

LIBERTY UNIVERSITY SCHOOL OF DIVINITY

Fostering Hope: The Christian Healthcare Chaplain in a Caring Relationship

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The views expressed in this thesis do not necessarily represent the views of the institution and/or of the thesis readers.

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ABSTRACT

FOSTERING HOPE: THE CHRISTIAN HEALTHCARE CHAPLAIN IN A CARING RELATIONSHIP PROVIDES SPIRITUAL CARE INTERVENTION TO A PERSON WITH SUICIDAL THOUGHTS TO PROMOTE RECOVERY, REPAIR AND RESTORATION

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In 2017, the data from suicide prevention resource center (National Survey on Drug Use and Health) showed an increasing rate of 10.6 million persons between the ages 18-65 that have had suicidal thoughts, a precipitating factor from hopelessness that triggers the goal of killing themselves. Given this challenge, the study seeks to understand how the Christian healthcare chaplain in a caring relationship, fosters biblical hope as spiritual care intervention to persons with suicidal thoughts to promote recovery, repair and restoration. The research was designed to use purposeful sampling to collect responses by anonymous online survey from 35 Christian healthcare chaplains (CHC) from a pluralistic chaplain ministry working in a hospital setting. The result from the survey reveals the importance of fostering hope as God's spiritual care of healing the person with suicidal thoughts and promoting personal, family and community wellbeing. The result further reveals the necessity for specialized training in suicide prevention both at individual, seminary and hospital institutions.

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LIST OF ABBREVIATIONS

ASIST:	Applied Suicide Intervention Skill Training
ACE:	Ask, Care, Escort
CSSRS:	Columbia Suicide Severity Rating Scale
CDC:	Center for Disease Control
CHC:	Christian Healthcare Chaplain
CPE:	Clinical Pastoral Education
DOD:	Department of Defense
JC:	Joint Commission
MHP:	Mental Health Professional
PDA	Post Deployment Adjustment
PTSD:	Post Traumatic Stress Disorder
SA:	Spiritual Assessment
SPRC:	Suicide Prevention Research Center
SPT:	Suicide Prevention Training
URL:	Uniform Resource Locator (Web Address)
VHA:	Veteran Health Administration

CHAPTER 1

INTRODUCTION

The Christian healthcare chaplain in a caring relationship fosters biblical hope as spiritual care intervention to a person having suicidal thoughts to promote recovery, repair and restoration. Likewise, the human necessity to believe in the virtue of hope that influences individuals to engage in hope-list of socioeconomic and spiritual activities is indispensable to life because “God is the source of hope” (Rom 15:13 NIV). Vincent Geoghegan recalls that in Greek mythology “the presence of hope trapped in the Pandora jar is believed to help humans survive adversity and possibly flourish.”¹ This belief aligns with the Apostle Paul’s teaching that “endurance produces character and character hope” (Rom 5:4).² In contrast, the presence of hopelessness in individuals is a precipitating cause for suicidal thoughts. Norman H. Wright counsel helpers (CHC) to “build strong components of hope in suicide prevention.”³ In social psychology, “hope has been identified to improve the quality of life and overall wellbeing.”⁴ Warren Kinghorn asserts, fostering “hope cannot be attained by human efforts alone; they can only be infused by God, in God’s grace.”⁵ Hope stimulates a positive expectation that stirs the

¹ Vincent Geoghegan, “Pandora’s Box: Reflections on a Myth,” *Critical Horizons* 9 iss.1, (May 2008), 28, accessed April 18, 2018, <https://digitalcommons.liberty.edu/cr/vol9/iss1/>.

² Unless otherwise noted, all biblical passages referenced are in the New International Version Bible (Grand Rapids, Michigan: Zondervan, 2014).

³ Norman H. Wright, *The Complete Guide to Crisis and Trauma Counseling: What to do and Say When It Matters Most* (Minneapolis, Minnesota: Bethany House, 2014), 312.

⁴ Paul Kwon et al., “The Role of Hope in Preventive Intervention,” *Social and Personality Psychology Compass* 9/11, (2015): 698, accessed April 18, 2018, <https://digitalcommons.liberty.edu/Spc/vol9/iss11/>.

⁵ Kinghorn Warren, “Hope that is seen is no hope at all: Theological constructions of hope in Psychotherapy,” *Bulletin of the Menninger Clinic* 77, iss. 4, (Dec 2013): 383, accessed April 18, 2018, <https://digitalcommons.liberty.edu/bumc/vol17/iss4/>.

individual to “[a] belief that the future can offer new life.”⁶ Therefore, the purpose of this study is to understand how the Christian Healthcare Chaplain (CHC) in a caring relationship fosters biblical hope in prevention of suicidal thoughts.

Statement of Problem

The Christian healthcare chaplain (CHC) integrates hope, one of the three cardinal biblical virtues: “Faith, Hope and Love” (I Corinthians 13:13), as spiritual care intervention to foster patients’ belief and expectation to overcome “spiritual despair.”⁷ In contrast, Kathleen Galek and other authors confirms that “clinicians do not see the link between physical symptoms and spiritual issues,”⁸ so chaplains have been exempted from the spiritual care of patients with suicidal thoughts. Second, the challenge of “trust and confidence between clinicians and chaplains.”⁹ Third, the “degree of collaboration and referral between clinicians and chaplains on spiritual care related to pain, depression, anxiety and anger is very low.”¹⁰ In 2017, “the data from suicide prevention research center (SPRC) in United States shows that 10.6 million adults (eighteen years and above) had serious thoughts of suicide.”¹¹

⁶ John C. Thomas and Lisa Sosin, *Therapeutic Expedition: Equipping the Christian Counselor for the Journey* (Nashville, Tennessee: B&H Publishing, 2011), 43.

⁷ Mary Elizabeth O’Brien, *Spirituality in Nursing: Standing on Holy Ground* (Burlington, Massachusetts: Jones and Bartett, 2014), 67.

⁸ Kathleen Galek et al., “Referrals to Chaplains: The Role of Religion and Spirituality in Healthcare Settings,” *Mental Health, Religion and Culture* 10, no. 4 (July 2007): 370, accessed September 20, 2018, [https://digitalcommons.liberty.edu/mental health religion & culture/vol10/iss4/](https://digitalcommons.liberty.edu/mental_health_religion_%26_culture/vol10/iss4/).

⁹ Ibid.

¹⁰ Ibid.

¹¹ Suicide Resource Prevention Center. National Survey on Drug Use and Health, 2017, accessed April 18, 2018. <https://www.sprc.org/scope/attempts>.

The essence of fostering hope in human beings is God's way of providing spiritual care intervention to recover individuals from despair; just like "he made garments of skin for Adam and Eve and clothed them" (Gen 3:21). Likewise, David in his lament cries out to God "Why are you in despair, O my soul? And why are you disturbed within me? Hope in God, for I shall again praise him" (Ps 43:5). Gerard Egan recalls that "hope as a religious concept is as old as man."¹² Jerome Groopman affirms, "To have hope is to acquire the belief that you have some control over your circumstances, that you are no longer entirely at the mercy of forces outside yourself."¹³ To this extent, hope in a person influences the desire to live and face the challenges of life.

Jurgen Moltmann says "in despair there is no power to renew life, but only in hope that is enduring and sure."¹⁴ The CHC believes in the divine power of God to restore hope in a patient. Apostle Paul says, "And hope does not put us to shame" (Rom 5:5). Moltmann admits further, "hope takes seriously the possibilities of change."¹⁵ Roger E. Olson mentions Moltmann's experience as a prisoner of war in Belgium and Scotland camps when faced with crisis of faith speaks of his transformation:

"I experienced both the collapse of those things that had been certainties for me and a new hope to live by, provided by the Christian faith. I probably owe to this hope, not only my mental and moral but physical survival as well, for it was what saved me from despairing and giving up. I came back as a Christian, with a new personal goal of studying theology, so that I might understand the power of hope to which I owed my life."¹⁶

¹² Gerard Egan, *The Skilled Helper: A Problem-Management and Opportunity-Development Approach to Helping* (Belmont, California: Brooks/Cole, 2014), 286.

¹³ Jerome Groopman, "The Anatomy of Hope," *The Permanente Journal* 8, no. 2 (Spring 2004):45, accessed April 20, 2018, <https://digitalcommons.liberty.edu/PermJ/vol8/iss2/>.

¹⁴ Richard Bauckham, *Jurgen Moltmann: Collected Readings*, ed. Margaret Kohl (Minneapolis, Minnesota: Fortress Press, 2014), 16.

¹⁵ Ibid.

¹⁶ Roger E. Olson, *The Journey of Modern Theology: From Reconstruction to Deconstruction* (Downers Grove, Illinois: InterVarsity Press, 2013), 453.

In like manner, the CHC fosters biblical hope as spiritual care preventive intervention to patients in despair. In recognition of chaplains theological and clinical training to provide spiritual care to patients, the Joint Commission (JC) established “spiritual care policy mandating all healthcare facilities to integrate spiritual care of patients to achieve holistic wellbeing.”¹⁷ In 2010, the Veteran Affairs Administration (VA) and Department of Defense (DOD) identified chaplains “important roles in caring for Veterans and Service members with mental health problems, including suicidality, PTSD), and PDA, as well as in addressing high priority issues such as homelessness, women’s health, and family caregiver needs.”¹⁸

Statement of Purpose

The purpose of this research is to understand how the CHC in a caring relationship fosters hope to patients with suicidal thoughts as spiritual care preventive intervention to promote, recovery, repair and restoration. First, the study seeks to understand how the CHC who is theologically competent, and clinically trained is invited as a first-line of contact to provide spiritual care to a person with suicidal thoughts. Second, the study seeks to understand how the CHC conducts spiritual assessment of a person with suicidal thoughts to determine appropriate spiritual care and foster hope as preventive spiritual intervention. Third, this study aims to understand how the CHC fosters biblical hope as spiritual care intervention to persons with suicidal thoughts to choose life. Fourth, the study seeks to understand how CHC demonstrate a caring relationship attitude to establish trust with a person having suicidal thoughts to create an atmosphere that promotes care.

¹⁷ Mary Elizabeth O’Brien, *Spirituality in Nursing: Standing on Holy Ground* (Burlington, Massachusetts: Jones and Bartlett, 2014), 55.

¹⁸ Jason A. Nieuwsma “The Intersection of Chaplaincy and Mental Health Care in VA & DoD: Expanded Report on Strategic Action #23,” *VA/DoD/IMHS SA #23*, (Fall 2010): 4, accessed April 20, 2018, <https://www.research.va.gov/>.

Furthermore, my exposure as a Christian chaplain intern in a hospital provided the opportunity to spiritually care for two patients with suicidal thoughts. This opportunity created the interest in the study of CHC fostering biblical hope as spiritual care intervention to prevent suicidal thoughts. In addition, the prevalence of high rate of suicide heightened the interest to research on how to prevent suicidal thoughts in a hospital setting. The CHC is theologically and clinically trained, competent, has the spiritual authority and ministry experience to foster biblical hope as spiritual care preventive intervention to a person with suicidal thoughts to promote recovery, repair and restoration. The CHC in attending and incarnational presence, communicates biblical hope to encourage a person having suicidal thoughts, a precipitating factor from hopelessness.

Likewise, the CHC has spiritual identity to foster biblical hope. This is the rationale for a purposeful sampling to survey the population target in a pluralistic hospital setting. The central phenomenon to the study is to collect data from CHCs who provide spiritual care to patients having suicidal thoughts in a hospital or military chaplains who have served in a healthcare setting. The commonality of CHC and military chaplain who have served in a hospital facility is Christ's incarnational presence and biblical conviction to foster hope in individuals in despair.

In support of the CHC's spiritual role, Groopman affirms that recent research finding reveals that "patients were given placebo and the believe and expectation caused them to get better; hope improved their condition."¹⁹ Apostle Paul encouraged the believers suffering persecution to have hope and expectation (Phi 1:20). O'Brien believes that human desire to

¹⁹ Jerome Groopman, "The Anatomy of Hope," *The Permanente Journal* 8, no. 2 (Spring 2004): 46, accessed April 20, 2018, https://digitalcommons.liberty.edu/Perm_J/vol8/iss2/.

achieve “spiritual well-being is expressed through the concept of hope.”²⁰ The CHC has the theological competence to foster hope in patients with suicidal thoughts to choose life. Likewise, Moltmann says that “hope as a biblical virtue has the components of belief and expectation”²¹ to influence positively a person to desire life’s opportunities. Yet, the CHC who is recognized as the spiritual expert to foster hope in patients with suicidal thoughts is occasionally contacted for patient’s spiritual assessment and intervention.

Further, JC for accreditation of healthcare organizations acknowledges the work of chaplains as spiritually and clinically trained to minister spiritual care to patients in an interdisciplinary healthcare institution.²² Also, JC “recognize patients right to spiritual care, provide for patient’s needs through pastoral care and diversity of services offered by certified and ordained ministers.”²³ Furthermore, in recognition of chaplains spiritual care role in mental health problems, such as suicidality, posttraumatic stress and post-deployment adjustment, chaplains have been included in DVA and DOD integrated mental health strategy.²⁴ Likewise, spiritual assessment of persons with suicidal thoughts is the core responsibility of the CHC and no other interdisciplinary hospital staff is competent to do it.

²⁰ Mary Elizabeth O'Brien, *Spirituality in Nursing: Standing on Holy Ground* (Burlington, Massachusetts: Jones and Bartlett, 2014), 60.

²¹ Richard Bauckham, *Jürgen Moltmann: Collected Readings*, ed. Margaret Kohl (Minneapolis, Minnesota: Fortress Press, 2014), 12.

²² Mary Elizabeth O'Brien, *Spirituality in Nursing: Standing on Holy Ground* (Burlington, Massachusetts: Jones and Bartlett, 2014), 55.

²³ Ibid.

²⁴ Jason A. Nieuwsma, “The Intersection of Chaplaincy and Mental Healthcare in VA and DoD: Expanded Report on Strategic Action #23,” *VA/DOD IMHS SA# 23*, (Fall 2010), 4, accessed April 20, 2018, <https://www.research.va.gov/>.

Statement of Importance of the Problem

In 2017, the data from suicide prevention research center (SPRC) in U.S. shows that 10.6 million adults (eighteen years and above) had serious thoughts of suicide.²⁵ Further, the breakdown in percentage of high school students reporting suicide behavior shows females (22.1%) and males (11.9 %) who considered suicide.²⁶ Likewise, in 2015, research published by the Department of Health and Human Services showed three precipitating factors that triggers suicidal thoughts: mental illness, stressful life and hopelessness.²⁷ In 2014, a research result from 374 veterans college students reported that 136 (36.4%) had history of suicidal thoughts, 57 (15.2%) reported making suicide plan, 52 (13.9%) reported non-suicidal self-injury, and 29 (7.8%) reported making suicide attempt.²⁸ The Scripture instructs “hope deferred makes the heart sick, but when the desire comes, it is a tree of life” (Prov 13:12 NKJV).

Furthermore, the philosophy of life is the desire for all human beings to achieve wellness from the inner resource of an individual (White conference on aging).²⁹ In the true meaning of the philosophy of life, Apostle Paul says to the Athenians ‘For in Him we live and move and

²⁵ Suicide Resource Prevention Center. Suicide Thoughts and Behavior in the Past Year Among Adults, United States,” *National Survey on Drug Use and Health*, (2017), accessed April 28, 2018, [https:// www.sprc.org/scope/attempts](https://www.sprc.org/scope/attempts).

²⁶ Suicide Resource Prevention Center. Percentage of High School Students Reporting Suicide Behavior, United States, *Youth Risk Behavior Surveillance System*, (2017), accessed April 28, 2018, [https:// www.sprc.org/scope/attempts](https://www.sprc.org/scope/attempts).

²⁷ Jennifer L. Villatte et al., “Suicide Characteristic Among Veterans and Active Duty Service Members Receiving Health Services: Polled Data Analysis,” *Mil Behav Health*,3 no.4 (Sept 2015): 2, accessed April 24, 2018, <https://www.ncbi.nlm.nih.gov/pmc/article>.

²⁸ Craig J. Bryan et al., “Suicide Attempts Before Joining the Military Increase Risk for Suicide Attempts and Severity of Suicidal Ideation Among Military Personnel and Veterans,” *Comprehensive Psychiatry* 55, iss.3 (April 2014): 536, accessed April 18, 2018, <https://digitalcommons.liberty.edu/comppsycho.vol55/iss3/>.

²⁹ Frank Church of Idaho, Chairman 1971 White Conference on Aging 92d Congress 1st Session, Senate Doc No 92-53. (November 28-December 2): 24, accessed January 1, 2019, <https://www.aging.senate.gov/imo/media/doc/reports/>.

have our being, as some of our own poets have said, we are his offering” (Acts 17:28). Further, the study on “religious norms regulates a person’s maladaptive behavior and serves to protect the person, where social norms fail sufficiently to regulate the individual behavior.”³⁰ The CHC in a “talk therapy counsels”³¹ a person having suicidal thoughts to instill biblical hope to mitigate against killing oneself.

David Brown suggests that, individuals having “a strong sense of spirituality are able to maintain a strong sense of self confidence to address negative life issues.”³² It includes persons with suicidal thoughts whose inner coping strength may be influenced by hopeful thinking to choose life. Likewise, the person with suicidal thoughts is caught between the choice to live and the choice to die. Hence, “motivational interview”³³ helps to change the thought of killing oneself to the thoughts of living. Likewise, Johnson and Johnson posit that the patients “motivation for change is the most important”³⁴ factor to promote the desire to live. The CHC has the spiritual authority to verbalize biblical hope to motivate the person with suicidal thoughts to change their thoughts from killing themselves by applying the hope-list of life positive outcomes.

³⁰ Marek S. Kopacz et al., “Religious Well-Being and Suicide Ideation in Veterans: An Exploratory Study,” *Pastoral Psychol* 65, iss.4 (August 2016): 482, accessed April 18, 2018, <https://www.digitalcommons.liberty.edu/pastoralpsychol/vol65/iss4/>.

³¹ Brad W. Johnson and William M. Johnson, *The Ministers Guide to Psychological Disorders and Treatment*, 2nd ed. (New York, New York: Routledge, 2014), 7.

³² David R. Brown et al., “Assessing Spirituality: The Relationship Between Spirituality and Mental Health,” *Journal of Spirituality in Mental Health* 15, (2013): 117, accessed April 24, 2018, <https://digitalcommons.liberty.edu/wspi20/vol15/>.

³³ Peter C. Britton, Craig J. Bryan and Marcia Valenstein, “Motivational Interviewing for Means of Restriction Counseling with Patients at Risk for Suicide,” *Cognitive and Behavioral Practice* 23 iss.1 (Feb 2016): 54, accessed May 7, 2018, <https://www.digitalcommons.liberty.edu/cbpra/vol23/iss1/>.

³⁴ Brad W. Johnson and William M. Johnson, *The Ministers Guide to Psychological Disorders and Treatment*, 2nd ed. (New York, New York: Routledge, 2014), 9.

Hope is an essential virtue for survival (Job 13:15). The CHC has incarnational presence of hope in Christ (Col 1:27; 1 Tim 1:1). Hope is the anchor to the souls (Heb 6:19). Hope is the virtue that fosters belief in God for help and happiness (Ps 146:5). Likewise, the scripture says, “But the eyes of the Lord are on those who fear him, on those whose hope is in his unfailing love, to deliver them from death and keep them alive in famine.” (Ps 33: 18). God is the source of hope and restorer of hope (Rom 15:13). In a notable manner, Groopman reveals that “patients whose hope was largely based on faith in God experienced rapid and permanent recovery.”³⁵

Statement of Position of the Problem

The CHC has a level of theological and clinical training and is adequately equipped to foster biblical hope to patients with suicidal thoughts to promote recovery, repair and restoration. Robert L. Carrigan submits that “biblical hope appears over 125 times, a remedy for despair, estrangement, hatred and loneliness.”³⁶ King David in his lament of despair cried for help from God (Ps 43:5). Hope in God creates opportunity for a person’s wellbeing and future possibilities. Moore Bennet Zoe argues in favor of biblical study and cites Lesley Orr Macdonald’s view that “the value of our theology should demonstrate Christ-centered convictions that cares for other people.”³⁷ The good Samaritan reflects the CHC’s caring attitude to foster hope (Luke 10:34). The virtue of biblical hope encourages individuals with positive expectations for survival.

³⁵ Jerome Groopman, “The Anatomy of Hope” *The Permanente Journal* 8, no. 2 (Spring 2004): 47, accessed April 20, 2018, <https://digitalcommons.liberty.edu/PermJ/vol8/iss2/>.

³⁶ Robert L. Carrigan, “Where has hope gone? Toward an Understanding of Hope in Pastoral Care,” *Pastoral Psychology* 25 no.1, (Fall 1976): 40, accessed April 24, 2018, <https://www.digitalcommons.liberty.edu/pastoral/vol25/iss1/>.

³⁷ Bennett Zoe Moore, “The Place of Research in Theological Education,” *British Journal of Theological Education* 13, nos.1 (2002): 7, accessed April 15, 2018, <https://www.digitalcommons.liberty.edu/BJTE/vol13/iss1/>.

Further, in times of “layoffs, economic recession, bankruptcy, the CHC is often the minister of hope.”³⁸

Likewise, William R. Myers points out that research by the Christian “shows clarity and voice through ones (biblical/theological) lenses.”³⁹ The CHC is the voice of hope for patients in despair. Rowatt Wade argues for a study that “sets in order careful judgment of biblical/theology to the reality of specific human suffering (suicidal thoughts).”⁴⁰ The CHC’s caring relationship to foster hope in patients having suicidal thoughts is consistent with the theology of compassion for human suffering. Meanwhile, Norman Geisler cautions that one should “reject any methodology inconsistent with biblical truth and good reason.”⁴¹ In this manner, the research focuses on fostering hope as the biblical truth to spiritual care preventive intervention, integrating the knowledge of social sciences to promote individual wellbeing within Judeo-Christian faith practices.

Limitations

First, the study limits the participant of this study to a CHC who is currently working in a hospital setting or a Christian military chaplain who has served in a health care setting and is between 18-65 years of age. The Bible is the main primary source that speaks of the chaplain’s incarnational presence inferred in Christ’s commendation, “I was sick, and you visited Me”

³⁸ Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, Pennsylvania: Judson Press, 2006), 57.

³⁹ William R. Myers, “Keeping the Faith While Doing Research in Ministry,” *The Journal of Pastoral Care* 50, no. 2 (1996): 506, accessed February 26, 2018, <https://www.digitalcommons.liberty.edu/pastoral-care/vol50/iss2/>.

⁴⁰ Rowatt Wade Jr, “What Is Pastoral Research?” *Review and Expositor* 79, no.3 (Summer 1982): 505, accessed April 1, 2018, <https://www.digitalcommons.liberty.edu/pastoral/vol79/iss3/>.

⁴¹ Norman L. Geisler, “Beware of Philosophy: A Warning to Biblical Scholars,” *Journal of the Evangelical Theological Society* 42 (March 1999): 16, accessed February 26, 2018, <https://www.digitalcommons.liberty.edu/JETS/vol42/iss1/>.

(Matt 25:36). Although, the study mainly focused on the Judeo-Christian perspective, it “integrates biblical/theological knowledge with empirical human sciences for the practice of ministry.”⁴²

Second, chaplaincy has been pluralized to include non-Judeo religious and humanist secular groups, yet, the CHC’s spiritual identity in Christ and theological convictions would remain true to the individual faith but works with all persons of different beliefs or no belief. The CHC has integrated responsibility to provide spiritual care to multicultural patients in hospital facilities

Third, hope is a biblical virtue that is as old as man, and traceable to the Judeo-Christian God, the creator of man (Gen 1:26).

Fourth, the recruitment of participants to this study is by email through an anonymous online survey. The restriction of participants (CHC) within certain geographical zones listed was difficult to maintain. The locations are Roanoke and Lynchburg, in Virginia, Durham in North Carolina, and the Veterans’ Affairs and Liberty Baptist Fellowship data bases.

Fifth, the primary survey instrument was developed by the researcher using electronic web-based Survey Monkey tools where participants received the URL link for easy access to complete the survey.

Sixth, the challenge of reducing subjectivity of participants responses and incomplete responses to the survey was a limitation.

⁴² Rowatt G. Wade Jr., “What Is Pastoral Research?” *Review and Expositor* 79, no.3 (Summer 1982): 506, accessed April 1, 2018, <https://www.digitalcommons.liberty.edu/pastoral/vol79/iss3/>.

Conclusion

The purpose of this study is to understand how CHC in a caring relationship fosters biblical hope to persons suffering from suicidal thoughts. The importance of this study is to support the Judeo-Christian theological convictions that the CHC has the spiritual authority to foster hope as spiritual care preventive intervention to persons in despair. The previous findings on persons with suicidal thoughts includes high school, college and adults both in the military and civilian population. The CHC's incarnational presence and spiritual authority makes him competent to foster biblical hope, which aligns with Christ's acknowledgment "I was sick, and you visited me" (Matt 25:36).

In recognition of the ministry of Christian chaplains, which date back to the 14th century in caring for patients and restoring hope; the JC and DOD acknowledged their responsibility: To provide spiritual care intervention to persons with health challenges to promote holistic patient's wellbeing. To utilize their ministerial calling and ordination to provide pastoral care to patients in need of spiritual care. Hope as a Judeo-Christian concept is traceable to the origin of man, who is created in the image of God. This biblical knowledge allows the Christian chaplain to foster biblical hope in a pluralistic setting.

CHAPTER 2

METHODOLOGY

Research Methodology

This research methodology is based on qualitative study, which provides for some characteristic on human behavior in the specific context of CHC fostering biblical hope in a caring relationship as spiritual care preventive intervention to mitigate against suicidal thoughts. The study used purposeful sampling, with focus on CHCs in a pluralistic population of chaplains' ministry in a hospital setting. The characteristics of the sampling population is gender inclusive of male or female CHCs, who are 18-65 years of age and serving in a hospital, or military personnel who have served in a hospital facility.

An online survey was generated with adequate information and RIB approval (Appendix A and B) to allow participant's consent to complete the survey. In addition, participants views were analyzed and categorized into themes to aid the understanding of how the CHC fosters biblical hope in a caring relationship. The data from the study on biblical hope as spiritual care intervention is not quantifiable and the caring relationship process are not generalizable.⁴³

Survey Questions

The survey questions (Appendix C) to the study was created using online survey tools to generate a five-point Likert scale, multiple choice questions and a section to capture participants personal views to the study. The study used an anonymous online survey data collection tool that provides a uniform resource locator (URL) link for participants to complete the survey. The advantages of anonymous online survey are the low cost, easy distribution, easy data collection

⁴³ John W. Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. (Thousand Oaks: Sage Publications, 2014), 256.

through email, easy analysis and minimal risk. The safety of the stored data is encrypted as a security measure. The screening survey procedures requires participants to determine appropriately their faith/belief in Christ, the Bible as Holy Spirit inspired; seminary training and their ministry experience. This supports the purposeful sampling of CHCs as the population of the study.

The survey did not ask participants to provide personal, identifiable information to maintain anonymity of an online survey. The principal investigator does not know who said what, or who provided which response to protect the privacy of the participants. The online survey link, <https://www.surveymonkey.com/r/X8NRQJT> allows participants to click appropriate answer to verify their identity as a CHC. The survey was created to understand how a sampling population, the CHC fosters biblical hope in a caring relationship with a person having suicidal thoughts as spiritual care intervention to promote recovery, repair and restoration.

Data Collection

The data collection method used an anonymous online survey tool and a link to collect data from CHCs who have completed the survey question. The link allows only the researcher to have restricted and easy access to the data through the online survey using a private computer and a secured password. The data collection from participants locations are from hospital in Bedford, Lynchburg and Roanoke; Durham, Veteran affairs; and Liberty Baptist Fellowship data base.

The participants were contacted and recruited through their emails and the researcher obtained their permission to participate in an anonymous online survey. Further, accessibility to the participants was made possible through one's interpersonal relationship with CHC chaplains.

Eighty recruitment letters were sent through emails to participants. The survey link had easy access since participants do not need a password and user name to complete the anonymous online survey. The online survey tool monitors participants response to allow the researcher to keep track of the responses to achieve the maximum required for this research. Thirty-five responses were received and analyzed using Survey Monkey tools to generate result of the findings presented in chapter four.

Data Analysis

This section focused on the responses received from the participants and analyzed using the online survey tools. The data analysis shows the participants responses using simple percentage analysis and data display (tables and bar charts) to understand how the CHC fosters biblical hope to prevent suicidal thoughts. In addition, participants views were obtained, analyzed and categorized into themes to understand the purpose of the study. The result from the data analysis provide the knowledge and understanding of how the CHC in a caring relationship fosters biblical hope in prevention of suicidal thoughts. The data and the resulting analysis are securely stored and encrypted in a password-locked private computer.

The data analysis first presents the understanding of how CHC foster biblical hope. Second, finding to the study reveals the understanding of how the CHC is invited as first line of connection with persons suffering from suicidal thoughts. Third, the finding to the study shows how CHC conduct SA of persons with suicidal thoughts. Fourth, result of the study ascertained the CHC caring relationship with persons suffering from suicidal thoughts. Fifth, the participants personal views to the study was obtained, analyzed and categorized into themes to support the understanding of the study.

Conclusion

The research methodology of this study utilizes qualitative methods which allows the researcher to understand how CHC's fosters biblical hope in a caring relationship to persons with suicidal thoughts. The study used purposive sampling, that focused on CHC working in a pluralistic hospital setting. The characteristics of participants to this study are gender inclusive of male or female CHCs who are 18-65 years of age serving in a hospital, or military chaplains who have served in a hospital. The rationale for this study presents the CHC to foster biblical hope as spiritual care preventive intervention to a person with suicidal thoughts to promote recovery, repair and restoration.

The online survey was developed to generate a link for participants to complete a survey. The data collection and analysis utilized online survey tools to generate results in simple percentage and data display charts. The researcher analyzed participants views and categorized the words into themes to understand how the CHC fosters biblical hope through interrelated caring relationship dynamics.

CHAPTER 3

DEFINITION OF TERMS

The Christian Healthcare Chaplain (CHC)

The ministry of the Christian chaplain began in the “fourth century by Judeo Christian Bishop Martin who shared his cloak with a beggar out of compassion.”⁴⁴ The Christian chaplain by God’s calling, ministers “loving care to the disenfranchised of society;”⁴⁵ as the scripture proclaim (Matt 25:45). Steve Keith defines a Christian chaplain as “one who is called to, incarnationally minister in secular and sacred settings to glorify God by bearing Christ’s image and message to others, so that they can enjoy a holy and loving relationship with God and one another.”⁴⁶ The legal definition of a chaplains is to “provide for the free exercise of religion for everyone in the command, not just the people who were of the same faith tradition as a chaplain.”⁴⁷ The Christian chaplain has the calling to minister to multicultural persons without compromising their faith and theological convictions. In a notably manner, the term “patient” and “a person with suicidal thoughts” is used in this study interchangeably.

Caring Relationship

The caring relationship is the first interactive moment for the Christian chaplain to “demonstrate fit”⁴⁸ in a non-verbal connection that creates the opportunity to minister to the

⁴⁴ Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, Pennsylvania: Judson Press, 2006), 2.

⁴⁵ *Ibid.*, 5.

⁴⁶ Steven Keith, “Lecture on Biblical Foundation: Introduction to Chaplaincy,” CHPL 500, (Fall 2016), accessed August 30, 2018, https://digitalcommons.liberty.edu/lecture/CHPL_500/.

⁴⁷ Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, Pennsylvania: Judson Press, 2006), 4.

⁴⁸ Charles A. Kollar, *Solution Focused Pastoral Counseling: An Effective Short-Term Approach for Getting Back on Track* (Grand Rapids, Michigan: Zondervan, 2011), 95.

persons having suicidal thoughts. Collins believes that pastoral care relationship behaviors include: “personal warmth, attentive, acceptance, genuine interest, open, non-judgmental, friendly disposition and connecting smile.”⁴⁹ Insightfully, the Christian chaplain incarnational presence demonstrates the fruit of the Holy Spirit: love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, self-control (Gal 5:22).⁵⁰ Lawrence says, “the chaplain’s personal presence makes Christ redemptive love more real to the sufferer,”⁵¹ a person having suicidal thought. The CHC demonstrates Christ’s love to influence a caring behavior that values a patient as a person created in the image of God.

Recovery

The proposition of the term recovery means a crisis-situation for CHC to urgently provide spiritual care intervention to a person with suicidal thoughts.⁵² The CHC is the first line of contact with a person with suicidal thoughts who is in crisis. The spiritual care intervention of the CHC in a caring relationship, connects with the patient with suicidal thoughts to foster biblical hope and expectation to choose life. The CHC in a “talk therapy counsels”⁵³ to verbalizes God’s message of love, faith and hope (1 Cor 13:13) to encourage the person having suicidal thoughts to choose life. The knowledge gap between suicidal thoughts and life positive outcomes is the absence of hope. The person with suicidal thoughts is encouraged with the

⁴⁹ Gary R. Collins, *Christian Counseling: A Comprehensive Guide. 3rd ed.* (Nashville, Tennessee.: Thomas Nelson, 2007), 17.

⁵⁰ *Ibid.*, 67.

⁵¹ Lawrence E. Holst, *Hospital Ministry: The Role of the Chaplain Today* ed. (Eugene, Oregon: Wipf & Stock, 2006), 11.

⁵² Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, Pennsylvania: Judson Press, 2006), 81.

⁵³ Brad W. Johnson and William M. Johnson, *The Ministers Guide to Psychological Disorders and Treatment*, 2nd ed. (New York, New York: Routledge, 2014), 7.

essence of hope to access opportunities that life offers. The CHC is competent to counsel such a patient. Further, the Christian chaplain demonstrates incarnational presence and calling to foster hope (Matt 24:35). This is the critical stage of recovering the person from suicidal thoughts.

Repair

The proposition of the term repair means to establish rapport by the CHC in a caring relationship to provide spiritual care intervention through, active presence, warmth, empathy, friendly interaction, Christ redemptive love, active listening, prayer, and invitation to pray. At the repair phase the patient “receives encouragement through presence and prayer”⁵⁴ to choose life. In navigating through despair of life, the patient with suicidal thoughts must believe in “hope as an anchor to the souls (Heb 6:19), which keeps the person from drifting farther into despair. C.R. Snyder confirms that “repair of hope creates the opportunity to fill the void in a person’s life.”⁵⁵

The CHC repair of hope encourages the person with suicidal thoughts to believe in the God of hope, is motivated by hope survivors in the bible, prayer, and religious literature to promote hopeful thinking to live. Paul reveals how a person can have peace of mind through “prayer and praiseworthy thinking” (Phil 4:6-8). This will help the patient to explore opportunities that will change their thoughts from hopelessness to desire the hope-list of life positive outcomes. The center for disease control (CDC) finding on prayer for health reasons is mostly used by adults 18 years above for mind-body therapy including anxiety and depression⁵⁶.

⁵⁴ Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, Pennsylvania: Judson Press, 2006), 81.

⁵⁵ C. R. Snyder, “Hope Theory: Rainbows in the Mind,” *Psychological Inquiry* 13, no.4 (2002): 250, accessed April 14, 2018, <https://www.digitalcommons.liberty.edu/psychol/vol13/iss4/>.

⁵⁶ Patricia M. Barnes, Eve Powel-Griner, Kim McFann and Richard L. Nahin, “National Institute of Complementary and Alternative Medicine Use among Adults: United States, 2002,” *CDC Advance Data Report* # 343, 2004): 1-3, accessed April 28, 2018, <https://www.cdc.gov/nchs/data/ad/ad343/>.

The CHC believes in the efficacy of prayer and collaborates with the patient to offer prayer as well as spiritual counsel to influence positive change in behavior. So that, God's unlimited power can intervene in the precipitating problem that is responsible for the hopelessness.

Restoration

The proposition of the term restoration is the final stage of CHC's spiritual care intervention where the person with suicidal thought has been influenced positively to anticipate or expect transformation through hope-list from life positive outcomes. God deployed his divine agent, an angel to provide life resources of food, water and sleep to restore Elijah from the thoughts of death (1 Kings 19:6). The CHC encourages a person with suicidal thought to see the future with the mind of hope, trusting God and his resources such as "family relationship and the community of faith"⁵⁷ for their restoration. The family as a social support system is a relationship fulcrum, which provides an atmosphere of love and support to the person having suicidal thoughts to change. The family relationship support provides comfort and care to encourage the person to begin to experience care that will influence the change from hopelessness to desire hope-list of life positive outcomes. This stage is known as the restoration of the person whose thoughts is now positively influenced by hope-list of life resources. The patient's friends, religious support group also acts as restorative social system that promotes recovery. The absence of family support for the person suffering from suicidal thoughts creates a social imbalance that triggers hopelessness.

⁵⁷ William V. Arnold, *Introduction to Pastoral Care* (Philadelphia, Pennsylvania: Westminster Press, 1982), 63.

Hope-List of Resources

The propositions for hope-list of life positive outcomes are a list of resources that can influence a person to desire to live. It includes: reading the Bible, prayer, hope in the faithfulness of God, building family/friendship relationship, maintaining the desire to live and co-creating an achievable goal such as volunteering to help in a soup kitchen. Hope survivors like Jurgen Moltmann, Corrie Ten Boom and Emil L. Fackenheim cited in the literature were influenced by the hope-list of life positive outcomes to live.

Distinction of Suicides

First, “suicide ideation is an individual having serious thoughts about killing oneself. Second, suicide plan is the formulation of actual plot to kill oneself, and third, suicidal attempt is the performance of self-injurious behavior with some intent to die.”⁵⁸ The term suicidal thoughts in this study means a person who is planning to kill oneself. The person with suicidal thoughts who plans to kill oneself violates God’s principle of life “Thou shall not Kill” (Deut 5:17). Norman L. Geisler believes that suicide is a “form of homicide that comes under the prohibition of murder as the individual refuses to take responsibility for the life that God has entrusted to us”⁵⁹ Since it is generally agreed with the understanding that suicidal thoughts may lead to killing of oneself, Michael Banner says that suicide is “wrong because an individual life is not his own but belongs to God.”⁶⁰ In contrast, Louis P. Pojman argues that a person with suicidal

⁵⁸ Mathew K. Nock et al., “Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors,” *Psychiatry* 76, no. 2 (Summer 2013): 99, accessed April 6, 2018, <https://www.digitalcommons.liberty.edu/psych/vol76/iss2/>.

⁵⁹ Norman L. Geisler, *Christian Ethics: Contemporary Issues and Options*, 2nd ed. (Grand Rapids, Michigan: Baker Academic, 2010), 173.

⁶⁰ Michael Banner, *Christian Ethics and Contemporary Moral Problems* (Cambridge, United Kingdom: Cambridge University Press, 1999), 117.

thought who “plans to terminate one’s life is wrong, but the execution of the plan may be excusable for mental defect.”⁶¹

In all cases of suicidal thoughts, the CHC undertakes spiritual assessment to determine the appropriate care, foster hope through prayer, scriptural promises of restoration, counseling and a possible referral to mental health professional (MHP) for a holistic care of the patient. Johnson and Jonson declare that “a well-timed referral to (MHP) may be one of the most significant Caregivers (CHC) service offered to a patient.”⁶² The level of collaboration of the CHC and the MHP will achieve greater level of success in the patient’s recovery because of the CHC spiritual care intervention. The man from Gadarenes was healed from demonic spirit, which deranged his mental health through Christ spiritual care intervention (Luke 8:38-39).

⁶¹ Louis P. Pojman, *Life and Death: A Reader in Moral Problems*, 2nd ed. (Belmont, California: Wadsworth Publishing, 2000), 153.

⁶² Brad W. Johnson and William M. Johnson, *The Ministers Guide to Psychological Disorders and Treatment*, 2nd ed. (New York, New York: Routledge, 2014), 176.

CHAPTER 4

HOPE AS A BIBLICAL VIRTUE

The biblical virtue of hope has its origin from the scriptures. In the epic narration of Satan's destruction of Job's physical and material well-being, Job's hope in God created the buffer for him to bounce back. The CHC fosters biblical virtue of hope and comfort to persons in crisis, trauma, and grief in times of economic crisis, natural disasters and wars.⁶³ Robert F. Dees mention Job's traumatic crisis and his hope in God.⁶⁴ Job says, "though he slays me, I will hope in Him" (Job 13:15). So, God blessed Job with hope-list of life positive outcomes: physical well-being, Children, and livestock (Job 42:12-13). Carrigan affirms that "hope signifies what God instills in Christians who faithfully trust and patiently anticipate new realities in the life possibilities."⁶⁵ In this manner, the CHC has the theological conviction to foster biblical hope in a person with suicidal thoughts to influence change in behavior to live.

The Source of Hope

In the Scriptures, Carrigan affirms that the "expression of hope appears 125 times and it is used in conjunction with faith."⁶⁶ This truth, further emphasizes God as the originator of hope, which is indispensable for human survival and socio-economic activities. Paul instructs Christians to abide in hope, love and faith (1 Cor 13:13). The writer of Hebrew says, "hope is the anchor to the soul" (Heb 6:19). Further, Carrigan says, hope is a "language of relationship

⁶³ Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, Pennsylvania: Judson Press, 2006), 81.

⁶⁴ Robert F. Dees, *Resilient Warriors* (San Diego, California: Creative Team Publishing, 2011), 41.

⁶⁵ Robert L. Carrigan., "Where has hope gone? Toward an Understanding of Hope in Pastoral Care." *Pastoral Psychology* 25 no.1, (Fall 1976): 42, accessed April 24, 2018, <https://www.digitalcommons.liberty.edu/pastoal/vol25/iss1/>.

⁶⁶ *Ibid.*, 40.

through which the Christian community nurtures expectation and prospects of life in Christ Jesus.”⁶⁷ Paul expresses his expectation; “But hope that is seen is no hope at all. Who hopes for what they already have? But if we hope for what we do not yet have, we wait for it patiently” (Rom 8:24-25).

In response to Paul’s expectation in Christ, Carrigan submits that “to hope is to find basis for expectation, the possibilities of things not yet seen”⁶⁸ Moreover, to harness the virtue of hope, Apostle Paul declares to the Jews and Gentile Christians in Rome; “May the God of hope fill you with all joy and peace as you trust in him, so that you may overflow with hope by the power of the Holy Spirit (Rom 15:13). The CHC incarnational presence bearing the glory of Christ (Col 1:27), communicates hope to the person with suicidal thoughts to promote trust in God and influence the person to choose life and not death.

What is Hope

Moltmann says that hope as theological virtue in Judeo Christian relationship in Christ is both an “expectation for a promise and anticipation to be transformed.”⁶⁹ Although, the social sciences have contributed to the knowledge on hope, this study seeks to focus on Judeo-Christian biblical virtues of hope, how hope influences the CHC spiritual care role and the knowledge gained from Jewish peoples experience of hope to which Christ emanated and referenced (Luke 22:44). Kinghorn argues that the “rich virtues of hope must be harnessed not through modern

⁶⁷ Ibid., 41.

⁶⁸ Ibid, 44.

⁶⁹ Richard Bauckham, *Jurgen Moltmann: Collected Readings*, ed. Margaret Kohl (Minneapolis, Minnesota: Fortress Press, 2014), 12.

psychology but by the rich cultural and religious tradition that has been shaping the context of hope for thousands of years.”⁷⁰

Further, Kinghorn cites Thomas Aquinas’ view that theological hope, “applies to those who long for God and for God’s goodness and God’s life, but who have not yet attained God.”⁷¹ It is in the faithfulness of God and Christ’s incarnate life, that the CHC foster hope to the person with suicidal thoughts to embrace God’s life and his help. In a notable manner, hope in Jewish culture means trust in the faithfulness of God in this life as his covenant children. Kinghorn cites Fackenheim Emil’s affirmative statement about Jewish survival. “For over a thousand years, Jews have survived, mostly in exile. How? The answer is hope.”⁷²

What is Hopelessness

Johnson and Johnson declares that “hopelessness is one of the strongest predictors of suicide and the person appear to have lost all hope for change”⁷³ Collins reveals the behavior from hopelessness includes: “helplessness, guilt, extreme social withdrawal of self, antisocial behavior, excessive drinking, sadness and self-destructive threats.”⁷⁴ Likewise, the Scripture reveals David’s lament “Why, my soul, are you downcast? Why so disturbed within me? These questions mirror an expression of hopelessness (Ps 43:5). Solomon complains “Hope deferred makes the heart sick, but a longing fulfilled is a tree of life (Prov 13:5). Further, Paul in the

⁷⁰ Kinghorn Warren, “Hope that is seen is no hope at all: Theological Constructions of Hope in Psychotherapy,” *Bulletin of the Menninger Clinic* 77, iss. 4, (Dec 2013): 377, accessed April 18, 2018, <http://digitalcommons.liberty.edu/bumc/vol77/iss4/>.

⁷¹ *Ibid.*, 384.

⁷² *Ibid.*, 388.

⁷³ Brad W. Johnson and William M. Johnson, *The Ministers Guide to Psychological Disorders and Treatment*, 2nd ed. (New York, New York: Routledge, 2014), 18.

⁷⁴ Gary R. Collins, *Christian Counseling: A Comprehensive Guide. 3rd ed.* (Nashville, Tennessee: Thomas Nelson, 2007), 469.

center of a great storm and shipwreck, lost all hope for survival (Acts 27:20). However, God sent his angel to comfort Paul, and through Christ incarnational presence Paul could minister hope to those in the ship and they all survived.

In addition, other precipitating negative incidences that triggers suicidal thoughts are: “failing a test in school, not sleeping well, arguing with a loved one, experiencing mood swings of anger and sadness.”⁷⁵ Pojman, suggests other “highly emotional problems that may trigger suicidal thoughts includes fear, distraught, disappointment and fatigue.”⁷⁶ Likewise, the CHC demonstrates Christ’s love, incarnational presence, and clinical skills to foster hope in a person having suicidal thoughts to influence positive change. The CHC encourages the person with suicidal thoughts to explore new opportunities to life.

Suicide in the Bible

The Bible exposes suicide in the context of war, severe injury and hopelessness. Saul the first king of Israel was wounded in battle against the Philistines and fell on his sword and died (1 Sam 31:4). Second, Ahithophel, David’s counselor who deserted him for Absalom hanged himself and died (2 Sam 17 23). Third, Zimri who revolted against Asa, the King of Judah set fire on the king’s house and died in it (1 Kings 15:26). Fourth, King Saul’s amour bearer killed himself when he saw that Saul was dead (1 Chron 10:5). Fifth, Judas hanged himself because of guilt, betrayal and hopelessness (Matt 27:5). Accordingly, the biblical record of suicide was written to teach human beings about the choice to life and hope for God’s grace and healing (1

⁷⁵ “A Journey Toward Health and Hope” Published by US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) HHS Publication N0.SMA-154419, (2015), 12.

⁷⁶ Louis P. Pojman, *Life and Death: A Reader in Moral Problems*, 2nd ed. (Belmont, California: Wadsworth Publishing, 2000), 153.

Tim 3:16). Jesus emphasized the respect for human life that bears the image and likeness of God (Matt 5:21).

Fostering Hope

The CHC anchors his hope in Christ's goodness and faithfulness and demonstrates Christ's incarnational love to foster hope to persons in despair. Thomas and Sosin suggests that the counselee (person suffering from suicidal thoughts) is encouraged to believe future opportunities that will influence positive change.⁷⁷ The CHC fosters the belief in the possibility of change by renewal of the mind (Rom 12:2). Charles Kollar says, "God is always at work in the counselee's (patient's) heart, mind and spirit,"⁷⁸ since the individual is "created in his image and likeness" (Gen 1:27). This biblical truth helps the CHC to trust God for the positive changes that will occur in the person's life. In Romans 4:18, Abraham in a hopeless situation, believed in hope, and God who is "faithful to keep his covenant to a thousand generation" (Deut 7:9). Therefore, God's promise and capabilities promotes belief in the CHC and the person suffering from suicidal thought to anticipate future positive change.

Hope Survivors in the Scriptures

The Bible clearly describes some men and women who were in hopeless situation, but through God's grace, mercy and providence, they were restored to physical, emotional, spiritual and relational well-being. Joseph with the mind of hope in God's faithfulness would testify of his preservation and posterity (Gen: 45:7). Abraham's hope in God's promises provided the motivation for the positive change that occurred (Rom 4:18). Likewise, Naomi and Ruth

⁷⁷ John, Thomas C and Lisa Sosin, *Therapeutic Expedition: Equipping the Christian Counselor for the Journey* (Nashville, Tennessee: B&H Publishing 2011), 43.

⁷⁸ Charles, Kollar A, *Solution Focused Pastoral Counseling: An Effective Short-Term Approach for Getting Back on Track* (Grand Rapids, Michigan: Zondervan, 2011), 62.

experienced the death of their husbands, but through hope in God's faithfulness and his providence they were restored (Ruth 1:7). Job trusted God for his integrity and hope for transformation (Job 4:6). In Ziklag, David and his men were distressed but he encouraged himself in the Lord who granted him strength to recover all that was taken (2 Sam 30:7, 18). Paul had lost hope in a shipwreck, but God encouraged him with safety and life resources of food to eat (Acts 27:35). Frederick F. Bruce says, Paul "lived in hope that rest in the living Christ, dwelling within them as their personal hope of glory" (Col 1:27).⁷⁹

Hope as Sustaining Power-Holocaust Survivors

Corrie Ten Boom a holocaust survivor shares her testimony: "The silence of the night had fallen on seven hundred women, lying tightly packed, asleep in the barracks of a concentrated camp. Three days later my emaciated sister died, and ten days later just one week before all women of my age were killed, I was released from the concentrated camp."⁸⁰ Further, Ten Boom says, "Christ was all my sufficiency, I wrote home, the Lord is everything to me... with him there is certainty, with other things, only uncertainty and delayed hope, which hurts the heart."⁸¹

Furthermore, Kinghorn cites Emil L. Fackenheim a Jewish holocaust survivor, who affirms the indispensable virtue of hope: "I think merely to survive, to exist as a Jew after Auschwitz, is to be committed to hope: to hope because you are commanded to hope, because to despair would be a sin. It is to be commanded to hope that a second Auschwitz will not happen,

⁷⁹ Frederick F. Bruce, Paul, *Apostle of the Heart Set Free*. pbk. ed. (Carlisle Cumbria, United Kingdom: Paternoster Press, 2000), 210.

⁸⁰ Corrie Ten Boom, *A mazing Love* (Bungay Suffolk, Great Britain: Richard Clay and Company Limited, 1954), 8.

⁸¹ Corrie Ten Boom, *Don't Wrestle, Just Nestle, Her Jesus Is Victor* (Old Tappan, New Jersey: Revell, 1978), 37.

not for Jews, not for anyone”⁸² On February 8, 1939, Fackenheim was released from the concentration camp and returned to Halle, the city of his birth and former home. He writes “exile in not forever, and if a Jewish life, rich and far from joyless, exist in exile, it is, in the last analysis, in hope of redemption.”⁸³

Stories of Hope and Recovery (SPRC)

The stories from four suicide thought survivors viewed from suicide prevention lifeline reveals some caring relationship behavior: family love, care, joy, blessing, hope, trust, and listening as they verbalize their pain helped them to recover and desire life positive outcomes.⁸⁴ First, the survivor story of Mr. “A” who was 14 years old struggled with suicidal thoughts, but as he reflected on the love of his family, friends, and God’s beautiful creation, it helped him to change his mind towards hope to choose life.

Second, Mr. “B” who is a middle-aged health worker, suffered from suicidal thoughts and high emotional stress, which triggered the action of killing himself. The doctors (MHP), medications and his resolve to taking ownership to change helped him to believe and find hope for recovery. The caring attitude of the doctors and family members helped him to heal.

Third, Mr. “C” who is a 16-year-old undergraduate student was diagnosed with depression triggered by having a “C” grade in a subject, drunkenness, racial pressure as the only African American in a Caucasian school and lack of motivation to continue with his medication.

⁸² Kinghorn Warren, “Hope that is seen is no hope at all: Theological Constructions of Hope in Psychotherapy,” *Bulletin of the Menninger Clinic* 77, iss. 4, (Dec 2013): 388, accessed April 18, 2018, <http://digitalcommons.liberty.edu/bumc/vol77/iss4/>.

⁸³ Emil L. Fackenheim, *To Mend the World: Foundations of Post-Holocaust Jewish Thought* (Bloomington, Indiana: University Press, 1994), xli

⁸⁴ National Suicide Prevention Lifeline accessed April 2018 <https://suicidepreventionlifeline.org/stories/about/>

The hope survivor says that his recovery from suicide/coma came through by God's miraculous healing, the MHP talk therapy, medication and the love of his parents and his girlfriend fostered hope in him as well as help others because God has given him a second chance to live.

Fourth, Ms. "D" was ten years old when she attempted suicide, her second attempt was triggered by the loss of her husband, drinking, drug abuse, and feeling worthless. The caring relationship of the MHP and support helped her to develop inner coping skill, with hope to endure, hope to manage pain, and hope to live a pleasurable life.

Hope as Miraculous Belief for Healing

Lenworth M. Jacobs in a survey of 1006 (61.3%) respondents believed that divine intervention from God could save a person from life threatening injury and 57.4% believed in God's divine intervention to save a person.⁸⁵ In 2007, the Pew Forum on Religion and Public Life surveyed Americans from ages 18 and 29 on religious belief, 35,556 (79%) of the survey report agreed that miracles can still occur.⁸⁶ In 2002, a survey on religious faith in healing show that it is prevalent and strong in the southern United States and 80% of respondents believe that God acts through Doctors.⁸⁷ Further, Gallup Pools (1990) consistently reported that 95% of Americans believe in God , 42% attend church weekly, and some believe that faith impacts one's health and spirituality.⁸⁸ These reports show ministry opportunities for CHC bearing the

⁸⁵ Lenworth M. Jacobs et al., "Trauma Death: Views of the Public and Trauma Professional on Death and Dying from Injuries," *American Medical Association Arch Surgical* 143, no.8 (Aug 2008): 734, accessed March 26, 2018, <https://www.digitalcommons.liberty.edu/archsurg/vol143/iss8/>.

⁸⁶ Eric W. Widera et al., "Approaching Patients and Family Members Who Hope for a Miracle," *Journal of Pain and Symptom Management* 42, no. 1 (July 2011): 121, accessed April 13, 2018, <https://www.digitalcommons.liberty.edu/painsymp/vol42/iss1/>.

⁸⁷ Christopher J. Mansfield, Jim Mitchell, and Dana E. King, "The Doctor as God's Mechanic? Beliefs in the Southeastern United States," *Social Science and Medicine* 54, no.3 (2002): 399, accessed March 24, 2018, <https://www.digitalcommons.liberty.edu/socialscience/vol54/iss3/>.

⁸⁸ Ibid.

incarnational presence and clinical skills to foster biblical hope; the trust in God to help the person with suicidal thoughts to recover in a pluralistic hospital setting.

CHC Incarnational Presence and Spiritual Authority

The CHC incarnational presence is rooted in his calling to demonstrate the relational, loving, caring and holy nature of God (John 1:14). His spiritual care responsibility is to model Christ, in physical presence, ministry of the word and servant leadership caring attitude for the wounded (Matt 25:35-36). The CHC respects, honors human beings as God's creation, and is willing to offer spiritual care with "compassion and the disposition of love."⁸⁹ The CHC "claims his pastoral authority and identity"⁹⁰ from God to be his faithful minister; helping the needy in a caring relationship to promote holistic wellbeing.

The CHC is a credentialed religious leader and God's ambassador (2 Cor 5:20). He is trained in the seminary to acquire Master of Divinity and Clinical Pastoral Education to minister spiritual care to persons in despair. The CHC is affiliated to ecclesiastical faith organization that endorsed the Chaplain as an ambassador to work in hospital. As part of practical ministry training, the CHC acquires clinical pastoral education skills to collaborate with healthcare professional in wellness care of patients.

The CHC theological and pastoral care training allows for spiritual assessment (SA) of the patient to determine the emotional, relational, mental, spiritual and physical wellbeing.⁹¹ The

⁸⁹ Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, Pennsylvania: Judson Press, 2006), 6.

⁹⁰ William V. Arnold, *Introduction to Pastoral Care* (Philadelphia, Pennsylvania: Westminster Press, 1982), 79.

⁹¹ Mary Elizabeth O'Brien, *Spirituality in Nursing: Standing on Holy Ground*, 5th ed. (Burlington, Massachusetts: Jones & Bartlett, 2014), 62.

outcome of SA gives the CHC adequate information to offer spiritual care to mitigate a patient suffering from suicidal thoughts to improve quality of care. James W. Fowler postulates the understanding of individual “seven stages of faith and selfhood: infancy, preschool age, mid-childhood, adolescence, young adult, middle adult hood, middle adulthood and beyond enhances holistic assessment for better spiritual care intervention.”⁹² The faith and religious belief of the patient creates the opportunity for the CHC to foster hope.

CHC Fosters Hope as Spiritual Care Intervention

As a CHC, the incarnational presence and the message of hope is important to the caring relationship with the person suffering from suicidal thoughts. Wright suggests that our “words, tone of voice and propositions have a far greater impact than at other times in life.”⁹³ The CHC in a genuine heart of love and compassion is invited into the world of the person with suicidal thoughts. This is the connecting phase of getting the person to verbalize the crisis. The CHC understands the important relational phase of this connection as crisis moment that needs urgent spiritual care intervention to foster hope for recovery.

CHC Communication Skill

The CHC is invited or presents himself in a caring relationship with a person having suicidal thoughts to foster hope for recovery, repair and restoration. The CHC has opportunity to communicate non-verbal and verbal cues to the person suffering from suicidal thoughts. Egan mentions some non-verbal attitude of a helper (CHC): posture, eye contact, smiles, physical and

⁹² James W. Fowler, *Faith Development and Pastoral Care: Theology and Pastoral Care Series* (Philadelphia: Fortress Press, 1987), 96.

⁹³ Norman H. Wright, *The Complete Guide to Crisis and Trauma Counseling: What to do and Say When It Matters Most* (Minneapolis, Minnesota: Bethany House, 2014), 150.

emotional stability promotes relational connection with the person with suicidal thoughts.⁹⁴ The CHC has a pastoral care heart of compassion, affective smile, listening, expressing love to connect with the person, or lose him completely. The CHCs incarnational presence exudes peace and grace in the caring relationship.

In a seamless connection, the CHC communicates the message of hope compassionately to the person suffering from suicidal thoughts to influence change of behavior and choose life positive outcomes. James Peterson says “good-communication is like the oil that lubricates the engine of relationship.”⁹⁵ The CHC verbalizes empathy, compassion, listening with reflective attention, non-judgmental and friendly disposition to establish rapport with a person with suicidal thoughts for spiritual care intervention. Jesus in an act of compassion observed, listened to the man who was lame at the pool of Bethesda and healed him (John 5:5-8).

The CHC pastoral care relationship focus more on caring for the holistic well-being of the person with suicidal thoughts. Collins says that pastoral care helps patients to “experience healing, relational support, guidance, and reconciling people back to God.”⁹⁶ It is caring for the soul to help the person achieve holistic wellbeing. Puchalski and Ferrell mentions that, chaplains in a spiritual care relationship “promotes the dignity and value of every individual”⁹⁷ created in God’s image and likeness (Gen 1:26) to achieve emotional, physical and relational well-being.

⁹⁴ Gerard Egan, *The Skilled Helper: A Problem-Management and Opportunity-Development Approach to Helping*, 10th ed. (Belmont, California: Brooks/Cole, 2014), 75.

⁹⁵ James Petersen, *Why Don't We Listen Better? Communicating and Connecting in Relationships* (Tigard, Oregon: Petersen Publications, 2007), 4.

⁹⁶ Gary R. Collins, *Christian Counseling: A Comprehensive Guide. 3rd ed.* (Nashville, Tennessee: Thomas Nelson, 2007), 36.

⁹⁷ Christina M. Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Health Care* (West Conshohocken, Pennsylvania: Templeton Press, 2010), 37.

The CHC believes in the practice of prayer as spiritual care intervention, foster hope in the person with suicidal thoughts. Prayer to God fosters hope, influence the “the person to experience more purpose in life and general sense of well-being.”⁹⁸ A study by the National Institute for Complementary and Alternative Medicine showed that 75% adults 18 and above used specifically “prayer for health reasons for mind-body therapies including anxiety and depression.”⁹⁹ Further, Puchalski and Ferrell explains that “chaplains and clergy have been praying with patients for centuries”¹⁰⁰ as spiritual care intervention. Apostle Paul in his pastoral care instructs Christians to pray without ceasing (1 Thess 5:18).

The CHC theology, spiritual and pastoral identity is rooted in his ministerial callings and ministering spiritual care to patients. Douglas E. Lee mentions three non-negotiable religious practices that CHC upholds. First, “the Bible is Holy Spirit inspired, infallible and inerrant Word of God. Second, it is all about sin and forgiveness from Christ. Third, it is all about Christ who gives hope, love, mercy, forgiveness and grace.”¹⁰¹ The reading of Scripture promotes faith to trust God (Rom 10:17), and meditation promotes expectation towards good success for life positive outcomes (Jos 1:8).

The CHC’s spiritual care intervention provides counseling as a spiritual responsibility. After Jesus had healed the lame man at the pool of Bethesda, he counseled him to stop sinning or

⁹⁸ Mark R. McMinn, *Psychology, Theology, and Spirituality in Christian Counseling* (AACC Counseling Library. Wheaton, Illinois: Tyndale House, 1996), 80.

⁹⁹ Patricia M. Barnes, Eve Powel-Griner, Kim McFann and Richard L. Nahin, “National Institute of Complementary and Alternative Medicine Use among Adults: United States, 2002,” CDC Advance Data Report # 343, 2004): 1-3, accessed April 28, 2018, <https://www.cdc.gov/nchs/data/ad/ad343/>.

¹⁰⁰ Christina M. Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Health Care* (West Conshohocken, Pennsylvania: Templeton Press, 2010), 46.

¹⁰¹ Douglas E. Lee, “Don’t Ask; Don’t Tell: Repeal: What’s Next? (*Journal for Baptist Theology & Ministry* 9, no.1 (Spring 2012): 67, accessed February 8, 2018, <https://www.digitalcommons.liberty.edu/jbtm/vol9/iss1/>.

something worse may happen to him (John 5:14). Insightfully, the CHC using the information from SA can counsel the person suffering from suicidal thoughts towards holistic well-being. In the caring relationship interaction with the person with suicidal thoughts, some negative behavior (sin) may be noted that needs biblical counsel for Christ forgiveness. Collins, further, mentions that pastoral counsel aims to achieve “increasing awareness of God in the midst of life experience and surrendering to his will as well as develop deeper relationship with God.”¹⁰²

Hope theorist as Psychotherapeutics Intervention for Recovery

The paradigm to integrate the theory on hope from social psychologist with the biblical virtue of hope improves the quality of CHC’s spiritual care of fostering biblical hope in a holistic manner. What are the findings from social psychologist? Albert Bandura postulates that change in behavior of a person can positively or negatively influence outcome.¹⁰³ The precipitative factor of hopelessness triggers a patient to have suicidal thoughts. The CHCs role is to mitigate against such harmful thoughts.

First, Bandura declares that “efficacy of expectation is the conviction in a person, which can produce positive outcome, a behavior towards change.”¹⁰⁴ However, weak conviction affects a person’s behavior to accept change. The CHC has the theological conviction to verbalize the God of hope and his faithfulness to the person with hopelessness to instill conviction that will influence behavior to live. The CHC engages the spiritual influence of prayer to connect the

¹⁰² Gary R. Collins, *Christian Counseling: A Comprehensive Guide. 3rd ed.* (Nashville, Tennessee: Thomas Nelson, 2007), 37.

¹⁰³ Albert Bandura, “Self-efficacy: Toward a Unifying Theory of Behavioral Change,” *Psychological Review* 84, no.2 (1977): 193, accessed April 14, 2018, <https://www.digitalcommons.liberty.edu/psychol/vol84/iss2/>.

¹⁰⁴ *Ibid.*, 193.

patient to God who “gives inner coping strength” (Isa 40:29; Eph 3:16) to think and desire hope-list of life positive outcome.

Second, Bandura writes that an “outcome expectancy depends on a person’s positive behavior that can lead to certain outcome, but doubt affects the persons behavior.”¹⁰⁵ In contrast, a person’s having suicidal thoughts may be having doubtful thoughts which affects the behavior not to try the action that will lead to change. The CHC conducts SA to foster hope to desire hope-list of life resources to influence positive change from doubts and hopelessness. The CHC whose hope in Christ exudes his presence (Col 1:27) to speak relevant hope scriptures to promote believe, foster hope in the patients to encourage rightful thoughts to life (Ps 146:5). The CHC speaks Christ’s “peace” (Luke 1:79; John14:27) to encourages the person with suicidal thoughts to see hope-list of life opportunities to promote change in behavior.

Third, Bandura submits that the “measure of efficacy of expectation is dynamic and externally influenced by a mixture of hope, wishful thinking, belief in the potency of the procedure and faith in the therapy.”¹⁰⁶ The CHC believes in external divine influence of God, the Holy Spirit, family relationship and biblical counseling to foster hope in a person with suicidal thoughts to influence change. The CHC’s spiritual intervention from SA outcome integrates religious variables of hope in God, hope in life, hope in family/friends/faith groups and spiritual counsel to address the stressors to promote positive outcomes that lead to behavioral change in the person to embrace life.

¹⁰⁵ Ibid., 193.

¹⁰⁶ Ibid., 194.

Bandura further suggests that “efficacy of expectation thrives on social information which is verbal persuasion.”¹⁰⁷ To this end, the CHC in a caring relationship verbalizes non-judgmental attitude, reflective listening and tone of voice to foster hope in the person with suicidal thoughts to persuade positive change in behavior to live. The CHC’s tone of voice echoes pleasant words that are persuasive and health to the patient (Prov 16:21, 24).

On the theory of hope, C. R. Snyder defines “hope as the perceived capability to derive pathways to desired goals and motivate oneself via agency thinking to use those pathways.”¹⁰⁸ Snyder’s personal experience shares this view, “It appears that hopeful thought facilitates and motivates individuals to cope and heal better.”¹⁰⁹ The CHC instills hope in the patient to believe in God as the source of hope and encourages the person having suicidal thoughts to see hope-list of life opportunities to influence positive thoughts to living. Paul in his pastoral care to believers in Rome encouraged them to have hope in the glory of God (Rom 5:2).

First, Snyder postulates hope in the context of human interactions and thinks that “agency that is goal - directed energy sustains an individual to achieve positive goal outcome.”¹¹⁰ The CHC’s incarnational presence connects the patients with God’s love and peace. He offers prayer to engage the divine agency of God and the Holy Spirit to give “inner coping strength” (Isa 40:29; Eph 3:16), the energy required by the patient to desire sustainable positive goal. It is important to note that the CHC first line of contact with a person having suicidal thoughts is to immediately recover the patient from further harm and foster hope to motivate the person to live.

¹⁰⁷ Ibid., 195.

¹⁰⁸ C. R. Snyder, “Hope Theory: Rainbows in the Mind,” *Psychological Inquiry* 13, no.4 (2002): 249, accessed April 14, 2018, <https://www.digitalcommons.liberty.edu/psychol/vol13/iss4/>.

¹⁰⁹ Ibid., 260.

¹¹⁰ Ibid., 250.

Snyder calls this interaction “maintenance goals” to keep the person alive.¹¹¹ It involves the CHC informing the police, removal of self-inflicting weapons and keeping the person alive. Further, the CHC counsels the person having suicidal thoughts to desire hope-list of life opportunities: the joy of being God’s creation (Ps 139:13), God as the healer (Ps 147:3), as well as family support (Ps 68:6) to encourage change.

Second, Snyder suggests “pathways of thinking by the high hope person and low-hope person to find the means to accomplishing the positive goal.”¹¹² However, the person with suicidal thoughts is hopeless, and so the CHC foster biblical hope to encourage progressive pathways of thinking through the collaborative efforts of the family, friends and faith groups support to help accomplish the positive goal of living. Puchalski encourages SA to explore the patients “community in relation to family/friend and faith group support”¹¹³ to help a person with suicidal thoughts to accomplish the goal of living.

Third, Snyder postulates “agency thinking which allows the person to use their mental energy to motivate them to accomplish the goal.”¹¹⁴ Apostle Paul encourages “pure, excellent or praiseworthy thinking” (Phil 4:8). The CHC counsels the patient to have pleasant thoughts on hope-list of life resources freely available that can stimulate inner strength or energy to accomplish such goals. For example, developing family/social relationship.

¹¹¹ Ibid.

¹¹² Ibid., 251.

¹¹³ Christiana M. Puchalski, “The FICA Spiritual History Tool #274” *Journal of Palliative Medicine* 17, no. 1 (2014): 105-6, accessed December 18, 2018, <https://www.digitalcommons.liberty.edu/jpm/vol17/iss1/>.

¹¹⁴ C. R. Snyder, “Hope Theory: Rainbows in the Mind,” *Psychological Inquiry* 13, no. 4 (2002): 251, accessed April 14, 2018, <https://www.digitalcommons.liberty.edu/psychol.vol13/iss4/>.

However, Snyder warns that a person with suicidal thoughts may set a goal to killing oneself.”¹¹⁵ It is a paradox that the person with suicidal thoughts has the mental energy to set a goal to live or kill themselves. The CHC in a caring relationship counsels to motivate the person with suicidal thoughts to redirect the same mental energy to maintaining daily living and co-create positive goal that can sustain living. For example, the person with suicidal thoughts volunteers in a soup kitchen to support the poor and homeless through the faith community project.

Further, the theory on hope shows that “individuals learn hopeful thinking from other people (agency) from childhood to adults.”¹¹⁶ The CHC is theologically competent to foster hope, to influence hopeful thinking in a caring relationship with a person with suicidal thoughts to promote positive desire to live. However, Snyder says that “children who are raised in environment that lacks boundaries, consistency, and support are at risk for not learning hopeful thinking.”¹¹⁷ This finding may also affect youths and adults who have history of poor social support, and could this be the problem of suicidal thoughts? A future research that seeks to understand children with poor social boundaries and lack of parental support may help to increase the knowledge and understanding of children with poor social support. This will help to promote hopeful thinking and prevent suicidal thoughts. In like manner, the CHC in a caring relationship fosters hope in persons with suicidal thoughts to trust God to value living and access hope-list of life available resources.

¹¹⁵ Ibid., 251.

¹¹⁶ Ibid., 263.

¹¹⁷ Ibid.

Suicide Ideation Statistics Among Civilians

In 2017, the data collected on suicidal thoughts presents the following reports: (a) Individual record of suicidal thoughts (10.6 million eighteen years and above), (b) high school female students (22.1%), (c) high school male students (11.9%), and (d) undergraduates and graduates (7.7%), (e) not enrolled in college (9%) (SPRC).

Suicide Ideation Statistics (DoD)

In 2014, the data obtained from military personnel and veterans in colleges shows that; a (22%) experienced suicidal thoughts,¹¹⁸ (b) attempted suicide-service members and veterans (51 & 46%) respectively in a VHA,¹¹⁹ (c) male suicidal in 23 states increased by (60%) who did not use VHA.¹²⁰

Suicide Prevention Outcomes

Villatte, L. Jennifer indicates that in 23 states suicide decreased by 30 percent male veteran that utilized VHA services. Janet Kemp reports show decrease in suicide among VHA users over age 30 and decrease in the rate of suicide among VHA users with mental health in 2010.

Conclusion

The CHC has theological, clinical training and spiritual authority to foster hope as spiritual care intervention to a person having suicidal thoughts to promote recovery, repair and restoration. The CHC has a spiritual authority in a hospital, receives a referral to conduct SA and

¹¹⁸ Craig J. Bryan et al., "Suicide Attempts Before Joining the Military Increase Risk for Suicide Attempts and Severity of Suicidal Ideation Among Military Personnel and Veterans," (April 2014): 537.

¹¹⁹ Jennifer L. Villatte et al., "Suicide Characteristic Among Veterans and Active Duty Service Members Receiving Health Services: Polled Data Analysis," (Sept 2015): 6.

¹²⁰ Kemp, Janet. "Suicide rates in VHA Patients through 2011 with Comparisons with other Americans and other Veterans through 2010." Washington, DC: Veterans Health Administration, (2014): 6, accessed April 13, 2018, <http://www.mentalhealth.va.gov/docs/>.

foster biblical hope to a person having suicidal thoughts to influence change to living. The CHC integrates religious and psychological resources to provide appropriate spiritual care in a collaborative alliance with MHP. The data on fostering hope to persons with suicidal thoughts require a paradigm to engage the CHC to involve more in spiritual intervention. The person with suicidal thoughts is triggered by hopelessness. The CHC spiritual care intervention of fostering biblical hope encourages a patient with suicidal thoughts to trust God for hope-list of life available resources. Likewise, the CHC's integration of the theories of hope motivated from personal strength; the self-efficacy and the triad of human interactions (goal, pathways and agency) for hopeful thinking to achieve positive goals, contributes to the overall holistic care in suicide prevention. Although reduction in suicide was recorded, the collaborative intervention of the CHC and the MHP in suicide prevention as therapeutic alliance is a desirable plan to achieve greater degree in suicide prevention.

CHAPTER 5

RESULT OF THE RESEARCH

The finding of this study is to understand how the CHC foster biblical hope as spiritual care intervention in a caring relationship with persons having suicidal thoughts to promote recovery, repair and restoration. From the 80 anonymous surveys emailed to participants, I received 35 completed surveys, but three survey responses were incomplete and regarded as invalid. The remaining 32 survey responses were analyzed using online survey tool to generate results in simple percentage and display bar chart for easy interpretation. The participants' views were also obtained, analyzed and categorized into themes to understand how the CHC in a caring relationship fosters biblical hope as spiritual intervention to persons with suicidal thoughts to mitigate against killing themselves.

Question 1: Participants were asked to voluntarily participate to meet the IRB approval to complete anonymous online survey. The original proposal to recruit 30 participants was accomplished, as the survey responses to the questions shows 100% participation. In addition, five (16.66%) participants completed the survey which shows the importance of the study.

Question 2: Participants were asked if they believe in Christ, and the Bible as Holy Spirit inspired. The purpose is to confirm the characteristic of the sampling population of CHC belief, theological conviction in Christ, the Bible and the Holy Spirit to foster hope as a biblical virtue. The CHC derives his spiritual authority and hope in Christ (Col 1:27) to incarnationally care for patients with suicidal thoughts. The survey responses show that: 27 (84.38%) strongly agreed, three (9.38%) agreed and two (6.25%) remained neutral. In contrast three skipped answering this question. The result confirms the characteristic of the sampling population of CHCs in a pluralistic chaplaincy ministry in a healthcare setting.

Question 3. Participants were asked to indicate their working experience in healthcare settings. The purpose is to understand the CHC's working experience in providing spiritual care as a member of interdisciplinary team to promote holistic wellbeing of patients having suicidal thoughts. The participant responses show that: 13 (40.63%) have less than five years working experience, 11 (34.38%) have served in a hospital between 6-10 years, four (12.50%) have served between 11-15 years, one (3.13%) has worked for more than 16 years and three (9.38%) have worked for over 21 years. Three participants skipped this question. Nevertheless, The CHC work/ministry experience is important to the spiritual care of patients and the JC acknowledges their spiritual responsibility in holistic care of patients.

Question 4. Participants were asked whether theological training adequately prepared them for suicide prevention. The purpose is to understand the required level of training for CHC in fostering hope as a biblical virtue in suicide prevention. The CHC must have a Master of Divinity degree, a minimum of clinical pastoral education level 1 unit and ministry experience to work in a hospital. The participant responses show that: nine (28.13%) strongly agreed, five (15.63%) agreed, eight (25.0%) neutral, seven (21.88%) disagreed and three (9.38%) strongly disagreed. The result from participants suggest that theological training in relation to suicide prevention is not adequate for the skills necessary for suicide prevention.

In my seminary training, I received a Master of Arts in Pastoral Counseling, and a Master of Divinity in healthcare chaplaincy; soon to be completed. I received detailed biblical studies in Old Testament and New Testament, crisis counseling, and post-traumatic stress disorder (PTSD). I have also attended CPE level one training at Carilion Medical Center in Roanoke and applied suicide intervention skill training (ASIST) to develop my pastoral care skills to provide appropriate spiritually care and foster hope to patients with suicidal thoughts. The ASIST

training and other specialized suicide prevention training will improve the CHC pastoral care skills in suicide prevention.

Question 5. Participants were asked to indicate the levels of training in Clinical Pastoral Education CPE (levels 1-Board Certification). The purpose is to understand the competency level of CHC in integrating theological and clinical knowledge in helping patients with suicidal thoughts to embrace hope that influences a person to see life-positive outcomes and choose life. The participant responses reveal that: eight (25%) CPE level 1, 13 (40.63%) level II residency, one (3.13%) Supervisory, and 10 (31.25%) board certification. CPE training develops the CHC in pastoral care in interdisciplinary healthcare settings. The CHC integrates theological and clinical pastoral education training as competency skills to provide spiritual care intervention to persons with suicidal thoughts who may not have the same faith belief with the CHC in a multicultural hospital environment.

Question 6. Participants were asked if theological and CPE training adequately prepared them for suicide prevention. The purpose is to understand the level of competence of CHC in mitigating against suicidal thoughts. The participant responses show that: nine (28.13%) strongly agreed, 13 (40.63%) agreed that they had adequate training, whereas six (18.75%) maintained neutrality and four (12.50%) disagreed. The result suggests that some of CHCs have adequate theological /clinical training in suicide prevention, whereas, others are not adequately trained. In CHCs professional development, it will involve personal and institutional commitment to training. The CHCs professional development enhances pastoral care skills to carry out spiritual assessment to determine the patients “good mental health”¹²¹ (suicidal thoughts) to provide

¹²¹ Mary Elizabeth O'Brien, *Spirituality in Nursing: Standing on Holy Ground*, 5th ed. (Burlington, Massachusetts: Jones & Bartlett, 2014), 62.

appropriate care. The CHCs SA gives insight to the patient's "faith, importance to life, community/family/friend relationship and addresses stressors (FICA);"¹²² to foster hope and possible referral to the MHP through therapeutic alliance to provide holistic care.

Question 7. Participants were asked how often they attended suicide prevention training (SPT) and to specify the type of training. The purpose is to understand particularly suicide prevention skills acquired by CHCs through SPT. The participants responses show that: 14 (43.75%) occasionally attended SPT, seven (21.88%) frequently attended SPT, eight (25%) seldom attended and three (9.38%) never attended SPT. In addition, the participants mentioned the specific suicide prevention training they have attended to improve their competency to mitigate against suicidal thoughts. It includes: Applied Suicide Intervention Skill Training (ASIST), The Army Ask, Care and Escort (ACE) Suicide Prevention Intervention Training, Suicide Risk Assessment Training, Mental Health First Aid Training, Schwartz Rounds Care Givers Training and Workshops/Online training.

The participant responses suggest that CHC need to attend suicide prevention training (SPT) to improve competency in suicide prevention. Pajet, McCormack and O'Brien mention pastoral care skills, which are necessary in preventive intervention against mental health challenges such as suicidal thoughts. In addition, the course work in crisis counseling and PTSD towards the award of a Master of Divinity develops some level of CHC's skill in mitigating against suicidal thoughts. Nevertheless, the importance of professional development through specialized suicide prevention training to improve the competency and skill of CHC in suicidal thoughts prevention is necessary.

¹²² Christiana M. Puchalski, "The FICA Spiritual History Tool #274," *Journal of Palliative Medicine* 17, no. 1 (2014): 105-106, accessed December 18, 2018, <https://www.digitalcommons.liberty.edu/jpm/vol17/iss1/>.

Question 8. The CHC's were asked whether their incarnate presence is critical as first line of contact to provide spiritual care to persons with suicidal thoughts. The purpose is to understand how the CHC is invited as first line of contact to provide spiritual care preventive intervention to persons with suicidal thoughts. The participant responses show that: 11 (34.38%) strongly agreed, 14 (43.75) agreed and seven (21.88%) remained neutral. The responses suggest that the CHC should be invited to provide critical safety and spiritual care to persons with suicidal thoughts.

In addition, participants were asked to support their responses with personal reasons. The participants views were analyzed and categorized into three spiritual care intervention areas that represent CHC's critical role. It includes: fostering biblical hope, emotional care and physical safety. The views of CHC analyzed show increase level of knowledge about CHC spiritual presence in fostering hope and securing the safety of persons with suicidal thoughts.

Question 9. Participants were asked how often they are invited as first line of contact to provide spiritual care to persons with suicidal thoughts. The purpose is to understand the level of collaboration of the interdisciplinary team of clinicians in engaging CHC to provide spiritual care to patients with suicidal thoughts. The participant responses show that: 10 (31.25%) indicated frequently, 17 (53.13%) noted occasionally, whereas four (12.50%) and one (3.13%) indicated seldomly and never respectively. The responses suggest that CHCs are occasionally invited as first line of contact to provide spiritually care to persons with suicidal thoughts.

Kathleen Galek and other authors noted that the level of collaboration and referral of patients to chaplains related to hopelessness, depression and anxiety is low.¹²³

¹²³ Kathleen Galek, Keven Flannelly, Harold G. Koenig, and Rev. Sarah Fogg, "Referrals to Chaplains: The Role of Religion and Spirituality in Healthcare Settings," *Mental Health, Religion and Culture* 10, no. 4 (July 2007): 370, accessed September 20, 2018, https://digitalcommons.liberty.edu/mental_health/vol10/iss4/.

Question 10. Participants were asked how often they make referral/counsel a person with suicidal thoughts to meet a mental health professional. The purpose is to understand how CHC conducts spiritual assessment to determine referral/counsel a person with suicidal thoughts to meet the MHP. The participant responses to the survey revealed that: 14 (43.75%) noted frequently, 10 (31.25%) mentioned occasionally, whereas seven (21.88%) indicated seldomly, and one (3.13%) said never. The participants response reveals that some CHCs conduct SA to determine appropriate care while others do not conduct SA.

Fowler proposes that SA allow the CHC to understand the individual “faith and selfhood”¹²⁴ to provide holistic spiritual care intervention. Furthermore, Question 21, asked participants to specify the number of referrals of persons with suicidal thoughts to MHP. The responses show that: 14 (43.75%) indicated seven referrals, 10 (31.25%) specified three referrals, whereas eight (25.00%) mentioned eight referrals. The response from the participants suggest that more persons with suicidal thoughts were referred to the MHP. The finding highlights the “significance of SA and timely referral”¹²⁵ of persons with suicidal thoughts to the MHP. The CHCs mentioned the need for more clinical training in suicide prevention to improve their involvement in spiritual care for persons with suicidal thoughts.

Question 11. Participants were asked to consider whether their spiritual care role in suicide intervention is underutilized. The purpose to understand the significant role of CHC to provide spiritual care to a person with suicidal thoughts. The CHC responses from the survey show that: three (9.38%) and 12 (37.50%) agreed that they are underutilized. In contrast, 13

¹²⁴ James W. Fowler, *Faith Development and Pastoral Care: Theology and Pastoral Care Series* (Philadelphia: Fortress Press, 1987), 69.

¹²⁵ Brad W. Johnson and William M. Johnson, *The Ministers Guide to Psychological Disorders and Treatment*, 2nd ed. (New York, New York: Routledge, 2014), 176.

(40.63%) and four (12.50%) remain neutral and disagreed. The responses seem to suggest that CHC in some hospitals are invited to spiritually care for persons with suicidal thoughts, but in other hospital the pastoral care is underutilized. Kathleen Galek and other authors noted that research findings show that in some hospital referrals of patients to a chaplain for spiritual care is high, whereas in other hospitals the rate of referral is low.¹²⁶

Question 12. Participants were asked to indicate how they feel when encouraging a person with suicidal thoughts to choose life. The purpose is to understand how the CHC fosters hope as spiritual care intervention to encourage a person with suicidal thoughts to choose life. The responses from the survey show that: 28 (87.50%) express feelings of expectation and four (12.50%) remain neutral. The participant responses suggest that CHCs express feelings of expectation in attending to a person with suicidal thoughts to embrace life. Moltmann declares that hope as a biblical virtue has the components of belief and expectation.¹²⁷ The CHC expresses feeling of hope to encourage the person with suicidal thoughts to choose life.

Question 13. CHCs were asked to determine how often they conducted spiritual assessment to identify/care for a person with suicidal thoughts. The purpose is to understand whether the CHC conducts spiritual assessment of the person with suicidal thoughts to determine appropriate spiritual care. The participant responses from the survey show that: 12 (37.50%) indicated frequently, and 14 (43.75) occasionally but six (18.75%) mentioned seldomly. The result from the participants suggest that CHC conducts SA to help determine appropriate

¹²⁶ Kathleen Galek et al., "Referrals to Chaplains: The Role of Religion and Spirituality in Healthcare Settings," *Mental Health, Religion and Culture* 10, no. 4 (July 2007): 370, accessed September 20, 2018, https://digitalcommons.liberty.edu/mental_health/vol10/iss4/.

¹²⁷ Richard Bauckham, *Jurgen Moltmann: Collected Readings*, ed. Margaret Kohl (Minneapolis, Minnesota: Fortress Press, 2014), 12.

spiritual care. O'Brien states that SA is an integral part of pastoral care to determine appropriate spiritual care that promotes the patient's spiritual wellbeing.¹²⁸

Question 14. Participants were asked how they conducted SA using SA tool developed by Christiana Puchalski: "faith of the person, importance to life, community/family/friends and to address stressors/concerns" (FICA).¹²⁹ The purpose is to understand how the CHC conducts SA to determine appropriate spiritual care of fostering hope to mitigate against suicidal thoughts. The participant responses from the survey show that: 27 (84.38%) assessed the faith of the person, and closely followed is 26 (81.25%), which assessed the persons community/family/friends. Whereas, 25 (78.13%) assessed the person's stressors/concern and 24 (75.00%) assessed importance to life.

The responses from the assessment of a person with suicidal thoughts suggest the importance of faith, religious belief, a sense of spirituality which allows the CHC to foster hope in the patient to choose to live. The relationship of family and friends provide supportive care in the life of the person with suicidal thoughts to choose life. The pastoral care of addressing stressors and importance to life are related factors that influence the person with suicidal thoughts to see hope-list of life opportunities to influence change in behavior. Furthermore, the testimonies of survivors who attempted suicide connects their survival to the virtue of hope, family support, importance of life and addressing the stressor.¹³⁰

¹²⁸ Mary Elizabeth O'Brien, *Spirituality in Nursing: Standing on Holy Ground*, 5th ed. (Burlington, Massachusetts: Jones & Bartlett, 2014), 62.

¹²⁹ Christiana M. Puchalski, "The FICA Spiritual History Tool #274" *Journal of Palliative Medicine* 17, no. 1 (2014): 105-106, accessed December 12, 2018. <https://www.digitalcommons.liberty.edu/jpm/vol17/iss1/>.

¹³⁰ National Suicide Prevention Lifeline accessed April 28, 2018 <https://suicidepreventionlifeline.org/stories/about/>

Participants were asked to also specify other factors that are considered in SA. The comments from participants indicated: injuries, destructive behavior, substance abuse, and losses. The goal of SA is to determine appropriate level of spiritual intervention. It is important to note that the CHC secures the safety and life of the person having suicidal thoughts as critical recovery intervention. This is achieved through the collaborative efforts of the police and MHP. Further, the CHC's caring attitude implores "motivational interview"¹³¹ to foster hope to encourage the person having suicidal thoughts to change from killing themselves.

Question 15. Participants were asked to identify, which biblical virtues of love, faith and hope helped the CHC to influence/care for a person with suicidal thoughts to refrain from killing themselves and to choose life. The purpose is to understand how the CHC fosters biblical hope in a person with suicidal thoughts to promote, recovery, repair and restoration. The results from the participants show that: 26 (81.25%) mentioned the biblical virtue of hope and 21 (65.63%) indicated love as the next biblical virtue; whereas 16 (50%) noted faith/belief. The influence of biblical hope indicated by the participants suggest the indispensable influence of hope in recovery, repair and restoration of person from suicidal thoughts. Moltmann believes that "hope takes seriously the possibilities for change."¹³² The CHC fosters biblical hope to a person in crisis, socio-economic challenges and wars.¹³³ The scripture affirms that God is the source of hope and restorer of hope (Rom 15:13). Carrigan says, "hope is a language of relationship

¹³¹ Peter C. Britton, Craig J. Bryan and Marcia Valenstein. "Motivational Interviewing for Means of Restriction Counseling with Patients at Risk for Suicide." *Cognitive and Behavioral Practice*, no. 23 (Feb 2016): 54. accessed May 7, 2018, <http://www.digitalcommons.liberty.edu/cbpra/vol23/iss1/>.

¹³² Richard Bauckham, *Jurgen Moltmann: Collected Readings*, ed. Margaret Kohl (Minneapolis, Minnesota: Fortress Press, 2014), 16.

¹³³ Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, Pennsylvania: Judson Press, 2006), 57.

through which the Christian community (CHC) nurtures expectation and prospects”¹³⁴ to influence the patients to choose life.

Participants were asked to indicate other ways of CHC providing spiritual care to a person with suicidal thoughts to choose life. The participants opinion was analyzed and categorized into meaningful themes. It includes, forgiveness from God against injurious behavior (Ps 103:3), and compassion/empathy, self- worth, respect as well as trust. The CHC in a caring relationship provides spiritual care to “promote strength, integrity and healing of the patient”¹³⁵ to achieve emotional, physical and spiritual wellbeing. Overall, the person with suicidal thoughts embraces hope to see life with new opportunities to stay alive.

Question 16. Participants were asked to mention the religious practice that may have influenced positive change in the person with suicidal thoughts. The purpose is to understand how the CHC fosters biblical hope in a caring relationship. The report from participants show that: 29 (90.63%) counsel to achieve emotional/spiritual support, 24 (75%) encouraged family/friends/faith group support and 18 (56.25%) mentioned prayer. Whereas, 13 (40.63%) mentioned reading of Scriptures and 12 (37.50%) indicated meditation on the faithfulness of God.

The responses suggest that appropriate spiritual counsel influences positive change in a person with suicidal thoughts to see hope-list of life opportunities to choose life. The CHC spiritual counsel integrates emotional support, prayer, family support system, bible reading and meditation as practices that help to holistically influence the person with suicidal thoughts to

¹³⁴ Robert L. Carrigan., “Where has hope gone? Toward an Understanding of Hope in Pastoral Care.” *Pastoral Psychology* 25 no.1, (Fall 1976): 41, accessed 24, 2018, <https://www.digitalcommons.liberty.edu/pastoral/vol25/iss1/>.

¹³⁵ Christina M. Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Health Care* (West Conshohocken, Pennsylvania: Templeton Press, 2010), 37.

choose life and not death. Collins indicates that pastoral counsel helps the person with suicidal thoughts to achieve “awareness of God and surrendering to his will.”¹³⁶ The result suggests that the person with suicidal thoughts who surrenders to godly spiritual counsel is influenced to refrain from killing themselves.

In addition, participants were asked to indicate other religious practices that they feel influenced positive change by the persons with suicidal thoughts to choose life. The participant views were analyzed and categorized into themes of forgiveness and volunteering to serve others. The practice of forgiveness instills inner peace from God for the patient (1 John 1:9) and creates new purpose for the person with suicidal thoughts to see hope-list of life opportunities. Further, it is insightful to know that volunteering may motivate the person with suicidal thoughts to see new hope and opportunities to embrace life.

Question 17. Participants were asked to identify their personal attitude, which they feel is evident in a caring relationship with a person with suicidal thoughts. The purpose is to understand how a CHC demonstrates caring relationship behavior that promotes trust with a person having suicidal thoughts to create an atmosphere for spiritual care. The responses from the participants show that: 29 (90.63%) mentioned non-judgmental, 27 (84.38%) indicated reflective listening, 25 (78.13%) mentioned genuine interest. Participants indicated other personal attitudes: 20 (62.50) personal warmth, 16 (50.00%) tone of voice and 11 (34.38%) connecting smile.

The result from participant responses suggest that CHC’s verbal personal attitudes in a caring relationship is to be non-judgmental, reflective listening and tone of voice to create

¹³⁶ Gary R. Collins, *Christian Counseling: A Comprehensive Guide*. 3rd ed. (Nashville, Tennessee.: Thomas Nelson, 2007), 37.

positive connection and establish trust with a person having suicidal thoughts to foster biblical hope. The other non-verbal behaviors such as personal warmth, genuine interest and connecting smile helps to establish the connection with a person having suicidal thoughts to foster hope. Although participants rated smile as the lowest, Egan says that non-verbal attitudes like “smiling”¹³⁷ creates relational connection that fosters hope as spiritual intervention.

Similarly, Collins mentions “connecting smile” as important in the caring relationship.¹³⁸ Wrights also believes that CHC’s “tone of voice”¹³⁹ can encourage the person or loose the opportunity to foster hope. In ones caring relationship experience with patients, connecting smile as a non-verbal attitude motivates patients to willingly respond to the CHC’s spiritual care. The CHC comes into the caring relationship with a “cheerful countenance” (Prov 15:13 NKJV).

Question 18. Participants were asked to indicate the Christ-like attitude evident in their caring relationship. The purpose is to understand how the CHC incarnationally represents Christ in a caring relationship to establish trust with a person having suicidal thoughts to foster hope as spiritual care intervention. The participant responses indicate that: 31 (96.88%) mentioned kindness/compassion, 24 (75.00%) mentioned love, and 18 (56.25%) mentioned patience. The participants response to other Christ-like virtues shows: 15 (46.88%) faithfulness, nine (28.13%) joy and eight (25.00%) as self-control.

The responses suggest that compassion, love and patience was more evident in their caring relationship. Other Christ-like virtues are faithfulness, joy and patience which is also

¹³⁷ Gerard Egan, *The Skilled Helper: A Problem-Management and Opportunity-Development Approach to Helping*, 10th ed. (Belmont, California: Brooks/Cole, 2014), 75.

¹³⁸ Gary R. Collins, *Christian Counseling: A Comprehensive Guide. 3rd ed.* (Nashville, Tennessee: Thomas Nelson, 2007), 17.

¹³⁹ Norman H. Wright, *The Complete Guide to Crisis and Trauma Counseling: What to do and Say When It Matters Most* (Minneapolis, Minnesota. Bethany House, 2014), 151.

evident in supporting the caring relationship. Collins indicates that pastoral counselors (CHC) demonstrates all six godly virtues in a caring relationship.¹⁴⁰ Lawrence mentions “love as Christ’s greatest redemptive virtue that is real” in CHC’s caring relationship attitude with persons having suicidal thoughts to foster hope.¹⁴¹ Christ in his humanity demonstrated all six godly virtues in ministering pastoral care to the sick, wounded, depressed, oppressed and those in despair (Luke 8:22-25).

Question 19. Participants were asked to suggest how to improve on the CHC involvement in suicide prevention. The purpose is to understand how the CHC can be more involved in suicide prevention. The responses were analyzed and categorized into three key themes for improvement in suicide prevention: 14 (43.75%) participants mentioned training, seven (21.87) participants stated inclusiveness of CHC as healthcare team and four (12.50%) participants indicated referral. Whereas, seven (21.87%) did not give their opinion.

The responses on how to improve on CHC involvement in suicide prevention suggests that professional development of chaplains, requires training and retraining in suicide prevention as a continuous improvement plan to access the training opportunities available. It includes, ASIST, ACE, SRAT, Mental health first aid training and Schwartz Round care givers training. In addition, hospital organizations should include chaplains in suicide prevention training to achieve interdisciplinary effectiveness in suicide prevention.

Question 20. Participants were asked to mention the resources they utilized in ministering to a person with suicidal thoughts. The purpose is to understand how the CHC fosters biblical

¹⁴⁰ Gary R. Collins, *Christian Counseling: A Comprehensive Guide. 3rd ed.* (Nashville, Tennessee: Thomas Nelson, 2007), 67.

¹⁴¹ Lawrence E. Holst, *Hospital Ministry: The Role of the Chaplain Today* (Eugene, Oregon: Wipf & Stock, 2006), 11.

hope in a person with suicidal thoughts to choose life. The responses were analyzed and categorized into religious and non-religious resources. The CHC mentioned the use of religious resources such as Bible/Scriptures, prayer, meditation, relevant religious literature, and alphabet of gratitude for the patient to name each letter to represent God's faithfulness.

The participants also indicated non-religious training resources such as ASIST, DSM-IV, ACE, CSSRS, 3 Circle Application and Motivational interview-Miller and Rollnick and Referral to MHP. The religious resources mentioned suggests the CHC biblical/theological authority and convictions to use Christ's best resources and integrating non-religious resources to provide holistic spiritual care intervention to a person with suicidal thoughts. Lee, Puchalski and CDC, recognizes the application of bible/scripture and prayer as necessary resources to provide spiritual care therapeutic intervention for patient's recovery.

Conclusion

The purpose of this study is to understand how the CHC fosters biblical hope in a caring relationship as spiritual care preventive intervention to persons with suicidal thoughts to promote recovery, repair and restoration. The study recognizes the contribution and the rate of success in suicide prevention through the collaborative efforts of chaplains and MHP. However, the national statistics on persons with suicidal thoughts which triggers the killing of themselves is still increasing. The study provides knowledge and understanding of the CHC's spiritual care intervention in suicide prevention to reduce the rate of persons with suicidal thoughts; a precipitating factor from hopelessness that triggers killing of themselves.

The findings from the study indicates that participants conduct SA of persons with suicidal thoughts to provide spiritual care for the person with suicidal thoughts. The components

of SA, faith of the person, importance to life, family and addressing the stressors help to create the opportunity for the CHC to foster biblical hope.

Participants, 26 (81.25%) indicated that biblical hope influences the person with suicidal thoughts to see hope-list of life's opportunities to living. This finding illustrates that the virtue hope is an indispensable life resource and it influences the CHC to encourage the patient having suicidal thoughts that God is the source of hope and his faithfulness motivates individual to see future opportunities.

This study supports the finding that the family/friends/faith groups are important social relationship and religious practice that influenced the person with suicidal thoughts to embrace life. Out of 32 participants 26 (81.25%) and 24 (75%) participants respectively indicated these factors. The participants mentioned the use of religious resources that helped to foster biblical hope. It includes, Bible/Scriptures and relevant religious literature. Likewise, the biblical virtues of love and faith also formed the integral part of the CHC's spiritual care intervention to mitigate against suicidal thoughts.

The findings of this study show the CHC's religious practice such as spiritual counsel, prayer, meditation, Bible reading and reflecting on God's faithfulness provided the connection to foster biblical hope to influence positively a person with suicidal thoughts to see new opportunities to life positive resources.

The findings to the study show the CHC's verbal attitudes such as non-judgmental, reflective listening and tone of voice; and the non-verbal attitudes such as personal warmth, genuine interest and connecting smile creates the opportunity to foster biblical hope. The CHC's caring relationship attitudes help to establish trust, create cooperation and willingness of the

person with suicidal thoughts to receive biblical counsel on hope to choose life and mitigate against killing themselves.

The findings from the study revealed that the CHC in a caring relationship fosters biblical hope as spiritual care intervention to a person with suicidal thoughts with a collaborative team of clinicians to promote recovery, repair and restoration.

Recommendations

Inadequacy of Theological Training in Suicide Prevention

First, the finding from the participants present the need to recommend specialized training in suicide prevention to seminary students. The rationale for SPT training is to adequately train chaplaincy students with the skill to mitigate against suicidal thoughts and reduce the rate of suicide as a national crisis.

This finding indicates a knowledge gap in suicide prevention is prevalent in the participant's responses. This skill gap may be responsible for the level of CHC involvement in pastoral care of persons with suicidal thoughts.

Second, SPT gap creates opportunity for pastoral care department in hospitals and seminary institution to incorporate suicide prevention training as a priority to develop the necessary skills to reduce and prevent persons with suicidal thoughts from killing themselves.

Third, SPT programs should be organized bi-annually by seminary institutions in collaboration with the US Department of Health and other agencies such as National Suicide Prevention Help Line, National Center for Disease Control and Injury Prevention, and other non-governmental organizations to train and retrain seminary students in suicide prevention. A major course on suicide prevention should be incorporated into the Master of Divinity and CPE programs in seminaries.

The participants also suggested SPT programs such as: Applied Suicide Intervention Skill Training (ASIST), The Army Ask, Care and Escort (ACE) Suicide Prevention Intervention Training, Suicide Risk Assessment Training, Mental Health First Aid Training, Schwartz Rounds Care Givers Training and Workshops/Online training, Motivational Interview-Miller and Rollnick, Columbia Suicide Severity Rating Scale (CSSRS), and 3 Circle, Life Application Guide. This will improve the CHC's professional development competence to provide spiritual care to persons with suicidal thoughts and increase the success rate in suicide prevention.

CHC Inclusiveness in Healthcare Team

Participants noted the inclusiveness of CHC as members of the clinical team is necessary to foster biblical hope as spiritual intervention. The recommendation for inclusiveness may appear to suggest CHC's SPT skill gap as the reason for non-inclusion among the clinical team. Although, the pastoral care team in a hospital setting has inter-faith and non-faith chaplains, SPT is a necessary skill that will improve their competency. The CHC integrates biblical resources and SPT skills to care for persons with suicidal thoughts to promote recovery, repair and restoration. The recommendation for referral to MHP is part of the CHC's spiritual and therapeutic alliance to promote holistic care.

Hope Influence: Bible, Prayer, Religious Literature and Meditation

The study reveals the Bible as the manual for hope and the findings from CHC's fostering biblical hope indicates the positive influence of Scriptures, prayer, meditation, reflection on God's faithfulness in spiritual care to mitigate against suicidal thoughts. The finding suggests that CHCs should foster Scriptural reading, prayer and meditation to promote suicide prevention. The scripture provides rich genre of human experiences that believes in hope or expectation that changed their hopeless situation to bounce back to life positive resources. The

veracity of the CHC's spiritual intervention is to integrate other non-religious resources in the social sciences to enrich a wider scope in spiritual care of addressing factors of hopelessness that triggers suicidal thoughts.

Importance of Family, Friends and Faith Group Support

The findings to the study show that the family systems as a social construct has its roots in the scriptures since God created the family system (Gen 1:18). Further, since "God sets the lonely in families" (Ps 68:6), it is recommended that CHC as custodian of the family system should utilize social positive connection and support that influence persons with suicidal thoughts to promote recovery, repair and restoration. prevention.

Implication for Future Research

The study utilized purposive sampling, that focused on CHC's in a population of pluralistic healthcare chaplains working in a hospital setting. The main purpose of the study is to understand how CHC's fosters biblical hope in a caring relationship with a person with suicidal thoughts as spiritual care intervention to promote recovery, repair and restoration. The future study should focus on persons who have survived from the thoughts of killing themselves. The understanding of the influence of hope from individual accounts will help chaplains, MHP's, Department of Health and Social Services, DoD, CDC to engage more CHC to utilize religious resources, the bible, prayer, religious literature to influence suicide prevention.

BIBLIOGRAPHY

- A Journey Toward Health and Hope Published by US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) HHS Publication N0. SMA-154419. 2015.
- Arnold, William V. *Introduction to Pastoral Care*. Philadelphia, Pennsylvania: The Westminster Press, 1982.
- Bandura, A. "Self-efficacy: Toward a Unifying Theory of Behavioral Change." *Psychological Review* 84, no. 2 (1977): 191-215. Accessed April 14, 2018. <https://www.digitalcommons.liberty.edu/psychol/vol84/iss2/>.
- Bauckham, Richard. *Jurgen Moltmann: Collected Readings*. Edited by Margaret Kohl. Minneapolis, Minnesota: Fortress Press, 2014.
- Banner, Michael. *Christian Ethics and Contemporary Moral Problems*. Cambridge, United Kingdom: Cambridge University Press, 1999.
- Barnes, Patricia M, Eve Powel-Griner, Kim McFann and Richard L. Nahin. "National Institute of Complementary and Alternative Medicine Use among Adults: United States, 2002." CDC Advance Data Report # 343, (May 2004): 1-30. Accessed February 8, 2018. <https://www.cdc.gov/nchs/data/ad/ad343.pdf>.
- Britton, Peter C, Craig J. Bryan and Marcia Valenstein. "Motivational Interviewing for Means of Restriction Counseling with Patients at Risk for Suicide." *Cognitive and Behavioral Practice* 23, no.1 (2016): 51-61. Accessed May 7, (2018). <http://www.digitalcommons.liberty.edu/cbra/vol23/iss1/>.
- Bruce, Frederick F. Paul, *Apostle of the Heart Set Free*. pbk. ed. Carlisle, Cumbria, United Kingdom: Paternoster Press, 2000.
- Brown, David R, James S. Carney, Marks S. Parrish, and John L. Clem. "Assessing Spirituality: The Relationship Between Spirituality and Mental Health." *Journal of Spirituality in Mental Health* 15, (2013): 107-122. Accessed April 24, 2018. <https://www.digitalcommons.liberty.edu.wsp120/vol15>.

Bryan Craig J, AnnaBelle O. Bryan, Bobbie N. Ray-Sannerud, Neysa Etienne, Chad E. Morrow. "Suicide Attempts Before Joining the Military Increase Risk for Suicide Attempts and Severity of Suicidal Ideation Among Military Personnel and Veterans." *Comprehensive Psychiatry* 55, iss.3 (April 2014): 534-541. Accessed April 18, 2018. <https://www.digitalcommons.liberty.edu.comppsysc.vol55/iss3/>.

Carrigan, R. L. "Where has hope gone? Toward an Understanding of Hope in Pastoral Care." *Pastoral Psychology* 25, no.1 (1976): 39-52. Accessed 24, 2018. <https://www.digitalcommons.liberty.edu/pastoral/vol25/iss1/>.

Collins, Gary R. *Christian Counseling: A Comprehensive Guide. 3rd ed.* Nashville, Tennessee: Thomas Nelson, 2007.

Creswell, John W. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* Thousand Oaks: Sage Publications, 2014.

Dees, Robert F. *Resilient Warriors.* San Diego, California: Creative Team Publishing, 2011.

Egan, Gerard. *The Skilled Helper: A Problem-Management and Opportunity-Development Approach to Helping.* Belmont, California: Brooks Cole, 2014.

Fackenheim Emil L. *To Mend the World: Foundations of Post-Holocaust Jewish Thoughts.* Bloomington, Indiana: University Press, 1994.

Fowler, James W. *Faith Development and Pastoral Care: Theology and Pastoral Care Series.* Philadelphia: Fortress Press, 1987.

Galek, Kathleen, Keven Flannelly, Harold G. Koenig, and Rev. Sarah Fogg. "Referrals to Chaplains: The Role of Religion and Spirituality in Healthcare Settings." *Mental Health, Religion and Culture* 10, no. 4 (July 2007): 363-377. Accessed September 20, 2018. [http://digitalcommons.liberty.edu.mental health/vol10/iss4/](http://digitalcommons.liberty.edu.mental%20health/vol10/iss4/).

Geisler, Norman L. *Christian Ethics: Contemporary Issues and Options.* 2nd ed. Grand Rapids, Michigan: Baker Academic, 2010.

- Geisler, Norman L. "Beware of Philosophy: A Warning to Biblical Scholars." *Journal of the Evangelical Theological Society* 42, no.1 (March 1999): 3-19. Accessed February 26, 2018. <https://www.digitalcommons.liberty.edu/JETS/vol42/iss1/>.
- Goeghegan, Vincent. "Pandora's Box: Reflection on a Myth." *Critical Horizons* 9, no. 1 (May 2008): 24-41. Accessed April 18, 2018. <http://digitalcommons.liberty.edu/crit/vol9/iss1/>.
- Groopman, Jerome. "The Anatomy of Hope" *The Permanente Journal* 8, no. 2 (Spring 2004): 43-47. Accessed April 20, 2018. <https://digitalcommons.liberty.edu/Perm J/vol8/iss2/>.
- Holst, Lawrence E. *Hospital Ministry: The Role of the Chaplain Today*. Eugene, Oregon: Wipf and Stock Publishers, 2006.
- Jacobs Lenworth M, Karyl Burns, and Barbara Bennet Jacobs. "Trauma Death: Views of the Public and trauma Professional on Death and Dying from Injuries." *American Medical Association Arch Surgical* 143 no. 8 (Aug 2008): 730-735. Accessed March 26, 2018. <https://www.digitalcommons.liberty.edu/archsurgical/vol143/iss8/>.
- Johnson, Brad W. and William M. Johnson. *The Minister's Guide to Psychological Disorders and Treatments*. 2nd ed. New York, New York: Routledge, 2014.
- Keith, Steven E. "Lecture on Biblical Foundation: Introduction to Chaplaincy." CHPL 500, (Fall 2016). Accessed August 30, 2018. <https://digitalcommons.liberty.edu/lecture/CHPL 500/>.
- Kemp, Janet. "Suicide rates in VHA Patients through 2011 with Comparisons with other Americans and other Veterans through 2010." Washington, DC: Veterans Health Administration, (2014): 1-21. Accessed April 13, 2018. <http://www.mentalhealth.va.gov/docs/>.
- Kinghorn, Warren. "Hope that is Seen is no Hope at All: Theological Constructions of Hope in Psychotherapy." *Bulletin of the Menninger Clinic* 77, 4, (Dec 2013): 369-394. Accessed April 18, 2018. <https://digitalcommons.liberty.edu/bumc/vol77/iss4/>.

- Kollar, Charles A. *Solution Focused Pastoral Counseling: An Effective Short-Term Approach for Getting Back on Track*. Grand Rapids, Michigan: Zondervan, 2011.
- Kopacz, Marek S, Sybil W. Morley, Barbara M. Wozniak, Kelsey V. Simons, Todd M. Bishop and Garland C. Vance. "Religious Wellbeing and Suicide Ideation in Veterans: An Exploratory Study." *Pastoral Psychol* 65, iss.4 (April 2015):481-491. Accessed April 18, 2018. [https://www.digitalcommons.liberty.edu.pastoral psychol vol65/iss4/](https://www.digitalcommons.liberty.edu.pastoral%20psychol%20vol65/iss4/).
- Lee, Douglas E. "Don't Ask; Don't Tell" Repeal: What's Next? *Journal for Baptist Theology & Ministry* 9, no.1 (Spring 2012): 63-67. Accessed February 8, 2018. <https://www.digitalcommons.liberty.edu/jbtm/vol9/iss1/>.
- Mansfield, Christopher J, Jim Mitchell and Dana E. King. "The Doctor as God's Mechanic? Beliefs in the Southeastern United States." *Social Science Med* 54, no.3 (2002):399-40. Accessed March 24, 2018. <https://www.digitalcommons.liberty.edu/vol54/iss3/>.
- McMinn, Mark R. *Psychology, Theology, and Spirituality in Christian Counseling*. Carol Stream. Illinois: Tyndale House Publishers, 1996.
- Moore, Zoe Bennett. "The Place of Research in Theological Education." *British Journal of Theological Education* 13, nos.1 (2002): 5-9. Accessed April 15, 2018. <https://www.digitalcommons.liberty.edu/bjte/vol13/iss1/>.
- Myers, William R. "Keeping the Faith While Doing Research in Ministry." *The Journal of Pastoral Care* 50, no. 2 (Summer 1996): 201-04. Accessed February 26, 2018. <https://www.digitalcommons.liberty.edu/pastoralcare/vol50/iss2/>.
- National Suicide Prevention Lifeline: Accessed April 28, 2018. <https://suicidepreventionlifeline.org/stories/about/>
- Nieuwsma, Jason A. "The Intersection of Chaplaincy and Mental Health Care in VA and DoD: Expanded Report on Strategic Action #23." VA/DoD/IMHS SA #23, (2010). Accessed April 20, 2018. <https://www.research.va.gov/>.

- Nock, Matthew K., Charlene A. Deming, Carol S. Fullerton, Stephen E. Gilman, Matthew Goldenberg, Ronald C. Kessler, James E. McCarroll, Katie A. McLaughlin, Christopher Peterson, Michael Schoenbaum, Barbara Stanley, and Robert J. Ursano. "Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors." *Psychiatry* 76 no 2 (Summer 2013): 97-215. Accessed April 6, 2018. <https://www.digitalcommons.liberty.edu/psych/vol72/iss2/>.
- O'Brien, Elizabeth Mary. *Spirituality in Nursing: Standing on Holy Ground*. Burlington, Massachusetts: Jones and Bartlett, 2014.
- Olson, Roger E. *The Journey of Modern Theology: From Reconstruction to Deconstruction*. Downers Grove, Illinois: InterVarsity Press, 2013.
- Paget, Naomi K and Janet McCormack R. *The Work of The Chaplain*. Valley Forge, Pennsylvania: Judson Press, 2006.
- Paul, Kwon, Maira Birrueta, Emily Faust and Emilia R. Brown. "The Role of Hope in Preventive Interventions." *Journal of Social and Personality Psychology Compass* 9/11 (2015): 696–704. Accessed April 18, 2018. <https://digitalcommons.liberty.edu/Spc/vol9/iss11/>.
- Petersen, Jim. *Why Don't We Listen Better? Communicating and Connecting in Relationships*. Portland, Oregon: Petersen Publications, 2007.
- Pojman, Louis P. *Life and Death: A Reader in Moral Problems*. 2nd ed. Belmont, California: Wadsworth Publishing, 2000.
- Puchalski, Christina M and Betty Ferrell. *Making Healthcare Whole: Integrating Spirituality into Patients Care*. West Conshohocken, Pennsylvania: Temple Press, 2010.
- Puchalski, Christiana M. "The FICA Spiritual History Tool #274." *Journal of Palliative Medicine* 17, no. 1 (2014): 105-106. Accessed December 12, 2018. <https://www.digitalcommons.liberty.edu/jpm/vol17/iss1/>.

- Snyder, C. R. "Hope Theory: Rainbows in the Mind." *Psychological Inquiry* 13, no.4 (2002): 249–275. Accessed April 14, 2018.
<https://www.digitalcommons.liberty.edu/psycol/vol13/iss4/>.
- Suicide Prevention Resource Center. Suicide Thoughts and Behavior in the Past Year Among Adults, United States 18 Years and Above, National Survey on Drug Use and Health, (2017). Accessed April 28, 2018. <https://www.sprc.org/scope/attempts/>.
- Suicide Prevention Resource Center. Percentage of High School Students Reporting Suicide Behavior, United States (Past 12 Months), Youth Risk Behavior Surveillance System, (2017). Accessed April 28, 2018, <http://www.sprc.org/scope/attempts/>.
- Ten Boom, Corrie. *A mazing Love*. Bungay, Suffolk, Great Britain: Richard Clay and Company Limited, 1954.
- Ten Boom Corrie. *Don't Wrestle, Just Nestle*. Old Tappan, New Jersey: Fleming H. Revell Company, 1978.
- Thomas, John C and Lisa Sosin. *Therapeutic Expedition: Equipping the Christian Counselor for the Journey*. Nashville, Tennessee: B&H Publishing 2011.
- US Congress, House. 1971 White Conference on Aging 92d Cong., 1st Session Senate Document No 92-53., (November 28-December 2): 1-135. Accessed January 1, 2019.
<https://www.aging.senate.gov/imo/media/doc/reports/>.
- Villatte, Jennifer L, Stephen S. O'Connor, Rebecca Leitner, Amanda H. Kerbat, Lora L. Johnson and Peter M. Gutierrez. "Suicide Attempt Characteristics Among Veterans and Active-Duty Service Members Receiving Mental Health Services: A Pooled Data Analysis." *Mil Behav Health* 3 no. 4 (Sept 2015): 1-21. Accessed April 24, 2018.
<https://www.ncbi.nlm.nih.gov/pmc/article>.
- Wade, Rowatt G Jr. "What Is Pastoral Research?" *Review and Expositor* 79, no.3 (Summer 1982): 503-511. Accessed April 1, 2018.
<https://www.digitalcommons.liberty.edu/pastoral/vol79/iss3/>.

Widera, Eric W., Kenneth E. Rosenfeld, Erik K. Fromme, Daniel P. Sulmasy, and Robert M. Arnold. "Approaching Patients and Family Members Who Hope for a Miracle." *Journal of Pain and Symptom Management* 42, no.1 (July 2011):119-125. Accessed April 13, 2018. <https://www.digitalcommons.liberty.edu/painsurg/vol42/iss1/>.

Wright, Norman H. *The Complete Guide to Crisis and Trauma Counseling: What to do and Say When It Matters Most*. Minneapolis, Minnesota. Bethany House, 2014.

APPENDIX: A

IRB Approval Letter

LIBERTY UNIVERSITY

INSTITUTIONAL REVIEW BOARD

July 23, 2018

Felix Oniovogha Otuorimuo

IRB Exemption 3397.072318: Fostering Hope: The Christian Healthcare Chaplain in a Caring Relationship

Dear Felix Oniovogha Otuorimuo,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under exemption category 46.101(b)(2), which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:101(b):

- (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
 - (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and
 - (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Please note that this exemption only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued exemption status. You may report these changes by submitting a change in protocol form or a new application to the IRB and referencing the above IRB Exemption number.

If you have any questions about this exemption or need assistance in determining whether possible changes to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

LIBERTY
UNIVERSITY.
Liberty University | Training Ch

APPENDIX: B

IRB Consent Letter

The Liberty University Institutional
Review Board has approved
this document for use from
7/23/2018 to --
Protocol # 3397.072318

CONSENT FORM

Fostering Hope: The Christian Healthcare Chaplain in a Caring Relationship
Felix Otuorimuo
Liberty University
School of Divinity

You are invited to be in a research study to understand how the Christian healthcare chaplain (CHC) in a caring relationship fosters biblical hope as spiritual care preventive intervention to encourage a person with suicidal thoughts to embrace life. You were selected as a possible participant because you are a Christian chaplain theologically/clinically trained to provide spiritual care to a person in despair. Please read this form and ask any questions you may have before agreeing to be in the study.

Felix Otuorimuo, a Master of Divinity student in the School of Divinity at Liberty University, is conducting this study.

Background Information: The purpose of this study is to understand how the Christian healthcare chaplain fosters hope as spiritual care preventive intervention to a person with suicidal thoughts to promote recovery, repair and restoration. The participants to the study will be limited to CHC's who provide spiritual care as preventive intervention to a person in despair. The CHC's incarnational presence allows him/her to communicate biblical hope as spiritual care to individuals suffering from hopelessness, a precipitating factor responsible for suicidal thoughts.

Procedures: If you agree to be in this study, I would ask you to do the following things:

1. Click the start button, answer appropriately the survey questions (estimated time is fifteen minutes)

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Benefits: Participants should not expect to receive a direct benefit from taking part in this study.

Confidentiality: The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records. I, the researcher, will not be able to link your survey responses to the specific participants who provided or are associated with the data to maintain anonymity.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey without affecting those relationships.

The Liberty University Institutional

Review Board has approved
this document for use from
7/23/2018 to --
Protocol # 3397.072318

How to Withdraw from the Study: If you choose to withdraw from the study, please exit the survey and close your internet browser.

Contacts and Questions: The researcher conducting this study is Felix Otuorimuo. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at 434-473-8344 or footuorimuo@liberty.edu. You may also contact the researcher's faculty chair, Steve Keith, at sekeith2@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher[s], **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 1887, Lynchburg, VA 24515 or email at irb@liberty.edu.

APPENDIX: C

Anonymous Online Survey Questions

1. If you do not wish to participate in the research study, please decline participation by clicking on the "disagree" button.
 - agree
 - disagree
2. Do you consider yourself a Christian chaplain who believes in Christ and the Bible as Holy Spirit inspired?
 - Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
3. How long have you served as a Christian healthcare chaplain (CHC)?
 - 1-5
 - 6-10
 - 11-15
 - 16-20
 - 21 and above
4. Theological training adequately prepared me to counsel a person with suicidal thoughts?
 - Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

5. Have you attended Clinical Pastoral Education Training (CPE)?
- Level I
 - Level II (Residency)
 - Supervisory Education Training
 - Board Certification
6. Theological/CPE training adequately prepared me in suicide identification / prevention skills?
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
7. How often do you attend training on suicide prevention?
- Frequently
 - Occasionally
 - Seldom
 - Never

Indicate what type of training:

8. The CHC's incarnate presence is critical as first line of contact to provide spiritual care to a person with suicidal thoughts.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree

Kindly explain:

9. How often are you invited as first line of contact to provide spiritual care to a person with suicidal thoughts?
- Frequently
 - Occasionally
 - Seldom
 - Never
10. How often do you make referral/counsel a person with suicidal thoughts to a mental health professional?
- Frequently
 - Occasionally
 - Seldom
 - Never
11. Do you consider your spiritual care role in suicide intervention underutilized?
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
12. How do you feel when encouraging a person with suicidal thoughts to choose life?
- Expectant
 - Neutral
 - Pessimistic
13. How often do you conduct spiritual assessment to identify/care for a person with suicidal thoughts?
- Frequently
 - Occasionally
 - Seldom
 - Never

14. What aspect of a suicidal person's life do you consider when conducting spiritual assessment?

- Faith of the person
- Importance of life
- Community (Family/friends)
- Address (Stressors/concerns)

Mention other ways:

15. What biblical virtue helps you to influence/care for a person with suicidal thoughts to choose life?

- Love
- Faith/belief
- Hope

Mention other ways:

16. What religious practice do you feel influences a person with suicidal thoughts to choose life?

- Spiritual counsel (emotional/spiritual support)
- Prayer
- Meditation (faithfulness of God)
- Bible example on hope-survivors
- Family/Friends/Faith group support

Mention other ways:

17. What personal attitude do you feel is evident in your caring relationship?

- Personal warmth
- Tone of voice
- Reflective listening
- Genuine interest
- Non-judgmental
- Connecting-smile

18. What Christ-like attitude do you feel is evident in your caring relationship?

- Love
- Joy
- Patience
- Kindness/compassion
- Faithfulness
- Self-control

19. How would you improve on the CHC involvement in suicide prevention?

20. What resources if any do you use when ministering to a person with suicidal thoughts?

21. How many counseling referrals have you made for a person with suicidal thoughts?

- 1-3
- 4-6
- 7 and above