

LIBERTY BAPTIST THEOLOGICAL SEMINARY

**SIX KEY CONCEPTS IN TRAINING EVANGELICAL LAY CHAPLAIN FOR
EFFECTIVE LOCAL HOSPITAL MINISTRY**

A Thesis Project Submitted to
The Faculty of Liberty Baptist Theological Seminary
In Candidacy for the Degree of

DOCTOR OF MINISTRY

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LIBERTY UNIVERSITY BAPTIST THEOLOGICAL SEMINARY

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ABSTRACT

KEY CONCEPTS IN TRAINING EVANGELICAL LAY CHAPLAIN FOR EFFECTIVE LOCAL HOSPITAL MINISTRY

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Liberty Baptist Theological Seminary, 2015

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Many professional hospital chaplaincy organizations have ethics statements that specifically prohibit paid chaplains from proselytizing, unless specifically requested by the patient. The intension of the dissertation is to train lay chaplains in what to communicate with the patients, family and friends. Restrictions will be imposed on lay volunteer chaplains by the hospital and the chaplaincy department dealing with proselytizing and other topics concerning religion.

The presentation will introduce biblical principles regarding ministering to the sick and dying, providing comfort to those who are hurting, and fostering hope and who are grieving. Between the survey findings and the interview key concepts was created for lay Christian volunteer chaplains.

Abstract Length: 110

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ABBREVIATIONS

CPE	Clinical Pastoral Education
DNAR	Do Not Attempt Resuscitation
ER	Hospital Emergency Room
TJC	The Joint Commission
NFR	Not For Resuscitation
NIV	New International Version
NKJV	New King James Version

SPECIAL TERMINOLOGY

Complicated Grief is a disruption in the normal grief process that prohibits healthy closure and healing for the affected person. It manifests itself as a reaction which may be prolonged, delayed, distorted, absent, concomitant, excessive, unresolved/layered, or trauma-related.

Countertransference is the personal blind spots and emotional baggage originating in childhood experiences in their families of origin. Virtually all certified pastoral counselors are further trained in the concepts of transference and countertransference as classically defined. Before proceeding to the most recent constructivist developments it therefore may be helpful to examine how the concept of counter-transference has traditionally been incorporated into the pastoral theological disciplines.¹

Countertransference is a situation in which a therapist, during the course of therapy, develops positive or negative feelings toward the patient. These feelings may be the therapist's unconscious feelings that are stirred up during therapy, which the therapist directs toward the patient. A therapist might start feeling uneasy about therapy or the patient, unhappy with the way therapy is going, or unhappy with themselves. Just like transference, this is not an uncommon situation in the therapeutic situation. Of course, therapists must not act on any feelings they have.²

¹ Pamela Cooper-White, *Shared Wisdom*, (Minneapolis: Fortress Press, 2004), loc., 435-437, Kindle.

² Arthur S. Reber, Allen Rhianon, and Emily S. Reber, eds., *Penguin Dictionary of Psychology*, (New York: Penguin, 2009), 177.

Perturbation, in the context of mourning, means the capacity to experience change and movement. As it pertains to the result of mourning it is fear, distress, frighten, [sic] and anxiety.³

³ Alan D. Wolfelt, *Eight Critical Questions for Mourners....and the Answers That Will Help You Heal*, (Fort Collins, CO: Companion Press, 2010), 26.

CHAPTER ONE

INTRODUCTION

“For I will restore health to you, and heal you of your wounds, says the Lord.”⁴

This thesis project will survey fifteen ministers from the Kinston, North Carolina, area. Kinston is a small farming community with small churches. In these small churches, the minister is required to do everything if he wants to keep his position. The survey will focus on training of Christian volunteer lay chaplains. All results will be kept in strictly confidential.

The results are recorded in the dissertation. In addition to survey results, the dissertation will draw on noted professional chaplains Dr. Doka through an interview with his own experience as a hospice and hospital chaplain. The need is there for volunteer lay chaplains for Lenoir Memorial Hospital.

Lenoir Memorial Hospital is a non-profit hospital located in Kinston, North Carolina. The hospital is has 261 beds and serves the communities of Lenoir, Greene, and Jones counties. These communities are rural farming communities. The hospital is staffed with more than 100 physicians. The hospital offers inpatient, outpatient, and preventive healthcare services with an emergency room. A retired minister serves as part-time chaplain at Lenoir Memorial Hospital. He is one man and cannot do everything that is needed in the hospital. The need for Christian volunteer lay chaplains is important for the community. The volunteer lay program would benefit the community in areas of attending to them immediate needs of the emergency room for care, b following participation in the multidisciplinary intervention (Rummans et al., 2006). This efenifial for patients. “An increase in spiritual well-being was detected in the intervention group

⁴ Jeremiah 30:17, (NKJV).

outcome suggests that spiritual well-being can improve even in the midst of the challenges of cancer treatment.”⁵ Piderman’s study states there is something to being religious correlates with a patient getting better faster than taking longer to responds to treatment

Statement of the Problem

As more people age, there will be an increasing need for health care and services. While more people receive in-patient and outpatient hospital care in the years ahead, greater opportunities for Christian ministry will develop. This ministry needs to be done carefully to avoid violating ethical standards of the hospital industry and ensure that the opportunities remain. Chaplain volunteers should assist in do no harm to the patients as they minister to patients. A number of professional hospital chaplaincy organizations have ethics statements that clearly prohibit paid chaplains to proselytizing and sharing biblical principles unless specifically requested. “The Spiritual Care Collaborative is comprised of five North American professional chaplaincy organizations: American Association of Professional Counselors, Association for Clinical Pastoral Education, Canadian Association of Pastoral Practice and Education, National Association of Catholic Chaplains and National Association of Jewish Chaplains.”⁶ However, trained volunteers may be allowed to present these truths if done in a sensitive and caring manner. “Some of this training focuses on chaplaincy, but is more specialized for hospital patients, family, staff and friends at the hospital. The training program would be

⁵ Katherine M. Piderman, and Mary E. Johnson, “Hospital Chaplains’ Involvement in a Randomized Controlled Multidisciplinary Trial: Implications for Spiritual Care and Research,” *Journal of Pastoral Care & Counseling* 63, no. 3 (Fall/Winter 2009): 3.

⁶ Mark LaRocca-Pitts, “Fact, a Chaplain’s Tool for Assessing Spiritual Needs in an Acute Care Setting,” *Chaplaincy Today* 28, no. 1 (2012): 31.

those already involved in chaplaincy or a specific ministry area. As the volunteer chaplains are equipped to assist the churches in ministry.”⁷ This thesis project will provide a training to assist lay volunteers in knowing what to say and how to respond to patients. Key concepts will provide guidelines for lay chaplains to follow.

Piderman and Johnson share the impact chaplains have on patients: “Chaplains are very aware of the power of spirituality in the midst of illness. Each day witness the vital role that spiritual beliefs and practices play in providing comfort and guidance, and facilitating coping.”⁸ A chaplain ministers to patients and families in times of trouble and joy on daily basis.

The amazing thing about this and other privileges of being a chaplain is that people let us in. They let us know and let us journey with them through pain, sorrow, guilt, grief, and joy. There are married couples that don’t even let their spouse in on some of those things, believing them too personal. The trust that some people give us is truly amazing.⁹

Chaplains are told many things in confidence therefore the chaplain are humbled for that trust. Chaplains are told family secrets and must keep those secrets unless the secrets will do physical harm or break the law. Examples would be if the patient were thinking about suicide, murder or physical harm to an individual. Many times a patient will tell a chaplain a part of his or her personal life story not even the family knows about what the patient did.

Barbra Pesut states the role of a hospital chaplain is diminishing. “Hospital chaplains are being laid off or are working shorter hours due to cost-cutting measures.”¹⁰

The role of the hospital chaplain has changed profoundly since the Hospitalier of 1556.

⁷ Rickey D. Thrasher, “Equipping a Select Group of Georgia Baptist Volunteers in Basic Chaplaincy Skills” (D.Min. diss., New Orleans Baptist Theological Seminary, 1991), 8.

⁸ Piderman and Johnson, “Hospital Chaplains' Involvement in a Randomized Controlled Multidisciplinary Trial: Implications for Spiritual Care and Research,” 3.

⁹ Gilbert Allen Nash, “Why I’m a Chaplain,” *Journal of Pastoral Care and Counseling* 66, no. 2 (June 2012): 1.

¹⁰ Christian Duffin, “Trusts Cut Out-of-Hours Chaplain Services to Meet AFC Pay Demands,” *Nursing Standard* 20 no 18: (January 2006), 12.

As keeper of the 'house of God,' the chaplain was charged on behalf of the church with oversight for the daily activities of the hospital. However, relative to the sixteen century, the role of the chaplain has diminished substantially, and in some hospitals, it has disappeared entirely, with the secularization of society and the adoption of hospitals by government run health services.¹¹

The role of a chaplain has changed, as Richard E. Thompson explains. "Indeed, we probably harbor some old, obsolete notions about chaplains. For example, in my clinical practice days hospital chaplains were often retired ministers with no special additional training."¹²

In another training program, Rickey D. Thrasher has another view on how to train chaplains. The training Thrasher discussed will only cover Southern Baptist churches in Georgia.

First, the volunteer chaplains were asked to examine the call of serving as chaplains. Second, the volunteer chaplains they were asked to examine their listening skills. Third, the volunteer chaplains received instruction on ministering to people in the midst of grief. Fourth, they studied ways to minister when someone was in crisis. Fifth, volunteer chaplains examined several ethical and integrity issues. Finally, volunteer chaplains discovered ways to take care of their personal life.¹³

Rickey D. Thrasher wants the volunteers to do the job as a chaplain without the pay. Thrasher's training included watching clips of three movies and writing a paper on how the movies affected his or her lives as a chaplain. The training in this document is hands on training. Somehow, everyone thinks there is not a set of standard operating procedure for training chaplains. Clinical Pastoral Education (CPE) has established guidelines for training of chaplains. Thrasher wants the volunteers to complete the same training as he did to become a certified chaplain. Although Thrasher's work discusses instructing the volunteer chaplains, his program does not include the hours of training volunteers must have to be equipped to handle a crisis. Thrasher's training

¹¹ Barbara Pesut et al., "Hospitable Hospitals in a Diverse Society: From Chaplains to Spiritual Care Providers," *Journal of Religion and Health* 51, no. 3 (September 2012): 826.

¹² Richard E. Thompson, "Hospital Chaplains: What, Who, and Why?" *Physician Executive* 35, no. 2 (March-April 2009): 72.

¹³ Thrasher, "Equipping a Select Group of Georgia Baptist Volunteers in Basic Chaplaincy Skills," 4.

does not cover any crisis training. This training is open to all regardless of denominations and includes crisis training. This dissertation gives the volunteers a title of Chaplain Assistant for respect and honor.

Statement of limitations

This dissertation examines the hospital and health care facility chaplaincy only. This dissertation will provide a guide for volunteer chaplain assistants rather than paid professionals and will be limited to evangelical Christian ministries in the United States rather than those of all faiths or in all countries. The training is open to both genders with no qualifications being recommended by the local pastor and the will to serve.

Theoretical basis for the project

The methods used in this project will be rooted in scriptural truth, including an examination of what the Bible says about caring for the sick and dying. This project examines current best practices in evangelical chaplaincy ministry. There was an interview of practicing chaplains to find their opinions on the use of volunteer assistants, as well as interview successful volunteers for their insights. Finally, it will draw upon the extensive background of the author in hospital settings.

Important themes include the chaplain's role in the microsystem of the treatment team, patient and patient's family, and the needed sensitivity to cultural differences that is important for both safety and quality in patient care. The role of the chaplain in fostering sensitivity and responsiveness to racial, ethnic, religious and cultural differences between patients and staff—as well as among staff—is growing in importance in our increasingly multicultural society.¹⁴

The above statement concerns what message the chaplain's role is for a hospital.

As Schyve states, there must be standards especially from the chaplaincy's department

¹⁴ Daniel Craig Russell, "Educating Staff at Fulton State Hospital Regarding Client Spirituality Issues," (D. Min. diss., Midwestern Baptist Theological Seminary, 2002): 206.

when treating patients in acute care. There are times that one must recognize the patient's individual needs, apart from medical care. Schyve's statement points out that he clearly does not understand the standard of training for a hospital chaplain. Schyve's intentions are good but he is putting his idea what a chaplain should do and be in all cases.

Biblical Principles

This thesis project will examine biblical principles regarding ministering to the sick and dying, providing comfort to those who are hurting, and offering hope for those who are grieving. A survey of evangelical hospital ministry chaplains and volunteers will provide the basis for developing key concepts for lay chaplains some biblical principles are found in the last three years of Jesus' life. An example is the story of the Good Samaritan found in Luke 10:25-37.

Luke 10: 25-37 tells the story of a priest and a Levite were going down the path. They both saw a man hurt by the side of the road. The Levite and the priest both holy men could not be bothered for various reasons. Later, a Samaritan came upon the man and gave him assistance. The Samaritan gave freely of his or her service. One might draw the correlation between the Good Samaritan and a chaplain of today. A chaplain is called to give freely of his or her time and talents to the sick. The Good Samaritan gave of his time and money to assist the man on the side of the road.

Apostle Paul once said in Acts 20:35, "In everything I did, I showed you that by this kind of hard work we must help the weak, remembering the words the Lord Jesus himself said: 'It is more blessed to give than to receive.'" ¹⁵ These words could have been written as well about a chaplain, who is always giving.

¹⁵ Acts 20:35. Unless otherwise noted, all biblical passages referenced are in the New International Version.

Statement of Methodology

Surveys were handed out at random in the city of Kinston, North Carolina, with an envelope to mail back the survey. The surveys were given out to different denominations without knowledge of the pastor or affiliation. No one was paid to fill out the survey. When the surveys were returned, the outside envelope was opened and destroyed as a part of the approval from the IRB board at Liberty University to assure anonymity. The surveys were kept in a secure file; when all of the surveys were received, the results were tabulated. Any reference to any church, nationality, gender, or race was taken out in the dissertation. Therefore, there is no reference to any individual or religious affiliation recorded in the dissertation.

Chapter one has a discussion of training evangelical lay chaplain volunteers for effective hospital ministry. The questions were given out at Kinston, North Carolina, to local ministers in the area. Kinston is a small farming community. The community has a local hospital with a part-time chaplain. The same ten questions were asked of each pastor, and the results are in the dissertation. The queries were taken per instructions from Liberty University as to how the questions could be asked to protect amenity.

Chapter two includes an interview with Rev. Doctor Kenneth J. Doka, and survey results. Doka has been a hospice chaplain for more than thirty years. Doka shared observations on what it is like to be a hospital chaplain. Doka gives insights on how to distress. Inquiries contain a list of ten questions given to fifteen local ministers in Kinston, North Carolina. The questionnaires were taken in total amenity. No names of the ministers or names of churches were included on the completed interviewed. The tabulation of the results will appear as pie charts in the dissertation.¹⁶ For From the interview and survey key concepts have been developed.

¹⁶ Appendix A.

Chapter Three Summary

This chapter three defines the role of a chaplain. The dissertation also explains a chaplain's education; and a chaplain's daily hospital experiences. The dissertation gave insight into what a chaplain might run into while at the hospital setting. Some examples are end-of-life, crisis, crisis intervention, grief, and families.

Chapter four features the chaplain key concepts. The key concepts are distillation of the first three chapters. In the key concepts, there are scenarios on how to handle certain situations dealing with patients. Listed are some hospital rules a chaplain must follow. The key concepts will not cover all areas of concern that a chaplain might experience as a chaplain. However the key concepts will give the trainee a way in which to figure things out as a volunteer. Situations always change. One of the rules of a chaplain is he or she has to evaluate the situation within thirty seconds and respond to the event or hospital room meeting. The chaplain must be there for the patient.

Chapter five sums up the dissertation and gives hope to the volunteer chaplains. Being a chaplain provides a rewarding venue of volunteering as an evangelical Christian chaplain. A chaplain sees what happens when God is in control and not man. Awesome.

Review of the Literature

Books

Kenneth J. Doka and Amy S. Tucci, "*Elisabeth Kübler-Ross: New Perspectives on Death, Dying, and Grief.*"¹⁷ This book states Elisabeth Kübler-Ross's theories are not viable every time with everyone and there for Ross's theories are flawed. Chaplains and counselors

¹⁷ Kenneth J. Doka and Amy S. Tucci, *Elisabeth Kübler-Ross: New Perspectives on Death, Dying, and Grief* (Washington, DC: Hospice Foundation of America, 2011).

used Ross's model as the standard for grief. Meanwhile, types of grief have changed in the past forty years since Ross's book was published. Complicated grief was added. Completed grief was also added to the DSM-5 as criteria for prolonged grief disorder. DSM-5 is the guidelines that psychologists and sociologists follow to explain what a person is either going through or exhibiting in life. Doka is an expert in pathology and chaplaincy.

Linda A. Curran wrote *Trauma Competency A Clinician's Guide*. The book details different guidelines for traumatic experiences. One area the author is an expert is suicide prevention and aftermath. Curran gives a list of questions to ask if a patient seems suicidal. Some questions are, "What motivates your wish to die? How do you plan to carry out your suicidal plan? Have you had any suicidal thoughts today?"¹⁸

Curran's book is excellent dealing with suicidal patients and gives a variety of sources for suicidal care. The American Association of Sociology is a group of dedicated professionals, who finds ways to prevent suicide and give support to counselors in regards to all aspects of prevention and aftermath of suicide. Curran's work has played a major part in the training key concepts for lay chaplains.

Linda J. Schupp's book, *Grief Normal Complicated Traumatic*. Schupp's book, although relatively short, contains extensive information on grief. Schupp also makes a distinction between two different types of grief anticipated and completed. Grief is real just like death is real. Lastly it is anticipated grief like a terminal illness. Schupp wrote about complicated grief and was proactive in bringing about the inclusion into DSM-V. Schupp even suggested a grief diet. There are non-verbal grief methods, such as journaling, letters, and music. Schupp's book will be used as a guideline for chaplains in how to view grief.

¹⁸ Linda A. Curran, *Trauma Competency a Clinician's Guide*, (Eau Claire, WI: PESI, 2010), 57.

H. Norman Wright wrote *The Complete Guide to Crisis & Trauma Counseling*. Wright, a leading authority on trauma, has been counseling trauma victims for the past twenty years. This book gives step-by-step guidelines on treating trauma victims. Although the book was not written specifically with chaplaincy in mind. Wright states what works and what does not work. An example is Wright's "ball of grief".¹⁹ Wright states that men do not show emotions. As a result, Wright gives men a ball of words that have different words enter tangled on the ball. These words are expressions of feelings towards grief. Many men do not express grief according to Wright. The ball of grief this give the men the ability to express their feelings about grief. Wright asks the men to point out on the ball of grief how they are feeling about their situation.

Alan D. Wolfelt, wrote *Eight Critical Questions for Mourners*. Wolfelts' is expert in the field of grief. He has clinics at his training center for training the caregivers, how to overcoming grief, and many more situations. In this thesis project many discussions will start with how to recognize grief in patients and in self. A caregiver must first see how grief affects their own person life before the chaplain can help the patients. Reasons being if the caregiver is not whole spirituality and mentally than how can you as a chaplain listen to the patients when they are going through crisis. The whole concept is how can someone, as a volunteer, handle a shooting at a school if the volunteer is not free from personal grief. Here Wolfelt explains grief is internal and not shown on the outside. Many times a person is grieving and does not know how to express those emotions. Wolfelt asserts that loved ones left behind have feelings and that is all right to grieve. His works are invaluable to a chaplain in how to recognize grief in a patient, family, friends and staff. Grief is a process and it takes time to work through all the feelings. Wolfelt wrote a "Survival's Guide of Suicide."²⁰ This important

¹⁹ Appendix I.

²⁰ Alan Wolfelt, email message to author, September 13, 2013.

handout can be found in Appendix G.

Journals

Sarah Pulliam Bailey, In the Christianity Today article, *Chaplains Watch and Wait after DADT Ends* gives some background for a chaplain.²¹ Sarah Pulliam Bailey discusses the number of military chaplains actively serving today. Bailey discusses chaplains killed in the line of duty. During war times, and chaplains go to the battlefield. This article was used to demonstrate the different one of the many types a chaplain can be as a chaplain.

Nancy Berlinger, *The Nature of Chaplaincy and the Goals of QI: Patient-Centered Care as Professional Responsibility*, Hastings Center Report.²² Berlinger discusses hospital chaplain's goals as a hospital administrator sees the chaplaincy department. Her journal examines administrators' goals verses chaplains' goals. Administrators have been eliminating the chaplaincy department in hospitals. Different disciplines within the hospital offer views in how to perceive how a chaplain should do their position. The differences in goals account for the tendency of hospital administrators to undervalue chaplaincy departs, at times to point of eliminating them altogether.

Nathan Carlin, *The Hospital Room as Uncanny: Psychoanalytic Observations and Recommendations for Pastors and Chaplains*, Pastoral Psychol. Carlin believes chaplains should ask if the room is similar to home. The author stated birthing rooms are not typical hospital rooms. Carlin's article was inserted to make a statement on what effects a chaplain while at the

²¹ Sarah Pulliam Bailey, "Chaplains Watch and Wait after DADT Ends," *Christianity Today*, September 22, 2011.

²² Nancy Berlinger, "The Nature of Chaplaincy and the Goals of QI: Patient-Centered Care as Professional Responsibility," *Hastings Center Report* 38, no. 6 (2008).

hospital. Carlin point of view is the hospital rooms should nurture home like atmosphere for quicker healing. Carlin wants to put live plants in the patients' rooms.

Janice Coffing, work is, *Let the Little Children Come to Me: A Perinatal Palliative Care Experience*, Chaplaincy Today. Coffing wrote about a single day as a chaplain. This article is responding to an administration's desire to eliminate jobs of chaplains. The administration does not see the added value of having a chaplain on staff. Coffing points out that there is more than just doing church services for the patients.

Rhonda S. Cooper, wrote, *Case Study of a Chaplain's Spiritual Care for a Patient with Advanced Metastatic Breast Cancer*, Journal of Health Care Chaplaincy. This is a tribute to a patient. The chaplain gets all kinds of calls. This journal is the answer to why chaplains do what they do.

Paul M. Schyve, *Commentary from a Physician*, Association of Professional Chaplains. Schyve asserts that there must be standards in areas especially from the chaplaincy's department when treating patients in acute care. Schyve is a medical doctor and follows a set routine to assure positive results every time. Still another dissertation has the chaplains-in-training attending eight teaching sessions, ten training sessions, and three evaluations according to Schyve. All of the statements were broad generalities. "Faith-The-belief [sic] system, or set of beliefs, an individual develops personally, or through an organized religious group, or teacher/instructor."²³ Schyve is a medical doctor it a chaplain. A chaplain would not tell a medical doctor how to do surgery. As it was mention before, everyone has an idea on how to train volunteer hospital chaplains. The only problem is no one asked a hospital chaplain on what it takes to be a volunteer hospital chaplain.

²³ Paul M. Schyve. "Commentary from a Physician," *Chaplaincy Today* 25, no. 2 (Autumn/Winter 2009): 31-32.

Marty Wilson's dissertation focuses on training local clergy as volunteer chaplains. "Major goal is to design a chaplaincy program which utilizes volunteer clergy."²⁴ The program includes a test to see if the clergy are competent to be a volunteer chaplain and ten meetings for instruction. Whereas my training will eliminate the people people who should not be a chaplain. Clergy are very busy people. In contrast to Wilson's training, the training in this dissertation utilizes volunteer lay Christians in order to free up time of the local clergy to be with families and church members.

Bible Passages

The Bible is the reason for this dissertation. Bible verses are divided into three main categories: calling, how a chaplain is selected, and why chaplains are called to serve God.

Calling

In Matthew 22:14 that states many are invited but few are chosen. Some people are not called to be chaplains. That is why the volunteer program is in place to screen out the ones who thought they were called by God to be hospital chaplains.

1 Corinthians 12:27-28 gives authority to chaplains with the concept that some are called to do certain ministries. Isaiah 6:8 the prophet offers himself in service to God's purposes. Many ministers use that bible verse to proclaim their call to ministry.

1 Peter 2:9 are verse is used in the calling of the pastors in the Lutheran Church. It states you are a royal priesthood, a chosen race, and God, has chosen you as Christians to proclaim his good news. The volunteers must determine in the six weeks of training as to whether or not to

²⁴ Marty Watson, "A Project to Establish a Volunteer Chaplaincy Program for the Drumright Memorial Hospital," (D. Min. diss., Midwestern Baptist Theological Seminary, 1992): 4.

become a volunteer hospital chaplain. Ephesians 4:11-12 states some are called to be prophets, evangelists, pastors and teachers. Likewise some are called by God to be chaplains.

Chosen

When volunteer chaplain's training calls out for a letter from the pastor it is rooted in 1 Corinthians 16:3, where Paul mentions letters of explaining authorizing Christians to do a particular work of the Lord. Paul is stating this person is a good upstanding person and will act in my behalf. Likewise the letter from the pastor stating this person is capable and is acting in my behalf as a chaplain. Ephesians 6:11-14 talks about putting on the armor of God. As a chaplain one must put that armor on daily to do the task at hand for that day and for that patient. Clearly the volunteer's actions, thoughts, and prayers must be from God at all times. 1 Timothy 3:1-7 explains the rolls of a minister or chaplain.

Calling by God

In 1 Corinthians 16:14 Christians are called to have the love of Jesus in their hearts. Chaplains are called to love one another as Jesus did. 2 Corinthians 1:3-5 chaplains are called to comfort people in need. Jeremiah 30:17 calls chaplains to heal the sick.

Ecclesiastics 3:1-4 there is a time for everything. There is a time to mourn and a time to dance. Christians are to celebrate life and everything life offers. Chaplains are expert on mourning and death. Most importantly in Revelation 21:4 shows Jesus will be there to wipe away the tears of his people. There is no more pain in heaven.

CHAPTER TWO

INTERVIEW, SURVEY AND SURVEY RESULTS

*"For many are invited, but few are chosen."*²⁵

God invites everyone to be with him, however, very few answer the call to be with God's call. Instead they choose other things in life like of money, power, pleasures, and other sins. This bible verse is just a general topic for the whole chapter. However, according to the scriptures some will be teachers and some will be prophets. The case is true with the calling of chaplains. Not everyone is cut out to be a chaplain. This training will help the individual who is called to be a chaplain.

Interview

Kenneth J. Doka, PhD, M.Div., is a professor of gerontology at the Graduate School of The College of New Rochelle and senior consultant to the Hospice Foundation of America. Doka's books include *Counseling Individuals with Life-Threatening Illness; Disenfranchised Grief: Recognizing Hidden Sorrow; and Disenfranchised Grief: New Directions, Beyond Kübler-Ross Death and Dying*. In addition to these books, Doka is editor of *Omega: The Journal of Death and Dying and Journeys: A Newsletter to Help in Bereavement*. He has served as a consultant to medical, nursing, funeral service and hospice organizations as well as businesses and educational and social service agencies. Doka also gives interviews to doctoral candidate students. Doka is an ordained Lutheran minister. He has over forty years' experience in teaching, research, writing, and being an adviser to hospice, hospitals, and students.

Rev. Lisa Kanne, M.Div., has been a Christian chaplain for more than twenty years. She has training in crisis management, death and grieving, Clinical Pastor Education, (CPE), suicide

²⁵ Matthew 22:14.

prevention, and hospice. She was ordained by Christ Centered Church, Huger, South Carolina.

Doka is a primary source on matters of death and dying because of his research in that field. He is on the national board for Hospice of America. Doka was so kind to take his time out of his busy schedule for this interview so it could be included in this dissertation paper. The interview is as follows.

The questions were different from what was asked of the ministers. Dr. Doka is a leading authority in the field. What was asked was basic how you actually visit patients and what the normal accepted way of addressing the patient. Plus there were some personal questions like how do you relax? Being a chaplain or lay Christian chaplain volunteer can be very stressful. Dr. Doka gave some great insight on how to interact with the patient. With the CPE (Clinical Pastoral Training) it was stressed not to touch the patient. Doka states always ask and see if it is all right to touch the patient. The patient will speak up if they want to be touched. The hospital is not a touchy feely type of place. As Doka stated it may hurt the patient if they are touched. Give the patient a choice.

While a person is in the hospital choices are taken away from them. The choice is that of the health care professional and not the patient. With asking the patient if they want to be touched gives them control and most of the time they say, "Yes please do." They extend the hand not the chaplain.

There will be times where the care of the patient is very disturbing. Examples would be when a patient dies. How does a lay Christian volunteer chaplain departmentalize what has just happened. What kind of activities help process the event that just took place? That was the reason for question five. Dr. Doka's advice was get closer to family and love ones. He also said to exercise and let it go. He also mentioned to have a pastor to call and talk with especially if

there is a bad or good day.

“Yet, caregiving can be a burden that drains a person not only physically and psychologically but spirituality as well.”²⁶ This is a warning that even the best chaplains can get stressed out. This was written so the main caregiver will take time to relax. If one does not relax than one might be in the bed right beside the person they are taking care of.

Another key area is to be an advocate for the patient by the chaplain. As a lay Christian volunteer chaplain you have the obligation to speak out for the patient. This could be as little as the food one has for dinner. The patient needs for cord to charge the cell phone. As the lay Christian volunteer chaplain have the time to talk with the patient to ease their mind as to how everything is going at the hospital. The staff can only do what the doctor orders for the patient. Many times the patient has many questions about the health care and what might be next as to surgery, tests and when the patient can go home.

Lastly, the interview aligns more with the younger ministers in the survey. There are new ways in which patient care is going. The old way is good but leaves the patient still questioning what happened and where the care is going in the next few days; however, the new way gives the patient choices and not just leaving them to lay in the bed needing questions answered. There have been cases where the dose of the medicines a patient was taking was wrong. The chaplain listens to the patient to make sure the right medication was given to the patient. This is just one way the chaplain can assist.

A chaplain is more than just a person who gives services for the hospital on Sunday. A chaplain brings God to the bedside. A chaplain is also a witness not only to the patient but also

²⁶ Kenneth J. Doka, “The Spiritual Gifts and Burden of Family Caregiving,” *Generations* 27, no. 4 (Winter 2003/2004): 45-48.

the friends and family of the patient. The chaplain is also there for the staff. The staff also hurts when the patient dies. This happens for example when a little child dies and there is a death in the emergency room. Many times the question comes up what if I did this to assist the doctor. Or why did this child die so young?

This interview with Doka was not a simple interview. There were many feeling that were between the lines. Basically stated God is in charge. Many times all a volunteer Christian chaplain can do is just be present. Just being present is one of the hardest things to do as a chaplain.

Being present could be a hug, a nod of acceptance, just standing there and many more just being in the same room as the people who are hurting. As a volunteer Christian chaplain grows into the position of “being present” in ministry. It is one of those things that you will know when you know. It is like explaining what is love? Sometimes words are not said. It could be a smile or squeezing of the hand. It is just being there. It is okay just to stand there and let the patient, friend, family member, or staff person make the first move.

Being present in ministry is being still and waiting on God. Sometimes just being in a quiet place and say, “Jesus” over and over helps. What this does is allows God to work through and with you in troubled times. Some people have candles that they light and listen to soothing music. This chaplain does not recommend lighting of candles inside a hospital except if one is at the altar of a Catholic chapel.

“Over 70 percent of the chaplains were part time with other parish commitments many voiced the concerns of the pressures that time constraints enforced upon them those working in larger hospices reported significantly higher levels of stress than those working in smaller units and these chaplains tended to conduct a larger number of Funerals which was also identified as a significant factor in reporting higher perceived stress levels.”²⁷

²⁷ Mari Lloyd Williams et al., “A Prospective Study of the Roles, Responsibilities and Stresses of Chaplains Working Within a Hospice,” *Palliative Medicine* 18 (2004): 638-45.

The chaplains had high stress levels as they faced death every day at the hospital setting.

Chaplains who were at smaller centers had less stress because they did not face a death every day.

There was a survey and an interview taken. How does that equate to the training/education for chaplain volunteers? Below are the survey questions that were asked of ministers from Kinston, North Carolina.

Survey Questions

1. When you visit patients in the hospital what do you see as your primary role(s)?

This question was asked to prioritize the pastors' role while at the hospital. Generally speaking, most people do not like to go to hospitals. The prevailing feeling is one goes to the hospital to get better or die. This question was asked to see how the pastor felt about going to the hospital.

2. Describe a typical hospital visit. (Please give any information you believe would be helpful for one starting in a hospital ministry. For instance, how long do you typically stay, how does the visit begin, what do you say to the patient, etc.)

Question twows asked to see what exactly took place durning a hospital visit. What was needed by the church member like put the dog out and feed the dog. Maybe who the patient wanted to be called if they went to be with the Lord.

3. Have you ever received any specialized training in hospital visitation or patient counseling? If so

Please describe as the dissertation will include a section on professional chaplaincy training.

The third question was put into describe any formal training like CPE (Clinical Pastoral Education). Some ministers have been ministering before needing a master of divinity. Kinston is a small city. The people of Kinston does not like outsiders coming in to their town and say the church must change. The churches that are not changing are withering out and dying. The youth are going to churches with different music. However, the message is still the same. The message is Jesus is alive. It is the members of the church do not want to change the way they worship.

4. Do you believe that volunteers can play a helpful role in patient or staff spiritual care? If yes, what role(s) do you think they would best serve?

This goes right into the heart of who is in charge of the church. Is God in charge or, the pastor, or the members who give the most money to the church? Does the pastor embrace the change?

5. Based on your experience, what skills or knowledge training would hospital chaplain volunteers need to serve effectively?

This question was included to find out what the pastor had to say if they could give advice.

6. What are some of the potential spiritual, ethical, or professional dangers in using volunteers for hospital patient interactions?

This is another question where the pastor could express their feelings without ramifications. The pastors wanted to make sure that personal information was not the talk of the town. Possibly how the patient felt about the pastor.

7. What personality traits or personal skills do you believe are most needed for effective hospital ministry? (For instance, listening skills, Bible knowledge, counseling ability, etc.)

Here is where the pastor could state their feelings on what would make a great chaplain and likewise a not so great chaplain.

8. What are some professional, medical, or ethical limitations or requirements that volunteers should be made aware of?

Specifically this question was added to make sure no ethical issue was left out of the training of the volunteers. The volunteers could not preach the Gospel without proper authority.

9. What do you see at the greatest benefit or blessing of working with patients in hospitals? What gives you the greatest satisfaction in this particular type ministry? Why would you encourage someone to consider this type of volunteer position?

This is three questions rolled up into one huge question. The first one is the blessing one receives while being with the patient. Each patient has his or her own story to tell. The second part is what type of satisfaction a minister receives while visiting patients. The answer is simple. That being if the local pastor has done his or her job than dying is not a burden. Going to heaven is a reward for living the life as close as they could while on earth.

10. What warning(s) or potential pitfalls would you share with to prospective lay hospital chaplain volunteers (for example, burnout, excessive emotional involvement with patients, family members, etc.

What warnings are many for a volunteer chaplain? The volunteer chaplain may relive his or her trauma through the patient thus taking the trauma home and causing real pain and or illness for the volunteer. The objectives of the volunteer must be kept at bay so they can function as a person and not take home the troubles of the patient. It is very important that the volunteer has someone to talk things over with otherwise the volunteer will burn out and not be useful as a chaplain to the hospital.

There was one more question that was asked of the ministers.

That question was how many years have you been doing the ministry?

The number of years in the ministry correlated with the answers given. The questions were passed out to the local ministers in the community. Strictly confidential who received the questions and what was written as answers for the questions. Most of the ministers pastored small congregations. Below are the results of the survey.

Survey Results

Many questions were asked in amenity from fifteen pastors in Kinston, North Carolina area in 2013. The pie chart is the summary of the ministers' answers. Most are from small churches. Small church dynamics figure into the answers of the survey. Kinston, North Carolina, has a population of about 35,000 people. This is a farming community and works from sunup to sundown. They are a group of people that work very hard on the farms. They are a reserve type of people. So here are the results of the survey. Below is reference to the number of years a minister has been called:

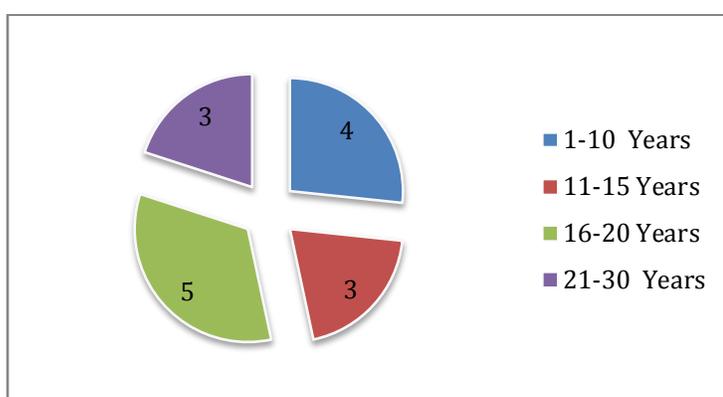


Figure 1. Number of Years in the Ministry

The survey had the following results.

The number of years as important when answering the questions. The more years the minister has, shows a reluctance of allowing a volunteer chaplain to see church members. This is evident with the formal training a minister has in hospital visits. The memberships of the churches were less than 150 members. A small church's dynamics plays into the role as to why ministers are leery of allowing lay delegates to visit members in the hospital. It all comes down to who holds the purse strings in the church. The most generous members really want a visit from the minister, not a stand-in minister when they go to the hospital. Therefore, if the member does not receive a visit, from the pastor, the pastor comes under scrutiny by the church.

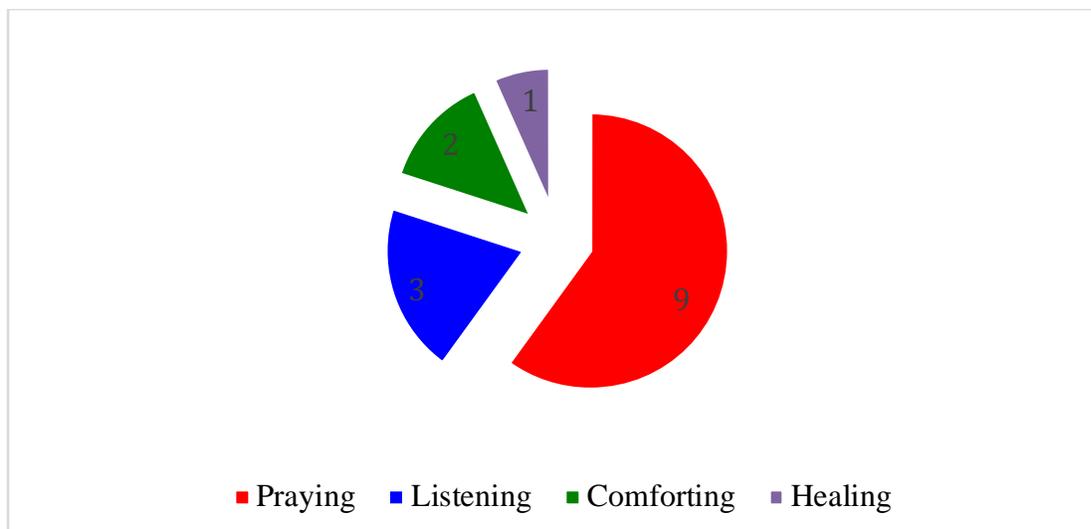


Figure 2. The Primary Goal of Pastors' Hospital Visits.

Figure two explains a hospital visit by the minister. The answers were typical in response. Nine ministers said prayer was the primary goal when they went to the hospital to visit church members. Three ministers said listening was the goal when they saw the church member. Only two said they went there to comfort the patient. Lastly, one minister went to the hospital to heal the church member.

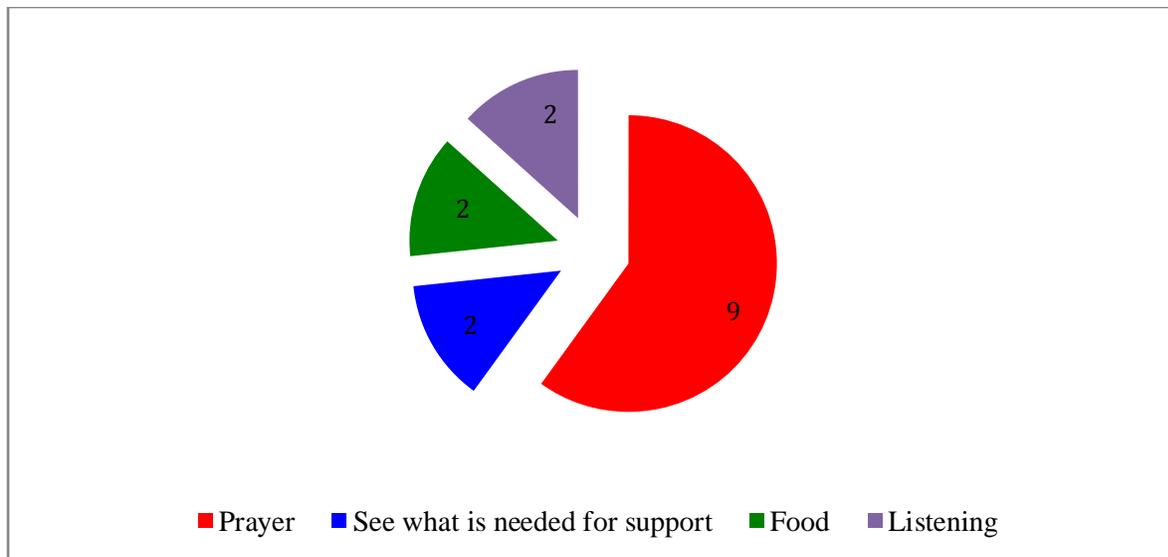


Figure 3. How Each Minister Spends His Time Ministering.

Figure three details how the minister feels his/her time is viewed. Start first with prayer. Next comes what type of support is needed. Then, the patient tells his/her story to the minister. Finally, two ministers mentioned patients complained about hospital food. If patients complain about the food, it could mean they would be going home soon.

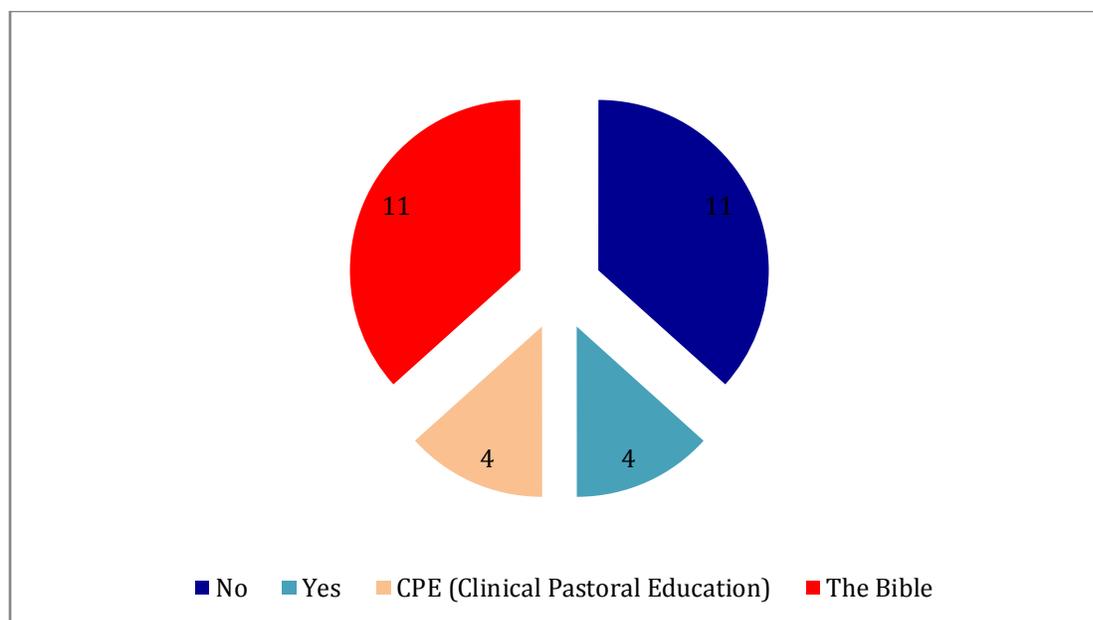


Figure 4. Have you received any specialized training in hospital visits or patient counseling?

Figure 4 deals with the education of a minister in the survey. This is where the number of years in the ministry correlates with specialized training. The length of ministry service may indicate may indicate the extent of formal training. The number of ministers with the most experience said, majority of their training came from the Bible; however, the ministers, with the least number of years, stated their formal training came from CPE as part of their seminary education. The fewer years in the ministry the more a minister has had formal education from CPE. The seminary teaches ministers to be a pastor of a church verse's being a hospital chaplain. There are different concepts in being a hospital or hospice chaplain verse's running a church.

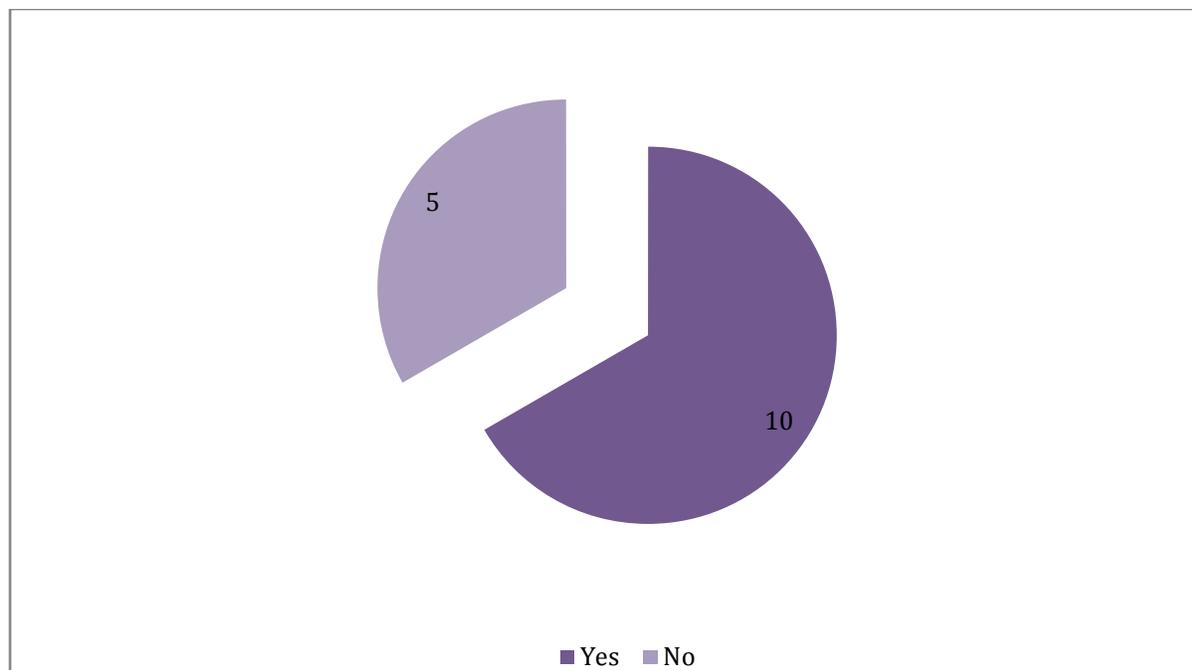


Figure 5. Do you believe volunteers can play a helpful role with patient or staff spiritual Care?

Figure 5 states ministers believe a volunteer lay chaplain will help in the hospital. This question falls into the small church dynamics. The answers concerned a minister's pay. A small church tells a minister what they can or cannot do as a minister.

Many small churches imply ministers must visit church members who are at the hospital. The younger ministers agreed to support a lay chaplain. This is a clear picture of the dynamics of the small church. Again, this goes along with the number of years in a minister's service. The ministers with the most years of service believe a layperson is not helpful. The number of minister who had training stated without a doubt, lay chaplains would help.

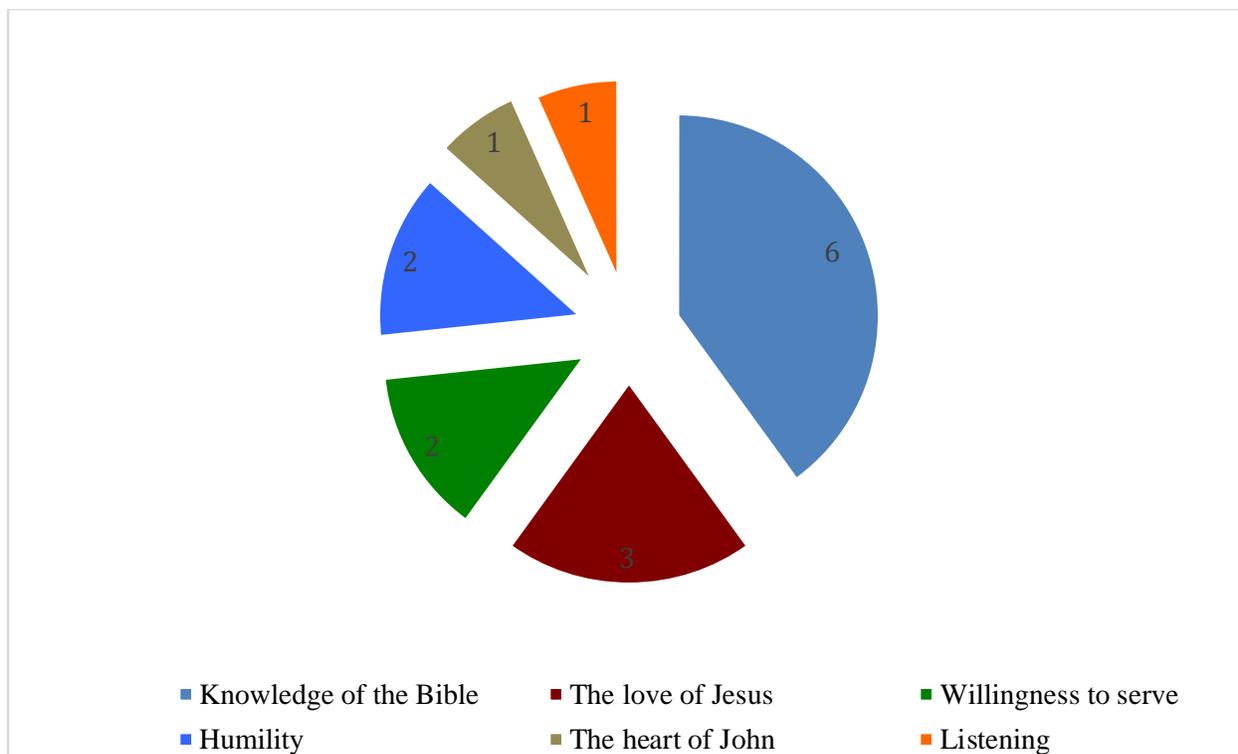


Figure 6. What skills or knowledge can help volunteers serve effectively?

Figure 6. Demonstrates the experience, knowledge and training for a minister. Do you believe volunteers' play a helpful role in-patient or staff spiritual Care? Again, this goes along with the number of years a minister has in service. The ministers with the most amounts of years stated: No, the layperson would not be helpful. The number of ministers with chaplain training stated without a doubt lay people would help with visits at the hospital. Most of the time if death was emanating the volunteer would can the minister to come to the hospital.

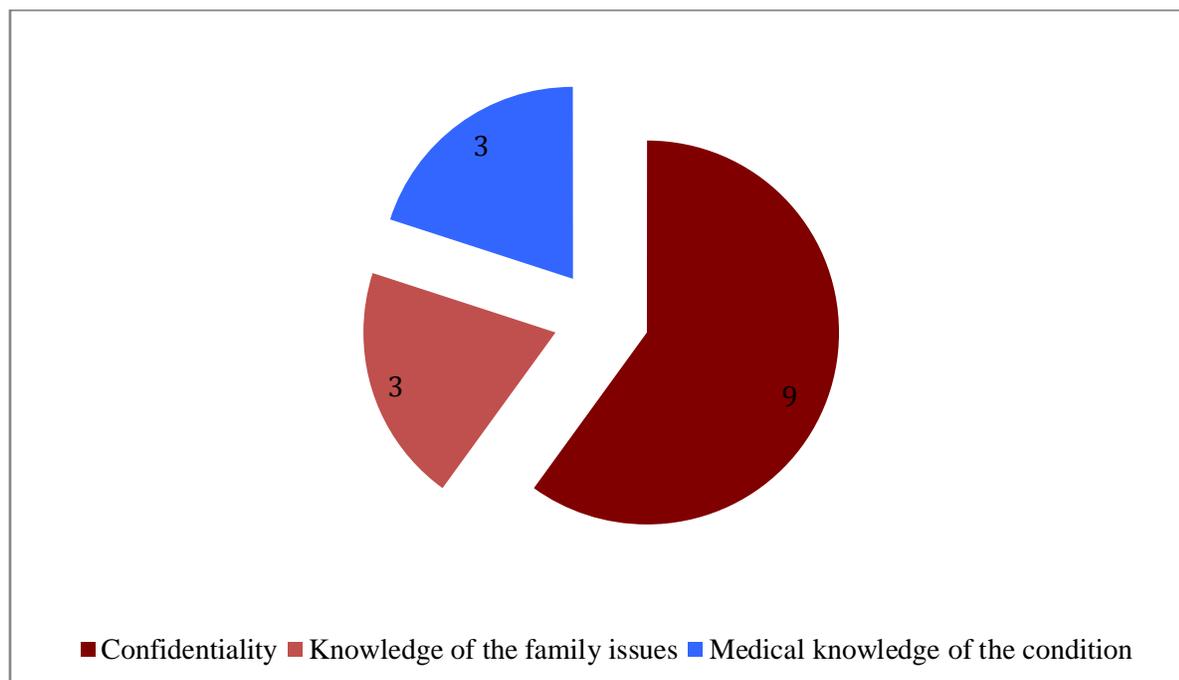


Figure 7. What are some potential spiritual, ethical, or professional dangers in using volunteers for hospital-patient interactions?

Figure 7. Maps out the potential dangers of using lay volunteer chaplains. The biggest concern in the surveys was confidentiality. The ministers added many comments about a patient's privacy.

The next problem involves knowledge of family issues. Many ministers stated family secrets are confidential; as well as a patient's medical condition.

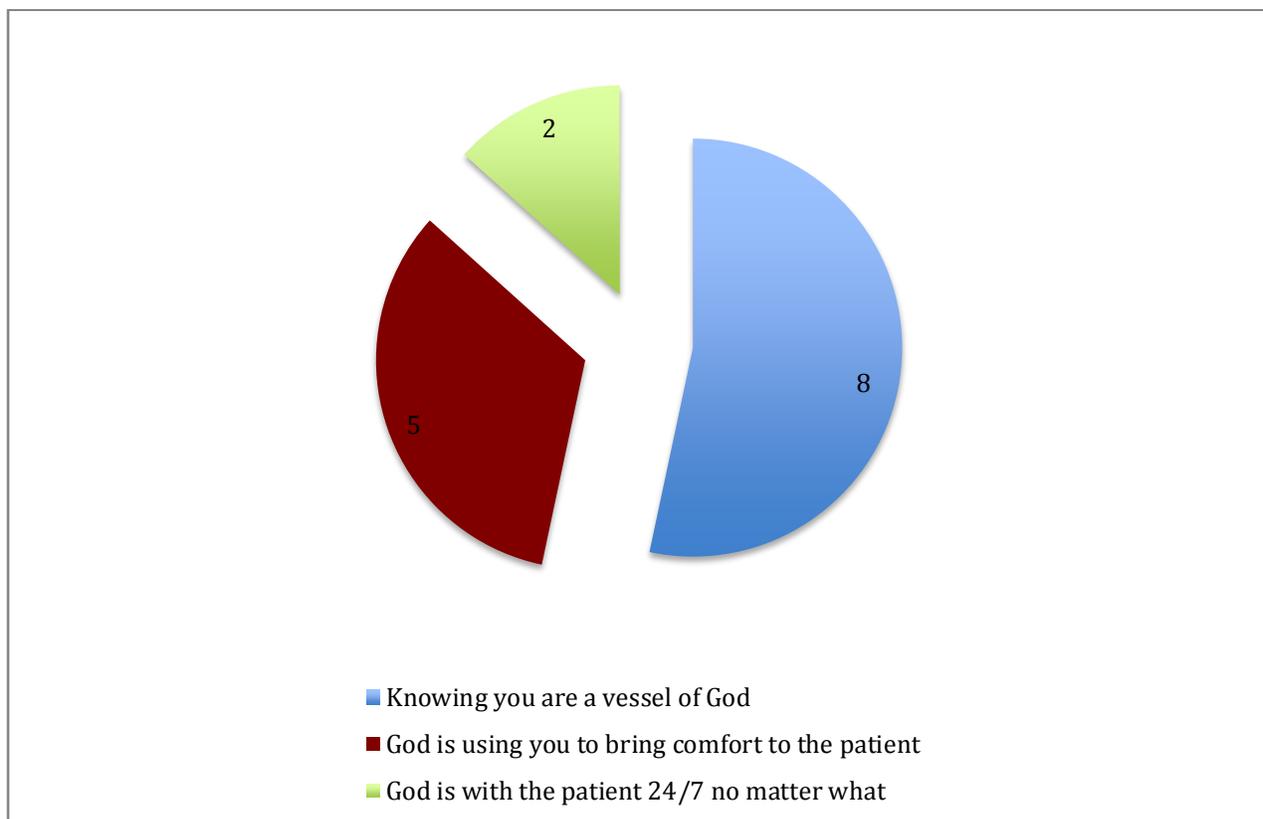


Figure 8. What personality traits or personal, medical, or ethical limitations or skills, do you believe are most needed for effective hospital ministry?

Figure 8: Lists the traits of a volunteer chaplain. The ministers' answers were surprising. Eight ministers stated the importance of realizing a volunteer lay chaplain is a vessel of God. The next statement was God is using the lay volunteer to bring comfort to the patient, patient/church member. The ministers emphasized their beliefs God is a constant presence while in the hospital.

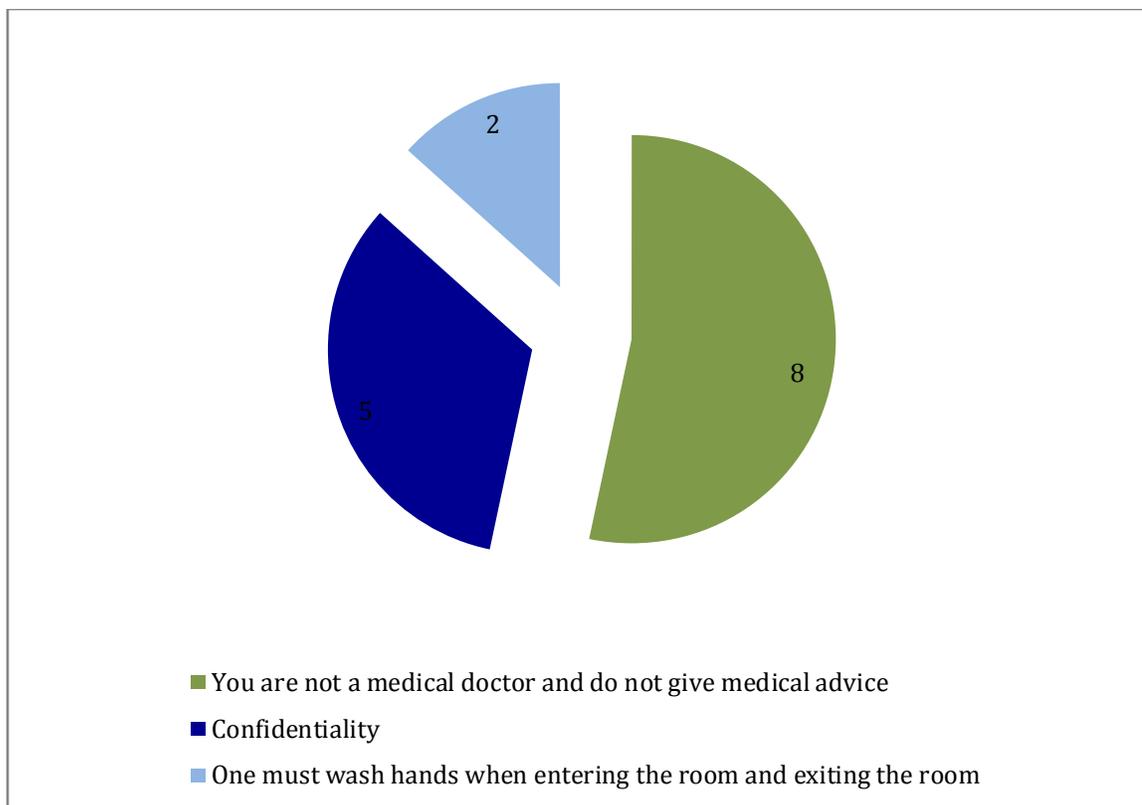


Figure 9. What are some professional, medical, or ethical limitations or requirements volunteers should be made aware of?

Figure 9. Ethical issues chaplains face. The answers were surprisingly honest. The top of the list was do not give any medical advice. A lay volunteer most likely will not have a medical degree. The next words of wisdom were confidentiality. The member's medical conditions are between the doctor and patient; not the doctor, patient, and the world. One must wash their hands when entering and exiting the room. The washing of hands tells the patient that the volunteer does not bring in other germs from other patients.

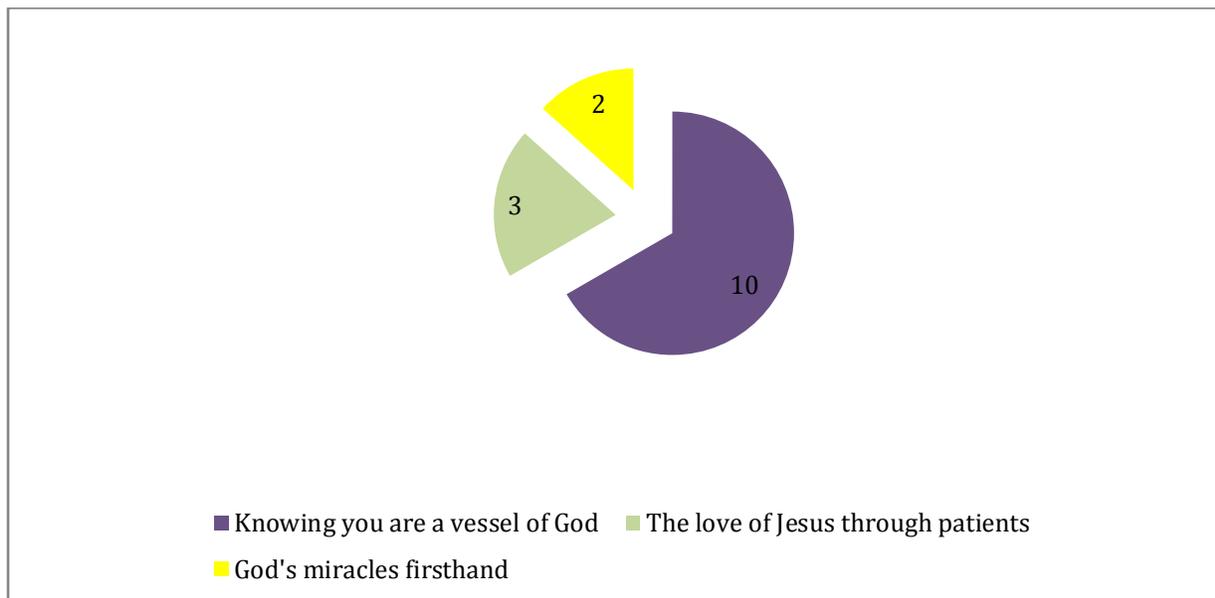


Figure 10. What do you see as the greatest benefit or blessing of working with patients in hospitals?

Figure 10. Lists some benefits of being a lay chaplain. There were no surprises with the answers. Again, the answers coincide with the number of years a minister has versus the new ministers. The greatest answer is a lay volunteer is a vessel of God to the patient/church member. If one looked at the patient/ church member, one can see Jesus in that person. One witness' the miracles of God through the patient/ church member.

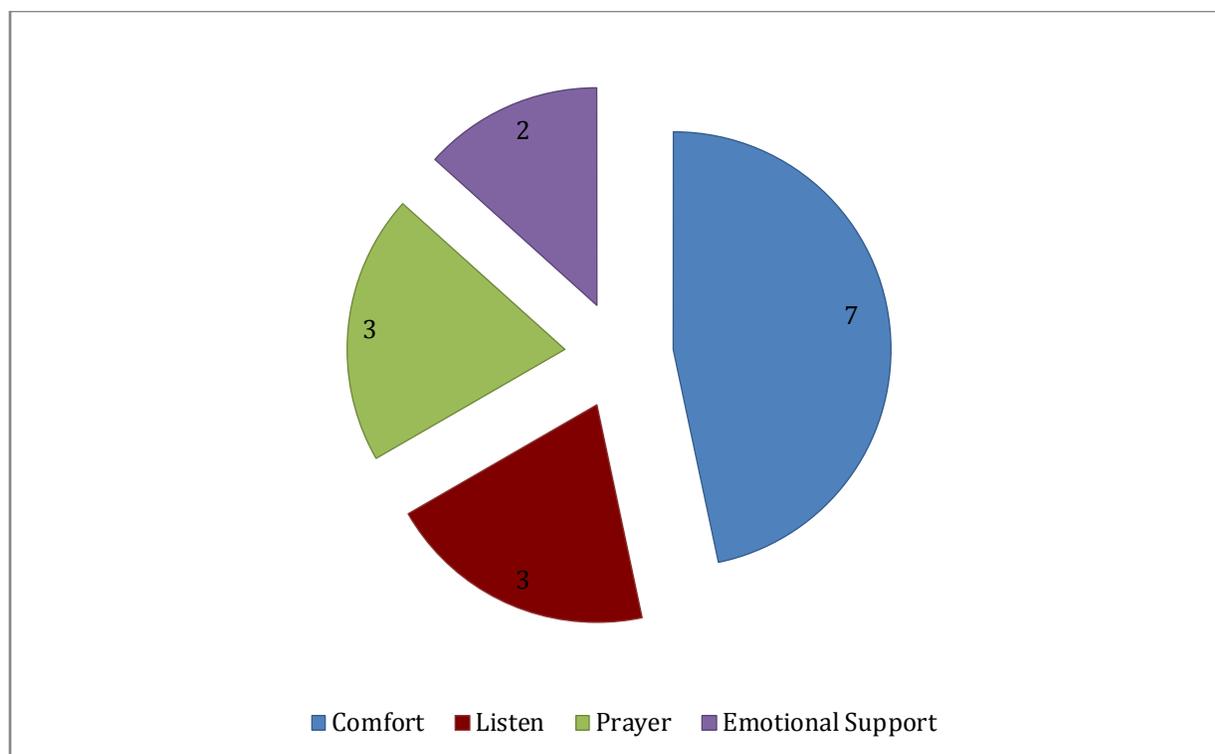


Figure 11. What warnings or potential pitfalls would you share with to prospective lay hospital chaplains?

Figure 11. Deals with the pitfalls of being a lay chaplain. As a lay volunteer, one brings to the patient/ church member comfort that Jesus is with them constantly. The lay volunteer is standing between / bridging the gap for them to God. The next is the art of listening. Many times, the church member/ patient is scared of the unknown. The lay volunteer brings forth the most powerful weapon one has: prayer. What goes along with prayer is emotional support. Again, it is the patient/ church member not in control of the outcome while at the hospital. When this happens, the patient/ church member realizes God is in control and not them.

CHAPTER THREE

EDUCATION

“For everything that was written in the past was written to teach us, so that through endurance and the encouragement of the Scriptures we might have hope.”

The Bible was written to be read, devour, absorb like a sponge, and learn from the past. The Bible, according to this scripture, was written so to give hope and encouragement. Part of being a chaplain is to provide hope and encouragement.

Education

The goal of the thesis project research is to give lay Christians more knowledge on how to be a volunteer chaplain at a hospital. What is a chaplain and a brief history of a chaplain? Where does the training start? How does the hospital recruit? These are many of the questions asked by everyone involved in the training. A letter has to be completed by the pastor stating the pastor welcomes this individual and has met the requirements to take the training for lay Christian volunteer chaplain. These are the questions to be answered with the proposed training being offered at Lenoir Hospital.

The hospital will publish in the local newspaper for a training class. The ad will contain all information about the training.

Start the training with prayer. Tell volunteers, not everyone will finish the training, which is expected and acceptable. Not everyone can be a chaplain.

Ephesians 4:11-12 states “It was he who gave some to be apostles, some to be to be evangelists, prophets, some and some to be pastors and teachers.” This passage is sometimes called the gifts of the spirits, and this verse is definite on who will be the leaders of the church.

A Brief History of Chaplaincy

When one first thinks of chaplaincy, the military comes to mind. “There were many chaplains in the Civil War. Historical records have revealed over one hundred chaplains killed in the line of duty in WWII. According to research, most chaplains are Christian. There are some Rabbi Chaplains. There were 2,900 active-duty chaplains as of 2011.”²⁸

There are also hospice chaplains, who deal with death and dying on a daily basis. A hospice chaplain handles the long-term illness, end-of-life-care, and terminal illness. The categories of a chaplain include military, hospital, and hospice. One might add crisis chaplain because of all of the violence in the world today. As the world is growing many more types of chaplains are developing such as sports, work, university, prison, congress, law enforcement, and music. First things first, one must know the extent of a chaplain’s duties.

Definition of a Chaplain

According to Dr. Charlie N. Davidson defines chaplaincy as “Chaplaincy is a ministry of presence, whose main purpose to listen, care and respond appropriately to a patient’s needs. Specific duties may include performing church services; praying with patients, family and staff; conducting funeral services, providing bereavement counseling, baptisms, communion and general ministry.”²⁹ This was an email from Dr. Davidson, a retired military chaplain, who now teaches at Liberty Baptist Theological Seminary, Lynchburg, VA. This is the best definition for a

²⁸ Bailey, “Chaplains Watch and Wait.”

²⁹ Charlie N. Davidson, email to author, September 11, 2011.

chaplain.

Another definition of a chaplain. “The most important part of being a chaplain is illuminating the psychospirituality in a person that motivates them to improve their mental status, emotionality, and quality of life.”³⁰

Calling of a Chaplain

Now we know what a chaplain is, one has to understand the biblical calling of a chaplain. This is one of my favorite Bible verses. Isaiah 6:8. “Then I heard the voice of the Lord saying, whom shall I send? And who will go for us?” And I said, "Here am I. Send me!"³¹

This is where Isaiah tells the Lord to send him. Many people use this verse to answer their call to work with the Lord. The verse is an emotional verse, because Isaiah loves the Lord. This is the first step in committing to work with the Lord.

There are a few parameters, according to the Bible; one must meet to be a minister in the church. First Timothy states: Sometimes a chaplain is called a minister.

1 Timothy 3:1-7 Here is a trustworthy saying: If anyone sets his heart on being an overseer, he desires a noble task. 2 Now the overseer must be above reproach, the husband of but one wife, temperate, self-controlled, respectable, hospitable, able to teach, 3 not given to drunkenness, not violent but gentle, not quarrelsome, not a lover of money. 4 He must manage his own family well and see that his children obey him with proper respect. 5 (If anyone does not know how to manage his own family, how can he take care of God's church?) 6 He must not be a recent convert, or he may become conceited and fall under the same judgment as the devil. 7 He must also have a good reputation with outsiders, so that he will not fall into disgrace and into the devil's trap.³²

A volunteer hopeful has been the same as a deacon, pastor, or teacher. The part where a person

³⁰ Kristin A. Crowe, “An Interview with Dr. Atty. Paris M. Finner-Williams,” *American Psychotherapy* (Spring 2008): 1.

³¹ Isaiah 6:8.

³² 1 Timothy 3:1-7.

cannot be a recent convert is important. As a chaplain, one will see and hear many things. Some situations will be against your beliefs, while others will be exactly what the chaplain believes. There will be many situations, a chaplain will experience; therefore, the chaplain must be of a sound mind, spiritually and mentally. “The nature of the God is that God cares for each person. Persons experience this in their deeper spiritual selves.”³³

This is what a chaplain feels about the role of a chaplain. Chaplains are more than just issuing out the weekly sermon or communion. Quinlan believes the patients have a voice in their spirituality while at the hospital. The chaplain needs to hear the patients’ own spirituality. Titus 3:6 states an elder of the church must be blameless. “An elder must be blameless, faithful to his wife, a man whose children believe and are not open to the charge of being wild and disobedient.”³⁴ A chaplain must be blameless.

“But you are a chosen people, a royal priesthood, a holy nation, God’s special possession, that you may declare the praises of him who called you out of darkness into his wonderful light.”³⁵ This is how special every chaplain is to God and mankind.

“As standard practice in professional pastoral care has moved from a model featuring clergy visiting patients of their own faith group to multi-faith chaplains visiting all patients on a given hospital unit, questions continue to arise about whether those who specify their religion as ‘None’ should be visited or whether this visit would be seen as an unwanted intrusion.”³⁶ The

³³ John Quinlan, “The Essence of Pastoral Care: An Investigation of Patient Satisfaction with Pastoral Care in an Acute and Psychiatric Hospital,” (diss., Boston University of Theology, 2000), 1-219.

³⁴ Titus 3:6.

³⁵ 1 Peter 2:9.

³⁶ George F. Handzo et al., “What Do Chaplains Really Do? Interventions in the New York Chaplaincy Study,” *Journal of Health Care Chaplaincy*, 14, no. 1 (2008): 39-59.

dissertation states there is a move from chaplains only seeing people of their faith, to chaplains seeing people of other religions.

“Because of their commitment and expertise, chaplains serve a specific and necessary role in the care of patients who are hospitalized. The results of the dissertation are a mandate for chaplains to continue their ministry, with a heightened awareness of the value placed on this ministry by those they serve. Referrals by other members of the health care team and specific requests from patients might assist chaplains in their response to patients' spiritual expectations and needs.”³⁷ This is what is expected from a chaplain at the Mayo Clinic in Jacksonville, FL.

This is what Thompson wrote about a chaplain: “According to them a good chaplain must be caring, compassionate, a good listener, and professional in demeanor; must have a strong sense of accountability in an earthly sense as well as to God, and must be blind to race, creed, color, sex, and social status.”³⁸

That is what some people believe a chaplain does. “I have made the case that chaplains and pastors should inquire about the patient’s experience and about what would make her stay better, and that pastors and chaplains should make these inquiries with certain psychoanalytic concepts in mind.”³⁹ This quote has to do with the dynamics of a hospital room.

One hospital did not have a morgue. When this chaplain walked into the room, the families standing around a dead baby in a crib. What a shock for the chaplain, who had to restrain his/her emotions while talking to the family. Later, the chaplain talked with the head

³⁷ Katherine M Piderman et al., “Patients' Expectations of Hospital Chaplains,” *Mayo Clinic Proceedings* 83, no. 1 (2008): 58-65.

³⁸ Thompson, “Hospital Chaplains: What, Who, and Why?” 72.

³⁹ Nathan Carlin, “The Hospital Room as Uncanny: Psychoanalytic Observations and Recommendations for Pastors and Chaplains,” *Pastoral Psychol* 58 (2009): 27-47.

chaplain about his/her emotional reactions.

Below is an incident that happened to a nurse in Dallas, TX. “(CNN) -- Gail Sandidge rushed to help when screams rang out during a stabbing at a Texas medical center on Tuesday. Horrified patients and family members watched as a man stabbed the nurse in the chest. ‘She was just saying...I'm hurt. He got me,’ witness Jana Jackson told CNN affiliate KLTU, ‘And that's when we realized there was blood all on the front of her scrubs.’ The hospital's president told reporters that the dedicated nurse died trying to save her patients.

Witnesses told KLTU they saw a man running through the surgery center around 7 a.m. with a hunting knife, screaming, "You're not going to kill my mother.’

‘He had a death grip on the knife and he was just muttering and his eyes were kind of wild-looking,’ said Jackson's husband, Chad. ‘It was just, he was very confused.’

Moments later, the surgery center, about 120 miles east of Dallas, turned into a crime scene. Some staff members rushed patients into safe areas. Others performed CPR on the victims, Chad Jackson told KLTU.⁴⁰

‘We're just telling them there's bad people out there,’ Chad Jackson told KLTU. ‘There's not a lot of things we can do about the craziness in the world. That's why we go to church. They pray.

They say their prayers every night. And now, he said, Sandidge and her family will be in their

prayers.’⁴¹ Jackson said the best action is to pray. This could be any emergency room in United

States. The chaplain is on call 24-hours-a-day, 7-days a week. Therefore, the volunteers must

be aware this could happen to them. One of the best Bible verses that comes to up is Isiah 40:28-

31. Here it states: without a doubt God is with us no matter what .we are going through.

Volunteer

Servant leaders follow Jesus rather than seek a position. (Based on Mark 10:32-40).

Servant leaders give up personal rights to find greatness in service to others. (Based on Mark 10:45). Servant leaders take up Jesus’ towel of servant hood to meet the needs of others. (Based on John 13:4-11). Servant leaders share their responsibility and

authority with others to meet a greater need. (Based on Acts6: 1-6).⁴²

⁴⁰ Catherine E. Shoichet, “Nurse Stabbed and Died for Doing Her Job,” *CNN*, November 26, 2013.

⁴¹ *Ibid.*

⁴² Johnny Elbert Renfro, “Pastoral Care in the Clinical Setting: A Training Initiative for Volunteer Chaplains in a Community Hospital,” (D.Min. diss., Erskine Theological Seminary, 2004): 25.

The only problem with Renfro's dissertation is: "Pastoral care in the clinical setting; a training initiative for volunteer chaplains in a community hospital."⁴³

Renfro never gives the volunteer the title of "assistant chaplain." The title of assistant chaplain demands respect. You are asking the volunteers to do a chaplain's work with no title or pay. Some titles demand respect. The title at Lenoir Memorial Hospital will be the title of assistant chaplain. They will have the respect of a person of God and the position.

In Matthew 18:20: "For where two or three gather in my name, there am I with them."⁴⁴ Just like when a chaplain goes into a patient's room there are two or three people gathered together. Expect a miracle! At Lenoir Memorial Hospital, they will be called assistant chaplains.

Renfro trained volunteer chaplains to work at a community hospital. This is how he proposes to train volunteer chaplains. "Four classes presented a variety of training materials intended as a refresher course for experienced clinical chaplains and a broad-base introduction for those whose experience to date has not included hospital service."⁴⁵ Renfro has only the four classes. Many volunteers can complete the classes with no personal hardship to family, job, or to their position in church. "A well-meaning caregiver told a family member. After a loved one dies, that 'God needed her more than you did.'⁴⁶ Statements like this are often spoken with good intentions, but can be traumatic. This is why lay chaplain training is needed. The training equips

⁴³ Renfro, "Pastoral Care in the Clinical Setting: A Training Initiative for Volunteer Chaplains in a Community Hospital," 27.

⁴⁴ Matthew 18:20.

⁴⁵ Renfro, "Pastoral Care in the Clinical Setting: A Training Initiative for Volunteer Chaplains in a Community Hospital," 27.

⁴⁶ Myra Raab, "Training Spiritual Care Volunteers," *Health Progress*; 86, no. 6 (Nov/Dec 2005): 60-61.

the volunteer on the proper language.

Travis is training ministers to be volunteer chaplains in small hospital settings. “As a general rule clergy who serve as a volunteer chaplain see this natural extension of their ministry in the local church.”⁴⁷ That statement may be true. However, not all chaplains are gifted as pastors. Likewise it is true with pastors. Not all pastors are chaplains. Sometimes extending the ministry is not a good idea for ministers.

“Effectively addressing emotional needs, which includes meeting spiritual needs and support from one’s religious community, is consistently among the top five priorities listed by patients and their families according to data collected by Press Ganey and other patient satisfaction organizations.”⁴⁸ Making patients comfortable when they come to the hospital is an important part of their care. To do so requires addressing their religion from the beginning, right after they present their insurance card. If the religious preference is not on the chart when the chaplain visits, the chaplain should record the information.

The credentials of the Board Certified Chaplain

According to the *Common Standards for Professional Chaplaincy*, any board certified chaplain will have the following basic qualifications and accountabilities: Obtained a bachelor’s degree from a college or university that is appropriately accredited. Obtained an appropriately accredited master’s degree in theological studies or its equivalent.

Be ordained, commissioned, or similarly recognized by an appropriate religious authority according to the standard practice and policy of that authority. Completed four units (1600 hours) of clinical pastoral education (CPE) as accredited by the Association for Clinical Pastoral Education (ACPE), the United States Conference of Catholic Bishops Commission on Certification and Accreditation or the Canadian

⁴⁷ Brandon Keith Travis, “Operation Balm Volunteer Chaplains for Small Hospital Settings,” (diss., D.Min. Erskine Theological Seminary, 2009): 19.

⁴⁸ John Olsen, “Improving Identification of the Religious Affiliations of Hospital Inpatients,” *Chaplaincy Today*: 27, no. 1 (Spring/Summer 2011): 1.

Association for Pastoral Practice and Education (CAPPE/ACPEP); one of these units may be an equivalency. A current endorsement by a recognized religious faith group for ministry as a chaplain. Met competencies for chaplaincy as established by the Spiritual Care Collaborative. Remain accountable to the endorsing faith group, employer and certifying body. Affirm and practice chaplaincy according to the Common Code of Ethics. Maintain membership in a certifying body by participating in a peer review every five years, documenting at least 50 hours of continuing education each year and providing documentation of endorsement with his/her faith tradition every five years.⁴⁹

It takes four years to earn a bachelor's degree. It takes three years to earn a master of divinity degree. In addition, the four CPE units required to be trained as a chaplain is yet another year. It is a total of eight years of college to become a chaplain. Many for-profit hospitals want to eliminate the chaplain program entirely. Administrators feel the chaplaincy program only deals with God and God-like things. The administrators' perspective might change if they were to walk around with the chaplain for a week. The administrator should be there when a patient dies, or when someone on staff breaks down after car accident victims comes to the emergency room and no one survives. The chaplain is there for the staff as well as for the patients. This is the main reason for having the Lay Christian Chaplain Training. At Lenoir Memorial Hospital, the chaplain is only there Monday through Thursday; many crises will occur outside this time. This training is needed for support of the community, family, staff, and patient.

While some administrators are unable to see the importance of the chaplains' work, many doctors understand the role chaplains play in patients' health. "We find that physicians generally see chaplains as part of interdisciplinary medical teams and work with them around certain topics, most frequently related to death."⁵⁰ Doctors see chaplains as part of the medical team.

⁴⁹ Stephen King and Jon Overvold, "Standards of Practice for Professional Chaplains in Acute Care," *Chaplaincy Today*: 25, no. 2 (2009): 4.

⁵⁰ Susan Strang and Peter Strang, "Questions Posed to Hospital Chaplains by Palliative Care Patients," *Journal of Palliative Medicine* 5, no. 6 (2002): 857-69.

The chaplain's importance is more than just doing "God-like" things around the hospital. Chaplains are called in to deal with car accidents, talk with the lonely patients, intervene between doctors and patients or staff, and talk with families and friends of the patient. The previous sentence only mentions a few things a chaplain does for the patient and or hospital. It all goes back to the amount of education a chaplain has for the minimal to become a Chaplain as outlined above. A chaplain can get certified in crisis intervention, suicide prevention, AIDS counseling, and hospice only to mention a few areas of expertise.

"They did in fact pose medical questions about illness trajectory, suffering, food, drugs, dyspnea, health care, and expected survival time."⁵¹ This is what chaplains said the patients asked them. The chaplain conducted the survey for the hospital.

"There were also specific changes in nurses' attitudes and knowledge, the chaplains were higher. The results indicate that training in spiritual care for nurses may have positive effects on health care that patients can experience."⁵² When the nurses received some spiritual training the patients asked for more referrals for the chaplain. Changes in clinical practice such as documenting spiritual needs and the number of referrals is common with the new training by the staff. The nursing staff changed their attitude and respect for what a chaplain really does for the patient and the good will for the hospital.

"Hospice staff and volunteers in this study expressed largely negative feelings about death rattle. Many believed that it distressed relatives even when they had not asked the relatives themselves. Others were concerned for patients in the same ward who heard the sound."⁵³ This is

⁵¹ Jan P. Vlasblom et al, "Effects of a Spiritual Care Training for Nurses," *Nurse Education Today* 31, (2011): 790-96.

⁵² Wendy Cadge, Katherine Calle, and Jennifer Dillinger, "What Do Chaplains Contribute to Large Academic," *Springer Science+Business Media*, (16 March 2011): 1-14.

⁵³ BL. Wee, "Death Rattle: It's Impact on Staff and Volunteers in Palliative Care," *Palliative Medicine* 22,

what the staff said about the death rattle. Many patients do this in the last minutes of life. This is something that a lay Christian may experience while volunteering as a chaplain.

The city of Kinston has become very violent in the past two years and the effects of crime pour into the only hospital in town. Shootings take place every weekend. In addition to shootings and other crime-related injuries, the hospital also regularly treats victims of car accidents. The hospital is the only hospital in a fifty-mile radius and has the opportunity to bring hope into the community.

Fiona Lai states, “The hospital environment is a special place where people are wondering about the meaning of life and questioning the presence of God.”⁵⁴ While most hospitals do not allow evangelism, there are other ways chaplains can respond to these questions and offer hope to their patients, coworkers, and the community. This dissertation will focus on training lay chaplains in these areas.

“The development of spirituality education in palliative care fellowships parallels has followed a growing interest in spirituality education in medical school and residency training that began around 1990.”⁵⁵ A chaplain is very much needed in this area possible to train the doctors and staff in caring for palliative patients.

“The caller introduced herself to me by tentatively stating, ‘My therapist told me to call you. She thinks I need a chaplain, although, frankly, I am not too religious.’”⁵⁶

(2008). 173-176.

⁵⁴ Fiona Lai, “A Manual of Hospital Counseling-Evangelism in Macau,” (Master’s thesis, Calvary Theological Seminary, 2000): 5.

⁵⁵ Lisa Marr, J. Andrew Billings, and David E. Weissman, “Spirituality Training for Palliative Care Fellows,” *Journal of Palliative Medicine* 10, no. 1 (2007): 174.

⁵⁶ Rhonda S. Cooper, “Case Study of a Chaplain’s Spiritual Care for a Patient with Advanced Metastatic Breast Cancer,” *Journal of Health Care Chaplaincy* 17, (2011): 20

I found this quote to be outstanding. Not every call for the chaplain is death and gloom. Sometimes the call can be humors. This is just one example of what goes on in a day of a chaplain.

Many chaplains do not even talk with doctors because the doctors sometimes do not want the chaplain around. This is evident with the following the paper states that doctors do not need chaplains.

Several chaplains indicated that they no longer even attempted to consult with medical staff because doctors were, ‘rude’ (CI: 30), ‘impatient, lacked the ability to listen’ (CI: 31), ‘arrogant—failed to listen then stuff things up’ (CI: 39), ‘stubborn about patient wishes’ (CI: 38), ‘hold a hierarchical view—nobody criticizes us!’ (CI: 62), ‘think they know the answers to everything but have no spiritual appreciation’ (CI: 29), or have an attitudinal exclusion about religion, spirituality and chaplains’ (CI: 47).⁵⁷

All one has to say what happens and that issue will not happen again in this program. Thus the problem will be eliminated.

Still another issue that one might face is the standing order of do not resuscitate. This is how one dissertation viewed the results. “Other chaplains noted however that some medical staff, particularly the younger doctors, would seldom consult with anybody, refusing at times to accept a patient’s/families NFR/DNAR request because they considered it a professional ‘failure’ not to resuscitate.”⁵⁸ Some chaplains have a personal religious belief to do all that is possible to keep a patient alive. Thus a conflict arises within the chaplain’s belief of do not resuscitate. Ultimately it is the patients’ wishes and not the chaplain’s wishes prevail.

⁵⁷ Lindsay B. Carey and Jeffrey Cohen, “Chaplain-Physician Consultancy: When Chaplains and Doctors Meet in the Clinical Context,” *Journal of Religious Health* 48, (2009): 354.

⁵⁸ Carey, Lindsay B., and Christopher J. Newell, “Chaplaincy and Resuscitation,” *Elsevier Review* 75 (October 2007): 12-22.

Grief

As a chaplain there is grief in many rooms and with many patients. Below is one of the experts of grief Elisabeth Kübler-Ross. Elisabeth Kübler-Ross somewhat made sense to the stages of grief. She said this is how a person departmentalizes grief. For many years the whole community bought into her theories of grief. Below is what Elisabeth Kübler-Ross said about grief.

Kübler-Ross wrote many books on grief and on five stages of grief. She was considered the expert on grief. However, experts proved her theory to be wrong. The experts stated they could not repeat the results every time. Therefore her theory on grief is not correct. However, her information is good for those limitations of not being able to repeat the results every time.

Five stages of grief

Denial “Denial is usually a temporary defense and will soon be replaced by partial acceptance”⁵⁹ Anger “Is displaced in all directions and projected into the environment at times almost at random. The doctors are just no good, they don’t know what tests to require and what diet to prescribe.”⁶⁰ Bargaining “The bargaining is really an attempt to postpone; it has to include a prize offered ‘for good behavior.’”⁶¹ Depression “When a terminally ill patient can no longer deny his illness”⁶² Lastly, Acceptance “It is almost void of feelings. It is as if the pain is all gone, the struggle is over.”⁶³

⁵⁹ Elisabeth Kübler-Ross, *On Death & Dying*, 1969, 53.

⁶⁰ *Ibid.*, 64.

⁶¹ *Ibid.*, 95.

⁶² *Ibid.*, 97.

⁶³ *Ibid.*, 124.

Many professionals still use the five stages of grief. The five stages of grief are basically for long term illness like cancer and such. A hospital chaplain at times might be involved with long-term care. Therefore a chaplain must have knowledge of long term care in order to serve the patient and family.

“The best thing a caregiver can do with a patient in the stage of anger is to encourage the patient to talk through his feelings. The caregiver must be aware that the anger is not directed at him.”⁶⁴ This professional uses the five stages of grief as an advantage to better assist the patient and family. Dr. Basie puts a warning in about how anger works and it is not directed towards the caregiver.

Years later Kenneth J. Doka and Amy S. Tucci wrote, “*Elisabeth Kübler-Ross: Beyond Death and Dying*”. Doka and Tucci’s thought is Ross’s theories did not happen all the time in the same way and therefore could not be proven. However, at the time Ross wrote her book it was a beginning to help change the outlook of the professional people in treating the death and dying. Kübler-Ross’ Stage Theory, through still popular in lay literature, is now recognized as problematic and inadequate as a way to understand the ways that individuals cope with the dying process. Many Hospice researchers are inclined to agree with Kenneth J. Doka. The main argument is the linear does not happen all of the time. The first argument is denial and it does not happen every time.

In another book written by Doka he has a chart of spiritual history. Spirit: Taking a Spiritual History, Maugans TA, 1997 and hope. Below are two different charts that are acronyms. They are Spirit and Hope. When you remember spirit it stands for spiritual belief and

⁶⁴ John A. Basie, “A Study of Hospital and Bereavement Care Training for Laymen through the Small Group Ministry of Ebenezer A.R.P. Church of Rock Hill, South Carolina,” (D.Min. diss., Reformed Theological Seminary, 1996), 1-278.

so forth. These acronyms help in healing of the patient. When the patient's spirituality is recognized the patient feels better and thus heals quicker. Hope stands for spiritual history.

S	Spiritual Belief System	Do you have a formal religious affiliation? Can you describe this? Do you have a spiritual life that is important to you? What is your clearest sense of the meaning of your life at this time?
P	Personal spirituality	Describe the beliefs and practices of your religion that you personally accept. Describe those beliefs and practices that you do not accept or follow. In what ways is your spirituality/religion meaningful for you? How is your spirituality/religion important to you in your daily life?
I	Integration with a Community	Do you belong to any religious or spiritual groups or communities? How do you participate in this group/community? What is your role? What importance does this group have for you? In what ways is this group a source of support for you? What type of support and help does or could this group

		provide for you in dealing with health issues?
R	Ritualized Practices And Restrictions	<p>What specific practices do you carry out as part of your religious and spiritual life (e.g., prayer, meditation, service, etc.)?</p> <p>What lifestyle activities or practices does your religion encourage, discourage, or forbid?</p> <p>What meaning do these practices and restrictions have for you? To what extent have you followed these practices?</p>
I	Implications for Medical Care	<p>Are those specific elements of medical care that your religion discourages or forbid? To what extent have you followed these guidelines?</p> <p>What aspects of your religion/spirituality would you like to keep in mind as I care for you?</p> <p>What knowledge or understanding would strengthen our relationship as a physician and patient?</p> <p>Are there barriers to our relationship based upon religious or spiritual issues?</p> <p>Would you like to discuss religious or spiritual implications of health care?</p>

T	Terminal Events Planning	<p>Are there particular aspects of medical care that you wish to forgo or have withheld because of your religion/spirituality?</p> <p>Are there religious or spiritual practices or rituals that you would like to have available in the hospital or at home?</p> <p>Are there religious or spiritual practices that you wish to plan for at the time of death, or following death?</p> <p>From what sources do you draw strength in order to cope with this illness?</p>

Figure 12. Spirit Chart⁶⁵

The Hope Chart is helpful when visiting patients and family for end-of-life visits.

Hope: A Spiritual History

H	Sources of hope, strength, comfort, meaning, peace, love, and connection
O	The role of organized religion for the patient
P	Personal spirituality and practices
E	Effects on medical care and end-of-life decisions ⁶⁶

⁶⁵ Kenneth J. Doka, "Spirituality and End-of-Life Care," *Hospice of America*, 2011. 40-41.

Figure 13. Hope Chart⁶⁸

All of the tables/charts make it simple to remember how to best assist the patients, families, and staff for end-of-life times. Plus the charts may be used for people fighting atrocious diseases.

“Identification of spiritual needs and the provision of appropriate support are the responsibilities not solely of chaplains; they are the duty of all healthcare professionals, although specialists may sometimes be needed.”⁶⁷ Cook states that a patients’ religious preference must be identified so the best possible care for the patient. Many times a patient will relax and heal once they know the doctors and staff will respect them as a person at the hospital for their religious beliefs.

Grief can be simply defined as inward expression of grief or private expression of grief. Whereas, Mourning is outward expression of grief. A way that a person expresses grief and mourning is taught. Many people confuse grief with mourning. Some people wear white when there is a death. Everyone is taught what to wear and what to express when doing public mourning. As a result grief and mourning is taught. Grief is an inward expression of death. Mourning is a public expression of death. As a society we grieve and mourn according to what society has taught us to grieve.

In India people mourn by wearing white clothes. Whereas in United States people wear black clothing. Mourning is taught what to do in times of a death. It is the same with crying. Men do not cry in public. Just like when chaplain comforts a family where a death has occurred some people wail, cry and shout. Whereas others keep everything inside. A chaplain must know the

⁶⁸ Ibid., 42.

⁶⁷ Christopher CH Cook, “Pathway to Accommodate Patients’ Spiritual Needs,” *Nursing Management*, May 2012, 33-37.

difference between grief and mourning and how society plays a role in the way people grieve and mourn.

End-of-Life

Religion affects the way a patient dies. It is the whole outlook on one approach the end-of-times. The professor Randy Pausch who died of pancreatic cancer. He never once mentioned religion when he went public with his dying condition. All he mentioned was what he planned to do with his family and the book they wrote about his experiences of the dying process. As a chaplain one would have to respect his lack of religion affiliation. He was a well-educated man who loved life. Dr. Pausch never once mentioned his religious background. As a chaplain one must honor his wishes. This is just one example of how people's view of religion vary. Personal note is this author has no knowledge of Pausch's religion or lack of religion.

In the process of designing this training program for the chaplains, the training team recognized the need to create a spirituality module, *Spirituality in Palliative and End-of-Life Care*, as well as a module on The Role of the Chaplain in Palliative and End-of-Life Care, *Psychosocial Aspects of Chronic & Terminal Illness: Taking care of our Patients and Ourselves and Grief, Mourning and Bereavement*.⁶⁸

Many patients who know when death is eminent .patients ask for a chaplain. Notwithstanding the evidence that religion/spirituality has generally positive health effects, research studies show that spiritual distress or spiritual struggle (e.g. feeling abandoned or punished by God) is associated with worse outcomes for patients with diverse conditions.

This is how Veterans Administration chaplains are doing for end-of-life patients.

“Spiritual care is kind of the whole gamut of life that they are reviewing . . . they are trying to . . . become at peace with themselves and others and I think it's a listening process or a questioning .

⁶⁸ Hillel Bodek. “Facilitating the Provision of Quality Spiritual Care in Palliative Care,” *Omega* 67, no. 2 (2013): 39.

. . . The social worker and . . . the rest of the staff are helpful too, and . . . we approach them as a team.”⁶⁹ This concept is great as a team effort. Again it is a hint of ministry of presence, just being there with the patient.

This quote best describes the term “Ministry of Presence.” Ministry of Presence is one of the hardest concepts for a new chaplain to accomplish. The hardest part is just standing there in the room waiting. The chaplain is waiting on God, patient, family, or staff to say or do something. The next statement is about a patient who cannot talk. “The chaplain walked into the room and the patient had cancer of the larynx that had metastasized to the bone and jaw and the tumor was protruding through his neck and he was dying and every time he tried to talk blood would squirt. His eyes were beseeching me not to leave. So I went to the nurses’ station and put goggles on and a gown and I sat on the side and held his hand as he was dying.”⁷⁰ This is the best example of ministry of presence. The chaplain just holds the hands and looks into the eyes of the patient. The eyes tell the story and the tears just well up. Most likely the chaplain’s eyes well up also. No words are exchanged just loving glances.

Families

As a chaplain duty is to be with the families in their time of need either a trauma, or death. One item that is very good is to write a letter to the dead person and put all your feelings in that letter. Put down all of the good items and bad items about the person. It is for the writer of that letter. When one finishes that letter read it and do not share the letter with anyone. It is your personal feelings about that person. When that person is ready burn that letter so no one

⁶⁹ Sue P. Heiney, Janis McWayne, and Jane Teas, “Being Real on Holy Ground: The Lived Experience of Chaplains,” *Journal of Psychology and Christianity* 26, no. 1 (2007).

⁷⁰ H. Norman Wright, *Helping Those Who Hurt*, (Minneapolis, MN, Bethany House Publishers, 2006), 25.

can read that letter. “Grief must be externalized. Our pain and sadness can be fully realized only when we release them, For many, writing letters to their loved one is a convenient, always available way to get the words out and communicate.”⁷¹ Many chaplains and counselors find this tool to work to help families and friends cope with the person whom died. The letter is a very powerful tool to be used by chaplains, ministers, and counselors at the time of death.

Many people do not know how to express their grief. There is a video out there Wright uses for children. It is entitled; “Tear Soup A Recipe for Healing after Loss” and states there is no time limit to grief. The DVD states it is alright to feel like you do after the death of a loved one. Everyone grieves differently and that is okay to grieve differently. The DVD asks a question; “If you can tell your loved one just one thing, what would that be? With that question it gets the individual to think this is what I need to say. If it is a child it might be; why did you leave me? Don’t you know I love you? Another question would be what do you want to do as a family to honor the loved one?”⁷² The DVD is hailed as a great tool to be used by chaplains, ministers, counselors, and families. The DVD is an easy way to get children to express their thoughts about death. There are many different tools out there to be used but somehow these tool mentioned is the leading one in the grieving community.

“What they may experience while remaining with their loved one during resuscitation this includes addressing aspects of health and safety guidance such as the dangers of defibrillation. It is vital that family members are aware they can choose not to be present during this event.”⁷³ Most times the family is out of the room per hospital regulations.

⁷¹ Ibid., 26.

⁷² Pat Schwiebert and Chuck DeKlyen, *Tear Soup*, DVD. Grief Watch, 2006.

⁷³ Norman H. Wright, *The Complete Guide to Crisis & Trauma Counseling*, (Ventura, CA: Regal, 2011), 21.

Crisis

When one thinks of a crisis one also thinks of trauma. Two terms must be defined. They are crisis and trauma.

“Crisis Any inflection point in the course of events. Strictly speaking, a crisis can be either a sudden improvement or a sudden deterioration point in the course of events. Strictly speaking, a crisis can be either a sudden improvement or a sudden deterioration. Any sudden interruption in the normal course of events in the life of an individual or a society that necessitates evaluation of modes of action and thought.”⁷⁴

“Crisis a difficult or dangerous situation that needs serious attention.”⁷⁵

Trauma “1 a: an injury (as a wound) to living tissue caused by an extrinsic agent.
b: a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury. c: an emotional upset.”⁷⁶

Trauma is a term used freely either of physical injury caused by some direct external force or of psychological injury caused by some extreme emotional assault.

This author prefers the terms from the dictionary of Psychology. Either dictionary is good to define both terms. Please follow the logic of not every crisis is a trauma. Likewise not every trauma is a crisis according to the definitions. A crisis could be any sudden interruption in the normal course of events in the life of an individual. An example could be a deviation from the route you take to work or school due to a car accident. A trauma is a term used freely either of physical injury caused by some direct external force or of psychological injury caused by

⁷⁴ *Penguin Dictionary of Psychology*, 39.

⁷⁵ Frederick Mish, ed., *Merriam-Webster's Dictionary*, (Springfield: Merriam-Webster, 2009), 296.

⁷⁶ *Penguin Dictionary of Psychology*, 832.

some extreme emotional assault. One could hit their thumb with a hammer and that causes trauma.

However most people hear trauma and crisis in the same sentence they say what is wrong, who died, or what building was blown up. The best example is the twin towers that were destroyed on September 11, 2001. Most chaplains will see auto accidents come into the emergency room for a trauma and a crisis. Other types of trauma and crisis could be heart attacks and trauma and crisis could be gunshots and car accidents.

Not every crisis deals with death. Likewise it is true, not every trauma is life ending. If one breaks their toe that is a trauma. The breaking of the toe does not result in death.

Crisis Intervention

There are many programs for training for crisis intervention. Most large police departments have their own crisis intervention teams. Most of the time those positions are given to police chaplains and license counselors. Chaplains receive very specialized training to respond to a crisis.

The ABC model is used for crisis intervention. “ABC model: One way to structure crisis intervention that includes (A) developing and maintaining contact, (B) identifying the problem, and (C) coping.”⁷⁷ The counselor maintains contact, boiling it down to just the basics, and coping. It breaks it down how to talk with the patient. Here is a list of good questions to ask a patient. How do you feel about losing your life partner? Why did you allow that person in your home? What are your thoughts about death? How did things get out of control in your home? How old are your children? Are you thinking about hurting yourself? Have you been checked out

⁷⁷ Kristi Kanel, *A Guide to Crisis Intervention*, (Belmont, CA: Thomson, 2007), 25.

by a doctor yet? How long have the two of you been married? Are you taking any medicines? These are just a few questions one should ask a person who is a crisis intervention.

Those are the types of questions that a chaplain should ask if a person is in a crisis. What are some things a chaplain can suggest a patient do to better themselves? First get plenty of rest. Eat a balanced diet. Get more fruits and vegetables in the diet. Exercise more or go for a walk with your dog or your friend. Go to a movie if you can. Don't make any decisions without the help of a good friend or family member. Do not forget to pray about everything.

A question was stated by Wright why was death is feared. The answer is most people believe is one will live forever. Death is unknown. The only person who came back from the dead was Jesus. Death is final. The following Bible verses support the statement that death is final.

Psalms 116:15
“Precious in the sight of the Lord is the death of his saints.” ⁷⁸
God cares about us as we die for everyone will die. The coice is perment death or eternal life with God in Heaven. A chaplain might point out our choices as the patient comes close to the end of life on earth if asked.

Hebrews 9:27-28
“Just as man is destined to die once, and after that to face judgment.” ⁷⁹

⁷⁸ Pslams 116:15.

⁷⁹ Hebrews 9:27-28.

Many people/patients fear final judgment or they do not believe there will be a final judgment. Some people believe they will live forever. We will all die as it is told in this bible verse and have a final judgement by God.

Revelation 21:4

“He will wipe every tear from their eyes. There will be no more death or mourning crying or pain, for the old order of things has passed away.”⁸⁰

This is what God has promised to his faithful no more tears. Death will end on earth according to God. There will be no more tears or mourning in heaven. There will be eternal life in Heaven this is what God has promised to his followers.

2 Corinthians 1:3-5

“Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God.”⁸¹

⁸⁰ Revelation 21:4.

⁸¹ 2 Corinthians 1:3-5.

Eternal comfort comes from God. It is like eating a bowl of ice cream. The eating of ice cream is only temporary. The comfort from God is everlasting.

“There is no limit to the number of losses and crisis that occur in the life. And some of them are inexplicable traumas that affect an entire family”⁸² That is one of the many reasons there are chaplains at the hospitals. Many people suffer losses through their lives and somehow a chaplain might bring sense to their lives if only for a moment.

“If chaplaincy cannot identify patient-centered care as its distinctive quality improvement goal, than it is hard to make the case that another profession ought to.”⁸³ A chaplain has been trained by God and man how to minister to the hurting, sick and terminally ill people. The chaplain knows what questions to ask each patient in time of need. Therefore the proper training must be implemented.

Another paper validates the roll of a chaplain. “Any caregiver can tend to the spiritual needs of the suffering, but a chaplain is the expert helping the patient and the family the questions that matter most deeply to them.”⁸⁴ The dissertation points out the care givers just pat the patient on the hand and say everything is all right. When actually the patient has more questions to ask and the sympathetic care giver can offer. According to the dissertation the chaplain knows exactly what to ask the patient and family. The care givers do not have the time that a chaplain has to ask questions of the patient and family. What a flattering statement for the

⁸² Wright, *The Complete Guide To Crisis*, 17.

⁸³ Berlinger, “The Nature of Chaplaincy and the Goals of Patient-Centered Care as Professional Responsibility,” 31.

⁸⁴ Martha R. Jacobs, “What Are We Doing Here? Chaplains in Contemporary Health Care,” *Hastings Center Report* 38, no. 17 (2008): 17.

need to have a chaplain on staff. Just like what H. Norman Wright stated one needs to ask the correct questions to get the needed results. The results may evoke emotions or just general knowledge. The chaplain asks the questions that best resolve the issues for the patient and family.

There is a dissertation that states what standards a chaplain should be in a hospital setting. “be accountable to the hospital administrator; cooperate with hospital staff; have a rational plan for selecting patients; keep records, e.g., notes recorded in the medical record, simple records to refresh the memory of the chaplain on patients seen, detailed notes on more difficult situations for the chaplain’s learning; be appropriately seminary educated with at least one unit of CPE.”⁸⁵

The same paper states what a hospital should do to have the correct chaplain. “Provide worship that is interdenominational and appropriate to the context; are selected by the hospitals but with input from the appropriate faith communities; provide a breadth of services to patients, families, staff and the organization.”⁸⁶

This is what this group is looking for in a chaplain. What they are doing is setting a standard for a chaplain for the hospitals they service. If a chaplain does not meet the minimum standards than that chaplain is not allowed to practice in their hospitals. This is the basic core values for a chaplain who goes through one unit of CPE. In the past many hospitals would allow ministers with ten years of experience as a minister of a church to become a hospital chaplain. The rationale was they have had ten years’ experience as a minister that was good enough to become a hospital chaplain. With this group stating the basic qualifications for a hospital chaplain. This is a bold step at that time. The rationale is just because one was a minister does not make a minister

⁸⁵ *Merriam-Webster's Dictionary*, 550.

⁸⁶ King and Overvold, “Standards of Practice for Professional Chaplains in Acute Care,” 152.

a chaplain. Not everyone is cut out to be a chaplain. The same is true not every chaplain should be a minister. In the South, hospitals were willing to accept minister with experience verses people whom were qualified with little experience. A standard must be set for chaplains.

The same paper states what a hospital should do to have the correct chaplain. “Provide worship that is interdenominational and appropriate to the context; are selected by the hospitals but with input from the appropriate faith communities; provide a breadth of services to patients, families, staff and the organization.”⁸⁷

In the next paper supports chaplains as providing the correct support for the patients. “Thomas Kuhn, noted for his landmark work on the nature of scientific revolution, identifies well-executed case studies as a crucial developmental talk for emerging and maturing disciplines, as they amass the paradigms necessary to reflect upon their practice.”⁸⁸ Brown stated there is a need to examine the effectiveness of hospital chaplains. A hospital chaplain does a valuable service as a chaplain in the community.

This is what a hospital does as a standard of operating procedures. I would like to quote a paragraph from what Chaplain Janice Coffing did that day and continue on until the job was complete.

“As I opened the door of his mother’s labor/delivery room, I was greeted by five-year – old Skyler, who was wearing purple surgical gloves. I squatted to meet him eye to eye. ‘Today is the day my baby brother will be born,’ he told me. ‘He won’t be able to live very long because he has a big hole in his face, but at least I finally get to see him and hold him. I am going to help

⁸⁷ Ibid., 150.

⁸⁸ Linda Brown, “Making a Case for Case Study Research,” *Chaplaincy Today*, 26, no. 2 (Autumn/Winter, 2010): 1.

too.’ With that, he trotted back to his mother’s bedside.’”⁸⁹

To complete the rest of the story one must include another paragraph to this spiritual understanding of life and death. What came out of the death was only God given. Everyone needs to thank the chaplain, doctor staff, and family for their giving hearts to start a new program at the hospital to save other children and families.

As a result of continued conversations with the professionals who participate in these unique births, and through consultation with local psychologists in attendance at our annual ethics retreat, we focused on the need for heightened care for our team and other staff members who assist. The impact of the birth and death of infants with grave anomalies, known as tertiary posttraumatic stress, may be as distressing emotionally for hospital staff as it is for those actually going through the trauma. Ramifications may be emotional, physical and/or spiritual.⁹⁰

What they did at this hospital set off a new way of handling births and stressful births that will lead to death. This was organized by the need for such of team. It was spearheaded by the chaplain with total cooperation by everyone involved at the hospital. This is an example of God’s work from the start. God worked through Skyler and everyone else. What a blessing happened with the birth of Chance, the baby that died few days later. Chaplains are needed at hospitals.

All across United States hospital administrators are trying to regulate what and how a chaplain works with the hospital and staff. However,

Having for decades tried to explain our work as chaplains to other medical staff and laity, I know that standards and scope of practice may be extremely helpful in letting other staff know how and when to use us. However, giving in to a too rigid a job description limits the time and freedom necessary for developing a spiritual care program, which truly fits and enhances the mission of the institution it serves. My fear is that we are stepping into the trap that physicians are now so desperately trying to get out of. The institution is telling them how to practice their craft.⁹¹

⁸⁹ Janice Coffing, “Let the Little Children Come to Me: A Perinatal Palliative Care Experience,” *Chaplaincy Today* 27, no. 1 (Spring/Summer, 2011): 2.

⁹⁰ *Ibid.*

⁹¹ Paul E Derrickson, “Thoughts from a Board Certified Chaplain/cpe Supervisor,” *Chaplaincy Today* 25, no. 2 (Autumn/Winter, 2009): 1.

This paper states he is tired of administrators tell him how to run the chaplains. A chaplain is all about God. An administrator is all about dollar and cense. It is not nice to play God or fool with God. Rev. Paul Derrickson just had his fill of administrators.

Yet another paper praises the work done by hospital chaplains. "Spirituality and faith are important in many people's lives, and there are numerous and important reasons for taking them seriously as a part of clinical health care (Koenig2007).

The isolation from their faith communities that people experience as a result of illness, for example, when admitted to hospital. The impact of religious belief on treatment decisions and compliance. Evidence that spirituality and faith affect health outcomes."⁹²

The core message is the patient responds quicker to health care when their religious needs are met. The type of religion affects the type of care one receives and improves.

Case in point. A chaplain had a patient one time that was screaming and moaning all day long. Physically there was nothing to make the patient moan. The chaplain within one hour had the patient stop moaning. What was done was a quick look through the phone book to find her husband in an assisted living facility. The chaplain located the husband and the patient got to talk with the charge nurse and found out everything was fine. When the patient stop moaning the whole floor at the hospital calmed down. The staff was able to do their jobs and the other patients could stop worrying about the other patient that was moaning. This chaplain knew the right questions to ask and the problem was solved. The staff didn't have the time to work with that patient as needed.

With the overall steps by the hospital administration to cut costs the first item they want

⁹² Christopher Cook, "Pathways to Accommodate Patients' Spiritual Needs," *Nursing Management* 19, no. 2 (May 2012): 1.

to cut is the hospital chaplain. In the eyes of the administration people bring their own minister to the hospital. Many chaplains put out standard operating practices for a chaplain at a hospital.

Standards of practice move professional chaplaincy closer to the paradigms that acute care settings utilize in general to define the scope, function, action and process to be utilized in the care of patients. These standards provide the template for understanding the chaplain's work specifically. More broadly, they indicate how spiritual care fits in the larger context of patient care. The need for the chaplain to be understood as a part of the interdisciplinary team is crucial as is the need for spiritual care to be understood as a part of the holistic continuum of care.⁹³

Snorton writes about the need to have chaplains as an intertidal part of the hospital team. In other words, the chaplain is the corner stone for the team or the anchor of the team. Everyone compliments each other. If a person is taken out of the wheel the wheel, the wheel will collapse. Therefore one needs a chaplain on the team to round out the patient care. With the chaplain the patient has their religious feelings looked out for. It could be as simple as dietary needs. The chaplain is there to assist in the total care of the patient. Plus the chaplain assist in the needs of the staff. Plus chaplains have a set of standards they must follow. That set of standards comes from the organization that gives the chaplain credentials like ACPE (American Association of Clinical Pastor Education).

Another chaplain through personal use found a way to face his albatross. He was burned over 40% of his body when he was a child. He has faced many fears and trepidation most of his life. Than all of a sudden he is in CPE and must face his fears.

[The shadow is] the unconscious repository of an individual's unacceptable impulses and characteristics (and painful experiences). Disowned and unacceptable parts of ourselves are shoved out of our awareness into the shadow. We used the shadow to hold those parts of ourselves that we learned were bad or unacceptable.⁹⁴

⁹³ Teresa E. Snorton, "The Proposed Standards of Practice (SOP) for Professional Chaplains in Acute Care," *Chaplaincy Today* 25, no. 2 (Autumn/Winter, 2009): 33.

⁹⁴ Douglas S. Phillips, "Living as a Burn Survivor: Implications for Pastoral Care," *Chaplaincy Today* 26, no.1 (Spring/Summer, 2010): 11.

This type of shadow gift maybe helpful to others in other types of trauma. I could see this type of therapy to a few different traumas. Phillips said it worked for him in a way that lifted a burden off his shoulders. What comes to mind is the parable of the lost coin. She searched until she found the coin. She was relieved that a burden was lifted off her shoulders.

“Our chaplaincy department is expected to perform and give evidence of results. If your hospital is not already at this point, it will be soon. Even faith-based hospitals are no longer allowing chaplaincy to operate without accountability and quality improvement.”⁹⁵ This is just another person stating the chaplaincy department has to come under a strict budget. The administrators have to account for every dollar spent at the hospital. No more free lunch for the chaplaincy department.

Another point that was well made by administrators was the chaplains couldn’t even decide what they do or define who they are.

As the care-giving relationship proceeds, the helpers hear care-seeker’s requests for a pastoral presence and support. Care-seekers call out the helper’s pastoral identity by accepting or rejecting the pastoral care giving, by sharing their life and crises, and by requesting help.⁹⁶

Still another group wants to discuss our differences. “The Theory of Living Human Systems (TLHS) aims to explain individual and group behavior; Systems-Centered Training (SCT) translates TLHS into methods for practice. SCT integrates many psychological practices but its signature method is functional subgrouping (FS). FS is used to discriminate differences within and between individuals and groups and to integrate them as resources in a more diverse,

⁹⁵ Margaret Richardson, “The Bottom Line Challenge: Demonstrating Effectiveness Beyond Press Ganey,” *Chaplaincy Today* 27, no. 1 (Spring/Summer 2011): 22-31.

⁹⁶ Samuel Park, “Pastoral Identity Constructed in Care-Giving Relationships,” *Journal of Pastoral Care and Counseling* 66, no. 2 (June 2012): 3.

functional system, instead of scapegoating differences in systems fraught with conflict.”⁹⁷

Still another huge group is saying folks the chaplains need to say what they do exactly so the monies can be appropriated properly.

In 2001, Catholic Health Initiatives (CHI), Denver, launched an 18-month report of chaplain performance and productivity. The findings-including a widespread lack of clarity and consistency in the understanding and measurement of what chaplains do- led CHI, one of the nation's largest Catholic health care systems, to make a set of recommendations to the spiritual/pastoral care departments at its hospitals and long-term care facilities in 19 states. As CHPs facilities act on those recommendations, their chaplains are learning to better define their roles, to articulate their duties, and to foster recognition of their contribution to patient care.⁹⁸

This group set out directives and challenged the chaplaincy department to get on board and tell everyone what you do.

The results of not saying what you do mean budget cuts. Where there should be five staff chaplains there will be just one chaplain to cover the whole hospital. More programs like what is proposed in the dissertation will take on nationally.

“In the culture of budget-driven programs health care chaplains are not immune to the measurement of outcomes. Although chaplaincy is not revenue-pending it can increase patients’ overall satisfaction with an intuition and the care they receive.”⁹⁹

“And when she finds it, she calls her friends and neighbors together and says, 'Rejoice with me; I have found my lost coin.’”¹⁰⁰ This verse lifts a burden off of your shoulders. Let us

⁹⁷ Richard M. O’Neill et al., “Systems-Centered training’s Functional Subgrouping: A Path to Koinonia in Pastoral Care,” *Chaplaincy Today* 28, no. 1 (Spring/Summer 2012): 4.

⁹⁸ Randy Shook and Laurie Fojut, “Measuring What Chaplains Do,” *Health Progress* 85, no. 2 (Mar/Apr 2004): 37-40.

⁹⁹ Emily McClung, Daniel H. Grosseohme, and Ann J. Jackson, “Collaborating with Chaplains to Meet Spiritual Needs,” *Medsurg Nursing* 15, No 3 (June 2006): 148.

¹⁰⁰ Luke 15:9.

be happy for we have found what is lost. That is what Jesus does every time we come back to him. Jesus welcomes us with open arms just like the widow did when she found the lost treasure. Sometime a patient gets lost and when the chaplain goes looking the patient gets found. The patient gets all hung up on the disease and takes the focus off the God.

“Then you will know the truth, and the truth will set you free.”¹⁰¹

That is what the “shadow gift” did for Rev. Douglas S. Phillips. Another area of concern is the registration of the patients’ religious preference. It goes back to providing the most efficient care for the patient. The author claims many staff people would skip the religious preference when checking a patient into the hospital. The truth lies within the patients’ religious preference.

A spiritual screen, a spiritual history, and a spiritual assessment are distinct in form and function. A spiritual screen is the shortest and generally uses one or two static questions aimed at whether the patient has special religious and/or cultural needs, such as diet, observances and/or restrictions, e.g. blood products... Spiritual history obtaining the patient’s spiritual well-being for the correct treatment... Spiritual assessment is an in-depth look at the patient’s spiritual makeup with the goal of identifying potential areas of spiritual concern.¹⁰²

This article is in the paper to show how much pull some chaplains have over the administration. Most doctors know the religion of the patient before elective surgery happens. This chaplain got the administration to get the surveys filled out by the staff other than the chaplain staff. Agree there should be a spiritual screen filled out for each patient. One religious sect that does not allow blood transfusions.

This next case to prove that chaplains are needed come to state the patients realize if the chaplain is giving lip service of they are really concerned about me the patient.

¹⁰¹ John 8:32.

¹⁰² LaRocca-Pitts, “Fact, a Chaplain’s Tool for Assessing Spiritual Needs in an Acute Care Setting,” 25.

Physicians, nurses, and chaplains should be well aware that it is not a small matter at all how one enters such a room or how one addresses the people there speech and gestures do give one away, and those who are in a desperate state of life develop an unflinching sense for what is genuine. It really does make a significant difference how patients and their relatives are greeted and talked to, how the curtains are drawn or how the meals are served. Speech and gestures do give one away, and those who are in a desperate state of life develop an unflinching sense for what is genuine. They immediately discern a fake, even though they might not any longer be capable to articulate it verbally.¹⁰³

Patients have the knack to tell if the staff person/chaplain is not sincere. What the patients do not like is coming in the room uninvited or without proper consent. Just because one is a patient in the hospital does not give the chaplain the right to walk in the patients' room. Therefore unwelcomed visits are seen as phony and invasion of privacy. Part of being a patient is the right of privacy. When a non-caring person comes in the room it could be viewed as a hostile for the patient for not allowing that person into the room.

This leads to the next topic of hospital rooms being non patient friendly. The following paper found accurate and surprising truthful and refreshing about what a chaplain does. At last the patients has some rights when they go in the hospital.

One response to the impersonal forces and dehumanizing tendencies of modern medicine has been 'patient-centered care' (Gerteis 1993; Stewart 2003; cf May and Mead 1999). And one example of an application of patient-centered care is the relatively recent efforts of trying to make the hospital room more like a home. By making the hospital less industrial, and by making it warmer and brighter, the hope is that the patients would enjoy their stays a bit more... Hospitals should not smell like bodily waste, the food should taste good, the walls should look good, and there should be plants and trees. Hospitals, in this sense should be homelike.¹⁰⁴

At last an investigation on hospital food. There is proof that the food must get better for the

¹⁰³ Chistoffer H Grundmann, "To Be with Them: A Hospital Chaplain's Reflection of the Bedside Ministry to Terminally Ill and Dying People," *Valparaiso* 9, no. 1 (2003): 84.

¹⁰⁴ Nathan Carlin, "The Hospital Room as Uncanny: Psychoanalytic Observation and Recommendations for Pastors and Chaplains," *Springer Science Business Media*, 2009. 30-31.

patients to get better/be homelike. There are too many communicable diseases to have plants and trees in the rooms. When walking down the hall one might forget the room number and if the room is say my room is green in color one can find the correct room. According to this paper the color of the room does affect how the patient recovers and gets well quicker with more homelike colors; however the author would agree not to have any neon colors on the walls. This paper also touches on the color of the walls at the hospital. One can walk into the children's wings and see book characters all over the walls which evokes a huge grin on many faces. The children's faces grin when they see tall giraffes and the characters from the latest children's books.

There is another paper that states the roll of chaplain is being eliminated from hospitals for profit and not for nonprofit hospitals.

This is especially true as hospitals are taken over by for-profit corporations through large mergers, where initial commitments to maintain the chaplain's office have not been upheld due to budget constraints. For example, chaplains in large managed-care organizations such as Kaiser Permanente are downsizing chaplain departments. The reasoning is that, if corporations can get community clergy or lay volunteers to provide care, then why pay for trained professional chaplains?¹⁰⁵

This is a medical doctor stating his outrage at for profit hospitals. The corporation figures the corporate wants to let the community to be the hospital chaplains or have trained lay chaplains be on staff for free. The big corporation wants not to pay for any religious involvement with the hospital. The love of profit is a way that some big for profit hospitals eliminates the chaplaincy departments.

This paper also states that for profit ask the local churches to pay for the services at the hospital. "Some of the managed-care organizations are even asking the churches to pay for the

¹⁰⁵ Harold G. Koenig, "Why Research Is Important for Chaplains," *Journal of Health Care Chaplaincy* 14, no. 2 (2008): 85.

salary of community clergy who come in for hospital chaplain duties. Indeed, chaplains don't have a labor union and are often at the mercy of hospital administrators-administrators who base their decisions on research data, not tradition."¹⁰⁶

This paper does not mix up the facts and calls it like it is. Without a trained chaplain his patients could possibility lean to death. The author's comments are direct and to the point; however, this thesis project is about helping the local pastor do their job better.

However, this author/researcher first learned to be as a lay chaplain as a volunteer. There were many times when this writer called the head chaplain and asked how this situation is handled. Therefore a trained chaplain is needed for the wellbeing of the hospital, staff, and patient. The profit administrators failed to realize that the chaplain is labeled part of the hospital. If the so called volunteered chaplain is bad so goes the creditability of the hospital.

The next reference has to do with what a chaplain does at the hospital. This role should never be left to a volunteer. A chaplain needs to be trained.

Rounds on the inpatient psychiatric unit. It's full today, with fourteen kids, ten of them teenagers that I will have in group this afternoon. This is my chance to speak about how they did in group yesterday (who's working on their issues, and who's malingering). I also try to figure out some theme that my group members have in common, and select a group format to meet most of their needs...The psychiatrist asks me to work with one of them on grief issues.¹⁰⁷

Would the lay chaplains in my training be allowed to do this type of service? Unequivocally no volunteer chaplain would be allowed to handle psychological patients at a hospital without the proper credentials.

Still another topic of pediatric intensive care is a great need for chaplains.

¹⁰⁶ Daniel H. Grosseohme, "A Day in the Life of a Children's Hospital Chaplain," *Med Surg Nursing* 15, no. 3 (2006): 152.

¹⁰⁷ Koenig, "Why Research Is Important for Chaplains," 85.

Head for pediatric intensive care to meet the parents of a newly admitted infant with food poisoning. This couple is appropriately scared, but doing well. Not especially religious people, they are nevertheless three counties away from home and feeling cut off from their usual supports. We talk about how important family and other close connections are, and their fear that she might die...they hold each other and cry. After a few minutes, their nurse walks over and puts an arm on each of their shoulders and reminds them what the doctors told them earlier, and how this is a very treatable condition, and although it will mean being here a week or more.¹⁰⁸

This is a typical event that a hospital does every day. There is an emergency and the parents are having a coping problem. In this case they are miles from home and no support system to assist them in their time of need. Please note the nurse cared but the nurse did not care like a chaplain would as part of their service. This paper proves there is a definite need to have professional chaplains on staff at the hospital.

They ask the nurse a few more questions; they haven't been able to absorb all that the doctor had told them earlier, and now God-people. By having time to be with them, and by paying attention to the in a different place and able to take things in. This is the part of chaplaincy that many don't think of if we are only seen as the God-people. By having time to be with them, and by paying attention to their feelings, a safe place was created where the mom could give a voice to her fear- and that opened the door for them to receive comfort.¹⁰⁹

What this chaplain did was to take a horrible situation and turn it around and made the parents feel relaxed at this hospital. Neither the doctor nor the nurse had the time to sit down with the parents and explain everything again to the parents. The doctor preformed their duties by informing the parents the progress of their child. They left and went on to other things. The nurse came by and saw how upset they were and put her arms around the parents and said the child should survive and left. Meanwhile the well-being of the parents fell to that of the chaplain.

Again the chaplain's day is not over. There is one more incident which to give a

¹⁰⁸ Grossoehme, "A Day in the Life of a Children's Hospital Chaplain," 152.

¹⁰⁹ Grossoehme, "A Day in the Life of a Children's Hospital Chaplain," 152.

report. “Another trauma page, this time for a 1-year-old who has fallen from a second story window coming from another county by helicopter. They are 45 minutes out, so the bulk of this work will fall to the staff chaplain. Seeing me, one nurse asks about a teenager who came in earlier in the week and who died, and was not eligible to be an organ donor. Hearing her anger at the lack of anything obviously redemptive out of that tragedy, two other nurses come over and bring up how they felt after taking care of two children who came in for seemingly routine accidents, and who turned out to have been physically abused.¹¹⁰

The staff sometimes has a hard time rationing why this has to happen to little children. This is when the chaplain says it is a sin and it is in Gods’ hands. If there is enough evidence than they could turn the children over to the police and a social worker. The chaplain’s main concern is the well-being of the staff. The chaplain might gather all of the facts and turn it over to the social worker for them to investigate. Plus as a chaplain I would seek higher counsel before any more action took place. If there is eminent harm than yes call the authorities.

This is a day in the life of a hospital chaplain. This is a disclaimer. Not every day is like this as a chaplain. This just happens to be true on that particular day for that chaplain. A chaplain’s day varies from day to day depending on what is happening in that city at that time. An example would be when there was a shooting at a school. There are not enough chaplains to go around for such a great need. One thanks God that there are not shootings at schools every day. However, chaplains are asked to sit in on group discussion in the rehabilitation (Rehab), departments all of the time. Will a volunteer Christian Chaplain be asked to sit in on groups in the rehabilitation department? 99 times out of 100 the answer will be no. There will be limits placed on the volunteer Christian chaplain by the facility and the chaplain in the hospital setting. Which leads to the next chapter key concepts in training for lay volunteer chaplains.

¹¹⁰ Ibid., 153.

CHAPTER FOUR

KEY CONCEPTS IN TRAINING LAY CHAPLAINS

This is a key concepts that lead to training of Lay Christians in the hope of serving God as a Chaplain for Lenoir Memorial Hospital. These key concepts are only the beginning of your walk with God as a volunteer hospital chaplain assistant. Your walk as a volunteer assistant chaplain is a rewarding call however, not all are called to be chaplains. Ephesians 4:11 states “And he gave some, apostles; and some, prophets; and some, evangelists; and some, pastors and teachers; some of you in this training will say this is not for me.” According to the Bible verse not everyone is called to be a chaplain. The reason for six classes is the attrition rate is fifty percent. Each week some volunteers will drop out of the meetings for many reasons. At the end of the training when it comes to time to commit there will be more dropouts. It will be up to the trainers whether or not to allow them to be volunteer lay chaplains. Remember many are called but few will answer the call.

How often the hospital provides this training depends on the need of the hospital and the availability of the staff to do the training. As a rule of thumb, the hospital might offer the training once a year in the fall after school starts.

Key Concept 1: Hospital Orders

Legal Issues

1. Do not touch any one unless you ask first and the patient agrees.
2. Follow all of the HIPPA rules.
3. The only agenda a chaplain should have is the patient’s agenda.
4. Do not give out medical advice.
5. You represent God and the hospital.

6. Confidentiality consists between chaplain and patient, chaplain and family, chaplain and staff, chaplain and doctor, chaplain and friend, and chaplain and chaplain.

Terms of Endurment

Chaplains must follow all of the rules of the hospital.

Dress code will be determined by director of patient care.

One must get three shots; hepatitis B, Flu vaccine, and tetanus.

Do not give medical advice. Chaplains are not medical doctors.

Wash hands before and after each visit.

Wash your hands if you touch your face, nose, eyes and or cough.

Introduce yourself to the staff before you visit the patients.

All chaplains must maintain confidentiality. See legal issues above.

Ask the staff for permission to visit the patients.

Do a record of each visit. This record shall be done in accordance with hospital protical.

When you enter the room of the patient of the opposite sex always leave the door open.

Be respectful of everyone.

If you have a cold stay home.

Be on time.

Ask Questions

Some of these questions came from Dr. Ed Wilder at Baptist Health Services Jacksonville, FL. Wilder is a supervisor of chaplain at Baptist Health Services out of Jacksonville, FL. The reason for the questions is to get the volunteers to think outside of the box. Plus one thinks one way yet the patient may think a different way.

1. What words do you use to make a meaning?

2. How do you define the words you use?
3. What theory or set of beliefs closely aligns with your thinking?
4. What person or people from the past or current time inspire you?
5. What stories, images, or writings help explain your point of view toward and how it makes sense of life?
6. Describe one of your meaningful life experiences?
7. How can you increase the likelihood that you can repeat that experience?
8. With whom do you feel a common bond with regardless your beliefs?
9. How do those persons help you find meaning? Are there ways they do not help?
10. How does your way of making sense no longer working? What have you done? What avenues of new thinking have you explored?

Key Concept 2: What is a Chaplain?

The training will divide into two groups. The first part of every meeting is classroom knowledge. The second part is actual hospital visits. The results of what was learned through the visits will be discussed after the visits.. Every week there will be two types of learning. The first is classroom where the discussion will be how to improve the patient visits. The second will be actually visiting the patients and how to do the visit with the upmost respect towards the patient, family, friends, and staff.

Let us see where the chaplain gets his or her authority as a minister.

Authority

“27 Now you are the body of Christ, and each one of you is a part of it. 28 And in the church God has appointed first of all apostles, second prophets, third teachers, then workers of

miracles, also those having gifts of healing.”¹¹¹

Why

“Let all that you do be done with love.”¹¹²

“1 There is a time for everything,
and a season for every activity under heaven:

2 a time to be born and a time to die,

a time to plant and a time to uproot,

3 a time to kill and a time to heal,

a time to tear down and a time to build,

4 a time to weep and a time to laugh,

a time to mourn and a time to dance.”¹¹³

¹¹¹ 1 Corinthians 12:27-28.

¹¹² 1 Corinthians 16:14, (NKJV).

¹¹³ Ecclesiastics 3:1-4.

Week One

Classroom

Introduction

1. Start with Prayer
2. Introduce everyone
3. Read Ephesians 4:11 and explain why this class is needed.
4. Explain once the training is completed you must commit to 10 hours of volunteer work as a chaplain for the hospital.
5. Go over the basic rules like appearance, cleanliness, grooming, and in general the chain of command for the hospital.
6. Explain what to do in case of a fire or medical emergency and what exactly the role of a chaplain is during evacuation.
7. Go over the list of definitions in below.

Special Terminology

Anger Rage, annoyance, fury, resentment, and wrath are some words the describe anger [sic].¹¹⁴

Bereavement is the emotional reactions felt following the death of a loved one. [sic]¹¹⁵

Chaplain Chaplaincy is a ministry of presence. The main purpose of a chaplain is to listen, care and respond appropriately to a patient's needs. Specific duties may include performing church services; praying with patients, family and staff; conducting funeral services, providing bereavement counseling, baptisms, and communion and general ministry.¹¹⁶

Complicated Grief is a disruption in the normal grief process, which prohibits healthy closure and healing for the affected person. It manifests itself as a reaction which may be prolonged, delayed, distorted, absent, concomitant, excessive, unresolved/layered, or trauma-related.¹¹⁷

(discussed in chapter 3), it therefore may be helpful to examine how the concept of countertransference has traditionally been incorporated into the pastoral theological disciplines.¹¹⁸

Countertransference is a situation in which a therapist, during the course of therapy, develops positive or negative feelings toward the patient. These feelings may be the therapist's unconscious feelings that are stirred up during therapy, which the therapist directs toward the patient. A therapist might start feeling uneasy about therapy or the patient, unhappy with the way therapy is going, or unhappy with themselves. Just like transference, this is not an uncommon

¹¹⁴ *Penguin Dictionary of Psychology*, 47.

¹¹⁵ *Ibid.*, 95.

¹¹⁶ Charlie Davidson, email to author, July 15, 2013.

¹¹⁷ Schupp, *Grief Normal Complicated Traumatic*, 11.

¹¹⁸ Cooper-White, *Shared Wisdom*, loc., 435.

situation in the therapeutic situation. Of course, therapists must not act on any feelings they have.¹¹⁹

Death. Before modern medical support devices, death was determined by the inability of an individual organism (brain death).¹⁰

An intense emotional state associated with the loss of someone with whom one has had a deep emotional bond.¹²⁰

Mourning is the act of sorrow an outward sign (as black clothes or an armband) of grief for a person's death a period of time during which signs of grief are shown.¹²¹

Perturbation. In the context of mourning it means the capacity to experience change and movement. As it pertains to the result of mourning it is fear, distress, frighten, and anxiety.¹²²

¹¹⁹ *Penguin Dictionary of Psychology* 177.

¹²⁰ *Ibid.*, 550.

¹²¹ *Merriam-Webster's Dictionary*, 812.

¹²² Wolfelt, *Eight Critical Questions for Mourners....and the Answers That Will Help You Heal*, 26.

1. Please divide into four groups. Let us number off one, two, three, and four.

In these groups we will learn about the characteristics of a chaplain. Where in the Bible is this found. What characteristics of a chaplain do you have?

Bible Verses

1 Corinthians 12:27-28

1 Corinthians 16:3

1 Corinthians 16:14

1 Peter 2:9

1 Timothy 3:1-7

2 Corinthians 1:3-5

Acts 6:1-6

Acts 20: 35

Ecclesiastics 3:1-4

Ephesians 4:11-12

Ephesians 6:11-14

Hebrews 9:27-28

Isaiah 6:8

Isaiah 40:28-31

Jeremiah 30:17

John 8:32

John 13:4-11

Luke 10:25-37

Luke 15:9

Mark 10:32-40

Mark 10:45

Matthew 18:20

Matthew 22:14

Revelation 3:20

Revelation 21:4

Romans 15:4

Psalms 106:23

Psalms 116:15

Titus 3:6

There are some bible verses missing from the list and you may add them to your list.

Note not all of the bible verses on the list relate to the characteristics of a chaplain.

When one goes and visit a patient here is a partial list of questions one might ask. After a few months or so one can come up with their own list of open-ended questions to ask a patient.

Open-ended Questions to Ask

1. Would you like to
2. Have you thought of....
3. Would it work to
4. I'm hearing you
5. You should.....
6. You seem.....
7. I sense
8. It sounds like

This is a listening active to gain listening technics. Don't give advice or ask close-ended questions. This list came from Ed Wilder, M.Div, M.Ed., BCC.

Key Concept 3: Scenario Time

Break into four groups to see how each group answers the scenarios. Let us number off one, two, three, and four. One does scenarios to get the lay chaplains a chance to practice what to do before they go out to visit patients. Plus with doing scenarios give the volunteers confidence on how to do visits with patients. Of course the leader/trainer can make up their own scenarios. The scenarios give the volunteers to get comfortable with the rules of the hospital and what to do if certain things happen. One can make mistakes in the classroom but not on the floor.

Scenario 1

The nurses station should know what language and religion of the patient. If it is Spanish speak what you know as long it isn't cause words. Or see if a friend or family member speaks english. Ask the patient is the patient has any concerns while in the hospital. Ask if the patient understands why the patient is in the hospital.

Check to see if the room needs to be clean or the patient needs a bath. Ask the patient if they need a priest. You looked at the patient 's file and you know what religion the patient is. Get down to their eye level so you are looking down at them. Ask if they wish to have communion. Look them in the eyes if they are American. Let the patient do the talking as much as possible. If they are sleeping donnot wake them up. See what the needs are and try to solve it in front of them so they know you assisted them in their time of need. Let the conversation go from that point. If they want to talk. Talk. If they don't want to talk leave a card and if you feel like talking call.

1. Ask if they would like a prayer. Always give the patent the choice.
- 2.. When the visit is finished go to the sink and wash hands per direction of the hospital.
- 3..This should take anywhere from 5-10 minutes. The patient is ill and many times they are

groggy and give you that blank stare. That is when you smile and leave.

- 4.. Ask for questions.
- 5.. Give encouragement stating tonight was a tough night and much information was disseminated. Promise the worst is over and it will get better as the classes continue.
6. Explain one must do some down time to remain healthy. One might sing on the way home in the car, listen to music, go for a walk, exercise, drink some tea, meditate, go for a walk with their dog, read poetry, or see a movie. The items listed are only possible suggestions. Maybe you might have one way of relieving stress that is not listed that you can mention next week to everyone.
7. End with prayer and say you next week.

You walk into a patient's room and they do not speak English. What do you do?

Discuss what you would do in the groups. Then come to a consensus on how to handle the scenario. Spend this time getting to know the other volunteers and see how much you have in common. When you as a volunteer are visiting patients all you have to fall back on are other lay volunteers like yourself. That is why we are bonding in class while doing scenarios.

Scenario 1 Answer

Follow the instructions that you do for every patient.

See what language the patient speaks and see if you need an interpreter for the visit.

Week Two

1. Start with prayer. Have some volunteer to lead prayer. Have a sign in sheet for attendance.
2. Review what was done last week.
3. Ask for questions.

4. Break out in four groups. Do the questions below.

Questions

These questions came from Dr. Ed Wilder at Baptist Health Services Jacksonville, FL.

1. What words do you use to make a meaning?
2. How do you define the words you use?
3. What theory or set of beliefs closely aligns with your thinking?
4. What person or people from the past or current time inspire you?
5. What stories, images, or writings help explain your point of view toward and how it makes sense of life?
6. Describe one of your meaningful life experiences?
7. How can you increase the likelihood that you can repeat that experience?
8. With whom do you feel a common bond with regardless your beliefs?
9. How do those persons help you find meaning? Are there ways they do not help?
10. How does your way of making sense no longer working? What have you done? What avenues of new thinking have you explored?

The next topic is a huge topic that happens in the hospital or hospice setting.

Key Concept 4: Death, Grief, Bereavement, and Mourning

Talk about countertransference and how that affects how you view death, grief, and mourning. See definition for what is countertransference.

Give examples of how to approach the patient, family, and friends. Always let the doctor tell the family if the patient dies.

Break into four groups to do scenarios two-four. Take fifteen minutes for each scenario.

Scenario 2

You walk into a patient's room where they are not Christian. What do you do?

Scenario 2 Answer

See, This is what you do for all patients before entering the room.

1. See what language the patient speaks and see if you need an inturpeltor for the visit.
2. The nurses station should know what language and religion of the patient.
3. Ask if there are any special concerations that need to be done so the patient can relax.
4. Example is some people from India do not eat meat or eggs. Check to make sure the food try comes to the room with their dietary restrictions.
5. Ask is there anyone from their religion that you can call for them.
6. Ask does the doctor know of your special needs for your religion?
7. Hand the patient your card and make sure that the patient knows that all phone calls will be answered.

Scenario 3

Patient just came back from surgery. Family members are present. The family members are fighting. You hear profanity coming from everyone. How do you react?

Scenario 3 Answer

See; This is what you do for all patients before entering the room.

1. Walk in and say who you are and see if there is anything that you can do as a chaplian for them.
2. Mention the fighting and cursing has to stop in the hospital.
3. State the fighting and cursing is disrupting the other patients in the area.

4. Be a friend and ask what is needed to get the fighting and cursing stopped immediately.
5. Ask to pray together.
6. Leave a card and say if you have any other concerns that need to be discussed then please call.

Sceniaro 4

You walk into the room and all of a sudden you realize that you use to date this person. You had a personal relationship with that patient. The new love of the patient's life is in the room. The eyes made contact. The other person saw the eye contact you had with the patient. The other person does not know about the two of you. You cannot walk out and pretend that this did not happen. What do you do?

Sceniaro 4 Answer

See; This is what you do for all patients before entering the room.

1. Treat the patient just like any other patient.
 2. Do not bring up the topic and let the patient tell the friend or other relationship about the two of us.
 3. Keep everything on a professional level.
 4. Offer paryer if wanted.
 5. Leave the card and say if you my assistance please call.
-
1. Ask for questions.
 2. Remind everyone to do some down time.
 3. End with prayer. Have someone volunteer to do the closing prayer.

Week Three

1. Start with prayer. Have the sign in sheet for attendance.
2. Ask for questions.
3. Review past material.
4. Break into four groups

Scenario 5

You walk into the room and the room is filled with several teenagers. You find out the patient was shot by a rival gang. They are planning revenge on the person who shot the patient.

What do you do?

Senario 5 Answer

See; This is what you do for all patients before entering the room.

1. Where the parents are for the teenagers wanting to kill the patient?
2. Make sure hospital security was called.
3. Wait until security came before one went anywhere in the area.
4. Ask would anyone like a cup of ice water? Coffee is hot and burns. Ice water is ice water you just get wet and cold.
5. Offer prayer and ask if they pray in a circle holding hands. If the are holding hands they are not hold a gun or knife.
6. Relinquish control to the security personal.
7. Once everything settled down contuinue with the ER visit.
8. Meanwhile be praying to God about the whole situation silently.
9. Follow all standing operating proceedures that the hospital has in place.
10. Remember to wash hands when leaving the room.

11. Ask for questions. Ask what Bible verses were used in Scenario five?
12. Ask the volunteers to read a book on death and dying.
13. Remind the volunteers to do some down time.
14. End in Prayer.

Week Four

1. Start with prayer.
2. Ask for questions. Have a sign in sheet for attendance.
3. Review material from the following three weeks.
4. Break into four groups.

Scenario 6

You are visiting with family members and they just received word that their family member died in surgery. The family members immediately start whaling and expressing their grief. What do you do?

Senario 6 Answer

See; This is what you do for all patients before entering the room.

1. Call them all together and ask if they want a prayer. If not then just stand in the presence with them.
2. Take your ques from the family and see exactly what they want to do now that the family member has passed on.
3. Normally a chaplain might help them with funeral arrangements and/or call their pastor.
4. Sometimes a chaplain has to explain about organ donation. The family might be asked to donate organs.
5. Stay with them and offer the family some coffee., prayer or just being in the moment.

6. Do not hug the family members unless they hugged first.
7. Go with them to view the body after the doctor said it was okay to go and see the the loved one. At this point a chaplain might hold hands if they so choose to do so.
8. Wait with them if they are local or until their pastor arrived.
9. Ask the family members to talk about the family member who just died.
10. Listen with great intent. Offer many boxes of tissues.
11. When the pastor comes do a slight debriefing to the pastor. Hand the pastor your card and say if you need me call.
12. Quietly exit when the chaplain's presence is no longer needed.

1. Review what to say and not say in patient visits.
2. Break into groups of two people each and go visit two patients.
3. Assign rooms to visit and give them 30 minutes to visit one patient.
4. Reconvene and discuss how the visits went.
5. Ask for questions.
6. Remind the volunteers to do some down time.
7. End in prayer.

Week 5

1. Start with prayer. Have a sign in sheet for attendance.
2. Ask for questions.
3. review the other weeks.
4. Do scenario 7

Scenanio 7

You walk into the room and the patient is clinging on to you for dear life. Oh don't leave me. I am scared. I do not know how to handle my heart condition. I will have a heart attack if you leave me. What do you do?

Senario 7 Answer

See; This is what you do for all patients before entering the room.

1. Ask them if they had talk with God today in prayer.
2. Start a prayer and it might be a long prayer. Why a long prayer? This is to get the patient to settle down and take a deep breath and relax.
3. Call the nurse and see if there are any drugs that the patient can have right now.
4. Ask the patient what he/she knew about the heart condition.
5. If the patient didn't know a thing call the staff to bring in lituriture about the condition to the room.
6. Reafirm many people have had a heart attack and they are still living.
7. Affirm to the patient that he/she has one of the best doctors around for this condition.
8. At this point call the social worker to the room and let the social worker talk with the patient.
9. Call the social worker to the room.
10. Stop at the nurses station to see how the patient is doing. Return to the room in about an hour or two to see how the patient is doing.
11. Break into groups of two's for patient visits. See two patients.
12. Reconvien and exchange ideas and thoughts how the patient visits went.
13. Ask for questions.
14. Talk about taking care of yourself and things you can do to take the stress away chaplain.

15. Remind the volunteers to do some down time.
16. End in prayer.

Week 6

1. Start with prayer. Have a sign in sheet.
2. Ask for questions.
3. Review what has happen in the last 5 weeks.
4. Do scenario 8.

Scenario 8

You are in the emergency room. An auto accident has occurred. The families and the accident victims come in to the emergency room. The innocent victim dies on the way to the hospital. The person who caused the accident is drunk. The family finds out the person who killed the family member, loved one was drunk. They start shouting murderer. What do you do

Senario 8 Answer

See; This is what you do for all patients before entering the room.

1. Call hospital security.
2. Wait until security came before entering the area.
3. Sepertate the family of the victim aside and see if we could go to a private room of the hospital where we can talk.
4. See if the family pastor has been called. If not call the pastor for them.
5. Take your ques from the family and see exactly what they want to do now that the family member has passed on.
6. Normally one might help them with funeral arrangements or their pastor called.

7. Sometimes a chaplain has to explain about organ donation. They might be asked to donate organs.
8. Stay with them and offer the family some coffee.
9. Do not hug the family members unless they hugged me first. Or ask permission to give a hug.
10. Go with them to view the body after the doctor said it was okay to go and see the body. At this point hold hands if they so choose to do so.
11. Wait with the family if locally, until their pastor arrived.
12. Ask the family to tell me all about the family member who just died.
13. Listen with great intent and see if there are many boxes of tissues.
14. When the pastor came we would do a slight debriefing or not. Hand the pastor your card and say if you need a chaplain please call.
15. Quietly exit.

Note: the answers to the scenarios are not the only possible answers for all of the scenarios.

Break into groups of two's for hospital visits. Visit two patients. They have 30 minutes complete two visits with patients.

Reconvene and talk about what happened in the patient visits.

Have the new volunteer chaplains fill out the commitment forms.

Ask for evaluation forms to be filled out.

Graduate the training class.

Remind the volunteers to do some down time and be with your family and friends.

End in prayer.

This is the training using key concepts for training lay chaplains written by Rev. Lisa Kanne.

Personal Notes

The classes start out in big groups. The reason is to make sure everyone gets to know everyone in the group. As the classes go on the groups get smaller until it reaches a group of two people. The reason are many for going to large groups to small groups.

1. It gives confidence that the person is actually called by God to be a volunteer chaplain.
2. It gives the volunteer a real look into what it takes to be a hospital and to see if that person is called to be a chaplain. There is more to being a chaplain than just talking with the patients.
3. It gives the volunteer exactly what the hospital want out of their service.
4. It sorts out the people who thought they wanted to be a hospital chaplain.
5. It gets the volunteer to question their personal thoughts and say “ am I ready to take this giant step and work with God to assist the greiving and sick patients, family, staff, and friends.”
6. There are six key concepts within the disseratation. These key concepts will help the lay hospital chaplain succede.
7. A volunteer chaplain has to feel comfortable with group prayer and listening to the needs of the patient.
8. A volunteer has to have the love of Jesus in their heart to be a chaplain.
9. Every volunteer must establish a way to have down time in their personal life.
10. Plus a prayer life with God Is a must for all volunteer chaplains and chaplins.

11. A chaplain's duty is to visit patients and to be advocate for the patient.
12. Remember when all else fails pray!

Reading list

The Bible.

Cooper-White, Pamela. *Shared Wisdom*. Minneapolis, MN: Fortress Press, 2004.

Doka, Kenneth J., *The Spiritual Gifts—And Burdens—Of Family Caregiving*, Generations 27, no. 4 (Winter 2003/2004).

Doka, Kenneth J., and Amy S. Tucci. *Beyond Kübler-Ross: New Perspectives on Death, Dying and Grief*. Washington, DC: Hospice Foundation of America, 2011.

Kanel, Kristi. *A Guide to Crisis Intervention*, Belmont, CA: Thomson, 2007.

Kübler-Ross, Elisabeth. *On Death and Dying*, New York: Macmillan, 1969.

Schupp, Linda J. *Grief Normal Complicated Traumatic*, 7th ed. Eau Claire: PESI, 2007.

Schwiebert, Pat, and Chuck DeKlyen. *Tear Soup*, DVD, directed by Pat Schwiebert and Chuck DeKlyen (Portland, OR: Grief Watch, 2006).

Wright, H. Norman. *The Complete Guide To Crisis & Trauma Counseling*, Regal, Ventura, CA 2011.

----- . *Helping Those Who Hurt*, Bethany House Publishers, Minneapolis, MN, 2006.

Wolfelt, Alan D. *Eight Critical Questions for Mourners*, Fort Collins: Companion, 2010.

There are more books but those books are just the beginning. Hospice USA has many good books on grief and dying you may purchase. The challenge to you is to make your own list of helpful books on grief, death, and dying. Please include books on poetry.

CHAPTER FIVE

The Answers

Ephesian 6:11-14

11 Put on the full armor of God so that you can take your stand against the devil's schemes. 12 For our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms. 13 Therefore put on the full armor of God, so that when the day of evil comes, you may be able to stand your ground, and after you have done everything, to stand.¹²³

The local hospital will run an add requesting that all interested in training to become a lay Christian Chaplain please attend the first meeting to get all of the details at a predetermined date and time. During that meeting all details will be released at that time. All information will be given out at that time and be given a time to return with all of the proper forms and letters filled out. A background check will be run on each person. Human Resources will be present to assist with the paperwork to become a volunteer at the hospital.

Please follow this logic. A chaplain is called in after the crisis had happen. Meanwhile the chaplain walks into the event without any knowledge that a crisis had happen. Wright has come up with many good ideas to lessen the crisis for the individual. Wright is known for his Ball of Grief. According to Wright he hands the picture of the ball to the men. “This ball has many grief words that evoke feelings. Some of the words are denial, pain, anxiety, rage, and many more words like that. This ball gives men a way to express how they feel. According to Dr. Wright men are brought up not to express emotions. This ‘Ball of Grief’ is very helpful to

¹²³ Ephesians 6:11-14.

express their emotions in a healthy way.”¹²⁴

Isiah 40:28-31 states that God never grows weary. “Whereas, men grow weary all of the time. I will not tire or grow weary if one looks to God. God also gives us hope when it looks like there is no hope. What a firm foundation to stand on when one is need of comfort. If one looks to God one will not be faint.”¹²⁵

The following Power Point was made as a direct result from what the pastors stated in the survey in the year 2013 in Kinston, N.C. The community has a mixture of large churches and small churches. The younger the pastor the more he was inclined to allow lay people to be chaplains for their church.

Another result was the number of years as a pastor the least they wanted lay people to be chaplains. They wrote on the surveys they were required by the cognations to do the hospital visits along to the other duties they were responsible to do per the contract. When a member of the church went to the hospital they expected the senior pastor to be at the hospital.

“Spiritual/religious concerns should be attended to in every patient's treatment plan. The role of the physician in this process is to make sure that the patient's spirituality is assessed and that referrals are made to a professional chaplain as needed. The role of the chaplain, as the spiritual care specialist on the treatment team, is to assess the patient in depth and provide spiritual support and treatment as appropriate.”¹²⁶ What was stated was spiritual concerns are everyone’s responsibility and that should be addressed by all.

¹²⁴ Wright, *Helping Those Who Hurt*, 64.

¹²⁵ Isiah 40:28-31.

¹²⁶ George Handzo, and Harold G Koenig, “Spiritual Care: Whose Job Is It Anyway?” *Southern Medical Association* 97, no. 12 (2004): 1242-44.

Note; the answers to the senioros are not the only possible answers for all of the senioros.

Conclusion

The dissertation was done to assist the local hospitals and the chaplain staff. One person cannot be at the hospital 24 hours a day and seven days a week. The training of chaplains has changed from 2000 to 2013. It use to be retired pastors/ministers became chaplains at the local hospital. That was proven not too good because of the leading edge of medicine. Plus more cases of terminal illness thus Hospice was created to handle this work load. Sure the retired pastors now chaplains could see patients all day long. However, they needed more training in specialized fields.

Another advancement was chaplains only visited patients of their own faith. That has changed for the better. Now chpalains see all patients no matter their religious affiliation. Today the chaplain has to be aware of the disserent religious practices. An example was food. Some religious donnot eat meat.

The next problem is administrators setting the worth of a chaplain. That is because chaplains have not written papers on the work they do. Every one thinks they just do the "God Thing". Many people nowadays are not very religious. They do not attend religious services. The bottom line according to administrators are chaplains do not add to the profit line. That is their opinion only. There are many studies out there that say otherwise. What comes to mind was when the chaplain sat with the patient as he died. The staff did not have the time to be there for the dying patient. The many studies proved when the religious concerns were acknowledged at the hospital it brought more patients back to the the hospital. What the patients told by word of mouth was they cared about me at the hospital. The solution is more chaplains need to write about what they do so the administration knows how hard the chaplains are working.

The administrators in some cases eliminated the chaplaincy department from the hospital. According to TJC there must be a certified chaplain for the hospital. That is true for all hospice facilities. Plus many doctors are now seeing that people who are religious get better quicker than those without any religious connection. The administrators do not understand what it is like to see a child of God die. The chaplains are there when the babies die, or when there is a shooting, or stabbing, or a person is burned over 80% of their body, or a bad car wreck and someone dies.

There are many different types of chaplains. As one gets deeper into this field of service one might focus on one definition of chaplaincy versus a broad heading as hospital chaplain. There are many areas to serve such as hospice, ER, intensive care, and youth. However, the palliative care teams rely on a certain chaplain to be there with them when needed.

Therefore, the dissertation aids not only for the hospital chaplains and the local ministers through this training. The volunteers will aid in patient care at the hospital. The lay volunteer chaplain will do the ministry of presence and just be there for the patient. Being a chaplain is a special calling not every one can do. They must truly be called by God for this ministry. Revelation 3:20 “Here I am! I stand at the door and knock. If anyone hears my voice and opens the door, I will come in and eat with that person, and they with me.”¹²⁷ This training is knocking at the hearts of the volunteers to answer the call to service as a volunteer chaplain.

¹²⁷ Revelation 3:20.

APPENDIX A
SURVEY QUESTIONS

Please review (and keep) the attached consent information. This is an anonymous survey.

Please do not give your name nor any identifiable patient or hospital information.

Tell us about yourself: (circle all that apply and note the number of years of ministry)

- a. Professional (compensated) full-time hospital or hospice or health care chaplain
- b. Professional part-time hospital or hospice or health care chaplain
- c. Volunteer hospital or hospice or health care chaplain
- d. Volunteer assistant hospital or hospice chaplain
- e. Pastor who does hospital visitation
- f. None of the above
- g. How many years? _____ .

The purpose of my doctoral dissertation is to train individuals to volunteer for hospital chaplaincy assistance. Please answer these questions to help determine the areas where you believe training is necessary.

1. When you visit patients in the hospital what do you see as your primary role(s)?

2. Describe a typical hospital visit. (Please give any information you believe would be helpful for one starting in a hospital ministry. For instance, how long do you typically stay, how does the visit begin, what do you say to the patient, etc.)

3. Have you ever received any specialized training in hospital visitation or patient counseling?
If so, please describe as the dissertation will include a section on professional chaplaincy training.

4. Do you believe that volunteers can play a helpful role in patient or staff spiritual care? If yes, what role(s) do you think they would best serve?

5. Based on your experience, what skills or knowledge training would hospital chaplain volunteers need to serve effectively?

6. What are some of the potential spiritual, ethical, or professional dangers in using volunteers for hospital patient interactions?

7. What personality traits or personal skills do you believe are most needed for effective hospital ministry? (For instance, listening skills, Bible knowledge, counseling ability, etc.)

8. What are some professional, medical, or ethical limitations or requirements that volunteers should be made aware of?

9. What do you see at the greatest benefit or blessing of working with patients in hospitals?

What gives you the greatest satisfaction in this particular type of ministry? Why would you encourage someone to consider this type of volunteer position?

10. What warning(s) or potential pitfalls would you share with prospective lay hospital chaplain volunteers (for example, burnout, excessive emotional involvement with patients, family members, etc.)?

APPENDIX B
PASTORAL LETTER

Lenoir Memorial Hospital

Chaplain Office

105 Airport Rd

Kinston, NC 28401

Dear Chaplain Lisa Kanne,

I, _____ do recommend

_____ this person to take the training to become a
volunteer Chaplain. This person has been a member of the church for over 6 months. The
classes will be from 6 PM to 8 PM for six weeks starting on Monday. Attendance is required for
5 out of 6 weeks. Please include a telephone number of the church.

_____.

In God's Service,

APPENDIX C

ADVERTISEMENT FOR THE LOCAL PAPER

Lenoir Memorial Hospital

Training for Lay Christian Chaplains

Training will be 6 weeks long starting the first Monday in February.

Time: 6 PM-8 PM

Place: Hospital cafeteria

How Long: 6 weeks

Call the Chaplain's office for more details. (252) 523-5500

APPENDIX D
LETTER TO LAY CHRISTIAN CHAPLAINS

Dear graduate from the Lay Christian Chaplaincy Training.

As part of the free training, Lenoir Memorial Hospital is asking for ten hours a month for the next six months or longer. Please fill out the form and give it back to the chaplain's office.

I _____, can work the following schedule.

Sunday AM _____ PM _____

Monday AM _____ PM _____

Tuesday AM _____ PM _____

Wednesday AM _____ PM _____

Thursday AM _____ PM _____

Friday AM _____ PM _____

Saturday AM _____ PM _____

Thank you for your volunteer assistance. The chaplaincy office at Lenoir Memorial Hospital.

In God's service.

Chaplain

APPENDIX E: Key Concept 5

The Suicide Survivor's Bill of Rights

Someone you love has ended his or her own life. Your grief is unique and profound, and you have special needs that must be tended to in the coming weeks, months, and years. Though you should reach out to others as you do the work of mourning, you should not feel obligated to accept the unhelpful responses you may receive from some people. You are the one who is grieving, and as such, you have certain “rights” no one should try to take away from you.

The following list is intended both to empower you to heal and to decide how others can and cannot help. This is not to discourage you from reaching out to others for help, but rather to assist you in distinguishing useful responses from hurtful ones.

1. **I have the right to experience my own unique grief.** No one else will grieve in the exact same way I do. So, when I turn to others for help, I will not allow them to tell me what I should or should not be thinking, feeling, or doing.
2. **I have the right to talk about my grief.** Talking about my grief and the story of the death will help me heal. I will seek out others who will allow me to talk as much as I want, as often as I want, and who will listen without judging. If at times I don't feel like talking, I also have the right to be silent, although I understand that bottling everything up inside will prevent my healing.
3. **I have the right to feel a multitude of emotions.** Confusion, disorientation, fear, shame, anger, and guilt are just a few of the emotions I might feel as part of my grief journey. Others may try to tell me that what I do feel is wrong, but I know that my feelings aren't right or wrong, they just are.
4. **I have the right to work through any feelings of guilt and relinquish responsibility.** I may feel

guilty about this death, even though it was in no way my fault. I must come to acknowledge that the only person truly responsible was the person who took his or her own life. Still, I must feel and explore any possible feelings of guilt I may have in order to move beyond them.

5. **I have the right to know what can be known about what happened.** I can cope with what I know or understand, but it is much harder to cope with the unknown. If I have questions about the death, I have the right to have those questions answered honestly and thoroughly by those who may have the information I seek.
6. **I have the right to embrace the mystery.** It is normal and natural for me to want to understand why the person I love took his or her own life, but I also have the right to accept that I may never fully and truly understand. I will naturally search for meaning, but I will also “stand under” the unknowable mystery of life and death.
7. **I have the right to embrace my spirituality.** I will embrace and express my spirituality in ways that feel right to me. I will spend time in the company of people who understand and support my spiritual or religious beliefs. If I feel angry with God or find myself questioning my faith or beliefs, that’s OK. I will find someone to talk with who won’t be critical of my feelings of hurt and abandonment.
8. **I have the right to treasure my memories.** Memories are one of the best legacies that exist after the death of someone loved. I will always remember. If at first my memories are dominated by thoughts of the death itself, I will realize that this is a normal and necessary step on the path to healing. Over time, I know I will be able to remember the love and the good times.
9. **I have the right to hope.** Hope is an expectation of a good that is yet to be. I have the need

and the right to have hope for my continued life. I can have hope and joy in my life and still miss and love the person who died.

10. I have the right to move toward my grief and heal. Reconciling my grief will not happen quickly. Grief is a process, not an event. I will be patient and tolerant with myself and avoid people who are impatient and intolerant with me. I must help those around me understand that the suicide death of someone loved changed my life forever.¹²⁸

¹²⁸ “The Suicide Survivor’s Bill of Rights,” Alan D. Wolfelt, Ph.D., C.T., www.centerforloss.com.

APPENDIX F**BIBLE VERSES**

1 Corinthians 12:27-28	1 Corinthians 16:3
1 Corinthians 16:14	1 Peter 2:9
1 Timothy 3:1-7	2 Corinthians 1:3-5
Acts 6:1-6	Acts 20: 35
Ecclesiastics 3:1-4	Ephesians 4:11-12
Ephesians 6:11-14	Hebrews 9:27-28
Isaiah 6:8	Isaiah 40:28-31
Jeremiah 30:17	John 8:32
John 13:4-11	Luke 10:25-37
Luke 15:9	Mark 10:32-40
Mark 10:45	Matthew 18:20
Matthew 22:14	Revelation 3:20
Revelation 21:4	Romans 15:4
Psalms 106:23	Psalms 116:15
Titus 3:6	

APPENDIX H: Key Concept 6**BALL OF GRIEF¹²⁹**

This image has been removed for copyright purposes. The image can be viewed at <http://www.hnormanwright.com/pdf/Ball-of-Emotions.pdf>

¹²⁹ “The Ball of Grief” H. Norman Wright, hnormanwright@lycos.com.

APPENDIX I

PERMISSION TO USE THE SUICIDE SURVIVOR'S BILL OF RIGHTS

Companion Press <books@centerforloss.com>

To: Lisa Kanne <123kanne@gmail.com>

Re: I need permission to reproduce the bill of rights

Hi Lisa,

You have Dr. Wolfelt's permission to reproduce the Suicide Survivor's Bill of Rights in the digital commons at Liberty University.

Please let me know if I can help with anything else.

All the best,

Bonnie Goss
Publications Coordinator, Companion Press
(970) 226-6050
books@centerforloss.com

On Sep 10, 2015, at 10:47 AM, Lisa Kanne <123kanne@gmail.com> wrote:
The school just called me and said I need permission to reproduce the "Suicide Survival Bill of Rights" by Dr. Alan Wolfelt in the digital Commons at Liberty University.

Thank you,

Lisa

APPENDIX J

PERMISSION FOR BALL OF GRIEF

On Sep 3, 2015, at 10:01 AM, hnormanwright@lycos.com wrote:
Greetings,

Thank you for your email.

Permission is granted to use the 'Ball of Grief' for your thesis.

Sincerely,
H. Norman Wright

n. 2015-09-03 02:44 Lisa Kanne wrote:

From: Lisa Kanne

I am a student AT Liberty University. I have until Friday to get your permission to use your "Ball of Grief" in my doctoral thesis.

Thank you,

Lisa

APPENDIX K

INTERVIEW

Doka was so kind to take his time out of his busy schedule for this interview so it could be included in this dissertation paper. The interview is as follows.

DK is Kenneth J. Doka, PhD, M.Div.

LK is Rev. Lisa Kanne, M.Div.

On September 7, 2012 an interview was conducted via telephone with Kenneth J. Doka. While researching this dissertation Doka's books came up many times. Dr. Doka has been a minister in the field of thanatology, chaplaincy, and hospice for over 40 years. The dissertation draws on many of his writings.

LK Question 1. The hospital is a sterile place. There is no touching from the staff to the patient. How do you approach the patient as to touching the patient in a clinical setting? Touching is a way of saying, "I care" and "you as a patient are important to God and to me."

DK: First some people are very sensitive to being touched. Never, never touch a person without asking them. For some people it is a culturally unacceptable to be touched. I would extend my hand and if they want you to touch or hug them they will say so. If you touch the patient do so gently because it might hurt to be touched.

LK: Question 2. How do you handle other people other than the patient?

DK: The nature of hospice is holistic—the family is the basic unit of care. In addition to the patient and the family, we need to be sensitive to staff needs as well.

LK: Question 3. How long have you been doing hospice/chaplaincy?

DK: I have done some teaching with hospice, education of chaplains, and research. The

main area of expertise is teaching, writing and research in the field of thanatology.

LK: Question 4. How do you use the Bible while comforting the patient?

DK: My main goal is to be an advocate for the patient. I am to facilitate their beliefs and their spirituality. I help them to get to their own spirituality. I would ask how I could help you in your spiritual walk.

LK: Question 5. Being a hospice chaplain is very stressful. What do you do to relax?

DK: I would make time to be with my family and friends. I would not go see a movie about hospitals. I might go for a walk.

LK: Question 6. Do you have any additional advice that you would give to new chaplains/hospice chaplains?

DK: I would find a way to nurture your own spirituality for your own life.

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IRB, IRB [IRB@liberty.edu]

Sent: Thursday, March 14, 2013 9:38 AM

To: Kanne, Lisa

Cc: IRB, IRB; Garzon, Fernando; Davidson, Charlie Nathan

Subject: IRB Exemption 1546.031413: Training Evangelical Lay Chaplain Volunteers for Effective Hospital Ministry

Dear Lisa,

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 that 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:

(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 that 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,

Fernando Garzon, Psy.D.

Professor, IRB Chair

Counseling

(434) 592-4054

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