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Caring^{for the} Human Spirit[®] magazine

FALL/WINTER 2017



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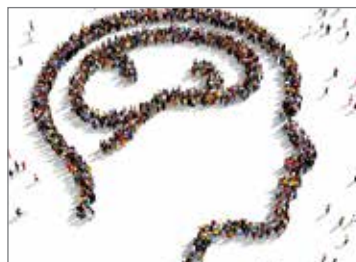


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Comments? Suggestions?

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HealthCare Chaplaincy Network™ is a global health care nonprofit
organization that offers spiritual-related information and resources, and
professional chaplaincy services in hospitals, other health care settings, and
online. Our mission is to advance the integration of spiritual care in health
care through clinical practice, research and education in order to improve the
patient experience and satisfaction, and to help people faced with illness and
grief find comfort and meaning—*whoever they are, whatever they believe,*
wherever they are. We have been caring for the human spirit since 1961.

A LETTER FROM REV. ERIC J. HALL



Rev. Eric J. Hall
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As I write this, Hurricane Maria has made landfall in the Dominican Republic and has strengthened into a category 5 storm heading for Puerto Rico. Hurricane Irma caused significant damage in southern and western Florida. As we watch vigilantly to see if Maria will follow the same path, the people of the Florida Keys brace for the possibility of another evacuation. As our elected officials in the nation's capital negotiate relief funding for the impacted regions, groups and individuals throughout the country have taken it upon themselves to provide much-needed relief.

I am not sure exactly why it is that devastating events bring out the best in us, but I am grateful that they do. Fundraising concerts raise tens of millions of dollars, organizations request our generosity to provide basic necessities to those in need, and the responses to clothing and food drives are shipped to areas where families wait for their next meal, a dry shirt and a supportive gesture. Even Eastchester Church in Eastchester, NY, where I serve as pastor, is currently seeking out a church that has been devastated by what nature has unleashed to assist them in rebuilding. The focus of these varied efforts is the same – to not only provide material and financial support in the hopes of restoring some sense of normalcy to those affected, but to surround them with visible care and support.

I am sure that each of you reading this will appreciate and understand when I say that prayer is not the least we can do. Prayer, meditation, and the simple offering of good will is something each of us can provide no matter our religious beliefs or faith traditions – even if we declare none. I sense a nation infused with concern and empowered by compassion – humanity accepting responsibility for humanity, neighbor for neighbor – to care for the stranger because they are us and we are them. For me, this response is an example of the sacred and divine encouraging us to make the effort, to reach out and to care for one another.

Now is a moment in our busy lives to stop and ask for grace and blessings to be with all the survivors of Hurricanes Harvey and Irma, and those in the path of Maria. Let us ask that there may be strength for those who are anxious and afraid, comfort for all who mourn, and for peace to find its way into the hearts of those who are struggling. Let us hold all these persons, our brothers and sisters, in our hearts, thoughts, and prayers. Then may we be instruments of that peace.

A handwritten signature in blue ink, appearing to read 'Eric J. Hall', written in a cursive, flowing style.



What Patients Really Want: Teaching Compassionate Communication to Health Care Professionals

By **Larry Dawalt, M. Div., Robert Michael Smith, M.D., MBA,** and **Patty Brown, RN**

Even though it was difficult for the young woman to speak as she walked from the hospice house room right after her father's death, she felt she had to express her gratitude to the administrator who had walked down the hall to express her sympathies.

"This place was so wonderful to us. You could just tell that everyone cared. It was like they were caring for their own dad. I'll never forget it."

Unforgettable care is not just about clinical skills and abilities, it's also about genuine compassion. Whatever happened to compassion? In February, the *The New York Times* ran an Op-Ed piece headlined "The Death of Compassion." Someone has even written a book titled "The Demise of Compassion: A Casualty of a Changing Culture." But compassion is more important than ever, especially in health care, and

communicating in a compassionate manner is a foundational component of 'unforgettable care.'

Recognizing the importance of this health care component, HCCN's fourth annual Caring for the Human Spirit Conference in Chicago was designed with a specific focus on compassion. From the opening keynote, "Perspectives on Compassion: An Essential Practice in Chaplaincy" by Roshi Joan Jiko Halifax, Ph.D, to the "A Compassionate Practice Toward Patient-Oriented and Clinically Relevant Evidence Based Approach" plenary by Shane Sinclair, Ph.D, to the "What Does Multidisciplinary Compassionate Care Look Like?" plenary by Deborah Marin, M.D. and her team from Mt. Sinai Hospital in New York City, the conference gave attendees the opportunity to move compassion to the front burner as a best practice in clinical care. It also

raised this question: can compassion, particularly compassionate communication, be taught to health care professionals and developed as a foundational skill by clinicians of all disciplines; and is there a need for such training in the current health care environment?

"The Patient Wish List" by Peter Provonost, was generated from patient feedback about their care.¹ The ten items on the list can best be summarized by 'keep my room clean, listen to me, and be fully present and engaged in my care.' The assumption here is that many care providers do not listen. A survey of 800 recently hospitalized patients and 510 physicians found broad agreement that compassionate care is very important to medical treatment, yet only 53% of patients and 58% of physicians said that the health care system generally

provides compassionate care.² Specific communication training was developed at the Warren Alpert Medical School at Brown University as a result of the conclusion that 'medical knowledge alone does not suffice in the education of proficient physicians. Effective communication helps physicians decipher patients' complex medical histories, and fosters the necessary alliance with patients to ensure optimal care.'³

At Hospice & Palliative Care Charlotte Region, we discovered the need for specific training in compassionate communication from an examination of our consumer concerns which revealed that consumers were more concerned by far about 'communication' than they were about 'skills/ability,' which ranked lowest in concerns. In response to this information, we chose to develop a compassionate communication course as part of an overall Exceptional Care Initiative. Utilizing basic communication principles from Neuro-Linguistic Programming, input from a compilation by one of our social workers, nursing and physician field experiences, and from specific studies of the principles of compassion, we developed a three-and-a-half-hour course that has become mandatory for all new staff members – clinical, administrative, etc.

While the training presents lecture information about the definition of compassion, levels of communication, the listening process, and practical applications in the field environment, there are also specific role-playing sessions designed to give participants a 'lab experience' similar to that which they may encounter in the field. Early in the training, after an introductory period and a discussion about the YouTube video "It's Not About The Nail," we pair the participants and give them the opportunity to role play the question 'have you ever been through anything like this before?' which is certainly a question they might encounter as part of end-of-life care. After five minutes, we use the group discussion time to find the 'question behind the question.' What are they

asking? Is it about past experiences, trust, competency or something else? Other discussion questions include 'I'm not going to get any better, am I?' and 'when a patient describes you to another individual as 'one of the family' what is the most professional yet compassionate response you can give?'

We present compassion as an emotion that is a sense of shared suffering, most often combined with a desire to alleviate or reduce the suffering of another. Drawing from Joseph Goldstein's "Mindfulness: A Practical Guide to Awakening" we emphasize that compassion is 'that feeling in the heart that wants to help others and ourselves be free of suffering'.⁴ We also suggest that it can't be just in the head, but hopefully compassion comes from the heart. As Goldstein writes regarding the purpose of mindfulness practice:

"It is not enough to admire from afar the qualities of kindness and compassion as being noble ideas, but somewhat removed from our daily

lives. It is not enough to cultivate them only in the solitude of a meditation retreat. Our practice is about the transformation of consciousness that makes compassionate responsiveness the default setting of our lives."

While we certainly can't teach The Four Divine Abodes (Love, Compassion, Sympathetic Joy, and Equanimity) at the depths of teachers like Goldstein or Jack Kornfield, we have found several exercises in compassion and equanimity to be valuable. One is a reading of the Dalai Lama's 'A Morning Ritual'. It seems to take on a hallow sacredness as the participants read it aloud together:

"Today, I am fortunate to have awakened. I am alive. I have a precious human life and I am not going to waste it. I am going to use all my energies to develop myself and expand my heart out to others. I am going to have kind thoughts towards others. I am not going to get angry or think badly about others. I am going to benefit others as much as I can."



**"... keep my room
clean, listen to
me, and be fully
present and engaged
in my care ..."**

Another important exercise is designed to teach equanimity and encourage participants to see themselves as part of a societal whole rather than as a clinician whose experiences are different from patients and their families. Using their partner from previous exercises, the participants sit knee to knee and alternate reading each other the following sentences excerpted from 'A Guide to Cultivating Compassion in Your Life' by Zen Habits author Leo Babauta:

1. Just like me, _____ is seeking happiness in his/her life.
2. Just like me, _____ is trying to avoid suffering in his/her life.
3. Just like me, _____ has known sadness, loneliness and despair.
4. Just like me, _____ is seeking to fill his/her needs.
5. Just like me, _____ is learning about life.

We point out that doing this exercise and inserting the name of a patient or family member is a powerful revelation of our shared humanity.

A time of reflection on not taking things personally is another important exercise. We ask participants to think of a time when they felt mistreated and reflect as to whether the action was specifically about them personally, or about what the other person was going through. We use a visual of a cotton swab with the acronym QTIP-quit taking it personally. Another powerful illustration of this is when our nurse educator tells the story – from her early days as a field nurse – of a short, frail patient who, visit after visit, referred to the nurse's 6-foot-3 height. The remarks eventually got to the nurse and she picked a day when she was going to 'set that woman straight' about referring to her size. But when the time came, before the nurse could even begin to express herself, the patient became tearful and said, 'I wish I was big. Maybe if I was big I could have fought this off and wouldn't be dying.'

Our communication education section starts with five specific levels

of communication- intrapersonal, interpersonal, group, public, and nonverbal. We spend the most time on intrapersonal, believing that change comes from within, and nonverbal, reviewing facial expression, gestures, para-linguistics, body language, proxemics, eye gaze, haptics and appearance in detail with emphasis on the fact that non-verbal communication is a two-way street that is sometimes accurate and at other times inaccurate. We also do an exercise designed to help participants learn if they prefer to use (or listen to) just a few words or many words in the verbal communication of information.

We teach three levels of listening: marginal, evaluative and generous and use that section to remind participants that most of us have gotten so good at multi-tasking that we've forgotten how to 'one-task' and be fully present. For specific examples of what to say, our nurse educator developed a detailed 'Instead of this, say that' handout. We also spend some time talking about implicit bias and the importance of examining some of our core perceptions and where they originated. We are in the process of developing a second level training for all staff members, but so far, with the development and implementation of the course and other specific areas of emphasis, we have seen our 'communication' consumer concerns drop by almost 50%.

While there are many ways to approach this subject and several outstanding companies who provide detailed communication training, it is important that any sort of compassionate communication training contain a spiritual component, and hopefully a well-trained chaplain on the presentation team. Through Clinical Pastoral Education and other training, including newly-developed topics by the Spiritual Care Association, chaplains learn to examine encounters in detail and receive input from supervisors and other professionals regarding ways to improve communication skills. Chaplains also have taken introspection time to learn where their

compassion comes from and how to renew it in times of fatigue and stress. Nurse educators, physicians and other clinicians who hold the need for compassionate communication close to their hearts are also potential members of a training team. Beyond the training, though, the goal is for compassionate communication to become part of the organizational culture so that patients and their families are treated with the care and concern befitting the dignity of human beings – just like us.

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Robert Michael Smith, M.D., MBA, serves as the organization's Chief Medical Officer.

Patty Brown, BSN, CHPN is the organization's Director of Staff Education and Training.

SCA: An Update

By Rev. Eric J. Hall

It has been almost a year and a half since HealthCare Chaplaincy Network (HCCN) launched the Spiritual Care Association (SCA). In that time, many have sought to better understand SCA's mission, why we have structured things the way we have, and the potential implications for professional chaplaincy.

HCCN/SCA's ideals of evidence-based best practice permeate all that we do.

The central feature of the SCA certification process is to, as objectively as possible, assess whether the candidate has the knowledge and clinical skills to deliver evidence-based quality process, structure, and outcomes for spiritual care. The new SCA process assesses whether one can objectively demonstrate the ability to deliver quality spiritual care as defined by evidence-based quality indicators. A candidate must first pass the content test (the first of its kind in the field), which is derived from a concrete and operational description of competence. The final process is a video-recorded, simulated patient spiritual care visit. This is completed online through a video call and offers objective assessment of evidence-based clinical skills. Both of these assessments – the content exam and the simulated patient visitor – yield objective results certifying a candidate's competency in both knowledge base and clinical skill.

The SCA and several other certifying associations are still not well known. SCA's hope is that the board-certified chaplains (BCCs) we certify will be evaluated fairly alongside others, with the best chaplains ultimately hired into each open position. If the new SCA system of certification is deemed inferior to any alternative system, this should bear out over

time as the candidates hired will best represent what an institution or system is looking for. SCA certification is becoming increasingly accepted as the field understands the benefits of this certification to their chaplains, patients, families, and staff.

The new SCA certification process offers a viable alternative, as the entire process has been developed to be as objective as possible. We do not claim superiority to other models, but rather offer our process as a kind of real-world laboratory within which we are seeking to strive after the ideals all chaplaincy organizations hold – to best assess a potential chaplaincy certification candidate as well qualified to provide evidence-based, best practice spiritual care.

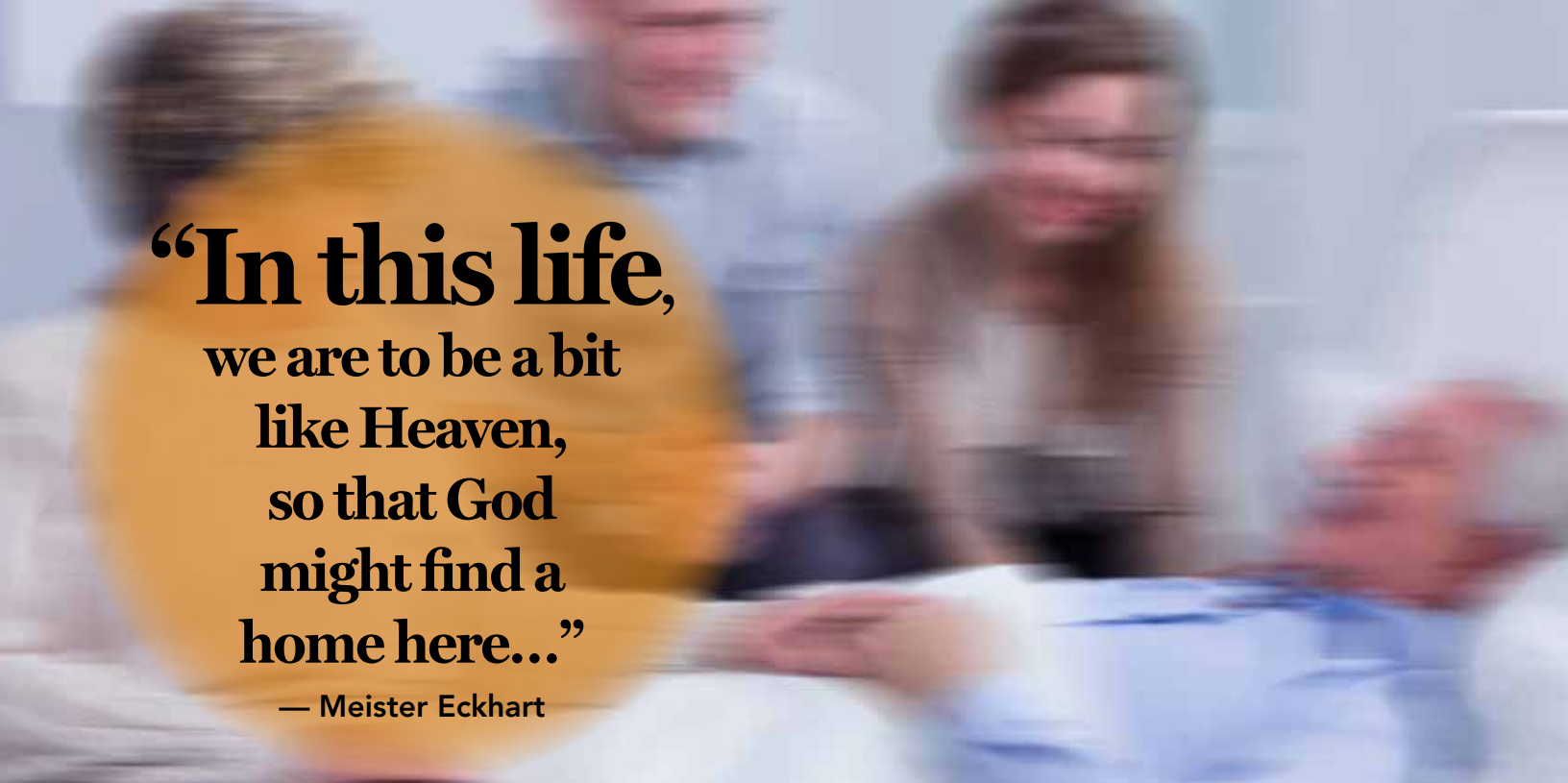
The HCCN board continues to contribute to developing and sustaining the spiritual care field and has made a significant financial investment over the last couple of years building new resources for chaplaincy. This includes the evidence-based white paper, *Spiritual Care: What It Means, Why It Matters in Health Care*, and the *Caring for the Human Spirit* magazine. These are offered free of charge to anyone who might benefit from them. HCCN/SCA also offers the courses in the Online Learning Center which, while there is a tuition, do not operate at a profit. HCCN also offers the other associations display space at its conferences at no cost. Many of the resources and technologies – including the online knowledge test – have been offered to the other associations for the benefit of their membership and the patients they serve. Discussions with several associations are ongoing.

HCCN and SCA continue to seek collegial and mutually-respectful professional relationships with all of the other certifying bodies in the hope that patients will receive better

spiritual care. We desire an open and transparent discussion of the how to move spiritual care forward and are prepared to integrate any evidence-based consensus which emerges. We will focus our efforts, both as an organization and in communication with other chaplaincy organizations, on seeking evidence-based best practice for serving the spiritual needs of patients, family members, and staff.

HCCN/SCA is acting in good faith as a professional partner with any and all other chaplaincy organizations. We strive to actively and openly partner with anyone who wishes to advocate for evidence-based best practice in spiritual care for the profession of chaplaincy. As always, we invite anyone who disagrees or has concerns with HCCN or SCA's position to communicate with us and help us understand your questions. We are committed to being transparent in both widely communicating those views and addressing them directly and specifically. Our hope is that our colleagues and sister organizations will be open to working together as many of us already are, even in the midst of our differences, to channel our energy, time, efforts, money, and vision for moving the profession of chaplaincy forward into an uncertain and challenging future.

We will accomplish more together and hope to begin conversations that will yield improved spiritual care for all of those in our charge.



**“In this life,
we are to be a bit
like Heaven,
so that God
might find a
home here...”**

— Meister Eckhart

By Valeri Briggs, M.Div., BCC

An elderly, Greek Orthodox gentleman was brought to the emergency room for possible stroke. He was accompanied by many supportive older family members, adult children and young grandchildren. When I entered the patient's ICU room in the early hours of the morning, about 15 members of his family were gathered. What struck me immediately was their positioning; each one was as close to the wall away from the patient as they could get. While they were forming a semi-circle around the patient's bed, they did so at such a distance that none of the family were within six feet of the patient. I saw so many emotions on the faces of this man's loved ones – fear, sadness, confusion, shock. I could tell so much needed to be said by the family, yet they did not know how to be present with this man as he lay dying.

As chaplains, we are trained not only in presence ministry, but also in facilitating communication between family that works to enhance the experience around death and dying and the grief therein. When I first entered the room, I joined the family, speaking with each one, being mindful of their angst and sense of helplessness and the unknown. Although I already knew the answer would be “yes,” I

asked if a prayer would be helpful.

As I always do, I asked what they would like to pray for, and while hearing their spoken prayer requests, I moved from the outer circle of family in toward the patient. When I approached the bed, I leaned over him, took his hand and introduced myself, stating that his wonderful family was surrounding him now with a great amount of love and support. I told him that we were all going to pray with him now, and one by one, family began to slowly approach the bedside. By the time we prayed, the entire family was holding this man's hands, touching his arms or gently touching his blanketed legs. After the prayer, each person was able to say their tearful goodbyes. I was touched by their outpouring of love for this man as he lay dying. Their final moments with him told me as much about his life as it did his impending death. He was loved and cherished and would live on in their hearts. As I watched the family comfort each other, they began to tell stories, even laughing at times.

Before leaving, I stood next to the patient and offered him support by telling him what a lovely family he had, how amazing his life must have been and how he would be greatly missed. At that time, I noticed a tear falling

down his cheek. His family recognized this as a gift of his love and affirmation that he was “okay,” that he would be at peace.

I left the room knowing that my ministry of presence goes way beyond my own skill. All that I can do is open a space for God to come in and God does come in...every time. I was later told that this man died a few hours later surrounded by his loving family who said that they had peace and were comforted knowing he was on his way home.

Valeri Briggs, M.Div., BCC, of Irvine California, is a chaplain working with Kaiser Permanente Foundation Hospitals in Southern California. She has certifications specializing in Palliative Care and Spirituality. Valeri is also an ordained minister with the Christian Church (DOC) as well as a board certified chaplain through APC. She is a strong advocate for patients and families at end of life and partners with staff around issues of moral distress, empathy fatigue and resilience through boundary setting.

WHOLEHEARTEDNESS

It Takes Courage to Listen to the Voice Within



By Chuck DeGroat, Ph.D., M.Div., M.A.

“I’M BEING PULLED IN A THOUSAND DIFFERENT DIRECTIONS.”

I hear this all the time.

I hear it from students and software developers. I hear it from stay-at-home mothers and fathers. I hear it from the underemployed, the unemployed, and the overemployed. I hear it from those who make seven figures, and those who covet that life. I hear it from spiritual leaders and coffee baristas. And, not surprisingly, I hear it from the therapists, pastors and rabbis who counsel all of these frazzled folks.

We all feel that nasty pull, that pull

to and fro, as if we’ll come undone at some point.

When it comes to the important resource of time, we feel dirt poor. We feel the scarcity of this precious good, one which doesn’t discriminate on the basis of ethnicity or religion or economic status.

As a result, we often experience our lives as divided. Feeling pulled in a thousand different directions, we wonder if a sense of balance and harmony is possible. We long for an elusive wholeness.

Beneath the frenzied activity and the frantic thoughts that dominate our daily lives exists a quiet voice. Frightened, we ignore it, particularly when it’s a mere whisper. Our tasks and to-do lists keep us dulled to its pulsing, inner existence.

In the moment of pause, we may hear it.

I should appreciate my family more.

I’m not impressive enough

at the office.

I don’t know what I should know at this point in my life.

We all know this inner stranger, this seemingly incurable virus called shame.

I believe that its presence is the fuel for our perfectionism, which ultimately leads to burnout and exhaustion. In shame, we hide behind masks that protect us from ourselves and others. In shame, we live divided lives that rob us of wholeness and peace.

Because we believe shame to be the enemy, we fight it. We conceal our shame in our addictions, our work, our amusements, our social-media selves, our cosmetic improvements. We pursue numerous social activities, perhaps afraid of what solitude might reveal within. We hide behind a forced smile. But somewhere beneath all this busyness and show, we know the truth. We’re barely keeping it together.

Because we’re fueled by the

belief that we're not enough, parts of us go into overdrive, frantically seeking the satisfaction we crave in more success, a better body, or the approval of others. But like the fast food customer, in the end we're left lethargic, tired and hungry for something more.

What I see in the lives of so many adult men and women is a kind of spiritual and emotional failure to thrive. Created to flourish, we experience nagging despair. Made to receive and give joy, we battle cynicism and resignation. Invited to relax our control strategies, we anxiously perfect ourselves for others and sometimes even for a God who we believe is eternally disappointed in our lack of progress. We fail to thrive. We fail to flourish.

And yet, beneath the shame, the desperation, the dissatisfaction, and the frantic striving, I listen for the deeper voice, the voice that declares desire—a desire for joy, freedom, flourishing and wholeness. It's a voice that often remains hidden, buried under cheap, drive-through versions of happiness and perfection. It's a voice we ignore or lose amid the varying selves we mediate in our real and virtual worlds. It's literally aching for expression, but in order to allow that, we often have to deal first with those other inner strangers like shame and disappointment. It takes courage to listen to the voice within.

Compassion is a kind of antidote to perfectionism, a response to ourselves that breeds greater wholeness and deeper rest. It comes from our less reactive, higher brain, giving us the capacity to love and empathize.

The Inner Critic, on the other hand, is connected to our brain's threat mechanism, a reptilian holdover from millennia of self-protection in the face of danger. It views life through a reactive lens.

Importantly, Kristin Neff¹ and others argue that self-compassion is far more critical to our well-being than self-esteem. Self-compassion is

the practice of an imperfect person, someone who is merely human in an age when we're all trying to be superhuman. Self-compassion allows us to give ourselves the gift of being adequate at many things instead of exceptional at everything. Self-compassion gives our Inner Critic the day off. Self-compassion frees us to pay attention to the inner conversations we're always having, as we debate which voice will decide the moment, the day, the future. Self-compassion allows us, in the end, to be imperfect.

If we become capable of a gracious compassion that reaches to every divided part of our being, we can become capable of living whole and holy lives.

Paying attention to what's going on inside is crucial for wholehearted living and flourishing relationships.

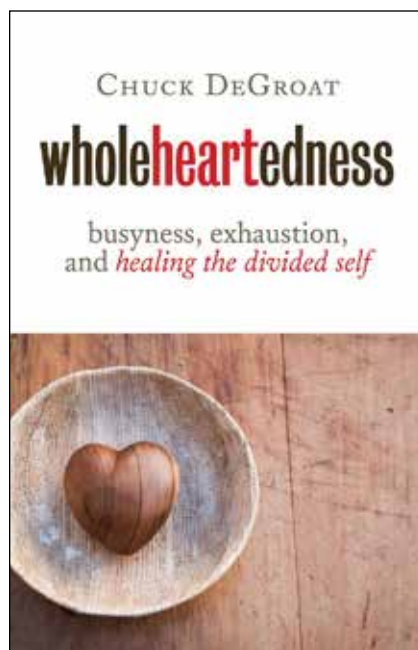
Think about it. When you and I lack self-awareness, we inflict our enraged self on a co-worker or our avoidant self on our spouse. Or we unwittingly project our unresolved anxieties onto our children, who then internalize the divide themselves. Unaware, we simply react to life's situations rather than reflecting on what we're feeling and where we are and what we need.

When we live reactively, we're prone to merely survive rather than to thrive and flourish.

It takes great humility to become self-aware, for what we see we might not like. But self-awareness or mindfulness is the first step toward change, toward wholeness.

The journey from division to wholeness is one in which we relax our tightly controlled grip on our little desires, realizing that they are not our true satisfaction, but echoes and foretastes of our ultimate Desire.

Most of the time, we barely have a hint of this Desire. We're so busy and preoccupied that we've tuned in to different rhythms—rhythms that actually deplete Desire and foster resignation, exhaustion and despair. We're left with little time to



ask, "Is this where I want to be?" The question itself feels selfish. But the fact is that we'll never have whole selves to offer the world unless we ask it.

So let me help you move toward that freedom—the freedom to live and love with our whole heart, life and strength.

Begin now by taking a very deep breath and exhaling slowly. Breathe in. Breathe out.

How was it?

It might have made you skeptical: Isn't every fitness guru today telling us how to breathe? But this intentional calming and restoring of the breath has been used by many spiritual teachers over the years.

It might also have made you realize that you haven't breathed much lately—not fully. And that deep, regular breathing is important—a significant part of the contemplative life, a descending back into our own bodies, a surrendering of our anxious preoccupations for just a few moments in order to find our center. Deep, regular breathing is a sign that we're living mindfully, intentionally, wholly.

As I breathe, I ask myself, "Where are you, Chuck?" And I listen carefully to my inner being for the responses, welcoming every one.

I don't have time for this.
I'm worried about next week's big presentation.

I'm just trying to figure out how I can get home in time for my son's concert.

I'm trying to be here, to be present.

It's hard to listen to all these different voices, but you must. You must welcome each scattered voice from the vast realms of your soul. This takes a bit of time, and sometimes a pen and a journal. It's important to listen, and listen well. Each voice is an indicator revealing one of our heart's attachments. Each gives us a window into a place where Desire's energy is being depleted.

This inner listening is the first step toward discovering your True Self. Your True Self is the "I" that is listening within.

We can dupe ourselves into believing that wholeness can be achieved only through some sort of monastic or ascetic existence,

where we sit perpetually in the yoga position minding our being with utter attentiveness, but this isn't real life. It's true that our wholeness is cultivated in quiet and mindful times, but it's also cultivated in the frantic and frazzling moments—racing to pick up the kids from school on time, cleaning up the dog's mess, waiting out a flight delay. Wholeness is experienced as we attend to ourselves with care in every circumstance.

In these moments of wholeness, we are fully present—present to what we're feeling, present to what we're saying, present to what we're seeing and present to who we're being. People around us feel the difference. They feel the lightness of our being. They sense that we're connected to ourselves, to the Spirit, to them, to all of creation. They see love, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control—the reality that our True Self is, quite literally, in control.

This is the elusive wholeness we long for.

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A TRANSDISCIPLINARY APPROACH TO CHRONIC PAIN: A Clinical Psychologist and a Chaplain Work Together

By Linda S. Golding, M.A., BCC

“The different skills and temperaments we bring are complementary, but not necessarily obvious.”

Individuals with chronic pain express their pain as life-limiting. Researchers have identified spirituality as an active coping process that can affect various health outcomes. In spite of these findings, a recent literature search does not indicate that spirituality has been included as an active treatment component led by an expert in spirituality within psychotherapy groups for chronic pain patients. The loss experienced by these patients often results in an existential crisis and a disintegration of their sense of self.

We are perhaps an unexpected treatment team: a psychotherapist and Associate Professor in Columbia University's Department of Anesthesiology grounded in Cognitive Behavioral Therapy (CBT) and a Board Certified Chaplain. Working with patients with chronic pain, Dr. Nomita Sonty had begun to think that for all the efficacy of therapy there was a missing element of the wholeness she was looking to help patients achieve. She approached me, a second-career chaplain with a prior career in the contemporary classical music world, to discuss adding spirituality to an outpatient therapy group.

The group would be unusual in that we would be from different, although related, fields and would co-lead each session. There are groups led by clinical psychologists for patients with chronic pain, groups led by chaplains for people wanting to address spiritual pain, and groups where a chaplain comes in periodically for a session on spiritual concerns. But now, we were going to lead an integrated group to address chronic pain. The recipe would read: take chronic pain, defined by the International Association for the Study of Pain as “a multidimensional construct with sensory, cognitive, behavioral and affective features;” add CBT, a directive and often short-term therapeutic approach used to help patients understand that their thoughts and feelings influence their behaviors; and add spirituality, that which assists an individual to live the fullest experience of life with hope, meaning and connection. Then stir.

As co-leaders of the proposed group, the clinical psychologist and the chaplain each knew that our area of expertise offers support, sustenance, and transformation; that our work would assist patients in making successful

adaptations to living with pain. What we did not know was where this would overlap, how it would expand our practices, or the exact way to develop a working collaboration and models for our now shared patients.

We embarked on a series of conversations to identify the strands of spiritual and psychological aspects of chronic pain; to develop a transdisciplinary methodology for support and healing; and to create a path to working with a colleague from another discipline to create new conceptual, theoretical, methodological, and translational ideas that integrate and move beyond discipline-specific approaches. We began our first group (a pilot of 12 weeks) in 2013 with the goal of reconciling the losses resulting from chronic pain and to increase the awareness of the self within this context using the two lenses of psychotherapy and spirituality. We now run two groups, each bi-weekly for 75 minutes.

THE WORK ITSELF

The patient groups are drawn from Dr. Sonty's ongoing practice and are a combination of people with the motivation to attend and participate and who have a psychological and spiritual interest. One of the earliest learnings occurred when the patients

began to express relief in being with others who suffered in similar ways. The patients began to tell and show us how the pain of isolation was being reduced through topic-based conversation, making art, and bringing in songs and readings to share and discuss. We brought the group relevant videos and small chunks of sacred and secular texts and asked them to do "homework." The patients began to challenge each other's negative thinking and notice their own positive, if non-linear, transformation. We noticed physical changes (sitting straighter, wearing brighter colors, more active participation) as well as emotional changes (increased equanimity, reduced dread, the belief that they deserve to be happy and that the focus on pain had kept them from other feelings and experiences). We heard that meaning and values were important, that letting the mask slip in a safe environment would heal rather than harm.

WHAT WE BRING

Periodically we take stock of what each of us brings to the group to make sure that we are using and combining our skills to their best advantage. The different skills and temperaments we bring are complementary, but not necessarily obvious. Each brings

expertise in theory, application, and listening skills. The psychologist often listens through a lens of helping patients overcome and manage difficulties, or helping them cope more effectively with their concerns. While the chaplain also listens through the lens of coping, there is the addition of spiritual assessment and a tendency to wait and not problem solve. We found that Dr. Sonty "runs" a group and will often address the group using "you" while I tend to "hold" a group, stepping through the perimeter using "we."

THE RESULT?

Our patients tell us they are now able to recognize resilience in themselves and in each other. They show us that transformation through loss can result in personal growth and that our transdisciplinary model has power.

Linda S. Golding, M.A. is a Board Certified Chaplain serving at New York-Presbyterian Hospital. She holds a Masters from the Jewish Theological Seminary and a certificate from the JTS Center for Pastoral Care and Counseling.

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In a clinical partnership, HCCN staffs and manages on-site chaplaincy services. Whether a hospital has one chaplain or a department of eighteen, we encourage our clinical partners to access our wide range of online educational offerings, technology-oriented chaplaincy services, and participation in the *Excellence in Spiritual Care Award* program, which is a unique recognition designed to affirm strengths and create a roadmap for improving the provision of spiritual care based on identified best practices. In addition, many of these institutions are now able to provide a Clinical Pastoral Education (CPE) program.

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astrano@healthcarechaplaincy.org, 212-644-1111 x219**

Once operating in separate silos, the fields of mental health and chaplaincy are slowly converging, attempting to share knowledge with the goal of creating a mutually beneficial partnership among care team members as well as with their patients.

This special section on mental health examines the process of collaboration and how professionals from both fields can partner in new ways to create what both are ultimately striving for — improved, holistic patient care...

Designing Mental Health Care Systems for Chaplain Involvement

By Jason A. Nieuwsma, Ph.D.; William C. Cantrell, M.Div., BCC; and Keith G. Meador, M.D., ThM, MPH

“For that again, is what all manner of religion essentially is: childish dependency.”


This quote from Albert Ellis — one of the premier figures in 20th century psychology, a pioneer within the field of cognitive behavioral therapy (CBT), and a life-long atheist — would hardly be taken as an invitation for spiritual care providers to come alongside and partner with the mental health profession. Rather, the statement evokes recollections of Freud’s contentious assertion decades earlier that “religion is an illusion” and serves to reinforce the perception that the worldviews of mental health professionals and chaplains are at the very least incompatible, if not outright oppositional. As with so many stereotyped perspectives,

this perceived conflict between psychological and spiritual worldviews is overly simplistic, exaggerated, and laden with inaccuracies — and more worryingly, is detrimental to those in need of care.

Encouragingly, evidence from multiple sources has been converging to suggest a couple of things: 1) on the whole, even though mental health professionals may not be the most traditionally religious group, many do want to sensitively attend to spiritual issues; and 2) the mental health struggles of patients are frequently expressed within spiritually-framed understandings and are most optimally interpreted and treated by spiritually informed care providers. With respect to the religiosity of mental health professionals, studies have found that while they are less traditionally religious than other health

care providers,¹ many of them are yet interested in learning more about spirituality and want to sensitively attend to it in their patients.² In a large qualitative study relying on extensive interviews of nearly 400 mental health professionals and chaplains across 33 geographically diverse locations in the U.S., our group found that the lack of mental health-chaplain collaboration was less due to a disregard for the other discipline as it was a simple lack of awareness.³ Indeed, during our interviews, many mental health professionals became excited to learn that chaplains existed at their facilities and that they could be resources for collaboration.

Such receptivity from mental health was encouraging, not just because it defied stereotypes of conflict between the disciplines, but because patients need the



disciplines to collaborate. Whether it be depression, anxiety, schizophrenia, posttraumatic stress disorder (PTSD), or a host of other mental health problems, persons with such psychological struggles often experience them as fundamentally intertwined with their religious/spiritual beliefs, practices, and experiences. Most clergy would not be surprised by epidemiological data indicating that persons with mental health problems often turn to them for help.⁴ Intriguingly, there is data to suggest that something of the reverse also happens. In a study of veterans with PTSD, the major motivation for veterans to seek mental health care from the Veterans Health Administration (VHA) was not PTSD symptom severity or social isolation, but rather guilt and a weakening of religious faith⁵ – in other words, religious and spiritual struggle.

Believing that the dynamically interrelated psychological and spiritual needs of patients are best attended to by correspondingly dynamic interdisciplinary care teams, we solicited the engagement of 14 mental health and chaplain teams from VHA and military medical facilities to participate in a year-long systems redesign effort. This effort relied on a “learning collaborative” methodology – an approach that has been broadly used in health care settings to accomplish a range of different system improvements – to help teams devise individualized goals for improving the integration of mental health and chaplain services. Teams had substantial flexibility to develop and own personalized goals and many focused on making improvements in particular settings, such as integrating chaplains within a PTSD clinic, yet all teams were guided to attend to certain processes. Broadly speaking, these processes could be described as establishing awareness; communicating and coordinating care; and formalizing systematic processes.

To discover more about the lessons learned from this mental health-chaplain integration project, hear from participating teams of mental health professionals and chaplains, and explore ways that you might undertake improvement efforts, you can view a three-part video series on the project at: www.mirecc.va.gov/mentalhealthandchaplaincy/Learning_Collaborative.asp.

Establishing Awareness

A few years back, we conducted an online survey of over 2,000 chaplains that found something interesting: slightly fewer than half of the chaplains in our sample felt that mental health professionals understood the spiritual work of chaplaincy, yet nearly three quarters felt that mental health professionals valued the chaplain’s role (in fact, chaplains were four times more likely to strongly agree with this sentiment).⁶ In other words, many chaplains perceived that they were vaguely appreciated by mental health, even when mental health had little clue as to what they did. While this is encouraging insofar as it suggests a welcoming posture from many mental health professionals, it does not suggest that care services (and the patients these services are designed for) are going to be well informed and able to integrate spiritual care when indicated.

Hence, one of the objectives for all 14 teams in our learning collaborative was for them to champion educational efforts about their respective disciplines at their facilities. Typically, mental health was most in need of receiving education about chaplaincy, in part because chaplaincy is a significantly smaller discipline than mental health, and in part because there can be a number of misconceptions about chaplains (if there are any conceptions at all). Chaplains held educational presentations, attended various mental health care team meetings to talk about their services, and spoke individually with mental health professionals throughout their facilities. Often, various misunderstandings

were remedied as part of this process, opening channels for better collaboration. Teams that have been the most successful at sustaining their integration improvements understood that these educational endeavors could not be one-time events, especially in facilities where turnover is frequent due to rotation of trainees, military personnel, or other reasons. Instead, sustainable integration requires reliable, recurring opportunities for ensuring that mental health professionals know about chaplaincy.

Communicating and Coordinating Care

All teams in the learning collaborative focused on screening practices, which in many ways served as a lynchpin for larger explorations of cross-disciplinary communication and care coordination processes. Depending on their context, teams could focus on screenings that chaplains used to identify mental health problems, screenings that mental health providers used to identify spiritual issues, or both. We encouraged teams to channel their efforts towards those areas most in need of improvement, and since most teams were focused on making improvements within existing mental health contexts (e.g., an outpatient PTSD clinic) this meant that many teams focused on improving how mental health providers screened for spiritual issues.

From the number of individualized screening practices that teams developed, there emerged two important principles. First, asking the question “Do you want to see a chaplain?” might be an

improvement over asking nothing at all, but is far from ideal. Patients can have inaccurate preconceived notions of what chaplains do or may be confused as to why a mental health professional would ask such a question. Second, and relatedly, mental health professionals must have an understanding of what chaplains can address and what services they provide. Screening questions should be crafted around these things. Ideally, mental health professionals should be equipped to have an informed "screening discussion" that asks about key spiritual areas of relevance to the context (for example, in a PTSD clinic context, these may be questions about forgiveness, shame, and guilt) while providing accurate information about chaplains and the services they provide.

As has been seen across an array of health care contexts, conducting screenings (even when using good screening tools) in and of itself does not improve patient outcomes. Similarly, while the development of psychometrically sound spiritual screening tools is absolutely desirable and important, screenings are only as useful as the care services that they are ultimately able to direct patients into undertaking. Mental health professionals need to know chaplains in their facilities, understand what they do, have regular opportunities to communicate with them about patients, and have reliable and standardized processes for coordinating care. It is in establishing this kind of context that screenings can then serve as the lynchpin for optimal patient-centered care.

Formalizing Systematic Processes

At the end of the year-long learning collaborative process, teams developed care coordination agreements that were signed by appropriate leadership (usually consisting of the head of chaplain services and the head of mental health services). Most teams used the agreements to solidify and standardize the improvements they had stood up,

including outlining such processes as: how to identify spiritual needs among patients in mental health settings; how to facilitate access to chaplain services for patients in mental health settings; and how to ensure ongoing multidisciplinary awareness between mental health and chaplain services.

Integrating mental health and chaplain services is a two-way street that involves commitment from both mental health professionals and chaplains. At the same time, there are structural realities that cannot be ignored. In health care systems where the mental health provider to chaplain ratio is frequently in the range of 25:1, chaplains need to advocate for themselves and become increasingly ready and able to explain to the larger system what they can bring to the table. The future for chaplain integration in mental health holds promise: the rationale for integration is strong; models and methods such as the one described in this article are beginning to emerge; and pioneering chaplains who are doing the work are proving their value to patients, mental health professionals, and the broader health systems.

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Spiritual Competency for Mental Health Providers

By **David Lukoff, Ph.D.** and **Cassandra Vieten, Ph.D.**

Psychology has a long history of ignoring and pathologizing religion and spirituality. Fortunately, over the past 20 years, psychology, along with the entire mental health field, has moved to a more inclusive approach to spirituality. This shift to integrating spirituality has been influenced by multiple factors, including the extensive publication of research documenting the mainly positive associations between spirituality and mental health, and the Joint Commission on Accreditation of Healthcare Organization's requirement implemented in 2001 that every patient chart contain a spiritual assessment.

Additionally, surveys of the general public consistently show that religion and spirituality are important in most people's lives, with clients preferring to have these aspects addressed, rather than ignored, in therapy and in the recovery process.

While the field of psychology already requires training in multicultural competence, and includes religion and spirituality in its definitions of multiculturalism, most psychologists receive little or no training in religious and spiritual issues. However, working sensitively and effectively with religious and spiritually-oriented clients often requires more than just general multicultural attitudes and skills. It can require specialized knowledge and training about the religious beliefs and practices of religious traditions and communities, about the spiritual issues and needs of human beings, and about religious and spiritual assessment and intervention techniques.¹

Current training in religious and spiritual competencies provided to psychologists is infrequent, informal,

and unsystematic. Just over a decade ago, only 13% of APA accredited clinical psychology programs included any formal coursework in religion/spirituality² and 90% of psychologists reported that religious and spiritual issues were not discussed in their academic training.³ The result is that most psychologists do not discuss religious and spiritual issues in psychotherapy, nor include spirituality in assessment or treatment planning. Currently, spirituality and religion are being addressed more often in supervision and coursework, but still only a quarter of psychology training programs provide even one course in religion and spirituality.⁴ In contrast, 84-90% of medical schools offer courses or formal content on spirituality and health.⁵

One obstacle to such training is has been the lack of an agreed upon set of spiritual competencies or

training guidelines. To address this gap, together with several colleagues, the authors of this article developed a set of empirically-based spiritual and religious competencies for mental health professionals (See Table 1).⁶ These are the attitudes, knowledge and skills that we propose every psychologist should have in order to practice psychology, regardless of whether or not they conduct spiritually-oriented psychotherapy or consider themselves spiritual or religious.

We developed these through a comprehensive literature review and a focus group with scholars and clinicians who were experts in the intersection of spirituality and psychology including a wide range of religious professionals and chaplains. We then conducted an online survey of 184 scholars and clinicians experienced in the integration of spiritual and religious beliefs and practices in psychology. The final step



was surveying a more general sample of psychologists (not necessarily with expertise, interest, or sympathy toward the domain of religion and spirituality).

Our goal is not to require that psychologists employ religious or spiritual interventions, nor to encourage them to personally adopt any form of spiritual or religious beliefs and practices. Determining how and when to actively include religious or spiritual interventions into psychotherapy for those clients who request it requires proficiency, rather than basic competence. In fact, when religious or spiritual interventions are requested by clients and are appropriate, psychologists should integrate them into psychotherapy only when they have the training and clinical competence to do so, have knowledge of the relevant literature, and are aware of ethical issues that may arise in terms of boundaries and multiple relationships, informed consent, and related issues.

Instead, the purpose of creating spiritual and/or religious competencies is threefold. First, we hope these competencies will help clinicians avoid biased, inadequate, or inappropriate practice when they encounter spiritual or religious issues. Second, they are meant to enable clinicians to identify and address spiritual or religious problems, and to harness clients' inner and outer spiritual and religious resources, thus improving treatment outcomes. Third, the proposed set of competencies are intended to provide baseline standards for content that can be integrated throughout clinical training and supervision, which programs may choose to modify or elaborate according to their training models. As Brownell notes, "The assessment and development of spiritual competency requires an organized approach to the development of such competency."⁷

However, even among highly competent psychologists, there will be spiritual and religious issues that arise in clinical practice that will require

SPIRITUAL AND RELIGIOUS COMPETENCIES FOR PSYCHOLOGISTS

ATTITUDES

- Demonstrate empathy, respect, and appreciation for clients from diverse spiritual, religious or secular backgrounds and affiliations.
- View spirituality and religion as important aspects of human diversity, along with factors such as race, ethnicity, sexual orientation, socioeconomic status, disability, gender, and age.
- Awareness of how their own spiritual and/or religious background and beliefs may influence their clinical practice, and their attitudes, perceptions, and assumptions about the nature of psychological processes.

KNOWLEDGE

- Understand that many diverse forms of spirituality and/or religion exist, and explore spiritual and/or religious beliefs, communities, and practices that are important to their clients.
- Ability to describe how spirituality and religion can be viewed as overlapping, yet distinct, constructs.
- Understand that clients may have experiences that are consistent with their spirituality or religion, yet may be difficult to differentiate from psychopathological symptoms.
- Recognize that spiritual and/or religious beliefs, practices and experiences develop and change over the lifespan.
- Awareness of internal and external spiritual and/or religious resources and practices that research indicates may support psychological well-being, and recovery from psychological disorders.
- Identify spiritual and religious experiences, practices and beliefs that may have the potential to negatively impact psychological health.
- Identify legal and ethical issues related to spirituality and/or religion that may surface when working with clients.

SKILLS

- Ability to conduct empathic and effective psychotherapy with clients from diverse spiritual and/or religious backgrounds, affiliations, and levels of involvement.
- Inquire about spiritual and/or religious background, experience, practices, attitudes and beliefs as a standard part of understanding a client's history.
- Assist clients explore and access their spiritual and/or religious strengths and resources.
- Identify and address spiritual and/or religious problems in clinical practice, and make referrals when necessary.
- Stay abreast of research and professional developments regarding spirituality and religion specifically related to clinical practice, and engage in ongoing assessment of their own spiritual and religious competency.
- Recognize the limits of their qualifications and competence in the spiritual and/or religious domains, including their responses to clients spirituality and/or religion that may interfere with clinical practice, so that they a) seek consultation from and collaborate with other qualified clinicians or spiritual/religious sources (e.g. priests, pastors, rabbis, imam, spiritual teachers, etc), b) seek further training and education, and/or c) refer appropriate clients to more qualified individuals and resources.

consultation, additional training, or referral. There is a need for greater coordination between psychologists and clergy to address the religious and/or spiritual needs of clients while honoring appropriate boundaries between clinical mental health practice and spiritual.

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Chaplaincy and Evidence-based Mental Health Care: Promises, Pitfalls, and Pastoral Identity

By **Keith G. Meador, M.D., ThM, MPH; Jason A. Nieuwsma, Ph.D.;**
and **A. Keith Ethridge, M.Div., BCC, CPE Certified Educator**

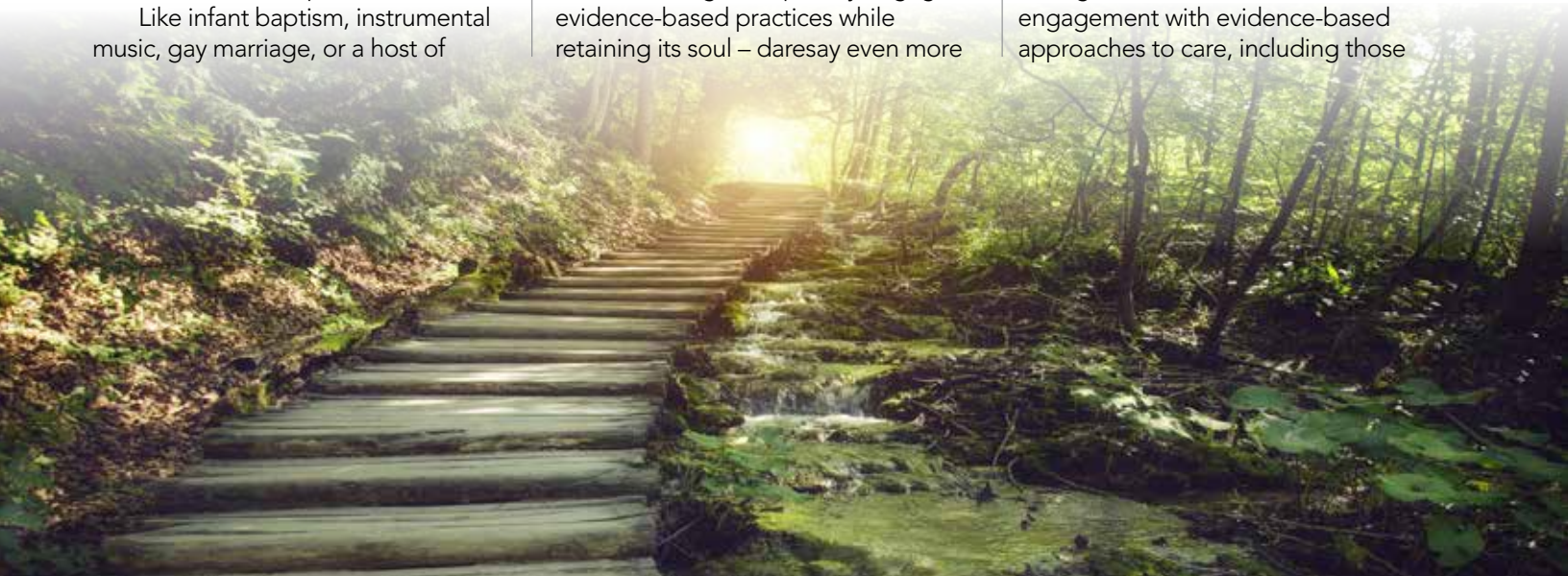
Historical retellings are inevitably fraught with the dangers of selective attention and revisionism, and yet we cannot escape the centrality that our histories have in guiding our development – whether that be at the level of the individual, society, or even of a professional discipline. This is certainly the case with respect to the disciplines of mental health and health care chaplaincy. Both disciplines can trace their lineages back over the course of at least a century within health care systems, over which time they have responded to developments across health care in their own distinctive ways. There have been many developments in health care over the years that have served as points for disciplinary reflection and response, but perhaps the most important development in recent times is the dramatically-increased reliance on evidence-based practice.

Like infant baptism, instrumental music, gay marriage, or a host of

theological doctrines, opinions about evidence-based care have the power to unite or divide communities. For its part, mental health care – influenced by external forces such as the move toward evidence-based care across broader health care systems as well as internal forces like the scientist-practitioner movement within psychology – has become more dedicated to being an evidence-based profession. This has not been a frictionless evolution, and debate, dissent, and discussion continue within many parts of the mental health community, but the general trend is evident. How health care chaplaincy negotiates this path is an important consideration for all of us committed to the work of chaplaincy within mental and behavioral health. What are the evidence-based expectations for chaplaincy for it to flourish as a discipline in contemporary health care? How might chaplaincy engage evidence-based practices while retaining its soul – daresay even more

fully embrace its faithfulness to patient-centered spiritual care?

Concerns about how “evidence-based” care is implemented are warranted across health care. There are numerous challenges in how scientific inquiry is often practiced, and the potential distortions of findings and their implications are substantial (perhaps especially in the area of religion/spirituality and health). Outcomes must be carefully conceived and humbly interpreted with respect to the practice of health care chaplaincy. Scientific evidence is increasingly significant, but only one of the many complex variables contributing to the rich tapestry of knowledge and practice accessed by chaplains in their engagement with human suffering. At the same time, chaplains and the health care systems in which they practice stand to substantially benefit from chaplains having a more intentional and careful engagement with evidence-based approaches to care, including those



that have developed out of mental health traditions. This is complex terrain that can be unfortunately susceptible to dichotomous thinking (i.e., for/against evidence-based approaches), and for nearly a decade it has been our privilege to navigate this dynamic landscape along with now well over 100 chaplains who have participated with us in different year-long intensive training programs and systems redesign efforts within the work of Mental Health and Chaplaincy as part of the VA health care system. In what follows, we consider some of the key issues relevant for those health care chaplains interested in traversing this terrain.

The Promise of Evidence-Based Care

Evidence-based approaches to care promise many benefits. For large health care systems, randomized controlled trials (RCTs) – which most typically compare average outcomes from one group against those of a control group (often “usual care”) – help administrators and policy makers answer a utilitarian question: what approach is going to do the most good for the most patients? Hopefully, over time, usual care integrates more of these evidence-based approaches, and new approaches must exceed an increasingly higher bar of effectiveness to be adopted, thus over the long term advancing health care. Additionally, putting different care approaches “to the test” discourages the persistence of approaches that can be based on a host of questionable foundations, such as tradition, inertia, strong or influential personalities, pet theories, or even financial incentives misaligned with the objective of patient improvement.

Along with the broader implications noted above, individual care providers also benefit from systematic approaches to care in clinical practice. Perhaps most obviously, evidence-based approaches give care providers a place to start, a “best guess” for what is most likely to work with the individual sitting in

front of them. Importantly, findings from empirical studies like RCTs provide best guesses, not definite cures. Individual care providers can also benefit from studies that seek to elucidate mechanisms of change, or those elements of a care approach that seem to pack the most punch, as this can help to guide where care providers choose to devote the most intensive time and effort. And finally, individual chaplains who become well-versed in evidence-based approaches to care are typically going to be better equipped to effectively integrate and collaborate with other disciplines in the health care system.

All of these benefits, at both the systemic level and individual care provider level, can benefit chaplaincy. At the systemic level, evidence helps to advance the profession, and as many have pointed out, evidence can ultimately translate into financial support for service lines within different institutions. At the individual level, chaplains stand to become more effective as spiritual care providers and members of integrated care teams. This is positive for the profession, yet care is warranted in the practice, interpretation, and application of scientific research relevant to clinical chaplaincy.

Potential Pitfalls

A central issue in the religion/spirituality and health conversation is how to design and structure spiritually informed health care interventions that are respectful of the varied religious and spiritual traditions and commitments represented within pluralistic health care settings. This is a challenging issue even for thoughtfully informed clinical chaplains to navigate. The ethically and clinically significant danger of the presumption of correcting or altering the spirituality of patients as a primary intention of the care provided by chaplains in mental health care must be noted for anyone involved in developing “interventions”

in this domain. To the extent that an analogy is applicable here, developing competence in attending to patients’ religious and spiritual traditions is probably more akin to developing fluency in different languages than to employing different treatments to cure a disease or pathology. Because of this, it is crucial not to make whether a patient has good/bad religion or spirituality the primary outcome of interest when developing evidence-based interventions. Systematically derived evidence-based mental health practices may help to enhance chaplains’ capacities to care while avoiding the ethically problematic territory of presuming to alter primary spiritual commitments of the patient.

So what outcomes should chaplains seek to identify and measure? The final sentence of most research articles is warranted here as an answer: further research is needed. While that may be even more true in clinical chaplaincy than in other health care disciplines, there are some developments in contemporary mental health care that could prove illuminating for chaplaincy to consider. As an example, Acceptance and Commitment Therapy (ACT) is an evidence-based modality that has been adopted by many mental health professionals who desire an approach that has demonstrated effectiveness but that is not bound to a disease and symptom elimination understanding of human suffering. Rather, ACT invites patients to explore their values (including spiritual values) and to willingly encounter difficult emotional content in their lives (including symptoms of mental illness) in order to live lives of meaning and purpose. Thus, while an RCT studying ACT may include measures of depressive or anxious symptomatology, the primary outcomes of interest being measured by ACT researchers and clinicians include things like willingness to experience unpleasant emotions and implementation of actions in line with

“Developing competence in attending to patients’ religious and spiritual traditions is probably more akin to developing fluency in different languages than to employing different treatments to cure a disease or pathology.”

one’s values. These are outcomes that chaplains might likely help support and develop in research.

Linking to Pastoral Identity

Including measures of religion/spirituality, mental health symptomatology, and satisfaction with care can certainly make sense in the context of chaplaincy research, but considering other outcomes such as those being advanced in the ACT literature could help to illuminate ways ahead that are consistent with important commitments in clinical chaplaincy, and thereby facilitate chaplains offering leadership within mental health care and research. Clinical Pastoral Education (CPE) places significant emphasis on pastoral presence, non-judgmental care, and journeying with patients. In embodying these commitments – and potentially even integrating care principles from an approach like ACT into such care – chaplains are modeling to patients a willingness to encounter and be present with unpleasant emotions and even suffering, a willingness on the part of the chaplain that is likely driven in some way by that chaplain’s values (e.g., love). Why not consider then ways to measure whether as part of this experience patients too are finding ways to be present to their own journeys, even aspects of suffering, while connecting to their values?

The development of skills and practices informed by evidence-

based practices provides the chaplain with tools and expertise by which to systematically engage the spiritually sensitive patient who seeks and trusts spiritually informed care within whatever tradition and spiritual worldview they present. The well-trained chaplain will have developed the sensitivity to provide supportive spiritual care in the pluralistic context as part of their basic training, but evidence-based skills and practices can add substantially to the repertoire of the mental health chaplain in addressing mental health challenges across the breadth of religious and spiritual communities and practices. Properly embraced, evidence-based practices need not compromise the integrity of the pastoral identity of the chaplain and can actually enhance the confidence and freedom of engagement for the chaplain with patients seeking spiritually informed and pastorally embodied mental health care. While “pastoral presence” is a treasured and invaluable gift the health care chaplain brings to the caregiving context, many chaplains with whom we have worked express an enhanced sense of competency and fullness of caregiving repertoire as they develop capacities with evidence-based methods such as ACT, which we consider to have a distinctive potential for integration into the pastoral work of chaplains. The systematic and reproducible tools provided by evidence-based interventions

such as ACT, while conceptually accommodating the values-informed engagement of chaplains, offer an opportunity for the chaplain to utilize the “science” of mental health care shared with mental health colleagues while retaining the particularity of their identity as spiritually formed, and informed, care providers.

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→ SPECIAL
WHITE PAPER
REPORT



Spiritual Care and Physicians: Understanding Spirituality in Medical Practice

**HealthCare
Chaplaincy
Network™**


**SPIRITUAL
CARE
ASSOCIATION**
Making Spiritual Care a Priority

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HealthCare Chaplaincy Network™ (HCCN), founded in 1961, is a global health care nonprofit organization that offers spiritual care-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Its mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve patient experience and satisfaction and to help people faced with illness and grief find comfort and meaning--whoever they are, whatever they believe, wherever they are.

The Spiritual Care Association (SCA) is the first multidisciplinary, international professional membership association for spiritual care providers that includes a comprehensive evidence-based model that defines, delivers, trains and tests for the provision of high-quality spiritual care. Membership is open to health care professionals, including chaplains, social workers, nurses and doctors; clergy and religious leaders; and organizations. SCA, with offices in New York and Los Angeles, is a nonprofit affiliate of HealthCare Chaplaincy Network.

www.healthcarechaplaincy.org
www.spiritualcareassociation.org
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INTRODUCTION

All physicians, over the course of their clinical activities, are likely to be impacted by the spiritual beliefs of their patients and their families. The leadership of the American Medical Association (AMA) has recently defined the need for patient access to spiritual services. Citing six past AMA House of Delegate policies, the AMA leadership emphasized that 41% of patients want to discuss religious or spiritual concerns in the health care setting, but less than half reported being offered the opportunity to receive such care.¹ The document resolves “That our AMA encourages expanded patient access to spiritual care services and resources beyond trained health care professionals”.

The AMA resolution follows recommendations by the World Health Organization contained in the Sixty-seventh World Health Assembly agenda item “Strengthening of palliative care as a component of comprehensive care throughout the life course,” to enhance the training of health care professionals in spiritual needs as well as foster partnerships between government and civil society on this issue.² This evolving national and international guidance validates the need to develop programs that strengthen chaplaincy training, encourage the expansion of spiritual services within the clinical settings and define available research that can guide this process. The Health Care Chaplaincy Network’s (HCCN) expert clinical panel has developed a comprehensive review of peer-reviewed published data on the clinical needs, existing practices and clinical outcomes for spiritual care. This white paper defines the scientific framework by which HCCN seeks to address obstacles to better spiritual care and propose evidence-based solutions for the medical setting.

HISTORY

Medicine has been practiced by human beings since millennia and considerable progress in medicine was made during the times of the ancient Egyptians, Greeks and Romans. The first of the hospitals known were built by the Greeks. However, during ancient times, distinctions between physical causes and spiritual/religious causes of illness were frequently blurred. Subsequent to the fall of the Roman Empire, Western Europe entered a period of medical stagnation and there were few advances in medicine throughout the Middle Ages. The Roman Catholic Church dominated all aspects of life in Europe and hospitals built during the Middle Ages were associated with monasteries and/or were run by monks and nuns. Medicine was steeped in superstition, and any thinking that veered from the church’s established doctrine, bordered on heresy. Following the Renaissance in Europe, the evolution of medicine advanced, helped by new scientific developments, and took a path away from any influence of religion on medical care.

From the 19th century onward, advances in modern medicine accelerated and beginning in the 20th century, medicine became highly compartmentalized into a multitude of specialties with each specialty developing an increasingly narrow focus on specific systems of the human body. While medicine in ancient times considered a mix of physical and spiritual/religious causes of physical or mental illness, modern medicine explicitly moved away from any role of religion or spirituality in medicine.

MODERN MEDICINE

By the middle of the 20th century, modern medicine was firmly anchored in science and developing technologies and had completely negated the role that religion and spirituality played in the health of people. However, there was gradual awareness among medical practitioners that, with all the advances in modern medicine, some aspect of care was being missed. Medicine, in fact, accepted very little input from patients and their families in treatment planning, once they consented to treatment. Patients were viewed as little more than passive receivers of medical interventions. The medical establishment, it was felt, had become dehumanized.³

The shift towards engaging patients as more active participants in their medical care began in the second half of the 20th century when, in the 1960s, psychologist Carl Rogers coined the term “person-centered” care in relation to psychotherapy.⁴ In the 1970s, psychiatrist George Engel recommended the use of the term “biopsychosocial model” of health as opposed to the existing “biomedical model” of health.⁵ For Engel, the psychological states of patients as human beings, as well as their significant interpersonal relationships, were equally important as their biological states. By the 1990s, these terms were used in mainstream medicine and in 1999 the Association of American Medical Colleges (AAMC) recommended that physicians should discuss their patients’ spiritual and religious beliefs and medical schools should develop curricula to teach courses in religion and spirituality.⁶ In 2001, the Institute of Medicine incorporated the term “patient-centered care” as one of its six aims of health care quality. Patient-centeredness is similar to the person-centered term of Carl Rogers but more specifically “encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient.”⁷

“Indeed, there is growing consensus that the study of the interplay between spirituality and medicine is here to stay.”

RELIGION AND SPIRITUALITY

The 1990s also saw the emergence of literature that reexamined the role of religion and spirituality in patient care. While there is no unanimous agreement,⁸ the preponderance of the literature suggests that both concepts are important for patients and play a role in health behaviors, compliance with medical treatments, provision of social support and coping with their illness.^{9,10} Indeed, there is growing consensus that the study of the interplay between spirituality and medicine is here to stay. This is particularly true in the United States where spirituality and religion have been central to the lives of millions of Americans.

In a recent survey of the religious landscape of the United States, 70.6% of Americans endorsed themselves as Christians, of whom 46.5% were Protestants, 20.8% were Catholics and 3.3% were other Christians including Mormons, Jehovah’s Witness and Orthodox Christians. An additional 5.9% of the population endorsed non-Christian faiths, including Judaism, Islam, Buddhism, Hinduism and other, whereas 22.8% of the population endorsed themselves as unaffiliated and included atheists, agnostic and none.¹¹ Thus, 76.5% of Americans consider themselves to belong to a faith. Of the 22.8% unaffiliated, 18% described themselves as religious; 37% described themselves as spiritual, but not religious and the remaining 42% said they were neither.¹² Since spiritual and religious expression can be diverse and idiosyncratic, it is therefore important to differentiate between the two concepts. Additionally, in order to further research in the role that religion and spirituality play in our health, clear definitions of these concepts are essential.

BIOPSYCHOSOCIAL-SPIRITUAL MODEL

A recent consensus conference comprising international experts from the fields of medicine, psychology, and spiritual care defined spirituality as “a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.”¹³

Spirituality is considered a broader concept than religion. Religion has been described as “a subset of spirituality, encompassing a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality or Nirvana (in Eastern cultures).”¹⁴

Thus, religion is one way for spiritual persons to express their spirituality. It also clarifies that religious people, by definition, are spiritual people, but not all spiritual people have to be religious. A related concept is a secular existential orientation which consists of concepts that do not require a belief in a transcendent reality. These include personal values, the value of life, responsibility to others, and freedom.¹⁵ A common thread within all three constructs is our attempt to make meaning of our lives. A “meaning” systems framework has been proposed and includes cognitive and affective components geared towards global beliefs and goals¹⁶. These beliefs and goals help us find meaning and purpose in life and a sense that we are connected to something of greater significance than us.^{16,17}

In the last two decades, efforts have been made to further broaden the biopsychosocial model of health proposed by George Engel to include the concept of spirituality. According to researchers in the field of spirituality, the biopsychosocial model does not provide any kind of metaphysical grounding for the notion of a patient as a person. Thus, the proposed biopsychosocial-spiritual model takes into consideration, not only the psychological and interpersonal states of the individual along with their biological state, but also addresses their spiritual state.¹⁸ This model has far reaching implications for research in spirituality and its relationship to health and it is likely to have a significant impact on clinical practice of physicians. This discussion about religion, spirituality and health is at the heart of our attempts to practice a more humane medicine.

“Religious people, by definition, are spiritual people, but not all spiritual people have to be religious.”

NEUROBIOLOGY OF SPIRITUALITY

Mindfulness and spirituality share some psychometric features, but also differ as mindfulness focuses on self while spirituality focuses on both self and other-than-self such as a higher power. Structural, functional and neural network brain imaging research provides new insights into the neurobiology of mindfulness, meditation and spirituality.¹⁹ Meta-analysis of 21 morphometric human brain studies with 300 subjects identify consistent alterations of eight brain regions that impact meta-awareness, exteroceptive and interoceptive body awareness memory, and emotional regulation.²⁰ Recent meta-analytic reviews of MRI studies suggest that meditation reduces default mode network activity with enhancement of focus and attention. Meta-analytic assessment of MRI studies indicate that meditation improves working memory, attention, and emotional regulation through functional activation of a wide network that include bilateral middle frontal cortex, cingulate and insular cortex among others.²¹ Frontal, insular and temporal cortices have been reported as altered by meditation and mindfulness meditation with the hypothesis that these mental activities may cause “neuroplastic changes” in the structure and function of brain regions involved with regulation of emotion, attention and self-awareness.²² Limited data on the neurobiology of religious/spiritual practices as compared to meditation suggest differences in the balance between prefrontal and parietal cortex activation although numerous similarities also occur.²³ In summary, the identified neuroanatomical regions correlated with components of spiritual thought or experience including a sense of self (insular regions), emotional modulation (frontal and cingulate regions) and executive planning (prefrontal cortex).

The molecular neurobiology of mindfulness meditation is undefined, but the documented reduction of stress induced cortisol may be protective through increasing levels of BDNF.²² Applied research on the clinical efficacy of spirituality is evolving. Recent evidence support mindfulness-based stress reduction as an effective treatment option for improving function in chronic low back pain that equals cognitive behavioral therapy.²⁴

PATIENTS DO WANT TO DISCUSS THEIR SPIRITUALITY AND RELIGION

There is a considerable literature examining whether patients would prefer if their physicians would inquire about their religious or spiritual beliefs as part of routine history taking, especially in palliative care.²⁵⁻²⁷ "A university teaching hospital surveyed 177 adult patients attending an office practice to examine patient acceptance of the following question in the medical history, "Do you have spiritual or religious beliefs that would influence your medical decisions if you became gravely ill?" Of responding patients, 66% stated that they would like their beliefs and the same percentage felt that it would enhance their trust in the physician.²⁸

Similarly, a multicenter survey in primary care clinics of six academic medical centers in three states (NC, FL, VT) was conducted to determine patient preferences for addressing religion and spiritual beliefs during their office visit. A total of 456 patients participated in the study: 65% of patients felt that physicians should be aware of their preferences, while 35% preferred that the physician ask them about their beliefs. Further, patients' desire for spiritual interaction with their physician increased with severity of illness.²⁹

"Of responding patients, 66% stated that they would like their physicians to ask them about their beliefs and the same percentage felt that it would enhance their trust in the physician."

In a multisite survey of family practice sites in Ohio, 83% of respondents wanted the physicians to inquire about their beliefs, especially in life threatening situations (77%), chronic medical illnesses (74%), and when a loved one was lost (70%). The most common reason for having a conversation about religion and spirituality was that the patients expected an improvement in the understanding between the physician and the patient.²⁷ One hindrance to patients' initiating these discussions is that they believe their doctors are not prepared to address these concerns.^{26,27,30} While, it is clear that not all patients want a discussion of their religious or spiritual beliefs, the majority do. Religion and spirituality consistently emerge as important domains in end-of-life care and communication, particularly with African-Americans.³¹⁻³⁵ It is therefore incumbent upon physicians to inquire about patients' beliefs in a thoughtful, rational and ethical manner, while respecting differing perspectives.³⁶⁻³⁸

SPIRITUAL CARE AFFECTS PATIENT SATISFACTION WITH CARE

Integrating spiritual care into patient care significantly enhances patients' satisfaction with the care they receive at a hospital. A study of nearly 9,000 patients found that chaplaincy visits increase patients' willingness to recommend the hospital and are more satisfied with their overall care, as measured by both Press Ganey (one of the most widely used patient satisfaction companies) and the Centers for Medicare and Medicaid Services' survey, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).³⁹ The Press Ganey survey specifically found that patients who have a chaplain visit are significantly more likely to endorse positive responses to questions regarding whether the "staff addressed my emotional needs" and "staff addressed my spiritual needs."

Press Ganey's own research among more than 1.7 million patients demonstrates that responses to the question "staff addressed my emotional and spiritual needs" is one of the three main drivers of patient satisfaction with the hospital experience.⁴⁰ A study of over 3,000 inpatients found that those who reported that their spiritual needs were met were more likely to be satisfied with their care⁴¹. Another study with cancer patients also demonstrated that when patients' spiritual needs go unmet, their rating of both satisfaction with care as well as the quality of their care received are significantly lower.⁴²

SPIRITUAL CARE AND HEALTH CARE OUTCOMES

A prospective multisite study of cancer patients has demonstrated that the amount of patient-reported receipt of spiritual support from the health care team has significant effects on several end-of-life experiences.⁴³⁻⁴⁵ Greater spiritual support from the health care team was associated with a substantial increase in quality-of-life scores near death, as reported by patients' caregivers.⁴⁵ Patients who reported a high level of spiritual support were more likely to receive hospice care and less likely to die in an intensive care unit, which were in turn associated with significantly lower health care costs.⁴⁴ In another study, those patients who reported high spiritual support from their local religious communities were less likely to receive hospice care and were more likely to receive aggressive end of life care.⁴³ Of note was the finding among patients who were well-supported by religious communities. Those receiving a high level of spiritual support from the medical team were associated with higher rates of hospice use, fewer ICU deaths, and fewer aggressive interventions. All of these findings demonstrate how spiritual care affords patients and their loved ones the opportunity to choose their preferred choices for end-of-life treatment, thereby highlighting how spiritual care may be a key component in end of life medical care guidelines.⁴³

It is estimated that 40% of medical inpatients do not have the capacity to make medical decisions.⁴⁶ In such situations, physicians are likely to have discussions with patients' surrogates, who in turn may include spirituality and religion considerations to inform their decisions for the patient.⁴⁷ A multisite study that included interviews with surrogate decision makers found that, based on religious grounds, including belief in a miracle, 36% doubted physicians' ability to predict futility.⁴⁸ Those surrogate decision makers who doubted the ability of physicians to predict futility on religious grounds were more likely to request continued life support in spite of a poor prognosis. A recent prospective multisite ICU study that audio recorded family meetings in which goals of care were discussed with surrogates of critically ill patients provides important information regarding how physicians' address religious or spiritual issues.⁴⁹ While 78% of the surrogates considered religion to be important, only 16% of the conferences included any reference to spirituality or religion. Surrogates initiated these discussions 65% of the time and a health care professional raised spiritual concepts only 6% of the time. When surrogates did raise spiritual concepts, health care professionals usually changed the subject to the medical realities at hand.

CHAPLAINS AND COMMUNITY CLERGY

The work of health care chaplains differs from that of community clergy in several ways. Community clergy are ordained or authorized by a religious body to perform certain rituals, to teach and preach, and represent certain religious communities. Health care chaplains may or may not be ordained or authorized to perform any rituals, to teach any doctrine, or to represent a specific community. Community clergy tend to stay current in theological literature, whereas health care chaplains remain apprised of theological literature as well as scientific literature related to spirituality and health. Community clergy provide care that enables patients and their families to remain faithful to specific religious beliefs and practices while facing a health crisis, whereas health care chaplains provide care that helps patients and families access their own spiritual resources, however eclectic and diverse, to find meaning and comfort during periods of illness.

Because the work of health care chaplains and community clergy differ in these ways, each group has developed distinct educational and training requirements. The educational requirements of community clergy vary significantly. For example, in some Jewish movements, rabbis and cantors must study at a graduate level for four to five years. In some Christian denominations, no academic preparation is required other than reading the Bible from cover to cover whereas other Christian denominations require graduate theological degrees. Health care chaplains' education and training requirements, conversely, are standardized by professional associations and do not depend on the practitioner's religious affiliation.⁵⁰

“Patients who reported a high level of spiritual support were more likely to receive hospice care and less likely to die in an intensive care unit, which were in turn associated with significantly lower health care costs.”

In fact, health care chaplains are spiritual care practitioners who have undergone approximately eight years of training to become board certified. This usually includes four years of undergraduate education followed by at least three years of graduate theological education. Prospective chaplains must then complete one year of clinical training in a health care setting, known as Clinical Pastoral Education (CPE). CPE focuses on the formation of a reflective practitioner who is knowledgeable about world religions and spiritual systems, outcomes oriented chaplaincy, health care ethics, and research.⁵¹ The comprehensive nature of chaplaincy training explains why health care chaplains are uniquely suited to assess and address patients' and their loved ones' religious and spiritual needs.

PHYSICIANS' PERSPECTIVES ON ADDRESSING SPIRITUALITY AND RELIGIOUS CONCERNS

Fortunately, the majority of physicians recognize the importance of providing spiritual care, particularly at end of life. In a national survey of over 1,000 physicians, 50% of physicians reported that they often or always inquire about religious or spiritual issues when patients are facing the end of life.^{52,53} In general, physicians see the value of spirituality and religion in assisting patients in decision-making and in attempting to understand their illness. They also see the value that religion provides by way of social support. Some physicians also recognize the deleterious effect of religion, as when the patients' religious beliefs conflict with medical recommendations or when an illness may be viewed by the patient as a punishment for past sins. Most physicians would accept the importance of spirituality and religion in the same vein as they accept the importance of cultural competency, but physicians appear less willing to accept that spirituality and religion also have an impact on health outcomes, despite evidence to the contrary.⁵⁴⁻⁵⁹

BARRIERS

There are a few reasons why physicians are not engaged in providing spiritual care to patients or their families. Although there is a paucity of research in this area, the findings of the few studies that have examined this issue specifically, are remarkably striking. Almost three quarters of physician express that the foremost reason they cannot provide spiritual care to patients is that they do not have enough time during the medical encounter. The second most common reason given is that they do not have adequate training to provide spiritual care to patients and that such care is better provided by others. Thirdly, physicians also expressed discomfort about engaging in discussion on spirituality and faith with patients who were not of the same faith as the physician while others endorsed that they did not personally feel comfortable having discussions about spirituality and faith. A significant minority felt that it was not the physician's role to have these conversations with patients. Finally, physicians expressed concern that there was a power inequity between the patient and physician and that the patient would be uncomfortable having a discussion about spirituality and faith with them. Physicians who are more spiritual or religious are more likely to have a conversation with their patients about spiritual concerns when compared to those physicians who are less spiritual or religious.⁶⁰ Physicians state that they feel comfortable about discussing these issues only if their patients begin the conversation about their spiritual concerns.^{31,36,37,61}

IMPLICATIONS FOR PRACTICE

A plethora of emerging literature has identified the importance of religious/spiritual beliefs on the health outcomes. Therefore, it is important for physicians to incorporate understanding of these beliefs in their clinical work. It should not be expected that physicians will undertake spiritual assessments of their patients. Rather, the ability to recognize spiritual distress in their patients and thus make appropriate referrals to chaplains is desirable. Among physicians, the concept of an internist/generalist and a specialist is well established. It has been observed that, "every physician is taught something about cardiology, including how to assess and at least preliminarily diagnose cardiac issues. The internist/generalist is also able to treat a

few of these issues, especially in their less severe forms, without referring to a cardiologist. Nonetheless, at some point, for some patients, a referral will be necessary.”⁶² A similar model exists for spiritual care. Health care today needs spiritual care generalists i.e., physicians as well other members of the health care team, along with spiritual care specialists who are board certified chaplains (BCCs).⁶³ The physician, in the role of a spiritual care generalist, should be capable of assessing the need for spiritual care for their patient and make appropriate referrals to the spiritual care specialist, the chaplain, when more in-depth spiritual care is deemed necessary.⁶⁴

A spiritual screen, spiritual history and spiritual assessment are three distinct mechanisms for providing well-integrated spiritual care. Many institutions today have various versions of these three spiritual care tools and may assign different members of the health care team to each. Best practice expectations are for the admissions person, or a social worker, or nurse to perform the spiritual screen as a part of their initial assessment. This may, in turn, trigger a report or referral to the chaplain for those experiencing spiritual distress. Additionally, the physician would be the health care provider who would conduct a spiritual history as part of the initial history and physical examination. For those who have expressed a spiritual need or are experiencing spiritual distress that was not identified during the spiritual screen, a referral to a board certified chaplain would be initiated, who would then conduct an in-depth, specialized spiritual assessment and intervene to ameliorate the spiritual distress and/or meet the spiritual need. Unfortunately, there are many organizations where the actual practice does not meet the best practice of spiritual care, and do not use each distinct spiritual tool. Education, familiarity with the research, and communication are essential.

The spiritual screen is a triage tool seeking to identify spiritual distress in patients or families for referral to the chaplain. The spiritual care screen includes “a few questions to elicit basic preferences and any obvious distress that warrants follow up, with minimal expertise and time required.”⁶⁵ It serves to identify patients who may be experiencing spiritual distress.

The spiritual history instrument, on the other hand, looks more in-depth at the spiritual and religious context of the patient (much as a cultural assessment would), and determines what kind of spiritual support may be most helpful. The spiritual history includes a patient’s spirituality (however they define that), what gives their life meaning, the importance of their beliefs and values, a spiritual community (broadly defined to include faith communities and/or other types of spiritual communities such as family, yoga groups or others. There are several popular spiritual history instruments in use today, including the HOPE⁶⁶ and SPIRIT⁶⁷ instruments, Christina Puchalski, M.D., at the George Washington Institute for Spirituality and Health (GWISH), developed the FICA Spiritual History Tool, which has become one of the most utilized.⁶⁸

F – FAITH AND BELIEF: “Do you consider yourself spiritual or religious” or “Do you have spiritual beliefs that help you cope with stress?” (or contextualize to whatever the clinical situation is) If the patient responds with “No,” the history-taker might ask, “What gives your life meaning?” Sometimes patients respond with answers such as family, career or nature.

I – IMPORTANCE: “What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in your health?”

C – COMMUNITY: “Are you a part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?” Communities such as churches, temples and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

A – ADDRESS IN CARE: “How would you like me, and the entire medical care team, to address these issues in your health care?”

“The physician, in the role of a spiritual care generalist, should be capable of assessing the need for spiritual care for their patient and make appropriate referrals to the spiritual care specialist, the chaplain, when more in-depth spiritual care is deemed necessary”

Finally, the spiritual assessment by the board certified chaplain is defined as “a detailed process of listening to, interpreting and evaluating spiritual needs and resources (significant expertise and often more time required).”⁶⁵ A professional chaplain’s spiritual assessment is communicated clearly in the patient’s chart. This may take different forms depending on the Electronic Medical Record (EMR) platform in use in a particular health care organization.

Physicians can facilitate the provision of spiritual care to patients and their loved ones by including chaplains in patient management, particularly in the following situations:

- Any patient or family member spiritual request or apparent need that the physician is personally uncomfortable fulfilling or that the physician believes they are not adequately trained to engage
- If a patient is connected to a community clergy person, that clergy person may be invited to participate in the patient’s care. Chaplains are a good resource for communicating with local clergy as they often have a network of community clergy with whom they regularly interact. Chaplains can also educate community clergy about what constitutes optimal care of the patient
- A patient or their representative request to see a chaplain or priest
- There is the belief that the illness is a punishment from God
- Based on a religious belief, the patient or their surrogate is not agreeing with what is considered to be safe medical care
- End of life care is being considered

THE NEED FOR MORE RESEARCH

While there are compelling data supporting the importance of addressing patients’ and their families’ spiritual and religious beliefs and needs, there is a paucity of research that examines best practices in providing this important aspect of medical care. Physicians need training in order to increase their comfort and effectiveness in addressing their patients’ and loved ones’ spiritual and religious needs. In addition, we do not have data describing which chaplain interventions have the most impact on patient outcomes. Funding of research for these important endeavors is critical to moving the field of spiritual care forward.

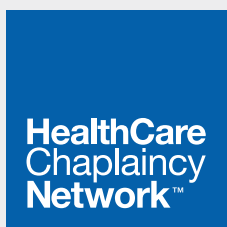
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Editor's note: This column is all about inspiration—to pass along to your patients and colleagues.

WORKING TOGETHER TO MAKE A DIFFERENCE

By Karen Blakeley, MSN, RN, CPN

You never truly know how you will affect someone's life or how they will affect yours. This is especially true in pediatric hematology, oncology and bone marrow transplant (BMT) nursing. It is much more than administering critical medications to patients. It's the collaborative teamwork that offers patients and families hope and something to look forward to while they walk through their personal journey with cancer. This team has many faces and each plays an important role, including that of the hospital chaplain.

One of my patients, and the work of a wonderful chaplain, touched my life and made an impact that I will never forget. This patient's path to recovery was long and arduous. Daily infusions barely made a dent in her afternoon lab levels and mucositis made it almost impossible for her to eat or talk. Her only comfort came when she was able to press her pain pump button and hear it deliver another dose. There were very few visitors, which made the illness feel even more isolating. One of the lights in her darkness was a daily visit from our hospital chaplain, who was a true gift to patient care, and whose love for others radiated from every pore. He had been the rock for families during some of worst and best events in our hospital, and an integral part of the in-patient team.

You can imagine how shocking it was the day we all learned that the grant, which paid his salary, had run out. With that, so had his time with us. The sense of loss was lightened a little by the fact that he had already found another position out of state. In addition to this news, we learned that not only would his girlfriend, who also worked at the hospital, be going with him, but that he had proposed to

her! The spirit truly works in amazing and unexpected ways. After some discussion, the two decided to wed in the hospital chapel. What a gift this was to both the staff and patients to stand witness to the love between these two amazing caregivers. It gave us all a way to express joy, gratitude and congratulations instead of the sadness of loss often felt in goodbyes.

Back in the BMT unit, my patient learned about the upcoming wedding. Able to speak and slowly recovering, she told me how important the chaplain had been to her and how much he had helped her recover during that past gloomy month. She said her greatest wish was to attend the ceremony. My heart broke. I knew BMT patients were not allowed to leave their specially-designed HIPPA filtered rooms, let alone travel through the hospital to sit in a crowded room where many unknowingly carried illness that could put her very life at risk. Still, I had to try. I said a silent prayer, took a deep breath and, with tears in my eyes, promised her I would do everything I could to get her there. Everything short of smuggling her out of her room, which of course, she immediately suggested.

When I first mentioned this to her primary physician, I saw daggers fly from her eyes as she exclaimed, "Absolutely not!" However, the wedding was a few weeks away and I knew I had some time to wear her down. My patient's daily infusions continued, her labs began to improve, and her blood counts were returning to more normal levels. She was able to get up out of bed, talk, and even eat a few bites of food. Again, I approached the physician with my request, this time with a plan. I stressed how much this would mean to the patient, and detailed the steps I would take to

reduce unnecessary exposure. After some debate, we were able to devise a plan that would work. It would not be easy, but I knew it would mean the world to my patient – and that meant the world to me.

Getting to attend the wedding gave this amazing and strong-willed young patient the chance to focus on something outside of her illness. It was a chance to be "normal" again, an opportunity to bask in the love and joy of the moment, and to truly celebrate life.

At the beginning of this year, I shifted my nursing focus and took a position at the National Office of Make-A-Wish®. I knew immediately this was the right choice for me, because few things in my life have been more powerful than being a part of a journey that lifts a child's spirits and provides them with the hope and strength needed to thrive, despite their illness. Health care needs each and every one of us: nurses, doctors, social worker, chaplains and so many others. It is about every person who touches the life of a patient, and how together we use every resource to holistically provide care for patients in all areas: physical, mental, emotional and spiritual. As part of this community, I'm affecting lives that affect me in ways I could have never dreamed possible.

Karen Blakeley, MSN, RN, CPN, is the Manager of Medical Affairs for Make-A-Wish America, as well as a certified pediatric registered nurse. She holds a master's of science in nursing leadership and management.

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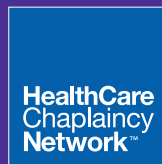
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