ways

APC Commission on Quality in Pastoral Services

You are doing Spiritual Assessments now if you have some idea:

Who and what is before you

- Needs, hopes, resources
- <u>Themes</u> running through his/her story
- Profile, or 'snapshot' of the person/family and their values/ beliefs

What to do next

How you will know when you are done for now

Spiritual Assessment: Driving Questions
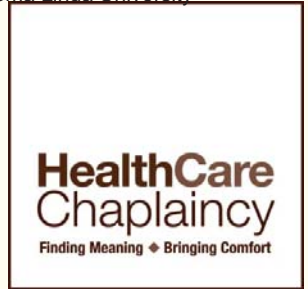
How do I know?

- ◆ Attacks assumptions
- ◆ Undercuts projective infilling

So what?

- ◆ Contexualizes
- ◆ Relevance checks

Identified Contributing Outcomes

Activity: Who I am and How I am *…* What I am doing/ saying

Intervention: Who/How I am and what I do/say in caring relationship … For the good of the person(s) in my care

Outcome: What flows from Who/How I am and what I do/ say … In terms of the other person's experience and being

You are identifying Desired Contributing Outcomes now if you:

Find yourself hoping your presence and care for Mr. Smith might…

Sometimes pray Mrs. Goldberg could…

Talk with a colleague about how you were so touched by Dr. Rana's story and just wish he could…

Identified Contributing Outcomes

In terms of the patient/family

Shared

Sensory based

Indicate movement or change

Able to be communicated

"So that…" - what will make a difference for the patient/family?

Identified Contributing Outcomes

Activity

Home Run

Desired Contributing Outcome

| Cubs | 5 |
| Mets | 4 **F** |

Plan

Clear

Communicable

Responsibilities distinguished

Mutual

Integrated

Interventions

Specific and concrete

Resources

Presence/Absence

Non-Defensive

Relational

Intentional

Faithful

Non-Judgmental

Measurement

Sensory based

Indicate movement or change

Able to be communicated

Referent for Measurement **MUST BE** the Desired Contributing Outcome(s) established earlier.

Measurement

- Makes use of religious and spiritual resources, faith practices, beliefs, and values by...

- An active partner in their healing process by...

- Identifies the significance of illness, recovery, life changes by...

- Identifies and connects with persons who are there for them by...

- Empowered to make decisions about their life direction by...

Department Before Outcome Oriented Chaplaincy

Staff Care

Patient/ Family Care

Worship & Ritual

Advance Directives

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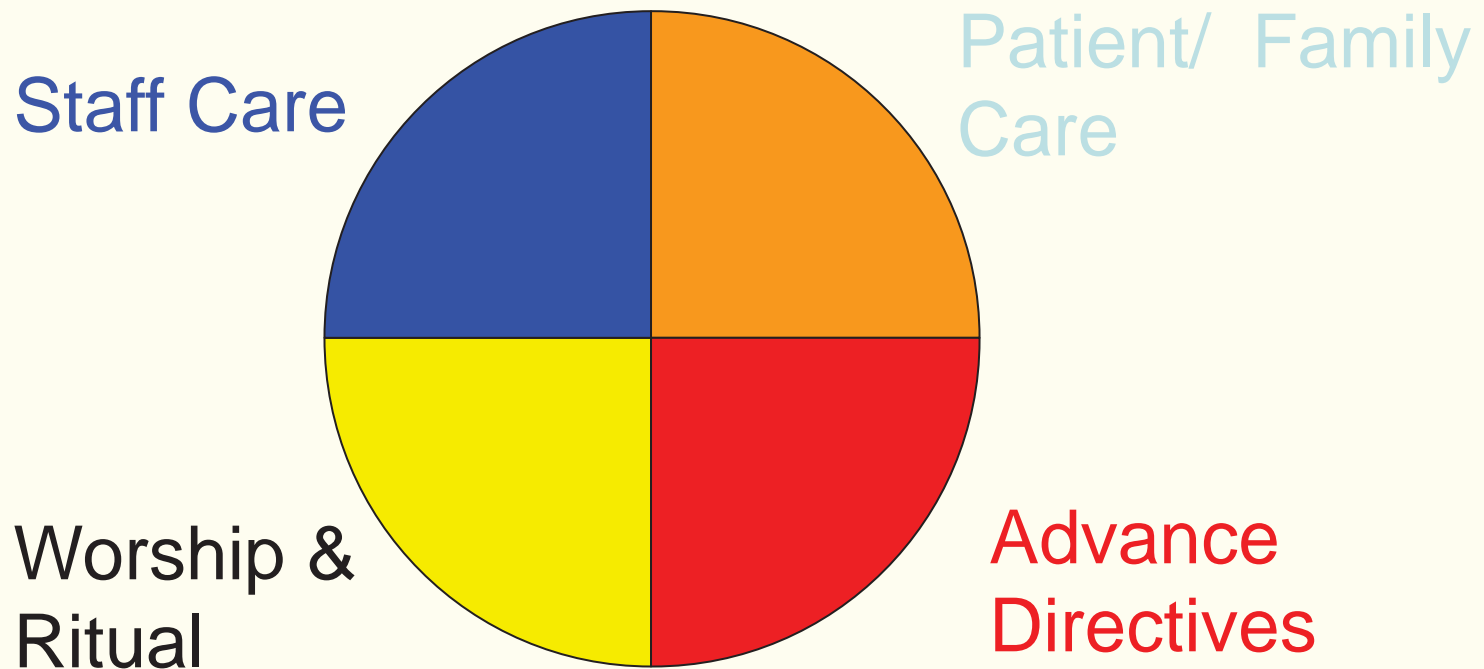
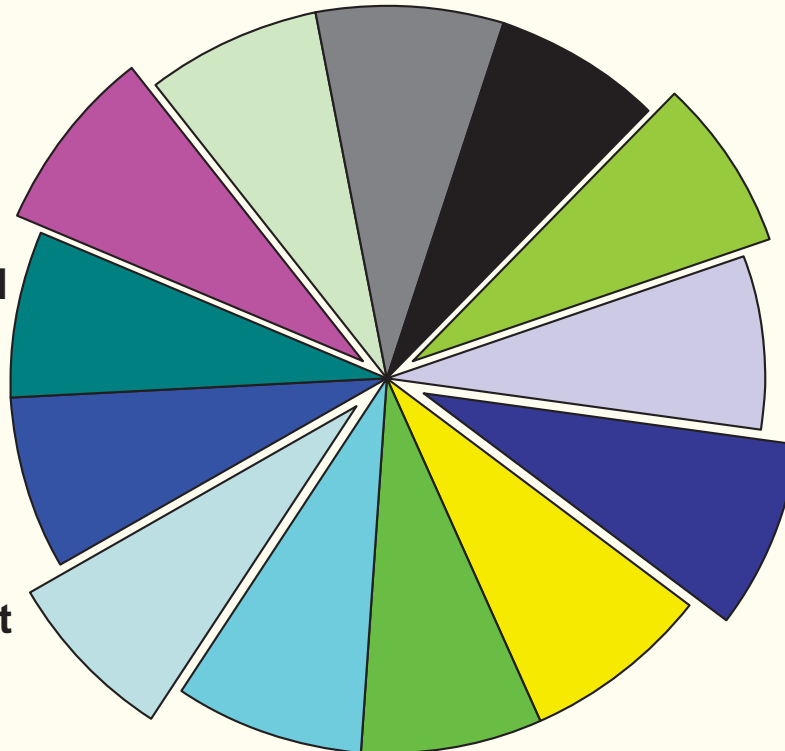# Department Since Outcome Oriented Chaplaincy

Staff & MD Care

Sacraments

Advance Care Planning

Ethics Consults

Medical staff, Clinical, and Medical Resident education

Medical & Clinical Rounds

Quality Improvement activities

Multidisciplinary Patient/ Family Care

Worship, ritual, meditation

Chaplain consult orders by MDs

Spiritual pathways incorporated into clinical pathways

Participation on projects at unit, service line, and administration level

Risk issues response

Clinical lines

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Referrals

Before Outcome Oriented Chaplaincy

- 70%+ Emergent/Urgent calls
- 30% -   Routine Activity
- Ask the patient if they want a chaplain

With Outcome Oriented Chaplaincy

- 70%+   By Protocol
- -30%   Emergent/Urgent Calls
- Chaplain is part of the team: trusted, recommended, and included

Case Example: Mary

Referral and Integration

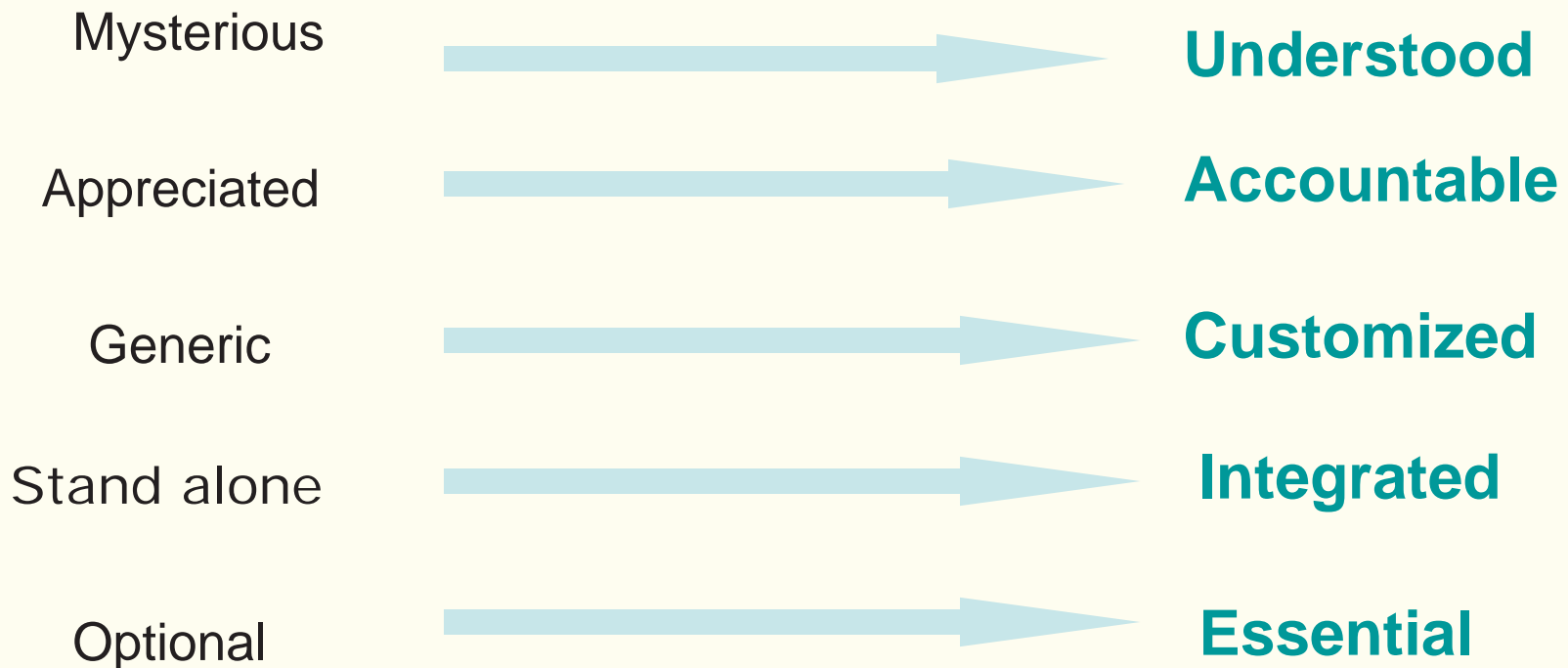Team communication

Patient outcomes

Chaplain documentation

> "We want your notes placed in physician progress notes because we want the residents to read them."
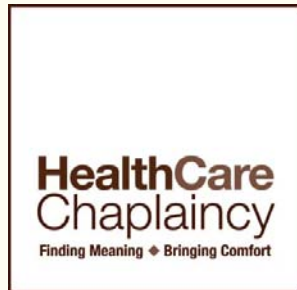
Outcome Oriented Chaplaincy

Connecting pastoral care with multidisciplinary team outcomes

Mysterious	→	**Understood**
Appreciated	→	**Accountable**
Generic	→	**Customized**
Stand alone	→	**Integrated**
Optional	→	**Essential**

Outcome Oriented Chaplaincy

Outcomes are desired differences

- The <u>desired difference</u> that chaplain contribution may help bring about

- The <u>accumulative</u> <u>benefit</u> from the attentiveness, collaboration, and cooperation of all

- An <u>observed and witnessed change</u> in ability to cope and adapt

- A <u>measurable "turn-around"</u> point (or points)

Outcome Oriented Chaplaincy

What outcomes are <u>not</u>

- ◆ Promises that we cannot keep
- ◆ Guarantees that we cannot fulfill
- ◆ Working solo, under the illusion that my actions caused something to happen--bad or good
- ◆ An attitude that I am in charge of someone else's spiritual destiny

Outcome Oriented Chaplaincy

Expect define contributions

- ◆ Noticed if it's not done
- ◆ Accountability

Role of the chaplain with the team

- ◆ Recognizing patterns in patients and unique spiritual dynamics
- ◆ Educating the team
- ◆ Integrated and accountable pastoral care
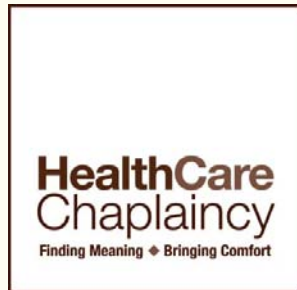- ◆ Increasing communication, both verbally and with documentation

Outcome Oriented Chaplaincy

Transitional questions

- What direction should I be heading?
- How am I going to get there?
- Am I expected to rethink how I normally do things?
- What else do I have to learn or consider in order to be an effective, outcome oriented chaplain?

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Outcome Oriented Chaplaincy

Transitional Answers: Rethinking

What will change:

- More focus
- More intentionality
- More clarity
- More constructive use of time

What won't change:

- Person-centered care
- Being a valuable resource
- Opportunity for growth and effectiveness

Case Study: Elizabeth

Referral from Nursery ICU RN: Mom whose baby daughter was admitted during the night is sitting by the baby's bedside crying.

Mom is 24 years old and married. 2nd pregnancy. She also has a 3 year old son.

Baby born at 28 weeks, currently on a ventilator.

Dad not currently present.

Elizabeth: Documenting Reason for Contact

Referral from NYICU RN to see mom Elizabeth of 28 wk pt named "Rebekah" currently intubated. Husband/FOB is David. 3 year old sibling. At time of contact, Mom was sitting alone by the bedside crying.

Elizabeth: Needs, Hopes, Resources

"I know I need to be strong, but I'm not sure I can stand to see her like this."   Need

"I want her to be okay, normal and healthy!"   Ultimate hope

"I want my older son, who is 3, to be able to see and hold this new sister and understand that she is sick."
Intermediate hope

"…my husband…my family…my faith…attend church occasionally; it's hard with a 3 year old…" Resources

Elizabeth: Profile

"Its so important we be a family through this."

"God can work miracles and heal her completely"

"I want my older son, who is 3, to be able to see and hold his new sister and understand that she is sick."

"Rebekah has already made such differences in us as a family— I want to help us all be able to see…"

"We have a good marriage, but my husband's job takes a lot of his time. He has to travel nearly every other week."

"I wish my mom could be here. All of my family lives in Ohio."

Family as an "ultimate value"

Elizabeth: Documenting Spiritual Assessment

Religious tradition is Presbyterian (USA) Christian. Mom describes God as source of strength, healing, and miracles. Stated hope for Rebekah is that she survive w/o significant challenges that will impair ability to live a whole and meaningful life. Greatest fear 'brain damage'. Wants to be able to parent child by holding and caring for her. Expresses sadness has not been able and for loss of normal pregnancy. States hope that husband and son will be able to see/be involved with baby so that they "can be a family". Feels isolated from her extended family in Ohio.

Elizabeth: Desired Contributing Outcomes (and Documentation)

Desired contributing outcomes of this contact with Mom are:

1. She will identify and utilize her religious and spiritual resources so that she will have lowered anxiety

2. She will be bond with baby through demonstrated verbalization and touch, including participation in care as appropriate.

Elizabeth: Plan (and documentation)

Plan for this contact was to assist mom in decreasing her anxiety, bonding with her baby, and connecting with her spiritual, personal, and NyICU resources.

Elizabeth: Interventions

Explored mom's feelings of loss.

Assisted mom in beginning to identify a future story of family to encourage her bonding with baby.

Explored mom's feelings of connectedness to family, friends, congregational faith community.

Activated mom's religious resources by notifying her church community at her request.

Assisted in connecting mom with NyICU resource persons.

Elizabeth: Documenting Interventions

Assisted mom in identifying losses experienced, including having a normal pregnancy/delivery and current inability to have baby home. Supported need and request for connectedness with faith community by contacting her pastor, Rev. Jones at First Presbyterian Church at (480) 555-5555. Introduced to the NyICU Developmental Specialist who engaged her in discussion of care mom can provide. Per request, prayer provided as she participated through touch and verbalization to pt.

Elizabeth: Measurements

Mom's statements:

- "I can't wait to touch/talk to/hold Rebekah" (using baby's name for first time in conversation)
- "I feel so much better after praying for my baby. I know that God is caring for her."
- "I want all the information I can get about the NyICU and preemies so I can learn what I need to know to help Rebekah."

Future Story Outcome: Begun and is in process. Re-evaluate at least every 72 hours or when significant changes occur in baby's clinical course

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Elizabeth: Documenting Measurements

Mom stated at end of contact: "I feel so much calmer." Voice had lowered, was able to move from chair to bedside. Demonstrated bonding by appropriate touch and soft voice. Used baby's name, changed diaper, assisted RN with positioning. Appeared able to interact appropriately with RN and Developmental Specialist by asking questions, stating fears/concerns for Rebekah, and participating in her care.

Elizabeth: Identifying Recommendations

Mom wants to:

- be present and supportive to her daughter
- include her husband and son in interactions with baby as they become a "new family"
- learn how to interact with premature baby
- hold on to her hope as expressed in her Christian faith
- renew her connectedness to a faith community

Elizabeth: Documenting Recommendations

Staff to note mom's desire to bond w/pt; encourage her to touch, talk to, and assist with care as appropriate. Significant support utilized is mom's Christian faith, particularly prayer. Appropriately encourage mom and facilitate visits from clergyperson. Significant to explain visitation and sibling policy for 3yo brother Max to see pt and to encourage dad's presence and inclusion according to his work schedule.

Chaplains can be the difference that make the difference

For the **recipient of the chaplain's care:**

- Whole person-centered, pastoral approach of NEEDS, HOPES and RESOURCES.
- Care for patient loved ones is also given.
- Strengthening the patient's community.
- Recognition that disease and/or loss is often unexpected, unwanted, or uninvited change.
- Team care recognizes that the patient or family's anxiety may be so intense that they are unable to hear what is being said to them.
- Plain speak in gaps of communication.
- Patient advocacy.
- Focus on spirituality.
- "I/we are not alone."

HealthCare
Chaplaincy
Finding Meaning ◆ Bringing Comfort

Chaplains can be the difference that make the difference

What outcome oriented chaplaincy provides for the **multidisciplinary team and organization**

- Patient satisfaction: Unit surveys indicate scores are as high or higher than other units despite fewer chaplain contacts
- Patient advocacy
- Impact on length of stay
- Improved communication
- Impact on risk issues: Fewer 'exceptional families' and quicker resolution
- Staff satisfaction and retention
- Education

Chaplains can be the difference that make the difference

HealthCare Chaplaincy
Finding Meaning ◆ Bringing Comfort

- What outcome oriented chaplaincy provides for the **chaplain**
  - Structuring what one does into a framework
  - Ability to articulate what one does
  - Improved ability to reflect on one's chaplaincy
  - Improved learning and collegiality
  - Improved communication with other members of the multidisciplinary team
  - Improved accountability
  - Further integration into the team(s)
  - Knowing what one contributes

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Training

Progression of Contacts

Patterns Emerge

Progression of Contact

Before

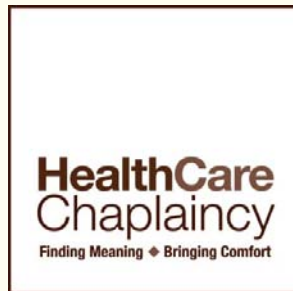- ◆ Gather Yourself
- ◆ Know What You Know

During

- ◆ Be There
- ◆ Notice the Difference(s) Your Care Is Making

After

- ◆ Reflect
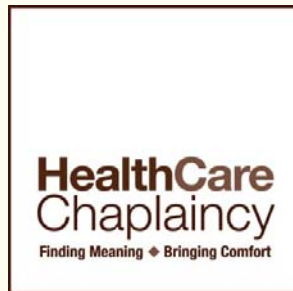- ◆ Own your Accountability

Progression of Contact - Before

Gather Yourself

- What is your mission in visitation?
- What is your purpose for this visit?
- Have you reflected on, integrated and let go of what ever you have been doing?
- Who are your allies?

Know what you know

- About yourself
- About the person in your care

Progression of Contact - Before
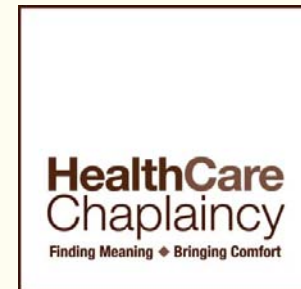
Know what you know about the other person

- ◆ What do you know or want to know
- ◆ About the person/family
- ◆ Systems, Spirituality
- ◆ About what is going on with him/her/them

What are you already assuming?

What do they know or believe they know about you?

- ◆ What pastoral relationship have you to build on?

Progression of Contact - During

Listen and Watch

- To Verbal <u>and</u> Non-verbal communication
- To what said <u>and</u> unsaid
- To individuals and the system
- For what you were not ready to see/hear

Follow Your Plan

- Touchstone in the onslaught of input
- Pay attention to your indicators

Notice what differences your care IS making

Progression of Contact - After

Reflect

Own your accountability – desired contributing outcomes

Integrate into your future ministry

- For this person or family
- For others

Progression of Contact - Charting

Reason

- What got you in the room?

Assessment

- Needs/Hopes/Resources
- Profile

Contributing Outcomes
This Visit

- Desired Contributing Outcomes
- Plan
- Evaluation

Plan if for Ongoing Care

- Desired Contributing Outcomes
- Plan

Recommendations

- For Interdisciplinary Team

Patterns Emerge

In terms of spiritual dimension dynamics more commonality was found among

people of different faiths facing the same health care challenge

than among

people of the same faith facing different health care challenges

Patterns Emerge

For example:

- Among lung transplant patients
  - Capacity to trust
- Among heart surgery patients
  - Ability to form positive vision of a new/changed future
- Among neuro-medicine patients
  - Ownership in care plan, care plan role

Patterns Emerge

In chaplains'"best practice"

↓

What is now Outcome Oriented Chaplaincy

Patterns Emerge

Reflect on why you do what are doing.

Think about what difference you made.

Pay attention to what your experiences with patients are telling you

Observe similarities and differences.

Use your experiences to identify patterns in order to build a theory.

Patterns Emerge

Confirm -Are your observations accurate?

Check them with team members.

Interweave your own experiences of patients with team contributions

Contribute to team communication and dialogue about patient care.

Collaborating With the Multidisciplinary Team

Understanding goals of care

Defining spiritual dimension

Clarifying what Chaplain focuses on

- Understanding how a particular person's spirituality functions
- Knowing how a particular person's spirituality informs and influences his/her current condition.
- Supporting a particular person's practice of his/her spirituality

Collaborating With the Multidisciplinary Team

Contributing outcomes as result of chaplain contributions

- Defines life goals, hopes, dreams
- Identifies the meaning and impact of life changes brought on by the progression of disease.
- Decides what is right for him/her in terms of treatment in light of beliefs/values

Collaborating With the Multidisciplinary Team

Chaplain accountability

- ◆ Charting
- ◆ Team meetings
- ◆ Rounds
- ◆ Consultations
- ◆ Patient/family conferences

Collaborating With the Multidisciplinary Team

Results

- Established protocols
  - Diagnostic
  - Psychosocial and spiritual triggers
- Know and understand spiritual care outcomes
- Expect Chaplain contribution
- Education by chaplain

Chaplaincy Staffing Design

Clinical

- By clinical service line and "patient experience"
- "A" Chaplain Initiative driven or "B" referral driven
- Variables -- Knowledge/skill, integration, continuity of care, consistency -- required to provide needed care
  - Professional board certified chaplains
  - ACPE Residents

Chaplaincy Staffing Design

HealthCare Chaplaincy
Finding Meaning ◆ Bringing Comfort

Religious

- ◆ As a resource for healing and well being
  - ◆ Vs. "substitute church" or "evangelism"
- ◆ Woven into overall spiritual care by clinically assigned chaplain
- ◆ Varies by patient population religious practice needs, especially <u>emergent</u> practice needs
  - ◆ Rabbi
  - ◆ Catholic Priest
  - ◆ Trained & Commissioned Lay Volunteers
  - ◆ Community Clergy available as needed

Spiritual Care: Whose Job Is It Anyway?

Rev. George Handzo, MDIV, MA, and Harold G. Koenig, MD

Abstract: The use of spirituality and religion in coping with illness is widespread among primary care patients. Although the overwhelming majority of healthcare providers agree that they should be aware of patients' spiritual beliefs, that these beliefs may influence their healing, and that patients benefit from spiritual care, there remains considerable debate about who should inquire about spiritual beliefs and deliver spiritual care. The authors, a physician and a chaplain, propose that, in general, the role of the physician is to assess spiritual needs as they relate to healthcare (ie, briefly screen) and then refer to a professional pastoral caregiver as indicated (ie, to address those needs). The chaplain is the spiritual care specialist on the healthcare team and has the training necessary to treat spiritual distress in all its forms. Seeing the physician as the generalist in spiritual care and the chaplain as the specialist is a helpful model.

Key Words: chaplain, religion, spiritual care, spirituality

In recent years, the role of spirituality and religion in the economy of health has been broadly acknowledged. Between 85% and 93% of physicians agree that they should be aware of or consider a patient's religious and spiritual beliefs[1,2]. Of all primary care specialties, family physicians are the most likely to be sensitive to these issues[1]. Even those who dispute the soundness of the scientific evidence linking religion and health agree that the sick and their loved ones can benefit from spiritual care. The Joint Commission on the Accreditation of Healthcare Organizations mandates that healthcare institutions ensure that patients' spiritual beliefs and practices are assessed and accommodated[3].

There is little disagreement any more in the healthcare community about whether spiritual care should be part of the treatment process. In many forums, the question has shifted to how spiritual care is to be provided and, more specifically, who should provide it. Spirituality might best be defined as ". . . the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community."[4]

This question of who should provide spiritual care can be contentious for several reasons. Every major profession involved in caring for the physically or mentally ill would claim at least part of this task. These would include medicine, nursing, social work, psychiatry, psychology, and pastoral care. We support the idea that spiritual care is everyone's job on at least two levels. As caregivers who have our own spiritual dimension, we should be relating to our patients and their loved ones on this level. In relating not just as a doctor or a social worker to a patient, but as a caring human being to another human being who needs help, we are giving spiritual care. We firmly believe, along with many others, that this care is a powerful contributor to healing.

Furthermore, every professional caregiver, while we each have a specialty on the healthcare team, needs to have an awareness of and a concern for the whole person—physical, emotional, and spiritual. If we do not have an awareness of the person in all of his or her dimensions, we cannot effectively attend to and put in appropriate context the dimension for which we have special responsibility. For example, the chaplain needs to be able to recognize and roughly evaluate suicidal ideation, both to be able to pass on this information to those on the team whose job it is to respond to it, and to be able to then properly interpret and treat the depth of the patient's spiritual distress. If the chaplain does not appreciate the medical facts of a dying patient's case, he or she will be unable to determine if the patient is being hopeless or realistic. The doctor or nurse needs to be able to recognize and

Key Points
- Spiritual/religious concerns should be attended to in every patient's treatment plan.
- The role of the physician in this process is to make sure that the patient's spirituality is assessed and that referrals are made to a professional chaplain as needed.
- The role of the chaplain, as the spiritual care specialist on the treatment team, is to assess the patient in depth and provide spiritual support and treatment as appropriate.

appreciate how a given patient's religious and cultural beliefs are going to color how that patient makes healthcare decisions, otherwise they will not be nearly as effective in coming to agreement with patients on what those decisions should be. A psychiatrist who does not understand how people use religion will be unable to evaluate the distinction between a vision and a hallucination.

While we agree that all primary healthcare professionals have an important role to play in spiritual care, we firmly believe that the specific roles of the various professionals are not the same, and are, in fact, definably distinct. While each profession has a role that could be discussed, for the purposes of this article we will restrict ourselves to two of them- physician and chaplain. We do this because they represent our individual professions so we know them the best. In addition, we believe they represent, in some ways, the two ends of the spectrum in terms of the involvement of any individual profession in spiritual and religious care.

In examining the relative roles of the physician and the chaplain in spiritual care giving, it may be most helpful to use the model of the general practitioner and the specialist. A major responsibility of the general practitioner is to perform a thorough assessment of all systems that could possibly have a bearing on the cause of the presenting symptoms.

While physical issues will always remain primary in these assessments, the ability of psychological, social and spiritual factors to produce or enhance physical symptoms has been increasingly acknowledged. Therefore, all systems should be assessed, including nonphysical systems. It is not uncommon for cancer survivors and cancer caregivers to present with symptoms of a specific cancer due solely to anxiety. Likewise, both somatic and psychological symptoms can be enhanced or mimicked by spiritual issues such as hopelessness or a lack of meaning in life. Like other areas of assessment, spiritual assessment does not need to establish a clear diagnosis. It only needs to establish the possibility of a problem or that enhanced support or rehabilitation might be helpful. After this assessment, the physician needs to decide what referrals are appropriate, whether a consultation with a specialist is required, and what he or she can treat without further assistance.

The treatment of spiritual issues and concerns fits into this model. We believe that spiritual assessment should be a part of a patient's overall assessment by their primary care physician, along with assessment of the physical and psychological domains. Essential to good medical care is knowing how a patient's religious beliefs help or hinder them in coping with illness, and how those beliefs influence their healthcare decisions. Although physicians can develop their own assess-

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ment, several models have been developed.[5] The assessment should be brief but cover the necessary areas relative to the intersection of the patient's beliefs and issues of health and illness, and how the patient wants those beliefs and practices incorporated into their healthcare.

The myth among many caregivers is that one has to be a theologian to do a spiritual assessment. This is the same as saying that one has to be a psychiatrist to do a mini-mental status examination. It is not the physician's job to discuss theology, only to ask a few pertinent questions that will indicate how the patient's spirituality and religious beliefs relate to their coping with illness and medical decisions. There is also increasing evidence that many patients want their physicians to ask about their spiritual life.[6] Similarly, it is not the chaplain's job to discuss or offer opinions on the patient's physical condition, even if the chaplain has some knowledge in this area. However, it is appropriate to understand a patient's physical illness and to assess some symptoms such as pain to bring issues to the physician's attention.

There has been much discussion of whether physicians should engage in religious behavior with patients or try to treat spiritual distress.[7,8] Certainly, there are situations where such activity is permissible, such as one in which the patient and doctor have a relationship, are of the same religious background, or the patient wishes to engage in a religious activity such as prayer with the physician and the physician is willing. There may also be cases where spiritual issues arise, must be dealt with immediately, and there is no chaplain present (outpatient medical office), or the patient refuses to see a chaplain. In those instances, the physician has no other choice but to address the issue the best he or she can and then recommend that the patient seek more expert spiritual direction. Another option in some cases is for the physician to consult with a pastoral care professional before an intervention is provided. Especially in the outpatient or office setting, this consultation may be with a certified pastoral counselor in the community rather than an institutionally based chaplain.

However, in most other cases, the patient with religious and spiritual needs should be referred to a professional pastoral caregiver for intervention. Doctors should no more treat spiritual distress or address spiritual issues than they should treat any physical problem outside their expertise. The basic task of the physician in spiritual care is to assess and then refer if necessary. It is the chaplain's job to do a more thorough spiritual assessment and then to address spiritual and religious issues as required.

Part of the reason the relationship between the physician and the chaplain is not well understood is that the role of the

modern professional chaplain is not appreciated. However, comprehensive descriptions of this role have emerged recently.[9] Board certified pastoral caregivers are required to have graduate level theological education and significant supervised clinical training called "Clinical Pastoral Education." While each chaplain or pastoral counselor belongs to a particular faith tradition, they explicitly do not impose that tradition on patients. They are trained to assess each patient's faith system and religious practice and help that patient use that faith and practice to maximize their coping with illness. While congregational clergy are generally trained to minister only to members of their own faith group, professional chaplains and pastoral counselors have the ability to assist a patient of any faith—or no faith. The chaplain, then, should be seen as the spiritual and religious specialist on the treatment team, in the same way as the physician is viewed as the medical specialist. Each has specific training and expertise that the other members of the healthcare team do not have.

Like the physician, the chaplain has an assessment and treatment function. Like the physician, the chaplain's assessment function should at least touch on the physical and emotional as well as the spiritual. To treat spiritual issues, the chaplain needs to be able to put them in the context of the patient's physical and emotional issues. Fitchett[10] has a spiritual assessment tool that makes this point clear. The chaplain's spiritual assessment will be more in depth than the physician's. One way to understand the distinction is to characterize what the physician does as "spiritual screening" and what the chaplain does as a complete spiritual assessment.[11]

> The basic task of the physician in spiritual care is to assess and then refer if necessary. It is the chaplain's job to do a more thorough spiritual assessment and then to address spiritual and religious issues as required.

In terms of treatment, the chaplain's process is much like the physician's. The assessment should yield one or more diagnoses for which a treatment plan is developed. The professional chaplain is able to bring to bear a wide range of treatment options and decide which ones are most appropriate to the particular situation. These modalities center on relationship building and reflective listening, as well as on theological counseling and judicious use of prayer and ritual. The professional chaplain, like the physician, engages the patient in the treatment process. The chaplain helps the patient find his or her own way to spiritual healing rather than imposing a solution. This emphasis requires building a trusting relationship with the patient so that the patient feels understood and safe. Interventions like prayer and ritual are always used in response to a perceived patient need rather than as part of a set formula for a visit.

In summary, the way in which the physician and professional chaplain carry out their jobs is much the same. They both engage in a thorough assessment with more in-depth focus on their particular area of concern. They both possess special knowledge and skills to treat a distinct part of the patient's disease. They both defer to one another in treating areas that each is trained to address. Finally, both need to appreciate that the care the patient receives will be maximized when each professional is allowed to bring their particular expertise to bear in a fully coordinated plan as recently described in other areas of patient care.[12]

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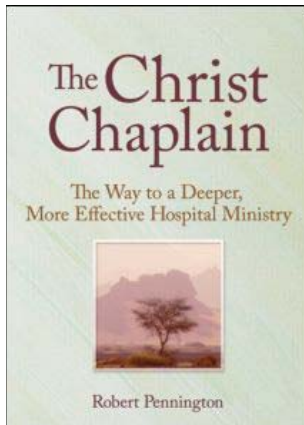
The Christ Chaplain: The Way to a Deeper, More Effective Hospital Ministry By **Andrew J Weaver**

Price: $50.50 **Binding/Format:** Paperback **ISBN:** 978-0-7890-0901-2 **Publish Date:** April 2nd 2007 **Imprint:** Routledge **Pages:** 86 pages

Contents: Foreword (Clarence Liu); Introduction (Andrew J. Weaver); Chapter 1. Welcome; Chapter 2. To Know Him: Acquiring the Mind of Christ; Chapter 3. And His Heart; Chapter 4. The Ministry of Presence; Chapter 5. The Power of Sacrament; Chapter 6. Sharing the Word; Chapter 7. Resting in the Presence; Chapter 8. A Final Word; Appendix. Selected Readings; Suggested Further Readings

Description: Use centering prayer to deal with the demands of hospital ministry. The Christ Chaplain: The Way to a Deeper, More Effective Hospital Ministry is an instructive guidebook for health care chaplains who struggle with the high levels of stress that have become commonplace in modern medicine as they work longer hours for lower wages yet get to spend less time with patients. The final book from Father M. Basil (Robert) Pennington, who passed away in 2005, cuts to the real heart of the matter—job burnout—by emphasizing not what a chaplain does, but what a chaplain is. This unique book teaches chaplains how to achieve better spiritual health by practicing spiritual self-care through centering prayer. The Christ Chaplain was written for hospital chaplains who find themselves at the limits of what they can do and what they can endure in living out their calling. Father Pennington ministers to the ministers, helping them to deepen their spiritual lives so they can better provide comfort to the sick and the dying. The book guides hospital chaplains through the Christian mystical tradition via lectio and centering prayer, a method of contemplative prayer rooted in silence that encourages a person to pay attention to God dwelling in the center of his or her being. The Christ Chaplain also includes appendixes that offer sacred reading, a prayer for the hospital, and suggested readings. This powerful book is an invaluable, how-to guide to better spiritual health for hospital chaplains and other religious personnel, including those working in pastoral care departments of seminaries.

Topics discussed in The Christ Chaplain include:
- the sacred text
- lectio divina
- the third step
- life as a school of love
- the ministry of presence
- the power of sacrament
- sharing the word
- resting in the presence