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ABSTRACT

A PEDIATRIC SPIRITUAL CARE TRAINING MODEL
UTILIZING VOLUNTEERS AT CHILDREN'S
HOSPITAL IN NEW ORLEANS, LOUISIANA

by

Allen L. Mitchell

Adviser: Moses Taiwo

ABSTRACT OF GRADUATE STUDENT RESEARCH

Project Document

Andrews University

Seventh-day Adventist Theological Seminary

Title: A PEDIATRIC SPIRITUAL CARE TRAINING MODEL UTILIZING VOLUNTEERS AT CHILDREN'S HOSPITAL IN NEW ORLEANS, LOUISIANA

Name of researcher: Allen L. Mitchell

Name and degree of faculty adviser: Moses Taiwo, PhD

Date completed: March 2019

Problem

Children's Hospital—New Orleans is a regional medical center for children with a 247-bed capacity. The hospital is growing in size and scope. However, the number of quality spiritual care providers has not kept up with the growing needs of the institution. As a medical center continues to grow, more spiritual care providers are needed to meet the demand of our increasing patient population. Financial resources are limited and budgets do not favor hiring additional full-time staff chaplains.

Method

A spiritual care training manual was developed to increase the number of trained volunteers to provide spiritual care coverage. A 12-hour orientation training course was

developed and utilized at Children's Hospital—New Orleans in the fall of 2017. The course provided basic pastoral care visitation skills to volunteers. The 14 participants were asked to answer pre- and post-test surveys and also to complete an evaluation at the conclusion of the course. Data was extracted from the surveys using a qualitative case study research methodology.

Results

The study reflected the attitudes of the participants and their understanding of spiritual care in a pediatric setting. Out of 14 participants, nine completed all the course work. A certificate of achievement was given to those who completed the course and they were encouraged to complete the process to become spiritual care volunteers. One of the participants was a nurse on staff at the hospital. She was informed by administration that she could not volunteer to provide spiritual care and also work as a nurse in the same hospital. Five of them now actively serve as spiritual care volunteers at Children's Hospital. In addition, there is now a manual to guide the training of volunteer spiritual care providers.

Conclusions

Based on the participants' learning as expressed in their evaluations and comments, the course was well received. As a pilot program, this model of spiritual care will serve as the foundation to further develop the spiritual care program at Children's Hospital—New Orleans. This model will be explored, revised and further developed to promote the growth of spiritual care in this pediatric setting.

Andrews University

Seventh-day Adventist Theological Seminary

A PEDIATRIC SPIRITUAL CARE TRAINING MODEL UTILIZING VOLUNTEERS AT CHILDREN'S HOSPITAL IN NEW ORLEANS, LOUISIANA

A Project Document

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Ministry

by

Allen L. Mitchell

March 2019

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CHAPTER 1

INTRODUCTION

The field of chaplaincy covers many areas of spiritual care. Pediatric chaplaincy is a specialized form of spiritual care designed to meet the spiritual needs of children and their families. The spiritual care of children is not for the faint-hearted. Many people feel ill equipped to provide good spiritual care to children and their families. They acknowledge that it is a difficult area of ministry that they would never choose to do.

Hospitalized children need spiritual care but there is a lack of people who are equipped to do so. There are some people who have an interest and desire to provide spiritual care for children, but they do not feel comfortable or competent. This project provides a model of teaching spiritual care to volunteers with the intention of having them provide spiritual care in pediatric setting. This is a pilot project in its early stages. It will serve as a guide for future programs designed to train volunteers to provide spiritual care to children and their families.

Description of the Ministry Context

Children's Hospital—New Orleans opened in 1955. It is a non-profit, consisting of a six-story regional medical center and a four-story ambulatory clinic center located in the University District of Uptown New Orleans, Louisiana, near Audubon Park. It is the only free standing pediatric medical center in the state of Louisiana specifically created to meet the medical needs of children. The New Orleans metropolitan area has an estimated

population of approximately 1.2 million people as of 2017 (United States Census, 2017) with over 20% of the population consisting of children under the age of 18 (United States Census Bureau, 2018). The hospital is licensed to operate 247 beds and serves as the regional medical center for children providing services for pediatric patients all over the entire State of Louisiana and the Lower Gulf Coast of Mississippi.

I have been serving as the only full-time staff chaplain for 16 years. There is no separate Spiritual Care Department. I report to the Director of Social Services, who in turn, reports to the Chief Nursing Officer of the hospital. I am an employee of Baptist Community Ministries, contracted to work at Children's Hospital. I also receive supervision from the Baptist Community Ministries Vice President of Chaplaincy Services.

The patient population ranges from birth to age 21. The hospital's policy is to never turn away anyone needing healthcare. Healthcare services are provided to people from all socio-economic backgrounds. The hospital patient census averages about 150 inpatient beds occupied, which is approximately 61% of capacity. The hospital has three intensive care units, a Pediatric Intensive Care Unit consisting of 18 beds, a Neonatal Intensive Care Unit with a 36-bed capacity, and the only pediatric Cardiac Intensive Care Unit in the state with a 20-bed capacity. There is also a hematology and oncology unit with 18 beds. There are also specialized units for dialysis, neurology and rehabilitation. There are additional medical and surgical units that make up the rest of the floors the hospital.

I work with three volunteer chaplains regularly. Two are Catholic deacons. One deacon does visitation on Tuesday mornings for a few hours. The other deacon does

visitation on Saturday mornings for a few hours. Their time varies depending on the patient census at the time. A non-denominational volunteer provides spiritual care when she does visitation on Tuesday mornings.

Statement of the Problem

When I began working at Children's Hospital more than 15 years ago, I was the only full-time staff chaplain working in the hospital. Since that time, the hospital has grown in both patient numbers and organizational complexity. Children's Hospital is the founding member of Louisiana Children's Medical Center, which now consists of five hospitals. Children's Hospital is the regional medical center for children and is currently in the midst of expansion. A new critical care tower is being built that will double the square footage of hospital space within the next two years. It is already a challenge for one staff chaplain to cover all the areas of the hospital at its current size. With the increased growth, there is an even greater need to have other individuals provide spiritual care. In order to better meet the spiritual needs of the children, their families, and staff, a spiritual care model utilizing volunteer chaplains is needed.

Statement of the Task

The task of this project was to develop, implement, and evaluate a spiritual care model for Children's Hospital that utilizes volunteer chaplains. The model was utilized to build a solid team of trained volunteer chaplains to provide quality spiritual care at Children's Hospital—New Orleans (see Appendix A: Research Approval and Consent). The additional spiritual care providers enhanced the provision of spiritual care in the hospital.

Delimitations of the Project

The scope of my work was limited in several ways. First, the project was conducted in Children's Hospital—New Orleans, a regional medical center serving a pediatric population. Second, the project was a pilot study consisting of 12 hours of training on the main campus. Third, the training modules focused on the provision of spiritual care by volunteers. The curriculum emphasized spiritual care by volunteers, not salaried chaplains. Fourth, it focused on volunteers who participated in the Spiritual Care Volunteer Training offered by the staff chaplain. Finally, the curriculum was limited to basic skills needed by spiritual care providers who desire to provide care at Children's Hospital.

Description of the Project Process

The project process involved reflecting on the needs of the institution and how best to address those needs utilizing theology and study of literature related to the task. It also involved studying other models for comparison and developing a model suited to meet the needs of Children's Hospital—New Orleans.

Theological Reflection

In order to form a theological basis for ministry, I chose to reflect on the compassionate ministry of Jesus and the high regard He had for children (Matt 19:14, Luke 17:2). I examined the ministry of Jesus as a servant leader, and His ministry as the Word incarnate which is the physical expression of the love of God and is the basis of my understanding of embodiment theology. Both concepts have helped me to develop a theological basis for pediatric hospital ministry. Jesus interacted with children through appropriate touch, taking them into his lap and blessing them (Mark 10:13-15). In many

miracles Jesus performed, He touched people. He often touched those who were considered the outcasts and lesser valued members of society. The role of human touch is important in healing, especially with children.

Jesus demonstrated a ministry of compassion in Matthew 14:14 NKJV. “And when He went out He saw a great multitude; and He was moved with compassion for them, and healed their sick.” In John 5:6 at the pool of Bethesda, Jesus asked the question, “Do you want to be made well?” The emphasis went beyond physical healing to restoration of the entire person. Jesus provided whole person ministry. Jesus had compassion on the multitudes and He healed the sick and the outcasts. I seek to provide compassionate ministry and to model an attitude of compassion to all with whom I come in contact.

I also reflect on the ministry of Jesus as he modeled both servant leadership and embodiment theology in (John 13:4-5 & 12-16) when He washed His disciples’ feet.

I recognize the importance of volunteering and servant leadership as part of my theological focus of this project. Volunteering is an important part of what makes our society better. When people come together to provide work and support without the benefit or motivation of pay, it expresses their passion and commitment to the task. Providing spiritual care, especially as a volunteer, is inspired by the genuine moral imperative to help others. In practically every culture in the world there is an ethical commandment to help and care for others.

I also believe in embodiment theology, which is the use of self to provide ministry. Working with children, this is an important part of what I do. I use myself as an instrument to communicate with children. Many young children, due to limited language

skills, depend on communication through bodily movement for expression.

Literature Review

I reviewed literature regarding the spiritual care of children, the spiritual development of children, literature related to pediatric chaplaincy, spiritual care models and spiritual assessments. I also included literature on the topic of servant leadership, the leadership of volunteers, and providing spiritual care.

Development and Implementation of the Intervention

The intervention grew out of the need to develop a spiritual care model for Children's Hospital focusing on the provision of spiritual care. My focus was on the essential spiritual services for children and their families. As I reviewed the literature, it became apparent to me that children and families have needs that may go unaddressed if no one is proactive in meeting those needs. Families desire spiritual care but do not always receive it (Fitchett, Meyer, & Burton, 2000).

The model utilized volunteer chaplains as part of a team to provide spiritual care and will act as a template and resource material in the future. The focus was training volunteers to provide spiritual care. I also sought feedback from our hospital staff and from other spiritual care providers. The spiritual care model reflects compassionate ministry, expressed in embodiment theology, to everyone with whom we come in contact. Everything was done with respect for the privacy and dignity of all involved.

Structure of the Intervention

The intervention was a four-week training course consisting of three-hour weekly sessions for a total of 12 hours of training. The course subject matter was training

volunteers to provide spiritual care in Children's Hospital. I was the primary instructor but I also utilized other chaplains and healthcare professionals to teach sessions. The course taught the volunteers basic skills in the provision of spiritual care to children, their families and hospital staff.

Evaluation Process

The evaluation process was ongoing. Much of the evaluation was performed by interview and survey or questionnaire. I developed a survey consisting of 10 questions. I used this survey as a pre-course survey and repeated it at the end as a post-course survey. I also created a course evaluation survey that I encouraged all class participants to answer to provide useful feedback at the end of the course. I include data gathered from volunteer chaplains in our conversations. The model was implemented and will be evaluated on an ongoing basis.

Research Methodology and Protocol

Surveys, as well as question and answer sessions during each segment of the course were utilized as a method of evaluating effectiveness. The pre-test was to reflect a "baseline" in terms of feelings toward the work. The post-test survey evaluated any changes in attitude and learning after the course was completed. All 14 students signed a consent form and it was provided with full disclosure that the information obtained would be used for purposes of the doctoral project and nothing else.

Summary

This was a pilot project which is not comprehensive. It was merely a *start*. It is my hope that others will build on the foundation of this material to better meet the needs

of those who seek spiritual care. This introduction is primarily focused on increasing the number of spiritual care providers in the hospital. One of its benefits is the minimal cost to the institution, while at the same time increasing the reach of the staff chaplain to extend the compassionate ministry of spiritual care to those who would not necessarily receive care due to the size of the institution. I intend to provide a beneficial service that leads to the healing and comfort of those who at times are neglected—children and families.

CHAPTER 2

THEOLOGICAL REFLECTION ON SPIRITUAL CARE

The evolving nature of spiritual care—a field that has primarily been known as pastoral care with a heavy Christian influence—is now open to others who may or may not be of a Christian background. Professional chaplaincy has grown in its scope and is now more encompassing and includes other religious communities. My framework for ministry flows out my faith as a Seventh-day Adventist, but, the work that I do extends beyond my own denominational framework. Reflecting theologically, I consider the type of ministry I provide, the clientele who receive care, and how that care is delivered.

Chaplains are called to be present with people during times of crisis, to support them and remind them of the presence of the Divine. The chaplain is motivated by the sense of calling felt to provide support to persons in need. It involves being sensitive to the needs of others, not just physical needs, but spiritual needs, especially those of people who are experiencing spiritual distress.

This chapter examines the roots of spiritual care, based on history and the growth of spiritual care as a discipline. The various terms used tell the story of how theological principles driven by personal study and developed from my own understanding of Seventh-day Adventist theology have shaped the bulk of this chapter. Theological reflection has also guided me to deeper understanding of servant leadership and how it can be applied to spiritual care in the hospital.

Roots of Spiritual Care (Chaplaincy)

Early accounts tell the story of St. Martin of Tours, a military man, who while entering a city, observed an almost naked, shivering beggar asking for alms (Pernoud, 2006). Martin had no money. But he took off his cape, cut it in two and gave half to the beggar. According to the story, Martin saw Jesus come to him in a dream, wrapped in half a soldier's cape and saying: "Inasmuch as you did it to one of the least of my brethren, you did it to me" (Matt 25:40 NKJV). After his death, the remaining piece of his cloak, his *capella* or "little cloak," was enshrined as a testament to the ministry of compassion he demonstrated. The custodian of this cloak was known as the *cappellanus* or *chapelain.* Our English word, chaplain, derives from this cape of compassion and describes those who engage in ministries of compassionate care of others (Paget & McCormack, 2006).

Moving Toward the Use of the Term Spiritual Care

The term *pastoral care* was first used primarily in a Christian context in the late 1960s (Lartey, 2003). An early definition of pastoral care consisted "of helping acts done by representative Christian persons, directed toward the healing, sustaining, guiding, and reconciling of troubled persons, whose troubles arise in the context of ultimate meanings and concerns" (Clebsch & Jaekle, 1967, p. 4). Since the nation is becoming more diverse, the variety of faith traditions has diversified as well. As the times have changed, the terminology has evolved, utilizing inclusive language that respects other faith traditions that may not view the term *pastoral care* as a fitting description of who they are. The term *spiritual care* has become more acceptable today. Some departments still carry the traditional name of Pastoral Care Department but a number of healthcare institutions have

begun referring to the departments with chaplains as “spiritual care departments” (Paget & McCormack, 2006, p. 18). In this project I use the term spiritual care for the sake of promoting inclusive language whenever possible.

Handzo, Cobb, Holmes, Kelly, and Sinclair (2014) say one of the challenges of providing spiritual care is a lack of definitional clarity among practitioners themselves. It is hard to achieve best practice when there is no consensus on what best practice is. The Association of Professional Chaplains (2015) has provided a definition in its document, *Standards of Practice for Professional Chaplains,* defining spiritual care.

Spiritual Care Defined

The Association of Professional Chaplains offers the following definition of spiritual care:

> Interventions, individual or communal, that facilitate the ability to express the integration of the body, mind, and spirit to achieve wholeness, health, and a sense of connection to self, others, and [/or] a higher power. Spiritual care forms part of the care provided by a chaplain. (Handzo, Cobb et al., 2014, p. 24)

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significance of the sacred (Puchalski et al., 2009). Spiritual care is the provision of assistance to people in connecting with their spiritual resources to promote healing.

The Need for Spiritual Care

People desire spiritual care and have expressed their concern that hospitals do not always attend to their spiritual needs. Thus, the ministry of chaplains is important, not because chaplains say so, but because patients say it is important to them (Fitchett et al.,

2000). In pediatric settings, the physical health of patients is given the bulk of the attention, but patients and their families have expressed concern that their spiritual needs were not always met. Those surveyed agreed that there were three barriers to providing spiritual care: inadequate staffing of the pastoral care department, inadequate training of the healthcare providers to detect patient's spiritual needs and being called to visit patients and families too late to provide all the care that could have been provided (Feudtner, Haney, & Dimmers, 2003).

In hospitals, people experience anxiety and often struggle to find meaning in their circumstances. Spiritual distress results from unresolved spiritual issues the patients and their families may be facing. In a children's hospital, there is a motivation as a human being to care for children, who we often view as vulnerable and innocent to the dangers of this world. Our motivation arises out of a sense of compassion and concern for those who are ill or suffering. Those who have suffered spiritual distress need spiritual care. Trained spiritual care providers can provide the assistance needed to promote spiritual healing.

Biblical Basis for Spiritual Care

The Bible is filled with motifs concerning the care of humanity through the ages. In both the Old and New Testaments, the theme of God's care and concern for humanity is woven throughout the entire Bible story. From the beginning we see the Godhead actively involved in the creation story, as every aspect of creation was accomplished by the creative power of speech; it was spoken into existence. Yet, Genesis 2 gives greater insight, highlighting special care for humanity. Genesis 2:7 says, "And the Lord God formed man of the dust of the ground and breathed into his nostrils the breath of life; and

the man became a living being." In the creation of Adam, for the first time God creates with His own hand, reflecting the special nature and relationship with humanity. In forming Eve, God does so using living tissue from Adam, indicating the unique nature of the woman. The creation story illustrates the relationship of the Godhead and the special care shown for humanity. This care coming from God is spiritual care to the greatest degree.

The Old Testament is filled with motifs of God's care; through the patriarchs, the prophets, and the priests, we see God caring for humanity. Spiritual care is the very nature of God, reflecting divine character attributes and the love God has for creation. The spiritual leaders were to represent God before the people. The patriarchs were leaders with whom God had a special relationship. The prophets were the spokespersons for God; they declared the message of God to the people. Spiritual care providers act in this role as well. The priests were the religious leaders who carried out the daily ministry on behalf of the people, they were the bridge between God and the people. As chaplains we may not do the exact same activities today, but the functions may be similar. Chaplains play a role much like an Old Testament priest by: interceding for people, providing spiritual care during times of illness, praying when appropriate, and providing counsel when reconciliation is needed.

There is evidence of spiritual care in the Old Testament:

> The Spirit of the Lord God is upon Me, because the Lord has anointed Me to preach good tidings to the poor; He has sent Me to heal the brokenhearted, to proclaim liberty to the captives, and the opening of the prison to those who are bound; To proclaim the acceptable year of the Lord, and the day of vengeance of our God, to comfort all who mourn, To console those who mourn in Zion, to give them beauty for ashes, the oil of joy for mourning, the garment of praise for the spirit of heaviness; that they may be called trees of righteousness, the planting of the Lord, that He may be glorified. (Isa 61:1-3 NKJV)

Spiritual care has at its roots the desire to alleviate suffering, not just physical, but emotional and spiritual as well. Holst (1985a) defines the basic, fundamental role of pastoral care as "the attempt to help others, through words, acts, and relationships, to experience as fully as possible the reality of God's presence and love in their lives" (p. 46). It deals with every area of life. Spiritual care is just as vital to the health of individuals as physical care. It deals with an area often ignored or overlooked in modern medical communities. Yet research has shown that people often desire spiritual care while hospitalized but do not feel their needs are always met (Fitchett et al., 2009).

Another example of spiritual care in the Old Testament is in the book of Job. Job's three friends heard of all his adversity and they agreed to go and mourn with him and comfort him. They saw his unrecognizable condition from a distance. They lifted their voices, wept, tore their robes, and sprinkled dust on their heads as signs of solidarity with him in his grief. Job 2:13 says, "So they sat down with him on the ground seven days and nights, and no one spoke a word to him, for they saw his grief was very great" (NKJV). What they did at first was effective. They provided a ministry of presence and support. The provision of spiritual care is an ancient tradition with historical significance when viewed through scripture.

There are also examples of spiritual care in the New Testament. Spiritual care is illustrated in the life and ministry of Jesus Christ. Spiritual care is also demonstrated in the ministry of the disciples. Jesus repeatedly showed care for people by healing the sick, alleviating suffering and helping people who were in spiritual distress. Four times in the New Testament the words "moved with compassion" are recorded in Matthew 9:36;

14:14; Mark 1:41; and 6:34. In each passage, Jesus does something to alleviate the suffering in the crowd.

In Luke 10:25-37 Jesus recites the *Shema* and then tells the parable of the Good Samaritan. In this story, Jesus describes two religious leaders who were not sensitive to the needs of another human being. Then he describes a Samaritan whose customs were not recognized by the Jews as legitimate. Jesus identifies the Samaritan as the one who truly cared for his neighbor, the person in need. Jesus is describing the importance of providing care to those in need no matter what the circumstance. This speaks to the call to care, the call to be a healing presence, an instrument of healing. In Luke 4:19-21 Jesus read from Isaiah 61:1 and proclaimed, “Today this scripture is fulfilled in your hearing” (NKJV). Jesus was declaring His mission, His “call,” to provide spiritual care for those in need.

Functions of Spiritual/Pastoral Care

There are six functions of pastoral care in our modern era: healing, sustaining, guiding, reconciliation, nurturing, and liberation.

Lester (1995) states,

> When people are wounded or hurt they need the pastoral function of healing. When they are confused or perplexed they need the pastoral function of guidance. When they are overwhelmed or stretched to the limit, they need to be sustained or held emotionally. When they are alienated or separated they need to be reconciled. When they are feeling stuck or trapped they need to be liberated. (p. 1)

These six functions provide a brief description of the daily work of the chaplain. Each function has a task that can help individuals and families to alleviate spiritual distress.

Ministry of Presence as Praxis

Much of spiritual caregiving involves the ministry of presence. Holm (2009) defines it as “a faith presence that accompanies each person on the journey through life” (p. 8). This presence in each of us reflects God’s presence, love, and peace. Ministry of presence is about “being with” someone. It communicates the love of God at a time a person may be in crisis. Chaplains provide powerful ministry through their presence. People often remark how appreciative they are to have had a chaplain present with them during a difficult time. A ministry of presence can bring comfort and express care without words. Ministry of presence reminds people that they are made in the image of God and are deeply loved by Him. By bringing the gift of self into the situation, we in a sense become instruments of peace. It is not about us, but about who we represent. We bring our spiritual selves into relationship with children and their families to help them locate and develop their spiritual resources to promote healing and wholeness.

A Theology of Spiritual Care

We are all God’s people. We are all connected and related as humanity and worthy of being treated kindly and fairly. We should tend to each other as children of God. Jesus believed all persons were of value. He was intentional in His care for all in need. He did not discriminate and as a result was criticized by many. Spiritual care is rooted in Christ’s compassion for all. Chaplains are also called to care for people who may come from different religious, social, economic and ethnic backgrounds. The call to care should be a core value of chaplains stressing the theological view of the importance of all people as children of God worthy of dignity and respect (Mauldin, 2017). The work of the chaplain is to shepherd the herd or flock so that they can grow and be protected.

A description of the work of the chaplain is the work of *orthopraxy*, which comes from two Greek words meaning *correct practice* or *right action*. By definition *orthopraxy* in theology is the belief that right action is as important as religious faith [from Greek *orthos* correct + *praxis* deed, action] (*Collins English Dictionary*, 2003). For the chaplain it involves how we do spiritual care. *Orthopraxy* is about how we do ministry in a practical way. Professional chaplains are trained to listen without judgment. We meet people where they are and we journey with them. A chaplain's role is not to make a person ascribe to our own personal theology and believe what we do, but to allow them to draw from their own theology to meet their spiritual needs. Chaplains are to show unconditional positive regard to people, in other words, to love them (no matter their condition).

Jesus brought people together. He sought to reconcile people to God and to each other. Jesus welcomed children (Mark 10:14, 24; 9:33-37; 10:13-16). Jesus valued inclusivity not exclusivity. He was welcoming to those who desired His presence. In a society which ignored women and children, Jesus turned things upside down (Luke 18:15-30). Jesus made physical contact when He blessed the children. In the Bible, physical touch is a way of showing approval. Jesus touched and healed women. He went counter to the culture in which He lived. Jesus broke the mold and shattered stereotypes for the purpose of restoring the worth and value of every individual. He said "Let the little children come to me" (Matt 19:13-15).

Jesus also valued the principles of mutuality and hospitality. He respected people and viewed them as equals. He treated people, all people, as important. He lived these concepts out on earth. Jesus saw people as important and hospitality was a method of

caring for the needs of people. This reflected His attitude and His willingness to serve others. This is a model for all who claim to be followers of Christ.

Seventh-day Adventist Theology and Spiritual Care

Seventh-day Adventist theology as a whole can best be understood in light of the "The Great Controversy" theme. The Great Controversy refers to the cosmic battle between Jesus Christ and Satan as it is also being played out on Earth. The concept is important in Adventist theology because it provides an understanding of the origin of evil, and how the Godhead will eventually vanquish evil and bring about the restoration of God's purpose for this world. The grand central thought is summed up in this statement:

> The central theme of the Bible, the theme about which every other in the whole book clusters, is the redemption plan, [which is] the restoration in the human soul of the image of God. From the first intimation of hope in the sentence pronounced in Eden to that last glorious promise in the Revelation 'They shall see His face; and His name shall be in their foreheads,' [Rev 22:4] the burden of every book and every passage of the Bible is the unfolding of this wondrous theme, man's uplifting, 'the power of God who giveth us the victory through our Lord Jesus Christ' (1 Corinthians 15:57). He who grasps this thought has before him an infinite field of study. He has the key that will unlock to him the whole treasure-house of God's Word. (White, 1903, pp. 125-126)

Seventh-day Adventists understand the restorative nature of the gospel as an integral part of God's plan (Fiedler, 2015). It is the restoration of the image of God in the human soul. The message of God was given to uplift humanity and guide humans to victory. Ellen White in the book *Desire of Ages* (1940) states, "The very essence of the gospel is restoration" (p. 824).

Seventh-day Adventists believe in a health message that is not just about the physical. It is also the intellectual and spiritual—but spiritual care is not what is

emphasized. It is about holistic health. The total restoration of the image of God to humanity is at the heart of Seventh-day Adventist theology and guides my personal ministry as a chaplain.

The Health Message is Based on Christ's Method of Ministry

Adventists believe that, at the Fall, all aspects of human nature—the physical, the intellectual, and the spiritual—were affected, and that Jesus, who said He had come to restore that which was lost (Luke 19:10), seeks to save the whole person. In His ministry Christ touched these three dimensions: He preached the gospel of the kingdom (spiritual), He healed those who were mentally deranged (intellectual), and He restored those afflicted with disease (physical) (Williams, Kuzma, & Van Dolson, 2002),

Jesus sought to restore the whole person. The ministry of Jesus was characterized by teaching, preaching and tireless restoration of the sick and suffering (Matt 4:23-25; 8:1-3, 14-16; Acts 10:38). When any part of the person is neglected restoration is incomplete. Secular institutions have not always emphasized the importance of spiritual health and wellbeing as part of wholeness. Salvation is part of the process of restoration and summarizes the message of the gospel. Seventh-day Adventist theology promotes total restoration. Total restoration cannot be accomplished without spiritual care. The Adventist health message emphasizes restoration to wholeness. Spiritual care has an important role in this restoration process.

Personal Theology of Spiritual Care

As a Christian and follower of Christ, the value I place on every person is influenced by the actions of Jesus. By dying on a cross, and atoning for sin, Jesus communicated His view of the value of human life. By sacrificing His own life, Jesus demonstrated the value of all human life. By His action, Jesus indicated that every person is of great value to God. By His activity on earth, Jesus communicated that every person is worthy of spiritual care. Everyone is worthy of being treated fairly and with dignity. During His ministry, Jesus declared the importance and value of women, children, the oppressed, the abused, the mistreated, and the outcasts of society. This is consistent with my Seventh-day Adventist theology of the Lord seeking to restore all humanity to the image of God (*Imago Dei*). All humanity is made in the likeness of God. My inspiration comes from the ministry of Jesus who displayed care for all who needed Him. In my own way, I seek to live out the values of integrity, justice, and character traits described as the fruit of the spirit found in Galatians 5:22 and 23. "But the fruit of the Spirit is love, joy, peace, longsuffering, kindness, goodness, faithfulness, gentleness, self-control."

My theology is summed up in a quote from the book, *Ministry of Healing* (White, 1942). "The Savior mingled with people as one who desired their good. He showed sympathy for them, ministered to their needs, and won their confidence. Then He invited them, 'Follow Me'" (p. 143). This describes incarnational ministry. It is meeting people where they are and providing them with the help they need. We are to live as representatives of the savior doing the same, calling people to follow the perfect example of the life of Christ. Jesus did not keep himself separate from the people, He lived among people. In John 1:14-18, Jesus is the "Word made flesh."

Jesus commanded us to go and make disciples—followers of Jesus.

> Go therefore and make disciples of all the nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, teaching them to observe all things that I have commanded you; and lo, I am with you always, even to the end of the age. Amen. (Matt 28:19-20)

Jesus lived a life that displayed humility and grace. He demonstrated servant leadership vividly in John chapter 13 when He washed His disciples' feet. Jesus is my model of servant leadership. Paul said, "Imitate me, just as I also imitate Christ" (1 Cor 11:1 NKJV).

Jesus provided further instruction when He said to His disciples, "The harvest truly is plentiful, but the laborers are few" (Matt 9:37 NKJV). There is a need for people to do the work, but just as Jesus said, there are few who desire this type of work. Hospital chaplaincy is not for everyone. Also, not everyone who desires to do the work will be employed as salaried staff. Volunteers are vital to make up for the lack of fully trained laborers to provide spiritual care. Volunteers can extend the delivery of spiritual care into areas that one chaplain cannot cover alone or cover at hours beyond regular business hours. Hospitals do not close. And spiritual needs do not just occur during business hours; thus, a need to provide broader coverage becomes apparent. Matthew 10:38 (NKJV) says, "And he who does not take up his cross and follow after Me is not worthy of Me." Again, Jesus is the model and this implies a degree of sacrifice on the disciple or volunteer's part.

A chaplain must have a living, authentic and active relationship with God that must be maintained in order to be revived, restored, and refreshed during the time of ministry. Being authentic involves wrestling with choices at times. Not seeing everything in black and white, trusting that God is aware of the situation and being willing to support

those in crisis when called to do so, a chaplain must develop the ability to recognize God's presence in human interactions.

In the Old Testament, God chastised His people because they refused to fulfill the role of priests. The role of the priest was to intercede between God and humanity. It has been said that the best measure of a church's effectiveness is how many people walk out to be the royal priesthood on Monday and Tuesday, and Wednesday (Larson, Anderson, & Self, 1990). The call of people into ministry, not necessarily professional ministry but ministry of service for the cause of the gospel, is important. It is part of discipleship. Jesus had disciples around him because He wanted them to provide ministry to others. He taught them how to provide compassionate servant ministry to those in need.

The Ten Commandments are an important part of Seventh-day Adventist theology. They are the basis of our morality and govern the nature of our relationships.

The Ten Commandments are summarized: Love for God and Love for people.

> "You shall love the Lord your God with all your heart, with all your soul, with all your mind, and with all your strength." This is the first commandment. And the second, like it, is this; "You shall love your neighbor as yourself." There is no other commandment greater than these. (Mark 12:30-31 NKJV)

Much of the ministry of Jesus involved caring for the sick and those who were disenfranchised. Excluded or forgotten, they were the outcasts of society. Spiritual care spans all races, cultures, classes, and religious backgrounds.

The Task and Goal of Spiritual Care

The task of the chaplain is to understand what the need of the person is and then how to address that need through spiritual care. The goal of spiritual care is to help a person in need to access their spiritual resources to promote healing. The first step in understanding spiritual care and how to provide it has to do with one's personal theology.

The hospital chaplain can have a role as a peripatetic teacher (Bickel & Middleton, 1985). Peripatetic pertains to traveling around. Jesus walked and taught as He went. His ministry was wherever He traveled and the people had needs. He rarely stayed in the same place for an extended period of time. A chaplain colleague gave me a pen which had a phrase printed on it that said, "Ministry by walking around." It is also known as leadership by walking around. Jesus demonstrated a life of ministry that moved around to where the people were.

Chaplains move around various parts of the hospital providing care and showing support to those who need it. Guiding is one role of the chaplain that has great importance. People are seeking a deeper spirituality and one way they obtain it is through the guidance of a spiritual leader. A chaplain can do this leading by example and remaining humble as he or she goes about. Pediatric chaplaincy is an even more specific call. Spiritual care is exemplified through the ministry of Jesus. He was and is the ultimate servant leader. He modeled spiritual care for us.

A Model of Spiritual Care

Paget and McCormack (2006) describe the work of the Christian chaplain as an extension of Christ's ministry to all people. Jesus did more work in ministry outside the walls of religious structures than within. He taught on the seashore, on mountaintops, over dinner tables, and along roads as He walked. Also, much of His ministry was to non-Jews. He healed and taught sinners, tax collectors, Romans and Samaritans, and He preached to crowds that had Jews as well as Gentiles in them. Christ is the example of one who had an all-encompassing, cross-cultural ministry. His ministry went beyond

natural boundaries, reflecting the principle of the universality of all humanity. Well trained chaplains recognize that all people are created equal and in the image of God.

Compassionate Availability and the Ministry of Presence

Jesus was an example of compassionate availability. There were crowds around Him whenever He entered a town or village. The people came seeking His healing touch. He often spent long hours healing the sick. He was compassionate and available to those in need. The Bible describes Him as laboring even to the point of being so exhausted that He fell asleep in a boat and was not aware of a storm that was about to sink the ship (Matt 8:23-34).

Compassionate availability is the willingness of the chaplain to be present to assist others. Availability is a message of scripture. God seeks those who are compassionate and available to be used as instruments. This attitude is important to the work of the chaplain. Compassionate availability is a trait that good spiritual care providers possess. It may develop into practices which address fundamental human needs as an expression of the light of God's presence in this world. Availability lends itself to being open to the leading of the Spirit of God (Isa 6:8).

Another aspect of spiritual care is the ministry of presence. Compassionate availability in *praxis* is the ministry of presence. It is the ability to listen when there are no words to be heard. As professional chaplains, we are called to offer a courageous listening presence. When there are no words to be heard, we listen at the 'heart' level, drawing upon our shared experiences of love, loss, and grief. Chaplains give voice to what must be said (Byrne, 2008) in ways others may be unable to communicate. Chaplains may "speak" at times simply by their ministry of presence.

Theology Influences Spiritual Care

A professional chaplain who serves in a multi-faith capacity has the ability to support a patient (or family member or staff person) in his or her theology, while at the same time remaining true to their own theology. Jacobs (2010) puts it this way,

> In order to be an effective multi-faith chaplain, I need to be secure in my own belief system. I also need to be able to be open to understanding and interpreting Sam's theology and that of any other patient, family member, or staff person that I come into contact. I have to be open to other people's theology and help them through using their belief system, not my own. (p. 5)

A board-certified professional chaplain must have the ability to minister cross-culturally, cross-generationally, cross-religiously, and in any area that may exist outside of his/her own belief system without allowing personal bias to block the provision of spiritual care to those in need. Professional chaplains are trained to minister to people who possess faith backgrounds different from their own. It is important to listen first, to understand the theology of those being served in order to work with them.

Effective spiritual care meets the needs of the people and provides support where they need it. When providing care, a professional chaplain seeks to support those in need based on their theology while at the same time depending on his or her own personal theological background to gain wisdom and provide quality care (Jacobs, 2014). Chaplains who are in touch with themselves and understand who they are and their own theology can better understand and appreciate the theology of others. Jacobs describes it as a dual-track mind-set and heart-set. Reflective listening is of great value in these situations when we need to be sensitive to the needs of others.

The Ministry of Jesus: A Model of Servant Leadership and Spiritual Care

Jesus provided the greatest model of how to provide spiritual care. He displayed kindness, compassion, patience, wisdom, and discipline (self-control). Jesus knew who He was and responded with authority and confidence in His ability, not to lord it over others but to serve and liberate.

The most powerful example of servant leadership demonstrated by Jesus is found in John Chapter 13 when Jesus washes His disciples' feet. Jesus, according to scripture, removed His outer garments. In the first century men often wore three garments, an outer cloak that was floor length, an inner tunic that was probably knee length and an inner short cloth, functioning like our underwear. When Jesus prepared to wash His disciples' feet, He removed His two outer garments. He washed feet in His inner garment. This was the garment worn by slaves as they worked. In essence He was showing humility in doing the service of a slave. He was teaching a lesson in servant leadership. The One who was divine was playing the role of a slave, a servant. Jesus said:

> If I then, your Lord and Teacher, have washed your feet, you also ought to wash one another's feet. For I have given you an example, that you should do just as I have done to you. Truly, truly, I say to you, a servant is not greater than his master, nor a messenger greater than the one who sent him. (John 13:14 NKJV)

There are many instances of Jesus providing spiritual care. He healed the sick, taught lessons, and shared in the joys and sorrows of the people (Jesus wept). One of the most powerful examples of Jesus providing care appears in John 13, where Jesus as a humble servant, washes His disciples' feet and then instructs them to do the same for each other. He was demonstrating servant leadership. Jesus is the model of providing good spiritual care. He healed, comforted, forgave, taught, and showed mercy and compassion.

Jesus was the greatest example of (*agapao*) love. He loved people and did not turn them away. Some left Him by their own choice; He never rejected them. Even when He rebuked the religious leaders of that time, He still showed love. Jesus modeled the love and acceptance that truly defines servant leadership. Jesus knew Judas was going to betray him, yet He washed his feet along with the other disciples. He modeled *agapao* love for Judas knowing that Judas was not doing what was right.

The life and ministry of Jesus is filled with examples of loving servant leadership and grace. Jesus exemplified love in His interactions with children and provided a model for how we are to treat them in ministry. He is our example to follow.

Literature suggests that servant leadership is not a new concept, but one followed by ancient monarchs for over a thousand years (Nair, 1994). More recently, servant leadership gained resurgence in the writings and teaching of Robert K. Greenleaf, who pioneered the principles of servant leadership in the latter part of the twentieth century. Focusing on the character traits of servant leaders, Greenleaf (1970) describes servant leadership based on seven principles:

1. Developing and empowering others
2. Humility
3. Authentic leadership
4. Open participatory leadership
5. Inspiring leadership
6. Visionary leadership
7. Courageous leadership

When Robert Greenleaf (1970) first put forth the concept of servant leadership in modern times, he spoke from a businessman's perspective. However, servant leadership can also be viewed from a theological perspective. It is theology with a practical application as demonstrated in the ministry of Jesus Christ. Jesus is the ultimate model of servant leadership. Greenleaf took the position that the leader is seen as a servant first, and that simple fact is the key to greatness. This principle of leadership is seen in the ministry of Jesus Christ. Effective not only in a business setting, servant leadership is a method of doing ministry that can be effective also in the healthcare setting.

The Chaplain as Servant Leader

Russell and Stone (2002) suggest that the attributes of servant leadership are vision, honesty, integrity, trust, service, modeling, pioneering, appreciation of others, communication, credibility, competence, stewardship, visibility, influence, persuasion, listening, encouragement, teaching, and delegation. Four attributes of great servant leaders are: humility, authenticity, stewardship including empowerment and clarity, and empathy and forgiveness which are linked together.

Servant leadership is frequently seen from a business perspective, but its roots are based in scriptural spiritual traditions. As a Seventh-day Adventist Christian, my approach to servant leadership is informed by modern writers such as Greenleaf and Russell and Stone but has its roots solidly in scripture. The ministry of Jesus is the model of servant leadership that shapes my approach to the practice of spiritual care in the hospital.

Scripture and Servant Leadership

The gospel of Mark can be summarized with the titles, *The Servant Who Rules* and *The Ruler Who Serves* (Stedman, 2002a, 2002b). This is an excellent description of Jesus' ministry and mission. The gospel is summarized in Mark 10:45, "Even the Son of Man did not come to be served, but to serve and to give His life a ransom for many," or as the King James Version puts it, "not to be ministered to, but to minister" (Stedman, 2012, p. 562). Jesus was living what He preached. He understood His mission and was sharing it with those closest to Him. As a spiritual care provider and person in a position of influence, I choose to use my influence by serving the needs of others.

Chaplains must approach this ministry with humility, with the recognition that we respond to the "audacity of ministry." The audacity of ministry is the boldness of flawed human vessels to work on behalf of a great and all-powerful God, who would actually choose to use flawed human beings to provide meaningful ministry that makes a difference in this sin-scarred world. The thought is humbling and also empowering. Great servant leaders realize that what they do has the power to transform them as well as those around them. A servant leader does not seek the glory—but the good, the best result for all.

Chaplains as Servant Leaders

The chaplain functions best while assuming the attitude of servant (Paget & McCormack, 2006). The ministry of care must arise from a servant heart, a heart conditioned to care. The chaplain is a servant leader within the organization, the person others look to for spiritual and moral support. The servant leader has the ability to minister to people from all strata. The servant attitude enables this to happen. When

providing spiritual care, it is the chaplain who maintains a humble approach that empowers others to excel. The chaplain tends to hurting persons, providing spiritual support during times of great need.

The chaplain's role as a servant leader is about relationships with others. This model is based on the cross. The cross can be viewed in two dimensions, the vertical and the horizontal. Vertically, we connect with God. Horizontally we connect with people. These dimensions reflect redemption and relationship, kingdom and society. For the Christian, the vertical is about our relationship with a God who is above us. The horizontal is about the relationships we have side-by-side with our fellow human beings. From a Christian theological standpoint, one cannot truly be effective as a chaplain without understanding the symbolism of the horizontal and vertical dimensions of the cross. How one relates to God and perceives God is also expressed in how one relates to others. A balanced theology leads to proper relationships with both God and other human beings. For the chaplain and spiritual care provider, it is never either/or; it is both/and.

Chaplains can be servant leaders in the hospital. They can play a role as transformational leaders and act as spiritual and moral guides. As servant leaders with the power to be transformational leaders, chaplains can provide a theological and moral basis for renewal in the institutions they serve. Jesus commanded His disciples to serve one another. The chaplain is an example of service to others. The chaplain's role as servant leader is to model good spiritual care before staff, showing *agapao* love as the way to treat others. This modeling influences volunteers to respond in the same manner as they provide spiritual care.

Paul said in 1 Corinthians 11:1 “Imitate me, just as I also imitate Christ.” Jesus was Paul’s model and as the professional chaplain, I model God’s love for all people as a way of impacting volunteers of any faith background who provide spiritual care. I recognize that modeling good spiritual care practices is a way of positively influencing spiritual care volunteers.

Mentoring Volunteers

As staff chaplain, I provide mentorship for volunteer chaplains. Proper training enables us to take care of “all God’s people.” The hospital chaplain, acting as the servant leader, can train volunteer chaplains and prepare them to provide spiritual care as a service to those in need. It is the job of the chaplain to equip them with the necessary skills to provide spiritual care in the hospital.

Every hospital has a mission and values statement. A chaplain can help translate those values. As a servant leader, the chaplain can help volunteers who may not be comfortable with ministry to other religious groups. As part of this project, a training manual was utilized as part of the process of teaching volunteers about relating and providing care in multi-cultural situations. The leader empowers the volunteers to utilize their spiritual authority to provide care to those in need.

Greenleaf (1996) says that the true test of the servant-leader is that people associated with the servant-leader become healthier, wiser, freer, more autonomous, and more likely themselves to become servants. In addition, the least privileged members of society are helped or at least not further deprived. The Bible has many references to this type of activity, in which the interests of other people are deemed to be important, in which to do good to all people is critical, and in which each person is considered

important and valuable. Philippians 2:4 says, “Do not merely look out for your own personal interests, but also for the interests of others.”

According to 1 Peter 2:5 which describes the priesthood of all believers, every person has the potential of providing compassionate service to others. In other words, every follower of Christ has been given instruction to care for others. In the hospital local clergy can and do visit their parishioners, but there are times and situations when someone with specialized pediatric spiritual care training care is needed. Professional pediatric chaplains have expertise in caring for children and families during times of crisis or times when they are experiencing spiritual distress and they may benefit from spiritual care. The training provided can also benefit local clergy who can receive additional training beyond their current level of functioning. I have received feedback from clergy and non-clergy who have voiced their discomfort in not knowing what to say or how to react when attempting to minister in a pediatric setting. They do not feel adequately prepared to provide spiritual care to children and families in crisis.

Translating Servant Leadership in the Hospital

Servant leadership includes four central tenets or principles that are particularly relevant in a hospital setting): (a) increased service to others; (b) a holistic approach to work; (c) the promotion of a sense of community; and (d) the sharing of power in decision-making. The exemplary servant leader follows these tenets and is both a follower and leader (Spears, 1996).

Chaplains act as servant leaders, providing leadership through spiritual care as an expression of love to others. This love is displayed by acts of kindness and compassion to those in need. Servant leadership in a pediatric hospital involves embodiment theology

where the spiritual care provider uses self in a manner that allows people to connect with each other, and promotes service to pediatric patients, their families, and staff. In the pediatric hospital setting, spiritual care providers help to foster a greater sense of community. Chaplains do this by serving in the role of prophetic voice acting as servant leaders, empowering others in decision making, promoting unity and togetherness, especially during, and also after times of crisis in the hospital.

This project was specifically inspired by the four tenets of servant leadership which are manifested in this project in some direct ways. First, by training and empowering spiritual care volunteers, the scope of spiritual care services will be increased. Second, designated spiritual care providers understand healing to be nurtured by a combination of physical, emotional, social, and spiritual care. This is a holistic approach to medicine, which is in line with the philosophy of the institution. Third, by training spiritual care volunteers, and thus expanding the reach of spiritual care in the hospital, this project seeks to expand and promote a greater sense of community within the hospital. Finally, fourth, this project is an effort by this professional chaplain to share power with newly trained spiritual care volunteers. Thus, the theology of servant leadership is at the heart of this project.

Although the literature contains many specific definitions and cultural variations of leadership, most of them contain three elements; "In its simplest form [leadership] is a tripod—a leader or leaders, followers, and a common goal they want to achieve" (Bennis, 2007, p. 3). This tripod is the model for much of the work in a hospital. Leadership, especially servant leadership, should place the focus not on the leader, but service. In other words, in the hospital my influence is a platform to serve others. Performing the

role of a servant should be the focus, not leading. Jesus changed attitudes by His example of leading by serving. The hospital is a place where such servant leadership can enhance the work of the organization throughout the facility. Medical facilities naturally focus on the treatment of medical conditions, and teamwork is often involved. It takes many disciplines working together to provide the best possible care.

Servant Leader and Mentorship

Jesus was an example of a leader who made a choice of a life of submission. He demonstrated love in this. He told his disciples, “You do not know what I am doing for you now, but you will.” In other words, He was setting the tone of leading by service to others. He wanted them to love one another and to care for one another.

As the only staff chaplain in the hospital where I currently serve, my role as servant leader is to follow the ministry model of Christ. Jesus led his disciples by example; He told His disciples to go and influence others, teaching them how to care for others and in turn build up the body of believers. My mission in this project is to train volunteers to serve and provide spiritual care in the hospital. The model for spiritual care put forth includes a training manual for spiritual care volunteers. It serves as a guide and reference manual that assisted them in their quest to provide spiritual care.

Summary of Reflecting on Spiritual Care

By examining spiritual care and how it can be applied in a pediatric setting, this project sought to focus on the clientele who receive care, mainly children and their family members. Theological reflection inspired ideas that helped to develop a structure for the delivery of spiritual care in a pediatric setting. The theological model was rooted in the examination of Jesus’ ministry with children. Just as Jesus taught his disciples to learn

from him and then to go out and serve others, my theological reflection has inspired me to utilize a similar method of developing others, training them to provide spiritual care.

The use of volunteers at Children's Hospital is not new because volunteers already provide care at the hospital, but the need to increase coverage became a driving force. Theologically it is rooted in the words of Jesus' to go and make disciples, to equip others for ministry. The model for servant leadership is how I sought to carry out the command to go and make disciples. The method of making disciples comes from the principles of servant leadership which originated with the ministry of Jesus Christ.

This project strived to remain true to the philosophy of servant leadership as a model for ministry. The goal was to transform spiritual care volunteers into servant leaders who can impact the culture of the hospital. At the end of this project, Children's Hospital—New Orleans now has a training model program for providing spiritual care. The servant leadership model utilizing volunteer chaplains provided much needed support to the mission of the hospital to care for children as our own. Those involved with spiritual care have become extra "hands and hearts" extending the ministry to promote total healing of those under our care.

CHAPTER 3

LITERATURE RELATED TO PEDIATRIC CHAPLAINCY, SPIRITUAL CARE MODELS, SPIRITUAL ASSESSMENT, AND UTILIZING VOLUNTEERS

Reviewing the literature regarding pediatric chaplaincy, there is not a very deep well from which to draw. There is not a large volume of published information about spiritual care models for children, and there is an even smaller amount of literature concerning specific, definitive, formalized pastoral care models for children. As a result of the limited amount of literature specifically related to the spirituality of children and providing pastoral care, material from the fields of psychology and education was also reviewed.

The scope of literature reviewed was related to the topics of spiritual care of children, spiritual development of children, spiritual care models, spiritual assessments, and the utilization of volunteers. Literature reviewed included books, periodicals, articles, and other information pertaining to the spiritual lives of children and the utilization of volunteers. Some of the literature reviewed is older than 10 years but remains relevant. The review of literature of each subsection is not exhaustive but provides a frame of reference by which to direct this project.

The works reviewed are divided into the following categories:

1. Spiritual Care of Children
    a. Spiritual Development of Children

b. Pediatric Chaplaincy

b. Spiritual Care Models

c. Spiritual Assessment

2. Utilizing Volunteers

a. Recruiting Volunteers

b. Preparing Volunteers to Provide Spiritual Care

c. Training and Retaining Volunteers

Spiritual Care of Children

Hospitals are places where the environment can be quite stressful, from sick children who are crying incessantly, to families in crisis, to staff members who are undergoing the challenges of increasing productivity with decreased staffing. In a national survey on the spiritual needs of hospitalized children and their families, pastoral care providers indicated that the spiritual care needs of hospitalized children and their families are diverse and extensive (Feudtner et al., 2003). Pastoral care providers cited system-wide barriers as limiting the quality of spiritual care. Yet they see hope, and they believe improvements can be made with dedicated effort.

When a child is hospitalized, it can be a traumatic experience for the child and for their parents as well. People of all ages in the hospital setting have stated that they feel vulnerable, afraid, and under great stress. Hospitalization can be overwhelming for an adult. So imagine how the hospital experience must be for a child who has less life experience and limited coping skills to drawn upon at a time when they are experiencing pain and are very vulnerable. Any person can feel vulnerable when they are sick and in

the hospital. The fact that they have been admitted to the hospital indicates that they are in a vulnerable situation that warrants medical attention and medical care.

Nevertheless, the spiritual care needs of hospitalized children and their families and the nature of the pastoral care that they receive have thus far generally been important yet neglected topics. The literature on the spiritual care of the sick consists mostly of case studies, reviews of theories regarding spiritual development, suggested methods, and editorial opinion (Feudtner et al., 2003). What has been lacking is a more useful approach suggesting how to address the spiritual needs of hospitalized children. What patients and families have expressed is the need for and desire to have spiritual support when in the hospital (Fitchett et al., 2000; Handzo & Koenig, 2004). In surveys, people have stated that spirituality is important to them and an integral part of the healing process. They have expressed that it is valuable and important to their well-being.

Spiritual Development of Children

A clear understanding of the stages of child development is necessary for pediatric spiritual care providers. There are definite stages of human development. Freud (2010), Piaget (1997), Erikson (1968, 2010), Fowler (1995), and others speak specifically to the development of children into adulthood. To ignore child development would be a grave mistake. As a pediatric hospital chaplain, knowledge of the spiritual development of children is vital to providing spiritual care to children and their families. The work of the pediatric chaplain involves an understanding of the world of children. Child development and spiritual development are related; however most of the literature focuses mainly on child development. There are however, a few sources that help inform pediatric spiritual care providers.

The Children's National Medical Center (n.d.) has descriptions of spiritual development in children. Their website document, *Faith and Spiritual Development in Children Ages Birth to Preschool*, states that the concept of "Awe" is the primary response of children in this stage of development as there are so many new things to learn about and explore. It is the beginning of a relationship with someone greater than themselves. They must put trust in parents to care for their needs. They also learn to trust in a world greater than themselves and to recognize the involvement of a higher power.

David Hay and Rebecca Nye (2006) offer other aspects of looking at faith and spiritual development in children. They call it geography of the spirit. They suggest a model utilizing the terms such as: Awareness sensing: Here-and-now, Tuning, Flow, Focusing; Mystery sensing: Wonder and awe, Imagination; and Value sensing: Delight and despair, Ultimate goodness, and Meaning. Nye (2009), says when spirituality is given the attention it deserves, we can make a vital and positive contribution to the lives of children. She expresses the importance of nurturing the spirituality of children; by neglecting its importance we run the risk of damaging their spiritual lives. We may not know the extent of the damage done nor the degree of its permanence. Pastoral and spiritual care interventions are necessary to treat and provide well- rounded care to children (Grossoehme, 2008).

Pediatric Chaplaincy

Pediatric chaplaincy is a form of specialized spiritual care (Nye, 2009). The work of the pediatric chaplain requires specialized skills and specialized training because of the unique stages where children are in their spiritual development (Koenig & Freisen, 2000). It is also challenging to provide spiritual care to children because they have different

ways of communicating and interacting. These are all reasons why knowledge of child development is important for pediatric spiritual care providers.

The literature describes how children think. A child believes that everyone sees the world just as he/she does. They are egocentric; they see things according to their view of the world around them. Sommer (2012) says children believe they are the center of the universe. They believe in the power of their own magical thinking. Children think that their thoughts and actions cause things to happen. As a result, they develop feelings of guilt and view God as the cause of suffering because of their actions, either something they did or did not do. It is very simplified; if they become sick, they often believe the illness must be a punishment from God for being bad. If a family member becomes sick, it was because of the power of their thinking (Singer & Revenson, 1996; Sommer, 2014).

Development is the outcome of transactions between the child and his or her environment (Davies, 2011). As children age and move into new developmental stages they experience changes in orientation of relationships. If they are given proper guidance and provided with good behavioral models from others, they learn good behaviors and how to relate to others. Some children witness immature behavior modeled before them and they imitate it. Children learn by what is modeled before them (Grossoehme. 1999).

Child development literature provides descriptions of the stages of faith of children, and how they respond differently based on age and developmental level (Erikson, 1950/1993; Singer & Revenson, 1996). Every child has a “spiritual life that grows, changes, and responds constantly to other lives that, in their sum, make up the individual we call by a name and know by a story that is all his, all hers” (Coles, 1990, p. 308). The pastoral care giver is a representative of God and a representative of the love of

God; the chaplain can help to promote peace and safety in the life of a child (Erickson, 1963; Fowler, 1987).

In social referencing, toddlers assess the safety of a new situation or person by paying attention to their parent's affective cues (Davies, 2011). Children watch their parents to assess if hospital staff members are "safe" people to allow close to them. In the hospital this is challenging because children are often traumatized by simple medical procedures such as the taking of vital signs or more invasive procedures involving needle sticks, such as IVs being started or blood being drawn. Children may also be overwhelmed by the activity of various medical personnel entering and exiting the room.

The trauma that a child may experience during hospitalization can lead to greater mistrust and the child may become highly sensitive to violations of their personal space (Grossoehme, 1999). When working with children, chaplains enter their world, and must respect who they are and how they function in order to provide quality spiritual care. Chaplains come in as strangers and consider it a victory to establish any form of trust with a child. A chaplain must develop trust with the child in order to have an effective relationship.

One major theme of spiritual care with children is the isolating nature of illness. A chaplain can help break through the isolation that children experience in the hospital by providing a ministry of presence. Children are naturally inquisitive and learn from their experiences and observations of the world around them. As they develop new skills, they learn how to connect and communicate their needs. Most children use different words to express their emotions. At the same time, spiritual development also takes place. Spiritual

care is best provided by connecting with children and discovering their needs along with them. The care plan is then tailored to meet those spiritual needs.

An understanding of human development provides an awareness that children learn and acquire new skills as they grow and mature. This is why newborns are not treated the same way toddlers are treated. Toddlers are not treated with the same methods as school-aged children, and we should not treat elementary school children the same way we treat teenagers. It may seem obvious, but they all are different emotionally, intellectually, and have different needs. The chaplain must thus provide spiritual care that meets their age-appropriate needs (Grossoehme, 1999).

The pediatric spiritual care provider must work at building relationships quickly with youth at varying ages and stages of development. The relationship of the chaplain with the family may also be a means of enhancing the quality of the relationship with the child at any developmental stage. The chaplain has a role in supporting children and their families during this time of development. Studies have shown that families express greater satisfaction with care when they actively participate in the care of their child (Arnold, 1985; Carey, 1985; Fitchett et al., 2000).

The literature on providing care to adolescents substantiates a need for a different method of care. The primary developmental task of teenagers is to form their own identities (Grossoehme, 1999, 2008; Hadley, 2007; Lester, 1995). They are seeking independence from parents, but when illness, especially serious illness comes into play, they are impacted and can even regress when seeking support from their parents; their independence can be delayed as they must rely on parents during the illness.

The chaplain, as spiritual care provider and servant leader, is uniquely positioned

to support the adolescent and the parent as they seek to integrate their experiences into their spiritual lives.

> Quality Pastoral Care of children and youth means building a relationship with them not because there is a need but because the pastoral person regards them as equal members of the congregation with intrinsic worth because they are God's children. Seeing children and youth as a gift to be enjoyed and celebrated can be a source of motivation for building relationships with God's children just for the sake of having them. (Grossoehme, 1999, p. 25)

Several authors have defined pastoral/spiritual care in terms that help shape an understanding of how spiritual care is useful in pediatric settings. Fowler (1987) provides a broad definition of pastoral care, defining it as, "all the ways a community of faith, under pastoral leadership, intentionally sponsors the awakening, shaping, rectifying, healing, and ongoing growth in vocation of Christian persons and community, under the presence and power of the in breaking kingdom of God" (p. 21).

Grossoehme (1999) defines pastoral care as being oriented toward relationships.

> Pastoral care is the formation of relationships with persons of all ages that communicate (both with and without words) and bask in knowing one's self to be a child of God, so that all persons are enabled to live through their life experiences and to understand them in terms of their faith. (p. 5)

Lawrence Holst (1985b) states all pastoral care has a basic primary, definable fundamental role. He defines the role of pastoral care as "the attempt to help others, through words, acts, and relationships, to experience as fully as possible, the reality of God's presence and love in their lives" (p. 46). All of the definitions offered, point to the relational aspect of chaplaincy which is essential to the provision of spiritual care in the pediatric setting.

The scope of service of a hospital chaplain can also vary by institution, depending on the number of chaplains staffing the institution and what services the institution desires for them to provide. An article by Handzo, Flannelly et al. (2008) describes the

scope of service and what pediatric chaplains contribute to the hospitals they serve. In it the authors seem to suggest that the value and impact of chaplains is underestimated in many cases. Arnold (1985) states,

> Barbara Sourkes lists four areas of intervention helpful to families with a child undergoing treatment for cancer. I believe they are equally applicable for all chronic life-threatening illnesses in children. They are:
>
> 1. Facilitation of Communications
>
> Helping individuals convert the 'implicit' to the 'explicit,' allowing for clearer communication of feelings and needs.
>
> 2. Ongoing Availability
>
> Availability is not calculable; it cannot be accessed through numbers of hours spent . . . rather, availability is a subjective construct whose meaning derives from a recognized mutuality . . . an abiding trust.
>
> 3. Giving Permission
>
> To express ambivalent feelings, a respect for the individual 'pacing' or allowing people into family space when they are ready.
>
> 4. Modeling of Skills for the Parent
>
> Care-giving and coping skills or helping parents to be the kind of parents to their child they want and need to be. (Sourkes, 1977, as cited by Arnold, 1985, pp. 102-103)

The dialogue of healing is a covenant or a commitment one to the other. With support, most families do survive the crisis, forever changed but together (Holst, 1985c).

Operating along these four basic areas is the bulk of daily ministry in the pediatric hospital. All of these skills involve forming relationships. All of these skills involve work with families as a unit. Spiritual care (and the ministry a chaplain provides) are based on relationships with a family unit (Purvis-Smith, 1996). However, some families are dysfunctional; they actually become obstacles, hindering our walk with their child. As the child is our primary ministry focus, in order to have access to the child, we must sometimes navigate the obstacle course of a dysfunctional family.

It is important to remember to approach a child with the child's perspective in mind. During early stages of development, children believe that the world revolves around them, not because they are selfish by nature, but because they are at a stage of

development when they are learning more about the world in which they live. Children filter information through their past experiences. They learn that some things are not to be used for the purpose they perceive, but this concept is learned as the child has more life experiences (Singer & Revenson, 1996). The pastoral care giver thus teaches the child what a pastoral relationship means by modeling one (Grossoehme, 1999). The pastoral care giver, by his or her interactions with the child, provides a resource for the child, encouraging them to utilize a vocabulary to talk about God and becomes someone with whom to do that. All of this must be accomplished through a relationship with the child. The key is to develop some sort of connection with the child according to their developmental level and understanding.

Pastoral care of children in crisis involves the ability to remain a non-anxious presence. What may not seem major for an adult can be quite serious for a child (Hadley, 2007; Lester, 1985). Listening to children involves patience and skill. One must be able to encourage the child to talk but also avoid prompting the child to talk about our personal agendas instead of their own. The challenge is to maintain the delicate balance while providing good care. A chaplain has a role of helping children articulate their questions, express their emotions, search for creative answers, and connect with the community in meaningful ways. Also, a chaplain may have a role of helping family members to say good-bye to a dying patient if and when it is necessary (Handzo & Koenig, 2004; Ryan, 1983).

One spiritual care provider describes the actions one should take in the spiritual care of children in the hospital. James-Tannariello (2013) states the most beneficial action is to radiate love by:

1. Offering your full attention—a listening presence-without judgment
2. Showing sensitivity and acceptance
3. Exude care and compassion; empathy
4. Pray when appropriate
5. Read or quote scripture
6. Leave them an inspirational book.

James-Tannariello (2013) provides a good description of what a hospital visit should be like. “The most powerful medicine is to be present and focused as if no one else existed in the world at that moment. Your time with the patient should be brief but profound” (p. 37).

Often the first crisis a child may face is illness and hospitalization. Their reaction is influenced by developmental age, previous experience with illness and separation, acquired coping skills, the seriousness of the diagnosis and the support system available to them. The challenges of ministry to children involve the work of a team; not only for the child but for the parents as well (James-Tannariello, 2013).

Spiritual Care Models

One of the challenges of this project was to find spiritual care models designed to meet the spiritual needs of children. Work has been done in the field of child development theory, but I found no research offering a spiritual care model geared specifically to a pediatric population. Much of the work of pediatric chaplains incorporates child development theories. Nevertheless, a spiritual care model is necessary to provide guidance to meet the spiritual needs of the institution and to equip and empower people to provide relevant ministry in the hospital (Feudtner et al., 2003). The

special issues of children: emotional issues, fear, abandonment, loss of control, all need to be addressed in spiritual care. Spiritual care is the way chaplains provide support to patients and families who come into the hospital.

Nye (2009) offers a model focused on relational work. She argues that spiritual care can offer tools for working with young children. For example, work with toddlers may include presence, ritual, imagination, and reframing. These tools also work with adults. Berryman (1983, 2002, 2009), Byrne (2008), and Koenig and Freisen (2000) seem to suggest ministry of presence as the method of providing spiritual care with children. Another way of assisting is to encourage familiar adults who have a bond with the child to remain present with the child. Godly play is valuable in ministry with children. For a 12-month-old child and above, we can offer comfort and reassurance. Spiritual care providers can engage in activities like playing patty-cake and clapping our hands or playing peek-a-boo. This may not seem very spiritual, but it is a means of building a relationship and trust with children. In relating to children, chaplains must use simple, soothing words and tone of voice.

Spiritual Assessment

Screening for spiritual risk and spiritual assessments are the basis of the spiritual care plan. Screening for spiritual risk is designed to help chaplains efficiently find the patients most in need of spiritual care (Fitchett, 1999a). Spiritual assessments should be distinguished from spiritual screens. Spiritual screens can be conducted quickly, with just a few simple questions and can be completed in five minutes or less. They are designed to identify patients who may have spiritual risk (Dameron, 2005; Fitchett, 1999a). Spiritual assessments are more in depth than spiritual screens. A spiritual assessment is

designed to determine whether or not a patient has spiritual risk and to provide information needed to shape the spiritual care plan to address spiritual risk (Fitchett, 1999a, 1999b). All patients should be spiritually screened but not all may need spiritual assessment. The key is to have a means of evaluating and pinpointing the patients who are at spiritual risk and then having ways to address those needs.

The screening process should originate during the admissions process (Fitchett, 1999a, 1999b). Nursing staff, social workers and volunteer chaplains providing spiritual care may also do some initial screening of patients. If screening indicates a need for greater spiritual intervention, a referral to pastoral staff should be generated. Volunteer clergy and lay persons may have some knowledge of doing spiritual assessments, but do not perform assessments that go into the patient medical record. Volunteer chaplains and nursing staff may perform some spiritual screening. These screens can be evaluated and used as referrals to staff chaplains who will provide the professional assessment. Spiritual assessment should be performed primarily by professional chaplains who are trained to do assessments. However, some hospitals ask other staff to perform initial assessments. Several tools have been developed that can be used both by professional chaplains and by other well-trained pediatric staff.

The spiritual assessment of children is challenging. A spiritual assessment should include the following: determination of spiritual needs and resources, evaluation of the impact of beliefs on medical outcomes and decisions, discovery of barriers to using spiritual resources and encouragement of healthy spiritual practices (Anandarajah & Hight, 2001). One must have an understanding of child development and possess skills in relating to pediatric patients. Fitchett (1999a, 1999b) offers spiritual assessment tools that

can help one to do assessments but they are not quite geared toward children. Grossoehme (2008) developed tools to assess teenagers who have undergone psychiatric hospitalizations, but his material can also apply to other children.

There are a number of assessment models utilizing acronyms such as SPIRIT, FICA, HOPE, the 7x7 model, and FACT: A Spiritual History Tool (professionalchaplains .org, Association of Professional Chaplains website). In each model a letter stands for a portion of the assessment. Each of these models was developed as a way to assess the spiritual needs of adult patients. As I examined them, I began to think of what an assessment tool for children might look like. One useful tool was developed in 1996 by Dr. Todd Maugans. He developed the SPIRITual History Tool, and assigned the following meaning to the letters in the following acronym:

S—the spiritual belief system

P—personal spirituality

I—integration/involvement in a spiritual community

R—ritualized practices and restrictions

I—implications of care

T—terminal events planning (advanced directives)

In the FICA model developed by Christina Puchalski (1996), the letters stand for:

F—faith and beliefs

I—importance and influence

C—community

A—address—how would the patient like issues to be addressed

In the HOPE tool developed by two physicians, Gowri Anandarajah and Ellen Hight (2009), the letters represent:

H—sources of hope, strength, comfort, meaning, peace, love, and connection

O—role of organized religion for the patient

P—personal spirituality and practices

E—effects on medical care and end-of-life decisions

The 7X7 Model for Spiritual Assessment (Fitchett, 1993) has 7 holistic dimensions and 7 areas in the spiritual dimension. The 7 medical dimensions are:

1. Medical
2. Psychological
3. Psychosocial
4. Family systems
5. Ethnic and cultural
6. Societal issues
7. Spiritual dimension which has 7 components:
    a. beliefs and meaning
    b. vocation and consequences
    c. experience and emotion
    d. courage and growth
    e. ritual and practice
    f. community
    g. authority and guidance

FACT was developed by Mark LaRocca-Pitts (2007). In the FACT Spiritual History Tool, the letters stand for:

F—Faith or beliefs

A—Active, available, accessible, applicable

C—Coping, comfort, conflicts or concerns

T—Treatment plan

These acronyms are easy for nursing staff to remember and provide chaplains with information to do further assessments as needed (Dameron, 2005; Robinson, 2012). These acronyms are tools designed to help assessments to be made easier. In hospitals where nursing staff are asked to do any form of assessment, unless it is quick and easy, chaplains will not have their support (Fitchett, 1999a, 1999b). Nursing staff do not feel comfortable performing assessments but in the absence of trained chaplains they must at times assume this role. Chaplains sometimes receive referrals from nursing staff who perform preliminary spiritual screenings. Professional chaplains can gain valuable insight from spiritual screens that allow them to triage cases and determine where the greatest spiritual needs are and thus provide follow-up care where it is most needed.

When it comes to assessing children, there is not an abundance of material describing spiritual screening tools. In my research, I found no specific model designed for use with pediatric patients. An assessment tool focused on pediatric patients will differ from the models listed. Performing assessment of children can be difficult because the existing models are geared toward adults and have merely been adapted for use with children. Spiritual care as a whole would benefit from a pediatric specific assessment model that could be used as a guide in providing pediatric spiritual care. There is a need

for a pediatric assessment model that can focus on the specific spiritual care needs of the young. By performing a spiritual assessment, chaplains can help clarify real issues and then develop a care plan to meet those needs. The spiritual care model proposed for this project is a mixture of some of the tools and principles presented. The model utilizes embodied servant leadership along with input from spiritual care volunteers as the primary method of providing care. These volunteers do not perform formal assessments but bring back information that can be used by the staff chaplain for more efficient delivery of spiritual care.

Utilizing Volunteers

Children's Hospital—New Orleans has a strong volunteer program. There are a variety of people who volunteer at the hospital, who carry out many tasks. Yet when it comes to spiritual care providers who volunteer, the number of participants is very small. There is a shift in volunteering in this country. Even medical establishments are utilizing volunteers to provide assistance (Hotchkiss, 2007). The literature reviewed indicates a need to train volunteers for the work to be done in the hospital (Connors, 2011).

Spiritual care volunteers are a gift to the institution; they provide needed support in areas, multiplying and extending the reach of the staff chaplain. In essence, training volunteers is a way the staff chaplain can "duplicate" himself or herself in order to extend care to those who may otherwise not receive spiritual care on a consistent basis.

Preparing Volunteers to Provide Spiritual Care

The literature on volunteering indicates that those who volunteer must be properly prepared for the work they will assume. Safrit, Schmiesing, Gliem, and Gliem (2005)

describe the PEP model of volunteer administration: (personal) preparation, (volunteer) engagement, and (program) perpetuation. These areas should be monitored by the leader on an ongoing basis, making adjustments as necessary when leading a volunteer group (Connors, 2011). Volunteers should be given the same customer service training as staff members (Handy & Srinivasan, 2004; Hotchkiss, 2007). Volunteers should be given a hospital orientation and health screening. The HealthCare Chaplaincy Network (n.d.) based in New York City has a manual for training volunteer chaplains, which benefited the scope of this project.

Recruiting Volunteers

Volunteers usually have some intrinsic motivation to volunteer, especially in hospitals (Connors, 2011). They are often professionals who believe that the professional skills that they bring are needed, the skills they possess are valuable, and they do not believe in wasting time or talent. Although many people are secular in their orientation, they understand the biblical principle of good stewardship and see the under-utilization of their talents as poor stewardship. They want to contribute and make a difference.

The term *volunteer* in itself is loaded with undercurrents of meaning. When people hear *volunteer*, they do not think of a highly skilled person handling a job (Connors, 2011). They think of merely an extra set of hands and they think of physical labor. In the hospital, many volunteers answer phones and run errands, but spiritual care volunteers will not be used primarily in this fashion. Spiritual care volunteers provide actual spiritual care. The word volunteer comes from Latin "*voluntas*" meaning "free will" or "deliberate choice." A volunteer makes a deliberate choice to participate.

Volunteers themselves are the best recruiting tool for more volunteers. When

volunteers have a rich experience, they tell others and encourage them to become part of the volunteer pool. Much like other areas of life, word of mouth is the best advertisement (Connors, 2011).

Training and Retaining Volunteers

The 21st century volunteer does not have the same mindset as those who have volunteered years ago. They are similar in that they want to contribute their time and skills, but modern volunteers want something more (McKee & McKee, 2008). The new breed of volunteer in the 21st century is not motivated by sheer altruism; they want to see change, they want things to improve, and they want to have an impact.

Volunteers are special. They do not come seeking the work for a financial gain, but they do seek a reward of some type. Volunteers must feel they are contributing to something otherwise they will give up and leave the work. They must feel value and reward for what they are doing (Connors, 2011).

For many, the reward is in helping others. Spiritual care is of interest to people who want to contribute to the good of humanity. For spiritual care providers it is "ministry." For many it is a calling. In fact, when it comes to spiritual care of children, success will not come to those who are not called. Many people are volunteering but many, especially young people do have greater expectations these days. The numbers of young people volunteering are not as large percentage-wise as those over age fifty, but young people are involved in "causes" they view as important (Connors, 2011).

Volunteers do not operate independently in large organizations. They must have some leadership and direction. Retaining volunteers involves leadership. Leadership styles have adapted over the years; with the influence of Robert Greenleaf, the concept of

servant leadership was born. The style of leadership best suited to leading volunteers is servant leadership (Kouzes & Posner, 2012).

Robert Greenleaf (1996) was the originator of the term servant leader and his work has spawned a shift in leadership style. He succinctly defined leadership as:

> A new kind of leadership model-a model which puts serving others as the number one priority: servant leadership emphasizes increased service to others; a holistic approach to work; promoting a sense of community; and the sharing of power in decision making. (p. 33)

The work of volunteer chaplains is very different from that of most hospital volunteers. At times chaplains provide spiritual care to seriously ill children and their families. It may involve grief care or trauma care. The spiritual care provider comes in at a time when families are at their most vulnerable moments. When death is imminent, especially in the case of a child, anyone can feel uncomfortable; even experiencing anxiety. This presents a challenge in maintaining spiritual care volunteers. This type of care is just not what most people seek to be involved in. When the subject of pain and suffering and children become real, most people become uncomfortable and wish to back out (Sommer, 2012).

Dane Sommer describes four topics: children and suffering, theodicy, faith, and the suffering of chaplains. The work of a pediatric chaplain involves wrestling with these topics at some point.

> Anyone who works with extremely ill children is forced to observe and participate in human suffering. One cannot be close—in the room—when death is near and not feel all the elements of suffering. It is different with adults. We accept that death comes to adults and we recognize that life has its limits; we hold end-of-life conversations when we speak of adults. But it is not so with children. No one can stand idly by and just watch as a child suffers. Everyone is drawn into the pain and sorrow of the moment. Everyone is affected, touched, influenced by the sadness and sorrow that occur when a child is in pain or is afraid of what is happening. (Sommer, 2012, p. 259)

It takes a special person to provide spiritual care to children and their families. Chaplains are spiritual leaders. Leaders also have individual leadership styles. Maxwell (2011) states, “Leadership is influence,” and others agree with this succinct definition. Leadership is influence. All good leadership is based on relationships. The key to developing chemistry with our leaders is to develop relationships with them. It is the job of the leader to connect with the people they lead. Good chemistry with hospital administrators allows a chaplain to develop relationships with them and staff in other areas of the hospital. Leadership must also be a means of developing relationships with volunteers, especially those providing spiritual care. The literature says 360-degree leaders must take it upon themselves to connect not only with the people they lead, but also, the person who leads the leader, in this case administrators and direct supervisors.

The literature also suggests that there is a shift in how volunteers are viewed and utilized in organizations.

> Leaders of organizations engaging volunteers to help deliver human services and thus support the organization’s mission should have an expansive conceptualization of volunteering. They need to understand the complex interactions between the needs and goals of the organization (or the cause it serves) and the expectations and concerns of those delivering services “of their own free will”—volunteers. (Connors, 2011, p. 25).

Many people who volunteer want to use their expertise to help organizations. In the field of chaplaincy, the people who are inclined to volunteer are those who are moved by their faith and view chaplaincy as a valid way of expressing their faith. The challenge for leaders is to help them understand that chaplaincy is not about evangelizing or proselytizing as churches may do. The task today is to teach and train people to provide good pastoral care which is people-centered, not a church’s mission agenda.

Summary and Implications of the Literature Review

This chapter is not an exhaustive review of this field of study. It reflects a cross-section of works related to the topic. I crafted a model based on sound principles of spiritual care and principles of servant leadership. I read from various sources about the topic of servant leadership. Yet much of the literature seemed to be oriented toward the business world. Most people who volunteer as chaplains view it as ministry, not business. So I looked for material related to spiritual care and volunteering. My search was not exhaustive but I had difficulty finding material related to pediatric spiritual care and volunteering. To me this was an indication of the need for more work to be done in this area. It is my hope that this project could be a start of something new or an area of new emphasis in the field of spiritual care.

I also examined literature related to volunteering and the care of children. I sought some literature that I could use to guide the training of volunteers to provide spiritual care in a pediatric setting. According to studies, families have expressed the desire to receive spiritual care during their hospitalization. In pediatric setting, an understanding of the spiritual lives of children is paramount to the accomplishment of the task. Thus, literature related to child development and spiritual development was vital to the training manual development.

The review of literature inspired me to develop a training program using theological principles based on Christ's method of ministry. Jesus Christ is the ultimate example of servant leadership. Servant leadership is best expressed through the provision of compassionate care to others. In the review of literature, I sought ways to share with others the principles of servant leadership. The training program I developed was based

on Christ-centered principles of compassionate service to others. Seventh-day Adventist theological teaching is demonstrated in service to others. The goal in creating a training program was to assist in the provision of compassionate spiritual care to children and their families.

Seventh-day Adventists have utilized literature as a method of sharing the gospel since the church began. It was only natural to create something literature based to share with others. I was drawn to John Chapter 13 where Jesus washed his disciples' feet. This is how I think theologically about how to provide servant leadership and will teach it by example. I designed the training modules with servant leadership and the ministry of compassion as guiding principles.

CHAPTER 4

DESCRIPTION OF THE SPIRITUAL CARE VOLUNTEER TRAINING INTERVENTION

As an institution, we seek to provide the best possible care for our patients. There is a need for more professionally trained chaplains with pediatric expertise at Children's Hospital to provide the best care possible, but due to a lack of resources, the focus of this project became the development of a program to train and increase the number of pediatric spiritual care volunteers. By increasing the number of trained pediatric spiritual care volunteers, services can be expanded thus enabling patients and families to receive the best care possible. The intervention described in this chapter was an attempt to train volunteers to provide pediatric spiritual care and thus extend the scope of spiritual services to the children and families who receive treatment at Children's Hospital—New Orleans. As noted earlier, Children's Hospital is severely understaffed in terms of the number of trained spiritual care providers who provide care within the hospital.

The project is rooted in the values of servant leadership and sought to instill those values by offering a new model for pediatric chaplains, the P.R.E.S.E.N.C.E Model. This model is primarily focused on the specialized pediatric environment of this institution.

The chapter is broken down into sections. The areas of focus are: (a) the need to develop a pediatric spiritual care training intervention, (b) the development of a pediatric spiritual care model, and (c) the development of a curriculum used to teach pediatric

spiritual care, including how to support the family.

The Need to Develop a Pediatric Spiritual Care Training Intervention

Professional pediatric medical health care providers are required to engage in specialized training before they can be certified to provide care in pediatrics. Spiritual care providers are also involved in caring for a specialized population, so it makes sense for them to also receive specialized training because of the population being served. Children have special needs that are best met by persons with knowledge and understanding of child development and their age-related specific needs. We need more people willing to serve equipped with the training to provide pediatric spiritual care.

Children's Hospital is a challenging place to recruit volunteers because so many people are not comfortable serving in a children's hospital. It is difficult to see children and families in crisis; it tugs at the hearts and vulnerabilities of even the most seasoned care givers. The world of pediatrics is very different from other medical institutions. Many of the patients are very small, very young, and vulnerable and they are limited by their communication skills and their ability to understand.

I have the ability to teach volunteers skills necessary to provide pediatric spiritual care. The challenge was in recruiting and retaining volunteers. Many people who provide spiritual care in hospitals want training (Raab, 2005). Volunteers often express their dissatisfaction due to a lack of preparation to deal with people in crisis. Volunteers extend the reach of the staff chaplain. Our current volunteers are dedicated to the patient population and enjoy providing spiritual care. However, they function out of their own theological background and possess limited skills. Additional training better equipped them to provide effective spiritual care. The spiritual care training intervention is the

method selected to further develop the work going on at Children's Hospital as a means of providing a broader spectrum of care. One of the goals of this project was to develop a core of trained spiritual care volunteers with the ability to provide care in a pediatric setting. The spiritual care volunteer training course was a method of accomplishing that goal.

The Needs of Children

Children in the hospital and their families want their spiritual care needs to be met but many are not sure how to have their needs met. This uncertainty is exacerbated by the predominant emotion experienced by children and their families in the hospital; fear.

If adults are afraid of becoming hospital patients, just imagine the thoughts going through the minds of children who enter the hospital. Fear is the greatest concern of many hospitalized children. They are removed from their familiar environment with the safety and security of their parents, and strangers come in and poke and prod them—all without their permission. The provision of spiritual care best utilizes empathetic listening, prayer with children and their families, appropriate touch and other non-verbal communication, and conducting religious rites on behalf of the family (Feudtner et al., 2003). As these pastoral interventions are offered, the child's developmental stage must of course be considered in order to be effective.

Children Hospitalized for Illness or Trauma

One of the most upsetting and uncomfortable experiences in life for human beings is witnessing the frailty of children. Within most of us is the natural tendency to protect and care for children. It makes us uncomfortable to witness the suffering of children. It is a reminder of our own mortality. Many years ago, there were no hospitals for children,

merely orphan asylums where children were placed if no one else was willing or able to care for them. No hospitals or safe places specifically created for the care of sick children existed, so people would keep the child at home until death. Yet many times, due to the shame and stigma of a sick child, people would abandon the child and allow him or her to die. The first hospital specializing in children was founded in Paris in 1802 (Cone, 1981). If someone was compassionate, the child would receive something akin to our modern-day hospice care.

The origin of the hospital was a place to care for the terminally ill, those who had no hope of cure. The earliest faith-based hospitals were places of "care" rather than places of "cure." However, as society began to take on a more scientific approach to health and medicine, there seemed to be a shift in hospitals from places of care to places of cure (Richmond & Middleton, 1992). Nevertheless, many people still do not like hospitals because they see the suffering of others and are reminded of their own mortality.

The Spiritual Care of Children and Their Families

Much of the research I have uncovered in literature related to spirituality and children is fairly new. It is indeed an area with much work to be done. As one who has worked in chaplaincy for 16 years almost entirely in pediatrics, I have sought to gain insight into the spiritual nature of children. In the hospital where I provide spiritual care, children and their families are the very reason why we exist. Children's Hospital-New Orleans has a motto "caring for children as our own." We specialize in caring for children; it is in the DNA of our institution. As a pediatric chaplain, my focus is therefore specifically in providing care for the spiritual need of children and families.

Daniel Grossoehme (1999) suggests a framework for understanding and providing pastoral care to children that is rooted in being able to express thanksgiving for children. He contends that care of God’s youngest children is rooted in Jewish theology of Israel being God’s chosen children. Spiritual care of children is also rooted in Christian theology that celebrates a child in scripture. Annually every December, Christians celebrate the birth of a child who would become Savior of the world. Christians celebrate the gift of that Child and extend thanks to that Child by caring for the children around them daily. This is also motivation for the work of spiritual care in the hospital. We display the value of children by how we respond to them and treat them.

Although spiritual care often has a low priority in most hospital settings, as the primary orientation is toward the physical aspects of health, holistic care is nevertheless a basic element of healthcare practice (Chapman & Grossoehme, 2002). One main reason for this low priority is that the spiritual aspects of patients’ health can be confused with the patients’ religious preference. The patients’ religion is how they live out the rites and rituals of their faith. Spirituality goes deeper; it speaks to the questions of meaning: what gives the individual meaning and how the meaning affects how they live.

Current Staffing Situation

People look for spiritual support during times of crisis. In fact, many people express that spirituality and religion play a greater part in medical decision making than a doctor’s information. This cannot be ignored; patient satisfaction scores are higher where patients and their families feel spiritually supported (Fitchett et al., 2000).

The need for spiritual care exists (Fitchett et al., 2000); yet providing coverage

twenty-four hours a day, seven days a week, in a pediatric regional medical center is not realistic with only one staff chaplain and over 200 licensed beds. A chaplain may be needed any time of day, but the challenge is in providing coverage during every twenty-four-hour period. As staff chaplain, I have responded to "call outs" from home outside of regular work hours, sometimes in the early morning hours, or on weekends. This can be detrimental to the physical and mental health of the chaplain because there are no boundaries in that situation. Being on call almost twenty-four hours a day does not allow for downtime for the staff chaplain who can become overwhelmed by the demands of providing care. The spiritual care needs of children and their families cannot be adequately addressed without the utilization of multiple spiritual care providers.

Three volunteers also regularly provide pastoral care as volunteer chaplains; two are Catholic deacons and one is a non-denominational Christian. They spend a few hours each week visiting, but they come once a week primarily and are not present every day. As staff chaplain, I am unable to visit every patient that may need spiritual support. Each of the current volunteers has been volunteering several years now and they all have some experience dealing with crisis events. Although each of them has been at the hospital awhile, at times they still express feeling ill-equipped to deal with some situations, including the deaths of premature infants, sudden traumatic events, and non-accidental traumatic events.

The current spiritual care volunteers may feel ill-equipped in part because of a lack of theological grounding in the work they are doing. Groundedness, is very important to pastoral care. Being grounded in relationship to someone, and especially being bound to someone larger than one's own self, is the essence of religion

(Grossoehme, 1999). This understanding of a power greater than ourselves is what gives us the courage to provide ministry. A CPE supervisor once shared with a group of chaplains the concept of the "audacity of ministry," which he described as the incredible notion that we, as flawed human beings, could actually believe that we can be used by God to provide pastoral ministry to others. If called clergy persons have a sense of this, how do laypersons respond to the call especially when they do not function as clergy as their primary occupation?

Unique Challenges of Pediatric Chaplaincy

For most pediatric chaplains, our theological training and the desire to do good creates tension. This tension felt by the chaplain can be somewhat relieved when we stay rooted in our faith, remembering that God is present with us as we walk our life's journey (Sommer, 2014). As we provide pastoral interventions for children, our faith likewise calls us to remember that the role of a chaplain can be that of a prophetic voice speaking for God and declaring what is. Also, we are each called to be one who adds in giving voice to children who otherwise may have no say or may not be listened to concerning their personal choices (Sommer, 2014).

The concept of children and suffering is not a pleasant one for people to think about; however, at Children's Hospital, bearing witness to children suffering is a reality we encounter daily. Providing pastoral care to children and their families causes suffering for the caregiver as well. The belief that children are to be protected and it is our job to provide protection and at times we are unable to do so is a source of suffering for us. All too often I have heard parents say that they would wish to trade places with their children to alleviate their suffering. As Spiritual Care Providers, we also seek to alleviate

suffering. It is a spiritual value found in many faith-based communities. The problem of human suffering is universal but also intensified when children are involved. For most pediatric chaplains, our theological training and the desire to do good, creates tension. We struggle with the concept of suffering in our present world. To be successful in our work we must remember that God is present with us as we work and walk our life's journey (Sommer, 2014).

As we provide pastoral interventions for children, there are two things to keep in mind: the role of the chaplain can be that of a prophetic voice speaking for God and declaring what is. The other is to be one who adds in giving voice to children who otherwise may have no say or may not be listened to concerning their choices (Sommer, 2014).

The Need for a Pediatric Spiritual Care Model

As expressed earlier in this document, the need for increasing the number of spiritual care providers was apparent considering the needs of the institution. A cost-effective way to enhance spiritual care is through the use and development of volunteer spiritual care providers who extend the reach and presence of the staff chaplain. There was currently no model in place to provide care in this pediatric institution. The development of a pediatric spiritual care training model was an attempt to formulate a way of providing spiritual care with one staff chaplain and spiritual care volunteers.

Currently, there is no training model for the hospital. At one time, there was some Clinical Pastoral Education training, which ceased before I was hired over fifteen years ago. Since that time, there has been no move to increase the amount of coverage. The hospital has grown and the intensity of medical and clinical services has increased. Yet,

the spiritual care coverage, by the addition of professional chaplains, has not. The hospital is now the regional medical center for children serving a diverse population from all over the state of Louisiana and beyond.

To develop an appropriate pediatric spiritual care model, I researched what other institutions have done. Training lay caregivers in hospital ministry and visitation does not have just one model; there are many (Reimer & Wagner, 1988). The key is to provide a useful model that will work in the institution where spiritual care is to be offered. Much of the material for the developing model came from various sources. Derry James-Tannariello (2013), to whom I am indebted and also The Health Care Chaplaincy Network has published a *Chaplaincy Care Volunteer Training Manual*, which I drew from, can be used to train people to provide spiritual care.

In this project, I chose to design and develop a model specifically for Children's Hospital—New Orleans. To my knowledge, no published pediatric model existed at the time I began research on this project. This work is important because of the specialized needs of children in pediatric institutions. The needs of children are different, children need to feel secure, comforted, and supported. They are developing spiritually and need assistance when trying to express their spiritual condition and situation (Fowler, 1995).

I am introducing a pediatric spiritual care model which I call the P.R.E.S.E.N.C.E Model. This model is grounded in Embodiment Theology and this might also be called Ministry of PRESENCE as Embodiment Model. Embodiment theology grounds the P.R.E.S.E.N.C.E Model in its emphasis on relationships and connectedness. It reflects the belief in the presence of the holy in the midst of compassionate caring relationships. Embodiment is expressed through servant leadership of both professional chaplains, and

spiritual care volunteers. As the newly trained spiritual care volunteers offer ministry based on the P.R.E.S.E.N.C.E Model in the hospital, embodiment theology and servant leadership will be expressed in a pediatric setting in areas of the hospital as yet unreached by a professional chaplain.

One of the challenges of training volunteers to provide spiritual care in a pediatric setting is the realization that they may have no formal theological educational background. They may also have a limited understanding of pediatric patients and the environment of the pediatric hospital. I am aware that many volunteers are lay persons who have a heart to provide spiritual support to those in need. Pediatrics is a specialized medicine consisting of many subspecialties. Children's Hospital is a unique environment requiring "specialized" methods of providing spiritual care to children and families. Persons who volunteer to give their time and energy to the hospital are unique. I believe the P.R.E.S.E.N.C.E Model provides a method to train volunteers from various backgrounds to offer appropriate spiritual care to children and their families that is grounded in theological principles of servant leadership and embodiment. It provides a foundation for those who are interested in providing spiritual care for children with a method of how to do it.

I recognize that spirituality is an integral part of healthcare. In order to be treated holistically, spiritual care must be provided. It is an impossible job for one person to do; thus, trained volunteers can assist to extend the reach and presence of the chaplain. The ministry of presence is one of the greatest gifts we can offer during times of crisis and the use of multiple persons is necessary.

The Theological Basis for the P.R.E.S.E.N.C.E Pediatric Spiritual Care Model

The goal of this project was to develop a model that will work at Children's Hospital—New Orleans. The model is based on Jesus' call in Matthew 25 to care for others acknowledging their inherent worth and value, as well as a theology of servant leadership based on the actions of Jesus in John 13. These were my theological examples. When Jesus washed his disciples' feet, He served them and then instructed them to do this for others. He is our model of servant leadership and embodiment theology as a means of providing spiritual care.

Servant leadership is the ministry model I selected for developing a spiritual care program at Children's Hospital—New Orleans. Embodiment theology is how servant leadership is lived out by the servant leader. The activity of Jesus in John 13 has shaped my theology. My own theological underpinnings originate with His commands.

The commands to care for those in need are prominent in the teachings of Jesus. A spiritual care provider, in this case a chaplain, follows the ministry model of having ultimate concern for our fellow human beings no matter what their background. We do it simply because we see all as part of God's creation and members of the human family. We act as servant leaders by serving others and communicating the importance of the worth of every human being. Another theological motivation for this type of ministry comes from Matthew 25:34-36. In it the Lord is describing the judgment scene. He implores his followers to care for others, the "Least of these." According to Paget and McCormack (2006), Jesus encouraged people to care for the needs of others from various walks of life.

The purpose of any pastoral visit is to discern the need of the person being visited

and to respond appropriately to the need (Richmond & Middleton, 1992). Jesus taught His disciples about the work they were to undertake. In Matthew 25:36 NKJV Jesus said, "I was sick and you visited me." Jesus was reflecting the importance of caring for others. He gave a theological basis by his example of true servant leadership and with his embodiment, a basis for providing a ministry of presence in the hospital. To me these principles are universal they are not just confined to Christianity. Just about every major religion has as a part of its moral structure the care for those in need.

Description of the Intervention: A Spiritual Care Volunteer Training Manual

The intervention proposed in the chapter was an attempt to reflect the development and implementation of a training manual. This manual was used as a guide to train spiritual care volunteers to provide additional coverage in a hospital that has great needs. In my 15 years of work at Children's Hospital there had been an evolving need of a guide to provide a methodology of providing spiritual care. Examining the current literature, volunteer chaplains have been providing spiritual care thus extending the "reach" of staff chaplains in many places. Other training manuals do exist; however, the goal of this project was to develop one specific to this institution. The focus is on utilizing volunteers to broaden the scope of spiritual care services provided.

The HealthCare Chaplaincy Network recently developed the *Chaplaincy Care Volunteer Training Manual,* which was examined as a guide in the development of these training materials geared toward Children's Hospital. The training manual created by the Healthcare Chaplaincy Network did not exist when I began this project. I also gleaned ideas from Derry James-Tannariello (2013) who wrote a handbook for clergy and lay visitors concerning hospital visitation.

The training manual used in this project was developed by reviewing literature related to training volunteers and guide books on hospital visitation. The curriculum was developed and tailored to meet the needs of serving the population of Children's Hospital—New Orleans. Children's Hospital is undergoing some expansion. The additional growth also increases the demand for greater coverage by spiritual care. The growth of the institution makes it even more challenging for one chaplain to cover it all. Hence volunteers help to expand coverage in other areas of the hospital. The goal of this project was to develop a program that would be used to train more volunteers to provide spiritual care and use them to provide coverage to extend the reach of the staff chaplain.

The utilization of volunteers trained in providing spiritual care is an attempt to broaden coverage in the hospital. For example, the hospital has a very active two-floor emergency department. It has a busy flow of patients with over 100,000 patient visits per year; the staff chaplain is unable to cover all the units that may require a pastoral presence. Some visits to the emergency department are very benign minor bumps and scrapes but some visits are due to tragic events where death occurs.

The Context of the Training: Children's Hospital—New Orleans

The project involved training that is specific to the needs of Children's Hospital—New Orleans. Some of the training elements may possess universal appeal to others seeking to develop a training program for spiritual care volunteers in other institutions, but my focus was Children's Hospital. Pastoral care providers understand that the spiritual care needs of hospitalized children and their parents are diverse and extensive. With system-level barriers especially understaffing cited as limiting the quality of spiritual care, considerable improvement may be possible (Feudtner et al., 2003).

The Methodology

The development and usage of a training manual to guide the course was utilized in creating the curriculum for training volunteer spiritual care providers. The purpose of the manual is to provide an educational tool for developing competency in volunteers to provide spiritual care. The manual development is the author's focus for this project, but he acknowledges that there are other methods of training volunteers to do the work. This project is not an attempt to re-invent the wheel; again, the goal is to develop a model that is suited to support the work of providing spiritual care in Children's Hospital.

The Need for a Training Manual

There is a need to train others to provide spiritual care and there was a need to develop a training manual to guide their teaching. The purpose was to provide quality preparation and skill development to do the work of spiritual care. The training manual provides a concise methodology of providing spiritual care. It is the guide, the blueprint for providing spiritual care ministry in Children's Hospital in the present. Hopefully, it can and will be built upon in the future.

Research has shown that people really do want spiritual care. We live in a nation that is becoming increasingly secular but even those who are no longer connected to a particular church or denomination still desire spiritual connections especially during times of stress (Fitchett et al., 2000). According to Edward Wimberly (1991), the laity of the local church play a role in caring for the body of members. The hospital is an extension of the church or can be—as people spend time in it. At times the church has been referred to as "a hospital for sinners." If the church can be considered a hospital, then why not consider a hospital the church? Hospitals may not be formal congregations,

but they have people in them who need to be cared for in spiritual ways. People are seeking healing, both of body and soul. Who better than spiritually minded people to provide that care? In ministry to the dying and the bereaved, the task is to draw people into God's salvation drama of death and rebirth.

Every living person has had some type of difficulty or hardship in their lives that has left some scars. All pastors and believers are "wounded healers." God uses us in our "woundedness" to help others who are struggling or going through a crisis. As chaplains, we learn to provide care counseling support by being a witness for the person who is sharing their experiences with us (Dittes, 1999).

White (1942) emphasizes the importance of close personal touch in ministry. She said, "There is a need of coming close to the people by personal effort. If less time was given to sermonizing, and more time given to personal ministry, greater results would be seen" (pp. 143-144). She also emphasized the importance of Christ-like sympathy as being part of personal ministry. Providing spiritual care in the hospital is a very practical way of providing close personal ministry to those in need.

White (1925) describes the work of the chaplain as that of a medical missionary. She states, "Jesus devoted more time to healing maladies than preaching" (p. 132). I believe Jesus modeled excellent listening and counseling skills. And I seek to learn from His method caring for others. A passage I am familiar with from *Ministry of Healing,* White (1942) makes the point,

> Christ's method alone will give true success in reaching the people. The Savior mingled with men as one who desired their good. He showed sympathy for them, ministered to their needs, won their confidence. Then he bade them, 'Follow Me.' (p. 143)

Christ is our example, He went were the people were and ministered to them in

their condition. Chaplains go to the place where people are ill, in the hospitals.

Chaplaincy answers the call of the Great Commission and goes into serving others in sharing the love of Christ with the world. Chaplains minister in a place where they seek to serve the Lord and, also, remain faithful to the institution which they serve. White encourages people to visit the sick and suffering and show them kindness. She said, “If possible do something to make them more comfortable.” Most think of this as the physical part of medicine but chaplains working as spiritual care providers can do something to make them more comfortable. Spiritual care is a way of providing support to people who may have concerns about life, its meaning and their own significance. Job’s three friends went to him with the right thing in mind, to just be with him and to hopefully provide comfort. They got into trouble when they began talking, not in a truly pastoral sympathetic concern, but rather in an accusatory way. We should learn from this and not repeat the same mistakes.

Having encountered clergy persons in the hospital, some, who had more years of ministry experience than I have years of life, pulled me aside and confessed saying, “In all my years of ministry I have not had much experience in this area. I am glad you are here. I welcome your presence and I will follow your lead.” Children’s Hospital is “foreign territory” to many. It is not an easy place to provide ministry. It is uncomfortable for many people because deep within each of us is the instinct to protect a child. When a child is in danger—in this case facing the possibility of death, tension increases. The chaplain plays a role in reducing the tension for the family and staff.

The use of a training manual will also ensure that a template will be available for future training and a can be used as a means of building and maintaining the program of

training spiritual care volunteers in years to come. Spiritual care can be delivered in an organized manner that contributes to the greater good of the institution. The goal is to provide something tangible that can be a resource and to serve as a foundation on which others may expand and build upon.

The Development of a Curriculum for Pediatric Spiritual Care

The curriculum used for pediatric spiritual care grew from existing models geared to training volunteers and then further developed to serve the needs of Children's Hospital. For this particular curriculum the focus was on caring for pediatric patients and their families. The developed course material is in the *Spiritual Care Handbook: A Training Manual for Volunteers* (see Appendix B). The training manual is detailed and designed to be used by volunteers as a guide to providing spiritual care. Some of the material was delivered via PowerPoint presentations in the classroom setting.

The training manual contains 10 sections:

1. Introduction
2. Hospital History and Background
3. What Is Spiritual Care?
4. Communication and Listening Skills
5. Principles of Volunteer Ministry
6. Visitation Etiquette
7. Ministry to a Pediatric Population
8. Boundaries and Referrals
9. Death, Grief, and Loss
10. Self-Care

P.R.E.S.E.N.C.E Model Principles

These principles all relate the idea of ministry of presence. The goal is to offer ministry that is meaningful to the child and family members that helps them to connect to that which is holy in a meaningful way. The training topics listed above are evident within the P.R.E.S.E.N.C.E model principles listed below:

P—Pediatric Patient and Family Centered Care

R—Relationships (making connections with patients and their families)

E—Etiquette (for room visitation in a pediatric setting)

S—Sustaining (Support from Spiritual Care Representatives/Ambassadors)

E—Empathetic listening presence

N—Nurturing development of children and utilization of resources

C—Compassionate care and comfort (via connection)

E—Empowerment (in decision making-educate by using teachable moments).

The Training Sessions

In order to teach a course about providing spiritual care in a pediatric setting, I developed a curriculum of ten topics: Introduction; History; What Is Spiritual Care; Communication and Listening Skills; Principles of Volunteer Ministry; Visitation Etiquette; Ministry to a Pediatric Population; Boundaries and Referrals; Death, Grief, and Loss; and Self-care. Upon completion of each session participants were asked questions related to self-awareness, skills they learned, and their understanding of the mission and purpose of spiritual care in the institution.

The material used in the Volunteer training class is contained in the *Spiritual Care Handbook* (see Appendix B). It covers a multitude of information related to

spiritual care in Children's Hospital—New Orleans. Even after the course was completed, I was aware that this "first edition" would continue to expand and grow as new material is added. The manual is to act as a guide but does not contain every possible scenario or situation that may arise.

The course consisted of 12 hours of training, broken up into 4 different sessions of 3 hours each. My role was to teach others some basic skills to provide spiritual care in a pediatric setting. I am reminded of a statement, "The minister's identity can be integrated most effectively around his (or her) role as teacher" (Oates, 1964, p. 108). Teaching has also helped me over the years to develop a deeper spirituality and has enhanced my understanding of the topics that I teach.

Each person who desires to volunteer at Children's Hospital must go through a screening process. All Spiritual Care Volunteers must complete Children's Hospital volunteer application. It covers a background check and all the policies that anyone who desires to volunteer at Children's Hospital would be subject to.

Research Methodology and Protocol

The purpose of developing a spiritual care training program for volunteers was to have a structured program that modeled how to do spiritual care in Children's Hospital for years to come. The intervention was the method to accomplish the task of developing a larger, better equipped volunteer core of Spiritual Care Providers to tend to the needs of the patients and families who come to Children's Hospital seeking care. A pre- and post-test survey was given to each participant and the results were tallied. The same survey was given for both the pre- and post-tests. The results were reviewed to see if any change has occurred.

The Spiritual Care Volunteer Care
Training Curriculum

I led the Spiritual Care Volunteer Training Program. During some training events, I invited additional teachers who have expertise in particular areas of the curriculum to share with the class those things which would be beneficial to the new volunteers. The Volunteer training curriculum consisted of ten separate sections of curriculum, they were:

1. Introduction to the Spiritual Care Volunteer Program

The opening session provided an introduction to the world of Children's Hospital and spiritual care in the hospital.

2. Hospital History and Background

An overview of the hospital's history and origins was shared as a means of helping volunteers to understand the mission and principles of the institution. I shared with participants the importance of all spiritual care providers working to reflect the mission, vision, and values of the institution.

3. What Is Spiritual Care?

This section provided a framework and the motivation for providing spiritual care. We also examined spiritual distress, what it is and the role of spiritual care.

The volunteers were introduced to spiritual screening, not as intense as spiritual assessments, but as a tool used to "triage" the spiritual needs of the patient. As the class progressed, the spiritual care volunteers were taught to develop skills to help them assess on a most basic level the spiritual condition of patients and families in order to better provide spiritual care to them.

The volunteers were introduced to the following three skills:

a. Providing care that meets the needs of varying faiths: This was taught by

helping class participants develop good listening skills. It is not about entering into theological debate with those who believe differently, nor is it evangelizing or trying to convince someone to believe in something specific. The role of a chaplain is to understand the spiritual condition of the patient and family and to assist them in using their own spiritual resources to promote healing and bring peace and comfort.

b. Understanding the developmental stages of children: An important part of the training was learning about child development and how children express their spirituality. When the Spiritual Care Provider has no knowledge of the patient's spirituality then the intervention is not effective on a consistent basis.

c. Honest open sharing in a pastoral setting: the participants were invited to brief share their own spiritual journeys. At some point sharing within a group setting, role playing was used as a teaching method. It helped the volunteers get some valuable practice, which also enhanced their confidence. It also provided teachable moments that were used to help the volunteers discover more skills that were beneficial in providing spiritual care.

Finally, an understanding of spirituality and religion was also discussed. As chaplains, the idea of a person being spiritual but not religious may be encountered by persons who do not have a theological background.

4. Communication and Listening skills

Communication and listening are vital skills for anyone providing spiritual care. We practiced communication and listening skills during times of role play. Class participants were asked to listen to the story of a neighbor. After all involved were able to

share with a partner, I asked them to introduce the person whose story they heard. It became quite a teachable moment about listening because some acknowledged that they had not really listened to the other person well enough to introduce them.

I pointed out a few resources like Michael Nichols' (2009) book, *The Lost Art of Listening*, as an excellent resource for anyone seeking to improve communication skills. The subject matter and skills it covers are tremendous assets for spiritual care volunteers to improve listening and communication skills and can be applied to the work of providing spiritual care. Nichols provides insight into why communication breaks down and it is often related to how the persons involved respond or react to each other. Good listeners do not allow themselves to be side-tracked by their own agendas or others' agendas. Children sense when they are listened to, they feel secure and cared for. When they are not listened to, they grow more insecure and it carries over into other areas of life. Self-esteem is related to how they feel about many things.

Confidentiality and the importance of maintaining privacy were also covered. All chaplains are to respect and honor private communications with patients and their families.

5. Principles of Volunteer Ministry

The training manual covered hospital visitation protocol. The key is to follow all hospital rules and instructions (i.e., obey all signs posted on patient doors: wear gowns, gloves, masks when posted on patient door). This is for the safety of everyone, the patients we visit, the places we go, and also ourselves. Emphasis was made that the prevention of the spread of infection is a life or death matter.

Another principle is the understanding of identity. Every spiritual care provider

staff or volunteer, in essence, becomes an ambassador for the field of chaplaincy. All spiritual care volunteers must have their ID badge on with their name visible, according to Children's Hospital volunteer protocol. Another good practice is identifying ourselves to staff and families as we visit.

One of the challenges of providing spiritual care in a health-care setting is making "cold calls" when a chaplain is simply doing rounds and visiting all the patients in a particular area. This is challenging because the patient and family may misinterpret the visit as something that it may not be (Paget & McCormack, 2006). There have been times when I state to a family that I am visiting as a part of my daily routine. Sometimes when people hear the word "chaplain," they assume that bad news is coming. Part of the job of the chaplain or volunteer spiritual care provider is to help people to feel at ease by letting know that the presence of a chaplain does not necessarily mean something negative. As part of ministry functions in healthcare, the chaplain must also respect a patient's right of refusal. They have the right to not be visited if they so choose. For volunteers, the emphasis is on those who are seeking spiritual care. If they choose not to have spiritual support, they have the right; the chaplain must respect their wishes and move on.

Being a spiritual care volunteer in a hospital can be a challenging assignment. Yet with training, spiritual care volunteers can contribute by providing support and comfort to families that may otherwise not receive spiritual care (Powell et al., 2012). The training curriculum developed for this project is a way of equipping volunteers to provide care.

6. Visitation Etiquette

This provided an in-depth look at how to do actual patient visits—the dos and don'ts of basic hospital visitation. It set a foundation for those who will be providing

spiritual care through visitation with patients and their families. It is one area that I spent a lot of time teaching because it is the major foundation for doing spiritual care. It is quite detailed in the training manual and will not be repeated here.

7. Ministry to a Pediatric Population

In this section, an understanding of the special needs of children was taught. Rene Assetta Guilbeau, Director of Child Life and Creative Therapies, provided training on child development to the class. This area of training was what most set apart the training of pediatric spiritual care volunteers as compared to those in adult institutions. With a pediatric and family emphasis, I thought it was very important that volunteers receive specialized training in this area. Again, I refer to the training manual and the material within it as the source of information to be used in the course.

I also shared with the class the concept of ministry in the context of children and their family. This part of the training was what is specialized and designed to be used in a pediatric setting. I have not found material related to this area of specialized pediatric spiritual care in a training program like this anywhere else during the time of this writing.

8, Boundaries and Referrals

The class participants were introduced to the importance of boundaries for hospital volunteers. They were taught that they need to understand that they are not on their own "turf;" they are in someone else's space. A patient's privacy is to always be respected; their room is their home for now. Boundaries also include the type of questions are asked. In general, people will tell us what they want us to know. Ask concerning questions—Is there anything I can do for you today?

While culture colors the lens through which we see the world, social identity

impacts who we are. Prejudice is pre-judgment. Discrimination is deeper; it has malicious intent; it is purposefully mistreating others because of personal criteria. Examine our own bias: culture, religion, and health (e.g., Adventist health message impact). The service population has religious diversity. Although south Louisiana has a high Catholic population, other groups are well represented, too.

9. Death, Loss, and Grief

Participants were asked: In the case of bereavement or mourning, when was the last time you cried? How can we help? Listen first and foremost. Seek to understand; there is no need to preach a sermon. There is no need to spout out Bible texts machine-gun style. *The Art of Being a Healing Presence* (Miller & Cutshall, 2001) is a helpful book. “Preach the Gospel at all times. Use words if necessary” is a clever quotation, which is often attributed to St. Francis of Assisi. The true source is unknown.

10. Self-care

This last session was an opportunity for Commissioning and Blessing. At the close of the training program, those who completed the course work and attended all the sessions received a certificate of completion. I emphasized that the only way one could become a regular volunteer spiritual care provider is to go through the hospital volunteer orientation. In order to receive the privilege of providing spiritual care, they must present their certificate of completion to the Director of Volunteer Services.

At the end of the final night, a blessing-of-the-hands service was performed at the conclusion of the course. It is important to celebrate those who are willing to take on the challenge of providing spiritual care at Children’s Hospital—New Orleans, because it is an area of ministry that does not receive the recognition it deserves.

CHAPTER 5

NARRATIVE OF THE INTERVENTION IMPLEMENTATION

When teaching a course in an academic setting, grades are used as the basis of determining the level of knowledge acquired by the students. Evaluations can be based on formal testing of knowledge of material, grading of papers and evaluation of projects. Yet when teaching a course to train volunteers, there is no formal "grading" system so to speak. So how does one evaluate the effectiveness of the teaching or training? There must be some form of feedback to help evaluate course effectiveness and to indicate whether learning has occurred (or not).

This project focused on training that would equip spiritual care volunteers, not on providing an academic degree for the volunteers. The instructor was specifically concerned with training volunteers and improving their skills to provide spiritual care. When questions arose during the training sessions, we took time to discuss the issues and to provide possible solutions to the issues expressed. The students expressed having greater understanding and greater appreciation as we interacted. Some were even capable of providing examples of how they have applied the learning or how they would use what they have learned in the future.

The questions used to evaluate course effectiveness were designed to determine the attitudes and thoughts of the students toward spiritual care. The bulk of the data acquired is more of the qualitative than the quantitative type. I did not use any formal testing method but did solicit feedback from the participants via survey, written response and dialogue.

Most of the data acquired was qualitative rather than quantitative. Most of the questions in the survey were more concerned with opinions and views on certain issues, which were somewhat subjective and difficult to quantify. How can we really measure a person's feelings about spiritual care other than having them express their feelings either in open dialogue or in a survey? I was more concerned with the participants understanding the principles and concepts that lend to the provision of spiritual care. The goal of this course was to develop more trained volunteers who would become regular spiritual care volunteers at Children's Hospital. I envisioned a group of people who would volunteer and commit time to providing spiritual care out of their own inner motivation and moral values. My goal was to ascertain that they received the tools that would help them succeed as spiritual care volunteers.

Each segment of this chapter corresponds to the natural divisions of the class sessions that were taught. I focused on the experience of each day. The goal was to increase their skill level and competence. Each session had three objectives:

1. Increased self-awareness
2. Learning skills for the provision of spiritual care
3. Development of a sense of mission or purpose in the provision of spiritual care.

At the end of each session participants are asked to evaluate what they have heard.

Increased Self-awareness

Topics were selected for training volunteers that would help them provide spiritual care in a pediatric setting. Each training topic related to the P.R.E.S.E.N.C.E Model of spiritual care and could be reflected as servant leadership and manifested in embodiment theology. Participants were invited to think about how each topic reflected the P.R.E.S.E.N.C.E principles. When asked, the participants provided feedback by describing principles they had learned. For example, a participant described her increased awareness of how she comes across to young people, noting that she must form some type of relationship with families before she seeks to help them. She said she also learned a lot when she heard of the hospital's history and the legacy of caring that it represents.

As we got into the course material, I spent more time on areas that needed to be addressed. For example, in our discussion a question came up about how much of one's own faith and belief system should be shared, and I choose to spend some of our class time exploring that question. This question became an opportunity to examine what it means to be a chaplain or spiritual care provider. We examined the goal of our visit. Was it to be present to help the individual or to win a convert to one's particular faith tradition? I emphasized that the role of a spiritual care provider is to help the person work out their concerns and challenges through their own faith and values. To project one's own beliefs onto another was not being a genuine help to the individual in need of care. I shared with the class—at times my mantra or what I say is, "It's not about me." This was referring to the focus of the visits as well as when the spiritual care provider was uncomfortable due to a challenging situation. The responses from participants were

varied, but someone commented that they struggle with how much of themselves they should put into visiting. Again, I reminded them of the understanding of embodiment that we use our physical and mental selves in our ministry, yet we do not have to make it about us individually, the key is to focus on patient needs rather than our own.

I modified some of the course material to suit the needs and issues that arose during the course. As a pilot project, I was aware that some adaptation could be necessary. Each participant was invited to explore how one or more of the P.R.E.S.E.N.C.E pediatric principles was manifested in each topic.

There was more information to share than I could include in 12 hours of training. As part of self-disclosure, I let everyone know at the outset that this was part of my doctoral project and anyone could opt out if they chose to and there would be no penalty of any type for doing so. All information gathered was privileged and confidential. It would not be used for any purpose other than for the research related to this doctoral project. There was no pressure of grading based on performance or reciting particular answers. I stated that we would not be able to learn everything during these training sessions but those who chose to volunteer would continue learning during other meeting sessions geared toward those who were actively volunteering at Children's Hospital.

Information came from many sources, including information that I have taught or presented to others regarding chaplaincy work. I examined the content of volunteer training courses and considered what would work best for this institution and I emphasized what was most important to provide care at Children's Hospital. The course topics were designed to develop skills of the participants. Training did not end at just four sessions; it was ongoing as supervision was provided for volunteers.

Class Context

Fourteen people signed up to take the Spiritual Care Volunteer training course. It was scheduled to take place on Thursday nights over a period of four weeks, with four sessions which took place from August 31 through September 21, 2017. Each class session was three hours in duration. Of the 14 people who signed up for class and attended, eight completed the training and received a certificate.

Data Collection Methodology

The first step was an invitation to be part of the class. I sent out emails and had some of my colleagues distribute flyers in their places of worship. I also utilized word of mouth invitations. I also encouraged hospital staff members who I encountered with an interest in spiritual care to participate in the class.

A Pre-course Survey consisting of 10 questions was distributed at the beginning of the first session. This survey was repeated at the end of the final session. Various methods of sharing information were used. Most nights, PowerPoint presentations were used to teach the material to the students. I gave out outlines with the PowerPoint presentations at the beginning of each session. The students were able to take notes and follow along with each session. We also engaged one another by discussion and feedback. The focus was on providing spiritual care to children and their families using the principles of the P.R.E.S.E.N.C.E Model, and I always reminded them that these principles could apply in other situations as well.

Learning Skills for the Provision of Spiritual Care

What do participants know about Children's Hospital? Do they know the history? Do they know the present condition? Do they know its future plans? Why is any of this important? To best understand how to work within an organization, one must know how it operates, how it functions, its reason for existing, and its values.

Children's Hospital has as a core value "Caring for children as our own." The focus is on the provision of quality medical care for our region's children. Fourteen people signed up to be a part of the Spiritual Care Volunteer Training Course. At the beginning of the course I asked everyone to complete a pre-course survey. One participant was not present the first night at the beginning of the course, so 13 respondents completed the initial survey.

CLASS 1 - August 31, 2017

Section 1: Overview of Training Program

This training course was the pilot program. As far as I know, it is the first time anything like this was attempted at Children's Hospital—New Orleans regarding spiritual care in over fifteen years.

During the first class, I shared the historical perspective of Children's Hospital, how it came into being, and how its philosophy emerged. I also shared some of the history of Spiritual Care at Children's Hospital—New Orleans.

I shared the history of Children's Hospital, its conception, its early years, its present state, its future plans, and the competencies needed in the role of the Spiritual Care Volunteer see Appendix C.

Why should anyone provide spiritual care? The theological basis for providing spiritual care is that we are all created in the image of God. Restoring God's image is the purpose of providing spiritual care.

Why volunteer in a Children's Hospital? The motivation for volunteering in Children's Hospital as a Spiritual Care Volunteer is the human compassion factor. I read a powerful quote from Nelson Mandela (1995) that resonates with me, "There can be no keener revelation of a society's soul than the way it treats its children." Pope John Paul II (2000) says, "A society will be judged on the basis of how it treats its weakest members." And another variation from Pope Francis (2015), "A society will be judged by the way it treats its children." Those powerful leaders point to the importance of children. Jesus also reflected on the importance of children in his time of ministry on earth. Many times, He showed concern for children. He even rebuked His disciples who wanted to chase the children away. He said, "Suffer the little children to come." In other words, Jesus was more than tolerant of children. He had a desire to care for them. He healed children and showed great compassion for them. Something to note is that all these quotations are given by religious leaders who are governed by their spiritual and moral values.

Taylor, Highfield, and Armenta (1999) provide a definition of Spiritual Care: "That aspect of health care that attends to the spiritual and religious needs brought on by illness or injury" (p. 31). Spiritual Care is care that promotes spiritual health, a sense of meaningfulness, a sense of connectedness, or harmony with the self, others, and God. Spiritual Care is an essential component of whole person care (Shelly & Miller, 1999; Taylor, 2002; Thornton & Gold, 2000). In her study on Spiritual Care, Piles (1990) found that 96.5% of 176 nurses agreed that holistic care includes Spiritual Care. While

spirituality cannot be separated from religion, it is not synonymous with religion. Spirituality infiltrates all aspects of what it means to be human; it is part of the whole (Carroll, 2001).

What do we mean by spiritual needs? Spiritual needs relate to what we call the "big" questions of life. Spiritual needs are related to a search for meaning and understanding and purpose in life A great example comes from Victor Frankl's (1959) book, *Man's Search for Meaning*. Frankl describes his survival in a concentration camp under the direst circumstances. He states that the one thing that kept him sane and alive was the belief ultimately in a purpose for life.

Section 2: Introductions

Learning was happening. I had the class members find a partner and to tell them to introduce themselves, then when it was time to come back together I asked them to not introduce themselves but the person with who they talked. The people who stumbled, sputtered, and stuttered learned the very valuable lesson about being a good listener which is one of the greatest tools a chaplain can ever possess. It was a launching point for discussion about developing good listening skills. It was also a means of breaking the ice and creating conversation. The class members became very proactive in asking questions and seeking dialogue. I guided them to incorporate the skills of active listening in every aspect of their work with others. Active listening is a way to provide ministry. It can be used to provide the "ministry of presence." We discussed how a person can be present in the room (or in the same space) with us, but if we are not listening to the person then we have failed to utilize the opportunity to minister to someone who may need spiritual care.

The class responded by giving examples of how they have either listened to someone or someone listened to them and how it helped the situation.

I also included a subsection on volunteering. May people have expressed their desire to volunteer at Children's Hospital, when I sent out information asking people to volunteer to provide spiritual care; I knew there would be a need to educate people on what spiritual care is. During the course my emphasis was to help the volunteers think about their motivation to volunteer. I asked the participants their reasons for wanting to volunteer and some responded that they had an interest in helping children. Their motivations were because they naturally sensed the vulnerability of children and wanted to help them. I responded that they must also be prepared to help the parents and that most of the spiritual care would be provided in the context of the family. For a spiritually minded person, volunteering is motivated by spiritual and religious values. For many it is a "call to care."

Section 3: Spiritual Care

What is Spiritual Care? As I presented about the topic of spiritual care, the class members listened intently. They were focused and thought of the role as being a religious cheerleader for children, based on their responses. At times that may be what we think can help, but ultimately our role is to do more than that. The six functions of pastoral care go way beyond that. They seemed to see a greater depth into what chaplaincy is. I had not even focused on pediatrics at this point. Each class participant was invited to think of the principles of P.R.E.S.E.N.C.E during each spiritual care visit. Not trying to force them in but thinking through how they could engage and assist patients and their families during the course of their stay in the hospital. The participants came to realize the importance of

possessing good listening skills, possessing a nurturing attitude and the need to provide compassionate care were all a part of this type of ministry. Some expressed that they gained a deeper understanding of spiritual care through the class material.

Section 4: Communication and Listening Skills

Those early experiences became a way of introducing the group to the concepts of listening and communication skills. The understanding of communication on the very first night had an impact on them. Some of the class members acknowledged that they did not listen well, at least not well enough to tell the other person's story. I shared with them the importance of active listening skills as an important aspect of providing spiritual care. Quality spiritual care involves listening to the person and receiving their story as a gift that they were willing to share.

I recommended a few books to them. One was *The Lost Art of Listening* by Michael Nichols (2009) and the other was *The Art of Listening in a Healing Way* by James E. Miller (2003). The goal is to increase awareness of the need to listen. In the future, I may use one of those books to provide training for volunteers at other times.

The main point was to remind us all that we do not listen as well as we think we do. A major part of our communication can be lost if we are not paying attention. When listening to children, they communicate a lot with their bodies. Children do not communicate in the same manner as adults. They use their motor skills, as they develop them, to express how they are feeling. When a child is sick, it becomes more difficult to read their body language, partially because of the illness, and because of the hospital setting. Hospitals are uncomfortable places for most people, but especially for children. Our role as spiritual care providers is to "create a safe space" for them. It is done through

our verbal and physical responses. For example, we should not talk in a loud stern voice when addressing children. It can traumatize them.

Much of the first night was about communication and listening. It was setting the foundation of what would come later. The first lesson in listening was in the introductions. It got the group thinking about their listening skills and their focus. They wondered out loud "do we really listen to people or do we just want them to stop talking so we can talk." That beginning became part of a bonding process for the class members. It was the beginning of relationship building which I told them is a major role as a pediatric care provider. If they are not trusted, they will not be effective. Our experiences together helped the class members to bond with one another that enhanced learning because the group felt comfortable sharing with each other. It was an unintentional benefit of our time together, but I am glad it occurred.

Spiritual care: why do we do it? We are all created in the image of God. We talked about listening as a great skill for the spiritual care provider, but it is also a skill that must be developed. We should listen so well to a person that we could introduce them and tell their story.

Class 2 - September 7, 2017

Section 1: Hospital Visitation in a Pediatric Setting

The second week of class focused more on hospital room visitation, especially the etiquette of hospital visitation. A central theme of this class was about preparing for hospital visitation. There is protocol and etiquette in hospital visitation. In a pediatric setting it needs to be emphasized that in a pediatric setting all spiritual care must be done in the context of the family. Parents are often at the bedside of their children. At times

when there is no parent present, the chaplain must be careful to respect the rights of the family. Some families welcome chaplain visits even if they are not present; others do not. The chaplain should be aware that they must be cautious if they intend to visit. Being aware of child exploitation, we shared visitation tips which must be followed such as leaving the door open, not sitting on the bed or doing anything to make a child uncomfortable. Everyone seemed to understand and agree.

The participants were very interested in hospital visitation and some admitted that they thought it would be pretty easy to do, but after hearing the training involved one remarked that they now know it takes more skill then they realized.

The topic of confidentiality was discussed next. The issue of what happens to the things people tell us needed to be addressed. I emphasized that yes, what we hear is confidential, but in a pediatric hospital we are all mandated reporters. That is, if someone shared with us that they were being abused, we must report it. Also, if the person shared with us that they intended to do harm to themselves or another person, we must report that as well. We must protect the welfare of young people.

I used examples out of my own experience as a chaplain to give them a bit more insight. I next invited the same current spiritual care volunteers to reflect on the experience of being a spiritual care volunteer in a pediatric hospital, not just related to confidentiality but to the experience of working with children and families.

One class participant asked what it was like for the current spiritual care volunteers to be around and to see sick children. The volunteer said: "I have learned that children are resilient and very smart, in spite of illness they act and react just like other kids you might encounter." Then I shared with them how the P.R.E.S.E.N.C.E Model is

important. I believe that each one of us can use embodiment as a tool or method to connect with others. I also recognized that this question was about how to manage anxious feelings as they encountered sick children. We shared some examples of simple awareness techniques like taking deep breaths to calm unsteady nerves before entering a room or saying a prayer before entering a room. This reflects an awareness of self which is one of the goals of each session. It in turn helps us to practice embodied spirituality.

We discussed how to cope with feelings of uneasiness and I reminded them that it was ok to step away from an uncomfortable situation if they felt overwhelmed. I also reminded them of the need to debrief with a professional staff chaplain to help them as they serve. To me that extending of myself also exemplifies servant leadership. It is walking along side someone, with them, not dragging them along in an uncomfortable manner. The P.R.E.S.E.N.C.E Model is a tool, a training instrument, a guide, to help Spiritual care providers to care for themselves and in turn, better prepare them to serve others.

The training course was not meant to be comprehensive, but enough to allow a person to function effectively as a volunteer. I was intentional about not providing too much information because I did not want to overwhelm and discourage those who desired to volunteer. I told them that what I shared with them was just “the tip of the iceberg.” If they desired to really invest themselves in providing spiritual care, I told them I was willing to share the knowledge I have to help them learn and grow.

It is our nature to care for others. Being part of the human community, we are driven by religious, moral and theological principles to help others. We are all created in the image of God. These concepts were reiterated throughout the course sessions.

A foundational principle of Children's Hospital in New Orleans relates to how we view children and their families. We always treat the family, not just the child in our institution. If a parent is not doing well, often the child picks up on it and is affected by it. As a class we considered how we provide spiritual care ministry to help people cope and to feel supported while in the hospital.

Section 2: What is Spiritual Care?

We began this section by asking "What is spiritual care? Then we worked through PowerPoint slides to answer the question. The purpose was to help the volunteers understand generally what spiritual care is. All persons have spiritual needs. Some people have religious needs. The role of the spiritual care provider is to help patients, family members and staff, address both spiritual and religious needs. One class participant responded by stating that spiritual care does not mean one particular religion, but rather what is needed to help the patient while they are in the hospital.

Class 3 - September 14, 2017

Section 1: Child Development

For the third night of this course we took a look at child development—the importance of understanding the stages of development in children and how they respond and express themselves. I invited Rene Assetta Guilbeau, the Director of Child Life and Creative Therapies at Children's Hospital, to present on Child Development. She went through some of the very practical things people should know in treating, responding to and caring for children of all ages and developmental stages in the hospital. It was helpful to observe the spiritual care volunteers from a seat in the audience. I listened to the presentation and observed the student responses. Class members asked questions and

gave thought about to how they approach children at different ages and developmental stages. Her presentation was useful and definitely benefitted those who gave and those who received spiritual care.

Section 2: Death, Grief, and Loss

The topics of death, grief, and loss are not pleasant ones for people to think about, but the reality of working in a Children's Hospital is that children do die and sometimes not during pleasant circumstances. Some die in accidents. Some die from disease and some die from non-accidental traumas which seem to illicit the strongest emotions from everyone. This topic became a point of transition where I made sure to emphasize to the volunteers that they must be self-aware and know their own limits. I did not expect volunteers to handle such intense crisis situations but there will come a time when they may have to provide ministry during a major crisis. I made sure to emphasize another topic, which is self-care and healthy boundaries.

Class 4 - September 21, 2017

In our fourth and final class, I invited Chaplain Barbara Duke to present on Boundaries. At the time of the class, Barbara was just transitioning from another hospital to join me as staff chaplain at Children's Hospital. She was well received by the class participants. She is an experienced chaplain, who did residency at a pediatric hospital and also worked at a Women's and Children's Hospital some years ago. We had been talking about boundaries throughout the course as it was needed. Her presentation was directed at how spiritual care volunteers need to understand boundaries in the context of spiritual care giving. Class participants were asked about what boundaries are and how they are important to spiritual care. The class participants stated the need to practice good

boundaries was an important part of the P.R.E.S.E.N.C.E Model because it can help to ensure that dignity and respect were a part of the ministry of presence as we learned. The topic of boundaries provided some important guidelines for our volunteers and many remarked not only in the pediatric hospital but in all our other relationships as well.

Self-care, self-awareness, and knowing when to refer are important and help promote continuity with all spiritual care providers. I followed her presentation by providing some training in self-care and when to refer to someone else. I wanted them to understand that they should not try to handle everything on their own. I heard responses from them and they seemed to understand the importance of practicing good boundaries and taking care of themselves as they administer care to others. When I observed the survey post-test results, it was clear that they understood the importance of conferring with the staff chaplain when they experience a particular situation that they feel is overwhelming.

We concluded the night with a celebration by presenting certificates of completion to those who completed the training. We also used it as an opportunity to conduct a Commissioning Service. Chaplain Barbara Duke also blessed the hands of each individual to symbolize their work as Spiritual Care Volunteers. This is often done during Pastoral Care Week in many hospitals around the country. It is a reminder of the sacred work of caring for others.

A Look at the Responses

The pre and post-test surveys were used as a means of evaluating the participants perceptions of topics related to pediatric spiritual care. A comparison of the scores reflect some changes in perceptions and attitudes people hold when functioning in a pediatric

hospital environment. There were no identifying markers used to indicate the persons responding to the survey. It was totally anonymous. I did not ask anyone to identify themselves for any answers.

Although 14 people participated in the course at some point in time, one participant missed the initial pre-course survey and thus was not included in the results. This resulted in 13 initial respondents recorded in the results. The survey was distributed on paper with instructions to choose the answer that best describes their belief. Each concept was listed in the form of a statement and the responses were set to a Likert scale. The pre-course survey listed each statement by number. Participants completed surveys by answering using a Likert Scale, using responses such as: Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, or Strongly Agree (see below).

The survey was given to determine perceptions of what ministry in a pediatric setting could be like. The survey was administered as a pre-test using the following statements and at the end of the course it was repeated as a post-test:

1. Volunteers have a great impact on an organization. Eight respondents Strongly Agreed (61%), 4 respondents Agreed (31%), and 1 respondent Strongly Disagreed (8%) (see Appendix D). According to the results about the perceived impact of volunteers on an organization, about 8% Strongly Disagreed with the statement pre-course study and after the class 25% Strongly Disagreed. That is not what I expected. My expectation was that they would see the importance of volunteering and how it can positively impact an organization. I concluded that maybe I did not spend enough time making the case for volunteering. The next time I teach a class like this I will be sure to

emphasize the impact of volunteers on an organization. There was no significant change in the perception of the impact of volunteers on an organization based on the results.

The second statement examined the perceived role of the spiritual care provider by the class participants. The statement was:

2. My role as a spiritual care volunteer is to lead others to Christ. The pre-course responses to this statement were as follows: 2 Strongly Disagreed (15%), 2 Disagreed (15%), 5 Neither Agreed nor Disagreed (38.5%), 1 Agreed (8%), and 3 Strongly Agreed (23%) (see Appendix E). I expected some people to feel very strongly about this because for many, it is a motivating force and an important part of their theology. After the course when the post-test was administered, there was still a split in terms of perception, but the percentage of those who perceived the role as leading others to Christ did not change much. What I did discern is the percentage of participants who gained some understanding that spiritual care providers are not there to proselytize did increase.

The third statement concerned the perceived purpose of volunteer spiritual care providers. The statement read as follows:

3. Spiritual care volunteers extend the reach of the staff chaplain. Eight participants Agreed (61.5%), and 5 participants (38.5%) Strongly Agreed with the statement (see Appendix F). The post-test numbers reflected an increase from 38% to 75% of those who strongly agreed with the statement, indicating a belief that volunteers assist the staff chaplain.

The fourth statement looked at the perception of the level of comfort with visitation in the hospital. It read:

4. I am comfortable visiting pediatric patients and their families in their hospital rooms. One Neither Agreed nor Disagreed (12.5%), 5 Agreed (38%), and 7 Strongly Agreed (54%) (see Appendix G). The post-test results showed 12.5% not feeling comfortable visiting patients but an increase from 54% to 75% feeling more comfortable visiting patients and families in their hospital rooms.

The fifth statement concerning volunteer perceptions was:

5. I am comfortable praying with pediatric patients and their families in the hospital. In the pre-test One Neither Agreed nor Disagreed (8%), 5 Agreed (38%, and 7 Strongly Agreed (54%) (see Appendix H). In the post-test 12.5% of respondents stated that they were less comfortable visiting patients in the hospital, perhaps because they now know more about what spiritual care truly is. There was an increase from 54% to 75% of respondents who felt more comfortable praying with patients in the hospital.

The sixth statement about volunteer perceptions was:

6. I am comfortable providing spiritual support to children and their families during times of suffering, grief and loss. The pre-test results were: 1 Neither Agreed nor Disagreed (8%), 5 Agreed (38%), and 7 Strongly Agreed (54%). The post-test results reflected increases from 8% to 12% in those who Agreed, and an increase from 54% to 63% in those who Strongly Agreed. This reflected a slight feeling of becoming more comfortable providing spiritual care to children and their families during times of suffering, grief, and loss (see Appendix I).

The seventh statement about the perception of the class participants was:

7. I am able to provide spiritual support to people who are different from me, in terms of religion, culture, sexual/gender preference or ethnicity. One Neither Agreed nor

Disagreed (8%), 5 Agreed (38%), and 7 Strongly Agreed (54%) (see Appendix J). In the post-test there was a negligible decrease in comfort level in providing care, the percentage went from 54% to 50%. I believe they became more aware of what good spiritual care requires and that tended to make some uncomfortable. To me that is Ok. I would rather have someone feel uncomfortable and then to move cautiously rather than someone come into a situation and make it worse by their conduct.

The eighth statement was related to perceived competency. It read:

8. I feel competent to provide spiritual care to pediatric patients, their families, and staff. Eight Agreed (62%) and 5 Strongly Agreed (38%) (see Appendix K). In the post-test, 12% Strongly Disagreed, 38% Agreed, and 50% Strongly Agreed. It was a slight improvement. It indicates there is some perception of being competent; yet, there is still room for growth.

The ninth statement regarded the perceptions of free expression of spirituality.

9. I think the free expression of religion/spirituality is important. Two Neither Agreed nor Disagreed, 4 Agreed, and 7 Strongly Agreed (see Appendix L). In the pre-test 15% Neither Agreed nor Disagreed, 31% Agreed and 54% Strongly Agreed. In the post-test result, only one participant Strongly Disagreed slightly skewing the results downward. This was an indication of how the volunteers perceive religions and cultures different from their own.

The tenth statement was about perceived willingness to consult the staff chaplain.

10. When confronted with a situation I am not sure how to handle, I will confer with the chaplain. Five Agreed and 8 Strongly Agreed (see Appendix M). The pre-test results indicated 38% Agreed with the statement and 62% Strongly Agreed. The post -test

results reflected 12.5% Strongly Disagreed and 87.5% of those who responded Strongly Agreed to consult the staff chaplain.

The responses were not surprising because the participants came with the expectation of becoming volunteers. There was not a high degree of anxiety expressed by the participants. The fact that they were participating reflected a desire to do the work of a volunteer without a great deal of fear. If they had had major concerns they most likely would have avoided this course on volunteering. There was not much variation, but they did seem to learn some of the concepts such as not proselytizing or forcing their beliefs on any one.

The post-test did reflect some learning, but not everyone seemed to have grasped the concepts. One individual wrote negative responses to almost everything. It was surprising to me because everyone in the class seemed to be learning and growing in their viewpoints. This one individual based on the answers given did not seem to understand the basis of pastoral care. I do not know if they felt frustrated or tired or just did not care to answer. It seems as if they were just checking boxes to get out of there. I wondered if their answers were an honest reflection of their experience in the classroom. In one of the questions which really focused on proselytizing, at least two individuals seemed to think it was their mission to get people to accept Jesus Christ.

That topic becomes a challenge in chaplaincy. Many people from evangelical backgrounds have been so ingrained with the belief they must tell everyone about Jesus and ask them to accept Him as Lord that they consider this task as the most important thing they do. As a person with a strong belief in our Adventist mission to "tell the world," I understand the importance of evangelism but the point I want to make is the

concern over whether it is appropriate to do so in a hospital in the role of a spiritual care provider.

I remember one of my former supervisors saying that it is not fair to try to preach to, convert or give a bible study to someone in the hospital because it is unfair to them. It is unfair to them because they are a captive audience. If we go to someone's house they can shut the door, if we approach them on the street they can walk away, but in the hospital, they are in bed and they are there for a reason. I did not emphasize that point to them but perhaps next time I should. I asked everyone to complete the course evaluation at the end of the training. One person left before the evaluation was given and the eight remaining people filled out the evaluation and returned it.

Course Evaluations

A Likert scale was used for analysis patterned after the pre- and post-tests for answers.

1. How likely is it that you would likely recommend this course to a friend or colleague? On a scale from 1 to 10 with 1 being "Not at all likely" to 10 being "Extremely likely." The answers were all clustered toward the higher number of the scale. Two respondents rated is at 8, 1 respondent rated it at 9, and 5 respondents rated it at 10.

2. Overall how would you rate this course? Six rated it "excellent" overall, 1 respondent rated it "very good" and one respondent rated it "good."

3. What did you like most about the course? One respondent said, "Allen's presence- authoritative, welcoming, and knowledgeable about the subject matter, excellent teacher." Another person said, "hearing personal experiences from the chaplains

and guest speakers." "Topics were open for discussion." Another person said, "gave more clarity and insight and boundaries was very helpful." Another person said they liked "sharing this spiritual journey with a wonderful group of people." Another person commented, "I learned a lot." And someone liked the sense of community and dialogues. Another person said they liked: "insightful teaching about spiritual care. Engaging teaching."

4. What did you dislike about the course? Response was "All good." Another said, "It was great!" One person said, "That's a strong word." Another said, "Some shadowing time of the chaplain would be helpful." (Of course, this would come later. As the volunteers become active in the hospital, they would have some type of mentoring during their time in the hospital).

5. How organized was the course? Five responded that the course was extremely organized, and 3 others said it was very organized.

6. How helpful was the course? Four people said it was extremely helpful and 4 said it was very helpful.

7. How effective were the instructors? Six said extremely helpful and 2 said very helpful.

8. How much of the information provided will you use in your ministry? Five said all the information would be used in their ministry. Three said most of the info would be used in their ministry.

9. How would you rate the length of the course? All 8 respondents said the length of the course was about right. (I think it could be longer and with their comments they would not mind if they were learning and having fun). This is a pilot program that

will continue to be modified. Some things will be added and perhaps some things dropped over time. The main objective was to equip volunteers to provide good spiritual care. My hope is that they gained some new skills as well as increased confidence in the skills they already possessed.

10. Is there anything else you would like to share about the course? There were two responses one person commented, “well executed, enjoyed the other speakers as well.”

Another person simply responded, “Thank you!”

Conclusions

Overall there was not much negative in terms of feedback, everyone seemed to enjoy the course and each participant was well engaged. Some of the people who began the course did not finish. Some had to drop out due to family obligations. Two were Intensive Care Unit nurses who also had other responsibilities. One was a flight nurse who was on call. The other nurse was also in training to be a nursing supervisor. They were very involved in the course when they present, but unfortunately due to their other responsibilities, could not complete the course work and receive certification. However, both are very pastoral in their approach to caring for patients and families. I believe they did receive some spiritual care training that will be useful in their nursing careers and beneficial to those families who will be recipients of their compassionate care.

As I reviewed and reflect on the surveys, I sensed that there was more for the volunteers to learn. This was just basic and allowed them to get in the door, but additional training is part of the ongoing process. It is my intention to follow up and provide guidance and supervision to those who wish to volunteer on a regular basis.

As a pilot project this establishes a training program to develop a larger spiritual care volunteer program. I would like to give those who decide to become part of spiritual care volunteer team, the opportunity to shadow an experienced spiritual care provider. What they received was very basic at this point and is merely a launching point on the path to becoming more proficient spiritual care providers.

The training program now has a foundation and the institution now has a model on which to build a spiritual care program that I would like to see develop into a department that can stand on its own. Currently, one other chaplain serves with me fulltime, but we still fall under the umbrella of the Social Service Department. I want the model I have developed to continue to be refined and expanded as the needs for developing a spiritual care department become apparent.

This was all part of the Spiritual Care Training Curriculum Outline. This was given out to each participant during the training sessions as a handout.

Development of a Sense of Mission or Purpose in the Provision of Spiritual Care

What Are We Looking For?

A Spiritual Care Volunteer description: We are seeking individuals who are willing to provide spiritual care to patients, their families members/partners/significant others, hospital staff and volunteers. Spiritual care includes but is not limited to, the provision of comforting care and presence, empathetic listening, prayer, providing ritual as appropriate and providing grief support when necessary. Care will be provided in a manner that respects, and is sensitive to, the varying belief systems of all persons, without proselytizing or imposing one's own beliefs on others. We are seeking volunteers who may be willing to respond to call for spiritual care during emergencies or non-

emergencies in the hospital. We are looking for people who could provide care at times when a staff chaplain is unavailable.

Qualifications

Anyone who desires to provide spiritual care must obtain the recommendation of an assembly and membership reflecting good and regular standing in a local congregation (see Appendix N, Application). A theological degree is not necessary; it can be helpful, but training is provided for those desiring to be spiritual care volunteers. A willing and compassionate heart is the most important qualification. It has been said that the greatest ability that God looks for is availability (see Appendix O, Availability Form).

Spiritual Care Volunteer objective: to provide support and religious care to patients, families and staff as they address spiritual concerns. For competencies of a Trained Spiritual Care Volunteer, see Appendix C.

Spiritual Resources

Communication and Listening Skills

Some say listening is a lost art. I believe that all of us can improve our listening and communication skills. This was the first-time pilot program for training Spiritual Care Volunteers. It will be modified and refined in coming sessions. This is the first attempt to develop a model of this type for as long as I have been employed at Children's Hospital.

Visiting Patients and Families—Basics of a Visit

Derry James-Tannariello's (2013) book, *Heaven Touches Earth Through Hospital Ministry*, provided a guide that helped me describe a patient visit so I adopted parts of her

visitation model. I will encourage volunteers to read from her book. I may make it part of the material I use during meetings with spiritual care volunteers during quarterly meetings.

A very important area of emphasis that I expounded upon was the importance of being a mandated reporter. I emphasized to everyone that they have a responsibility to report any suspicion of abuse—clergy-client privilege does not apply. The law is designed in Louisiana to help protect children. Establish with patients *before* the session that we are mandated reporters and what they say may not be held as confidential if it violates state law, especially in a pediatric setting.

Prayer

The use of prayer in providing Spiritual Care is often to provide solace—also to empower and prepare the volunteer for what they encounter. One of the deacons shared his experience of going into the chapel and praying before he goes to visit patients. Our prayer life is not about our own comfort and wellbeing. It is meant to make us available for the work of God. Prayer should better equip us for the inward journey.

Children and prayer—select language that is appropriate for children to understand. Utilize the best type prayer to suit the situation. Chaplains should be able to pray spontaneous prayers when asked. Patients have expressed a need to have their spiritual needs met; they want Spiritual Care Providers to pray for them and they want someone to ask about their spiritual needs (Fitchett et al., 2000).

Three things to remember in providing sensitive care (Wintz & Cooper, 2003, 2009) are:

1. Different is different; it is not right or wrong.

2. I’m not afraid to ask (even if I feel uncomfortable).
3. It’s not about me!

Boundaries

The topic of boundaries is critical. We emphasized the proper use of boundaries while providing quality spiritual care. Established boundaries also protect the patient, family members, staff and chaplains from becoming entangled in things which can become detrimental to the relationships of the patient, family, and staff. I used a PowerPoint presentation and added it to the training manual.

In summary, in each course session, the P.R.E.S.E.N.C.E Model was the “glue” or umbrella under which everything came together. The model has principles that, when practiced, lead to quality spiritual care. Again, this was the pilot program for the P.R.E.S.E.N.C.E Model. There is still much work to be done, but this intervention has helped to establish a methodology for providing pediatric spiritual care utilizing volunteers. The students gained an increased sense of self-awareness. They learned skills for the provision of spiritual care in a pediatric setting. They developed a sense of mission or purpose in the provision of spiritual care.

CHAPTER 6

PROJECT EVALUATION AND INSIGHT GAINED

Summary of the Project

This project sought to extend the range of the staff chaplain by providing a manual for training to volunteers who were involved in providing spiritual care to our patients, families, and staff. This was a pilot project intended to further the reach of spiritual care by putting in place a spiritual care model that may be utilized in a setting where financial resources may be limited. The model was implemented with 14 students who participated in the training sessions.

The goal was to provide the training and to also encourage the participants to volunteer to provide spiritual care in the hospital. The focus was on teaching volunteers about the provision of spiritual care. It covered some very basic methods of care such as active listening skills and establishing ministry of presence. While 14 people participated in the course, only nine completed all the sessions. I prefaced my remarks with the understanding that providing spiritual care in a children's hospital is not for the faint of heart. It has its challenges and as some became aware of what spiritual care entails some realized it was not for them. This course was also an effective learning tool for participants to not only gain skills, but to also discern if this particular ministry was one to which they were called.

The volunteers who participated were encouraged to express their thoughts and

opinions as a way of promoting dialogue and learning. The four sessions of the course were: introduction with an emphasis of active listening, communication styles, patient awareness (child development), and providing ministry during times of grief and loss.

At the end of the course, students reflected on their experiences and provided feedback to the instructor with the post-test and course evaluation.

Description of the Evaluation

What follows is a description of how data from the intervention (Chapter 5) was evaluated and interpreted, along with a report of the resulting conclusions and outcomes.

Evaluation Method

This project was a qualitative case study in terms of research design. The written and transcribed data were evaluated using a process of content analysis. It involved the researcher reflecting on the data responses, the classroom interaction and the comparison of the themes that arose from our discussion. The findings and conclusions were drawn from the material and responses, looking for significance in terms of attitude shift or knowledge gained.

A qualitative research method best served this project as I was aware that the number of participants would be a small sample. The use of pre- and post-tests was a method of measuring the learning or shift in attitude of the participants. Qualitative research design seemed best suited to provide a description of how much impact the course had on the individual participants. The data analysis performed was not used to test a new hypothesis or even for results intended to be replicated by another study with a wider sample. The point of this study was to provide the researcher with insight as to how to further develop this teaching method and in turn enhance the level of proficiency of the

instructor to provide training to spiritual care volunteers.

Interpretation of Data (Chapter 5)

The analysis of the data at first did not seem to reveal significant change, but with a closer scrutiny, a theme emerged: this is a ministry that requires special skills which can be acquired and utilized. Most of the participants understand the need to provide care and feel empowered to do so.

Conclusions Drawn From the Data (Chapter 5)

As a first-time program, the number of participants was not a bad number at all. The people who participated had an earnest desire to learn about spiritual care to children and their families. The participants had a desire to provide spiritual care even prior to the course. Most felt capable of providing quality care to children. My expectation was an increase of skills necessary to provide spiritual care to children and their families.

Outcomes of the Intervention

The intervention provided the staff chaplain with a basic understanding of how to train and develop others to provide spiritual care in a pediatric setting. People remarked at how rare it is to receive any type of training on how to minister to children. In a class that began with 14 people signing up, nine completed all four class sessions and earned a certificate of completion enabling them to begin the process of becoming a spiritual care volunteer at Children's Hospital—New Orleans. Those who completed the training course now have an understanding of how to provide spiritual care based on the P.R.E.S.E.N.C.E Model. The model will be utilized to provide training to nay new

volunteers and will also be used as the foundation to build a dynamic spiritual care program.

Summary of Chapter Conclusions

Theological Conclusions—Chapter 2

My theology of ministry to children deepened as I taught others how to care for children. As someone who has been providing spiritual care to children and families over the course of fifteen years, this project forced me to consider and analyze the aspects of what I do. Many people think the work of a chaplain in the hospital is to just go in the room and "pray with people" and tell them about Jesus. That works well for persons in their local church who are visiting parishioners of their own congregation. However, the goals of spiritual care go beyond that. In my theology, I see the value that Jesus places upon children. He does not dismiss them, but rather takes the time to provide the special needed touch to express love to them. Jesus is my model of how to provide care and, as the scriptures indicate, Jesus valued every moment with children. Also, in Hebrew culture the concept of "blessing" children is vital to the next generation. Blessings were the seal of approval then and they can be that in our modern day.

Another observation in my work on this project is the renewed emphasis on Jesus' ministry of compassion. Matthew 9:36 NLT says, "When he saw the crowds, he had compassion on them, because they were harassed and helpless like sheep without a shepherd." That sense of compassion is what I think about as I do ministry, to show compassion and have a sense of connection to those who are suffering.

Also, I now have a deepened theological observation about how I provide care, use of self in ministry—theological embodiment. I communicate with children through

appropriate touch, body language, and facial expressions. Children because of their limited vocabulary react to adults when they can also use their bodies to communicate. I wonder about children who have illnesses that affect the use of their motor function. We have a large physical rehabilitation program. We have a number of children who struggle to either develop or regain the use of their physical skills especially after a traumatic brain injury or diminished neurological function resulting from disease. I did not know such a concept existed prior to my doctoral studies. It as if an awakening has occurred within me. My awareness of how much embodiment theology is a part of my ministry style has finally put a conceptual name to something that is so much a part of how I provide ministry to others. This project equipped me with language to express my ministry style.

My own awareness of my strengths and limitations helps me to plan how to proceed with this project. Having someone working with me who is not introverted, and who is outgoing could help with recruiting. A person who is willing to risk rejection could be an asset to me. I also realize that recruiting is only part of what is necessary to succeed. Retaining volunteers is very important. From the class roster 14 people attended at least one course session, but only eight people completed enough to gain certification by the hospital chaplain.

As I think about this project, I also hold the view as an Adventist that our ministry is not merely one of sharing the gospel to win converts but as a way of life that can transform lives as they come in contact with the Great Physician. I am not the Physician; but I serve Him and want to reflect Him in character to those I meet each day. This project has helped me to refine how I approach ministry and how it connects with my

expression of faith as a Seventh-day Adventist Chaplain. My purpose is to share what I have learned in training and educating others about the ministry of chaplaincy. This project allowed me the opportunity to put into practice concepts I have learned and want to share with others. I see it as consistent with Jesus method of making disciples. For those interested in providing spiritual care, this project can help those who want to follow the call to be a spiritual care provider and perhaps the role of chaplain.

Theoretical Conclusions—Chapter 3

A review of literature related to this project was conducted. As I reviewed the literature, I learned more about the spiritual lives of children and the effect of illness on them and their families. I gained a broader understanding of child development. I feel this is an area in pediatric chaplaincy that could benefit from more research, perhaps an area I or others may seek to do further study in. As I consider the field of pediatric chaplaincy, it is a developing field that may benefit from more research-related topics focusing on the needs and spiritual lives of children.

An important aspect of study for this project relates to spiritual care models, one area that is of interest to those especially in the field of pediatric chaplaincy. Although adult hospital spiritual care models exist, it is difficult to relate those models to the needs of patients in a pediatric setting. It is my hope that someone will be inspired to further the field of pediatric critical care. That was the initial desire for me in this project, but as I began working on the topic, I was guided to training volunteers because that was the greatest need of the institution where I serve. I proceeded with the understanding that this project would contribute to the field by creating a model that could be used in a pediatric setting or perhaps elsewhere with some modification.

Methodological Conclusions—Chapter 4

As I reflected on the project and its focus on training volunteers, I think the teaching model I used was beneficial for the development of people who desire to provide spiritual care. While the course was in no way comprehensive, it was an introduction to whet the appetite of those who have a true desire to become spiritual care providers in a pediatric setting. The length of the course was kept short with intention. As people were volunteering, I did not want to intrude on their personal time. I wanted it to be long enough to be effective, but also short enough to not create information overload. I will use this method again in the future with some modifications along the way. My goal is to continue training those who have chosen to volunteer and to enhance the skills they have learned in the training course.

It was impossible to include everything in the manual, but it provides some good resource material for training them. In addition to a training manual, I also provide supervision of the volunteers to ensure quality spiritual care is provided. This is an ongoing process. I will continue to mentor those who volunteer to provide spiritual care, encouraging them to keep on growing and developing pastoral care skills. I meet them at scheduled times to provide counsel, feedback and to debrief after difficult experiences in ministry.

Overarching Conclusions

The project required a great deal of time and planning. It is not a final product but rather, because it was a pilot program, it will be reviewed and revised as time goes on. The project was limited due to the number of participants, but I have been told that 14 people was a good number considering the type of project I was committed to doing. One

weakness I felt personally was that projects like this require a degree of "salesmanship" or promotion. I am not strong in advertising or promoting programs like this. I wonder if this project had received greater promotion, there might have been a wider response.

On the positive side, I believe the P.R.E.S.E.N.C.E Model of pediatric spiritual care provides a foundation for others to build upon. I see it as fluid and capable of changing and being adapted, rather than being a series of steps or a process, the P.R.E.S.E.N.C.E Model describes a set of skills, rooted in and flowing out of Embodiment Theology, which constitutes not only good general care, but more specifically, effective spiritual care with children.

The P.R.E.S.E.N.C.E spiritual care Model was designed for use at Children's Hospital in New Orleans but from the feedback I have received I believe it can be useful to other pediatric facilities. To my knowledge no model like this exists in pediatrics. I believe this is the first but my prayer is that it will not be the last. I see it as foundational starting point that I hope will be beneficial to the field of pediatric spiritual care for years to come.

Personal Transformation

As I started this Doctor of Ministry project, I wanted to advance myself academically. I wanted to increase my knowledge in the field of pediatric chaplaincy. I have not been consistently an "A" student for most of my academic life. This endeavor was very challenging for me. So, in order to be successful, I really had to push myself and stretch a bit. I learned more about spiritual care models and leadership than I would have in any other course of study. Some of the biggest breakthroughs for me were related to personality and leadership style. I am an introvert and at times I viewed it as a flaw,

but I learned that there are ways that introverts lead effectively.

I believe I have benefitted from the process by learning not just how to provide care but also how to teach others how to provide care. I also learned more about my own personality and how I can use my particular personality traits to provide ministry to others, not only inpatient care but also in leadership. I embrace the servant leader model. As a chaplain, it functions on many levels, especially in ministry to patients and families and also hospital staff members. I saw myself in the mode of a servant leader prior to this project but I feel an even greater affinity to servant leadership now. I am becoming a more confident leader and I have learned to operate in my own style.

I also recognize that I utilize an embodiment theology, which is the use of physical self in ministry. Working with children I have learned to adopt communication skills that may not always be verbal. The Bible says very young children came to Jesus, sat on his lap and he blessed them. I asked the Lord to grant me a heart and character like that, where a child and people of all ages would feel safe enough to come to me like they came to Jesus for blessings. I see some irony in the use of self, because we hear so often about dying to self and not depending on self. What I have learned is we are not to worship self or get out of balance who we are. I am not a large man and over the course of my life have viewed myself as this overwhelming presence who can take over a room or situation. Yet, in my work as a chaplain I understand that the ministry of our presence is important no matter what size we are. I remember a saying that goes something like, "It's not the size of the dog in the fight that you should worry about, but the size of the fight in the dog." There was a time in my life when I had to fight, but I was not a Christian then. God has changed my heart and now the intensity to fight still remains in

me, but it will be like David when he said, “You come against me with sword and shield and javelin, but I come against you in the name of the LORD.” Although I am small in stature, I have learned that we all have giants in our lives. David slew Goliath because he came in the name of the Lord. I am not going looking for Goliath but when he comes, I know the Lord is with me. I desire to serve the Lord as I am called based on the prompting of the Holy Spirit.

Recommendations

My recommendations are to continue to develop this training program. I would like to incorporate the P.R.E.S.E.N.C.E pediatric spiritual care model into program that would be used in a spiritual care department. My hope is that others will build upon this material and further develop it into programs that can be used in pediatric settings world-wide. It will enhance the field of spiritual care if put into use.

This project was a pilot project and I recommend expanding the course material. Twelve hours just provides an overview of spiritual care. It needs to be longer to ensure volunteers gain greater insight in the provision of spiritual care. I believe the best move would be to grow a spiritual care department that can be a stand-alone department. With the hospital growing there is a need to re-evaluate the use of spiritual care resources and how best to use what is already in place.

I would like to see growth in volunteer participation, especially developing a core of volunteers from various faith backgrounds. I would like to see an increase in denominational representation: Baptist, Presbyterian, Methodist, Non-denominational and also non-Christian religions such as Jewish, Muslim, Buddhist, etc., to meet the needs of other groups.

I would like to also do more to educate staff about spiritual care, what it is, and why we do it. We have had a large turnover of staff in the last two years. Many of the nurses are new and recent graduates. Many do not have a connection to any particular faith. It will take work to educate people coming from a secular mindset. If chaplains wish to survive and ministry effectively, we must "toot our own horn" so to speak.

The literature review reflects a small pool of material related to spiritual care and volunteering. They seem to fit together naturally to me, yet there has not been extensive writing about the two together. Perhaps this material could stir someone to take on this area of ministry. Although I am not a writer, I am aware of the need for more research to be done and more articles to be written. I would like to see others also write about their experiences with volunteers especially those who are serving in ministry.

Also, the literature review reflects an overall lack of material regarding pediatric chaplaincy. Literature is now becoming available but there is more related to nursing and spirituality than material related to chaplains and spiritual care. I would like to see chaplains contribute more to the world of research.

A Final Word

Spiritual Care is an important part of the healing process. In fact, I believe that it is impossible to be made whole while ignoring the role healthy spirituality has on our health. As Seventh-day Adventists there is an emphasis on health ministry, but I wonder if we view it as an aspect of spiritual care. Scripture describes the body as the temple of the Holy Spirit, and we acknowledge the importance of a spiritual connection to maintain health or even to restore health. I think this old definition from the World Health Organization (1948) should be remembered, "Health is a state of complete physical,

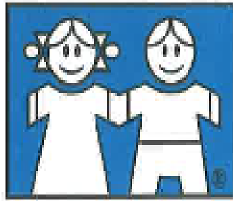
mental, and social well-being and not merely the absence of disease or infirmity" (p. 100). I believe that message of the gospel as proclaimed by Seventh-day Adventists is God's plan for total restoration of our health and the restoration of Kingdom of God. The Seventh-day Adventist Church has an excellent mission to promote healing and I believe, just like the World Health organization's definition, it includes spiritual well-being. The role of care of the spiritual well-being of humanity is being fulfilled by those who are spiritual care providers. Chaplains and those who work with them are essential to this role.

I believe this project is just tip of the iceberg; there is much more underneath than we can see. I think that there is more to be gained in studying and learning about spiritual care and how children and their families are affected by it. I believe the provision of spiritual care also affects the people who commit to volunteer their time in caring for others. The Bible says, "Work out your own salvation." I do not believe it is referring to salvation by works, but to the actions of the individual being expressed by a working, living, active faith that expresses itself in the care of others, especially children. I recognize that doing the ministry of a chaplain cannot save us, but by following Christ's example of providing servant leadership, the character of Christ is developed as I labor and learn to develop a closer walk with the Lord. This type of ministry most definitely can inspire a deeper faith and a deeper commitment to trust in the Lord. I am grateful for the opportunity to study, grow and develop. It lets me know I am on a journey and this is merely one road along the pathway that reaches beyond what my eyes can see.

APPENDIX A

RESEARCH APPROVAL AND CONSENT

Institutional Review Board
FWA 00000743



CHILDREN'S HOSPITAL

To: Mary R. Perrin
President & CEO

From: Institutional Review Board

Re: IRB# 16-06: A Spiritual Care Model Utilizing Volunteer Chaplains at Children's Hospital in New Orleans

The above titled project involving human participants was received in the Office of Sponsored Research. This project was reviewed and judged to be exempt from the Common Rule per 45 CFR 46.101(b)(2). The Principal Investigator(s) are hereby authorized to conduct this study as follows:

THE INVESTIGATOR acknowledges and accepts her/his responsibility for continuously protecting the rights and welfare of human participants of research conducted at Children's Hospital and will satisfy the intent and procedures specified in 45 CFR 46, 21 CFR 50, 56, 812 and other Federal, state or local laws or regulations that may apply. The investigator further agrees to report any emergent problems or serious adverse effects to the IRB AS SOON AS POSSIBLE, but no later than five (5) days after any problem is discovered. The investigator must also notify the IRB when the project is completed and no further work with the project or data will be performed.

THE INVESTIGATOR FURTHER acknowledges that the information collected in the proposed chart review will be recorded by the investigator in such a manner that subjects cannot be identified directly or by identifiers linked to the subjects.

Allen L. Mitchell
Allen Mitchell Date
Principal Investigator

4/30/16
Druby Hebert, M.D. Date
Chairman, Children's Hospital IRB

200 Henry Clay Avenue
New Orleans, Louisiana 70118

APPENDIX B

SPIRITUAL CARE HANDBOOK:

A TRAINING MANUAL FOR VOLUNTEERS

Children's Hospital—New Orleans Spiritual Care Handbook:

A Training Manual for Volunteers

Acknowledgements

This training manual is the result of information gleaned from a number of sources. It would be impossible to list them all and I apologize in advance for those not given credit during this process. The greatest acknowledgement I would like to make is to the Lord, Almighty, who has entrusted me with this work which I regard as sacred.

This training manual was developed with Children's Hospital in mind. The focus is on pediatric care; but its principles can be applied in other situations as well.

The material represented in this manual is my intellectual property and I do not seek any compensation for its use, but I would like to acknowledge that it is for the purpose of furthering the special field of chaplaincy, specifically pediatric spiritual care.

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2. Hospital History and Background
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4. Communication and Listening Skills
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6. Visitation Etiquette
   Understanding hospital jargon (signs and symbols, etc.). Make a great first impression. Be on time. Be yourself. Be appropriate (neat appearance) grooming. Be open (ready to hear and receive). Let them talk. Don’t dominate the conversation; just ask simple questions to prime the pump, to get things flowing.
7. Ministry to a Pediatric Population
   Understanding the special needs of children, child development, ministry to children and their families
8. Boundaries and Referrals
   Social workers, medical staff, and nurses can collaborate in delivering palliative care. We watched the Cleveland Clinic video, “If We Could See Inside Other People’s Hearts.”
9. Death, Grief, and Loss
   Five important things to say: Thank you, I love you, I’ll never forget, I’m sorry, I forgive you (Byock, 2004). The four things that matter most. Byock has four. Someone added a fifth one—I’ll never forget. CHILDREN DO DIE—and their deaths evoke some of the most intense feelings one can experience
10. Self-care
    Debrief if possible, know your own limits, take care of your own spirit.

Welcome to the Spiritual Care Volunteer Training Program

Thank you for your willingness and desire to provide care for those who we all have strong feelings about our children and families.

The goal of this handbook is to provide some guidelines and basic training for those willing to provide pediatric spiritual care.

Although not comprehensive, this training experience can help anyone desiring to become more proficient in providing spiritual care.

I. Introduction to Spiritual Care Volunteer Training

This handbook is specifically for Spiritual Care Volunteer Training and does not replace the Volunteer Training Handbook used by Children's Hospital's Volunteer Department. This material is intended to reflect the guidelines of providing spiritual care in Children's Hospital.

II. Hospital History

Children's Hospital was conceived in the late 1940's and early 1950s. It was originally called "Crippled Children's Hospital." It was first designed to treat patients with polio hence the name. Times have changed as well as the name. The hospital has grown since then and is now called Children's Hospital.

Children's Hospital is currently licensed for 236 beds, with expansion coming soon. A new critical care tower is being constructed at the present. And a new Behavioral Health Building will also be constructed in the near future. Spiritual Care is currently a two-person team under the direction of the Social Work Department.

III. What Is Spiritual Care?

Spiritual care is the aspect of health care that attends to the spiritual and religious needs brought on by an illness or injury or other crisis conditions.

Spiritual Care Versus Non-Spiritual Care

SPIRITUAL CARE	NON-SPIRITUAL CARE
Compassionate presence	Proselytizing
Reflective listening	Evangelizing
Reading from Sacred Texts	Advice giving
Empowered to find meaning	Focusing on one's own particular religion
Prayer based on their need	"Preachy" Prayers
Inspirational readings	Sharing texts espousing your own views
Sacramental Ministry	Pushing rites unrelated to their theology

Spiritual care is caring for the soul in such a way that spiritual needs are fulfilled and people respond to the meeting of their spiritual needs in healthy ways.

Govier (2000) defines spiritual care as comprised of the "four Rs":

- **Reason and Reflection:** People seek to understand the meaning and purpose in life. Patients often ask, "Why is this happening to me?" a skilled health care provider or a trained spiritual care provider can journey with a person and help them reflect and find meaning in their circumstances in life.

- **Religion:** Values, practices and beliefs are interpreted through a persons' spiritual framework. Many people develop their world view from their religious practices. Their religious practices help them to discover the answers about life and death. Some views may not fall into what would be considered traditional, but these views do affect their responses and their religious values must be respected whether or not the healthcare provider agrees with the person's religious beliefs.
- **Relationships:** The interpretations of relationships are the basis of our social interactions. Relationships to self, others and God are what help to form the spiritual center of a person. Two forms of relationships exist, vertical and horizontal. Vertical relationships refer to a God who is transcendent and horizontal relationships refer to interactions with other human beings.
- **Restoration:** Spiritual care aids in the restoration of the total human being, if one sees the human make up consisting of more than just flesh and bone, then, the restoration of total health and the value of spirituality is recognized. Conversely when a life event is so devastating that an individual cannot restore spiritual balance then the person may suffer spiritual distress. Spiritual distress is not "cured" by physical medicine it requires the treatment of spiritual or "soul" care.

What Is Spiritual Distress?

Spiritual distress is a disruption in one's beliefs or value system. It affects a person's entire being. Is shakes the basic beliefs of one's life.

Source: The Hospice and Palliative Nurses Association's *Patient/Family Teaching Sheet on Spiritual Distress:* http://www.hpna.org/pdf/Teaching Sheet_SpiritualDistress.pdf

In children, extreme behavioral changes can reflect spiritual distress. Knowledge of child development will help here.

- Reason or Need for Ministry
- Crisis event
- Search/struggle for meaning
- Drastic mood changes
- Increased anxiety, or increased emotional expressions of anger, or distress
- Depression
- Restlessness

Why Spiritual Care?

Each person is made up of more than bone, muscle and tissue, each one of us is also spiritual in nature. Our overall health is impacted by

our spirituality. If we are not well spiritually, then physical, psychological and emotional problems may arise to affect and impact our overall health. Spiritual care is the art of helping people who have experienced spiritual distress to utilize their spiritual resources to promote their healing and recovery from illness, trauma, or any other event that has caused suffering.

IV. Communication and Listening Skills

(Books) Listening in a Healing way and being a Healing Presence
Listening is the most important skill you need to serve in spiritual care
Listening—Listen with the third ear (your heart)
Caring/Concerned communication—Listen with interest, be an involved listener
Reflect compassion for the persons while listening and responding

V. The Principles of Volunteer Ministry (adapted from McCall, 2015)

Principle I PERSONAL CONDUCT AND ETHICS

Spiritual care volunteers must uphold the highest personal conduct at all times. Unethical conduct or unethical behavior that violates any policy outlined by Children's Hospital-New Orleans will lose the privilege of providing spiritual care at Children's Hospital.

Principle II PROFESSIONAL PRACTICES

Volunteer spiritual care providers both professional clergy and laypersons function in a role considered by our patients, families and staff as clerical in nature. Although volunteers may not be "professional clergy," they are viewed as such and must conduct themselves as such. The language and behavior must be in accordance with the highest standards of integrity and conducted **in a manner that befits a person held in esteem as a religious leader in the community.**

By agreeing to serve in this institution all volunteers must be empowered by their respective religious judicatory order who attest to the fitness of said persons to serve in a religious capacity. The people being served will not be able to distinguish between ordained and non-ordained clergy persons thus, conduct must be up to the standard of a professional in terms of conduct.

Spiritual care volunteers are bound to maintain the integrity of the office of chaplain no matter if they are professional clergy or laypersons serving in religious functions (i.e., a lay pastor, an elder, a deacon, or a Eucharistic minister).

Principle III CONFIDENTIALITY

Every person providing spiritual care must maintain confidentiality. All hospital policies regarding HIPPA apply to spiritual care volunteers. There is an expectation of maintain the sacred trust of those we serve.

***The only situations where confidentiality may be violated is when withholding information may place persons at risk of violence or imminent danger. In such cases information must be shared with those who can intervene and can make the necessary changes to ensure the safety of all individuals at risk of harm. Children's Hospital adheres to the law and considers all involved in care as mandated reporters. The safety of children takes precedence of maintaining confidentiality in such cases.**

Principle IV PROFESSIONAL DEVELOPMENT

All volunteers are expected to continue to hone and develop skills to improve the provision of quality spiritual care. This development may include reading articles, attending meetings and training opportunities as made available to enhance personal development in the provision of spiritual care.

Principle V FAITH GROUP RELATIONSHIPS

Spiritual care volunteers must have approval from their religious judicatory or appropriate religious leader. They must submit in writing a letter stating that they are authorized to function as a spiritual care provider from their own religious body. Volunteers may also be asked to serve as liaisons between people in the hospital and their own religious groups or someone of similar backgrounds as needed. Volunteers may be asked to contact someone outside of their own tradition at the patient's request.

Principle VI INTERDISCIPLENARY RELATIONSHIPS

Spiritual care volunteers also provide ministry by cooperating with other departments and disciplines in the hospital and the larger community. The use of referrals is a means of enhancing the provision of spiritual care to those we serve in the hospital.

Principle VII COMPETENCY

Spiritual care providers must be capable of providing competent care to those served in the hospital. The goal of the training provided **in this manual is to provide the tools necessary to provide competent care. It is in no way exhaustive.**

Principle VIII REPSONSIBILITY

Every spiritual care provider has the personal responsibility of understanding their own core values. It involves knowing your own values and understanding the importance of them in providing care. All spiritual care providers must model integrity in your volunteer work.

No volunteer is allowed to bring materials, equipment, and gifts to any patient or family unless the material is approved for use within the hospital. Also, no volunteer can accept materials, equipment, or gifts from any patient or family. This prevents the appearance of any type of conflict of interest—what we do is not to be compromised by accepting "payment" in any form.

Dress code—the key is modesty, no shorts, no skirts above the knee, no yoga or sweat pants, no tight pants, jeans or "jeggings," no low necklines, no cutoff pants or pants with holes, no shirts with any messages on them that can be construed as offensive. All clothing must be in good taste representing a well-ordered spiritual life.

BE SPIRITUALLY GROUNDED—UNDERSTAND WHO YOU ARE AND WHOSE YOU ARE!!!

VI. Visitation Etiquette

See PowerPoint notes, James-Tannariello's (2013) material, understanding hospital jargon, and knowing the environment and culture.

Basics of a Hospital Visit

The Biblical basis for hospital visitation has its roots in scripture where tending to the sick is considered a righteous act. Visitation is a response to Jesus words in Matthew 25 to tend to the needs of "the least of these," to visit the sick (Paget & McCormack, 2006). It is a call to go to those in need. The hospital is a place where a person is in distress and in need of care and support. The practice of going to people to provide ministry is what Jesus did. He went among the people, healed the sick, and cared for those in need.

The chaplain first focuses by practicing presence, by praying, take deep breaths and relaxing. This prepares the mind for the visit and what may be seen or experienced. At the doorway always knock and ask permission before entering; ask if it is ok to visit.

A chaplain shows respect for the patient and in the case of pediatrics the family by asking permission to enter their domain. Introduce yourself and allow the conversation to focus on the patient and not yourself.

Listen without planning to provide all the answers. Ask clarifying questions. If necessary, reflect back what you heard, "Let me see if I heard

you correctly?" Ask the patient or family member if they have any special concerns that you should know about.

Do not force prayer upon them but ask if they would like prayer. Pray in accordance with what you have heard in the conversation, if they are facing surgery pray that all goes well, if they are afraid then pray that God would provide them with peace and comfort.

When planning patient visits, get guidance as needed. Mentoring, shadowing, and learning the way things are done is beneficial to effectiveness since hospitals have their own culture. This is what we actually did. Aside from training it was confidence building and encouragement to be active spiritual care providers.

Why Visit?

- In the hospital the person in need of assistance is sometimes confined to a hospital bed or their room. The Spiritual care provider visits by going to where the need is.
- A visit should have a purpose. A good visit should comfort, support, and aid in the process of healing.
- One of the most vulnerable times a person may face is during a hospitalization. It is a time when a person can be most sensitive to any changes around them.
- What can a visit do?
- Create greater potential for healing.
- Bring the presence of God to a person in need.
- Decrease feelings of loneliness and isolation.
- Help the patient feel valued.
- What can a visit do? (cont'd)
- Help calm an anxious person.
- May provide reconciliation between those in conflict.
- May bring out information unknown to those nearest the patient or caring for the patient.

Preparation for Visit

1. **SILENCE YOUR CELL PHONE !**
   The other first. PRAY…**PRAY**…**PRAY**… and… Oh, yeah…**PRAY!**
   In your prayer ask the Lord to use you an instrument to bring glory to God, allow God to use you as an instrument.
2. Ask Yourself: **"Why am I going?"**

- Am I going to provide spiritual care or out of duty or curiosity?
- If you are resisting visiting someone or some place (cancer floor?), explore why and seek an answer from the Lord.

Ask: "How is my own health?"

Don't go if you are sick. You may jeopardize the health of the patient, the staff, and yourself.

Ask and think about "When is a good time to visit?"

You do not want to visit at mealtime or when a patient is receiving medical treatments, when wound dressings are being changed or when the patient is sleeping.

A good time is when a person does not mind company.

With children, be aware that some parents may not want someone visiting their child while they are not present. Always respect those boundaries. Also, be aware of the appearance your visit may have behind closed doors. If possible, visit a child with the door open unless they are older and give the OK for the door to be closed.

- Patients and families welcome visits prior to surgery.
- They seek prayer and often request chaplain visits prior to surgery.
- Visitation Protocol
- Hand washing
- Obey all signs on doors
- Precautions Gown/Gloves/Masks
- Knock on Door and identify self before entry
- Observations

The Visit

- Introduce yourself and be sure to identify yourself as there to provide spiritual support.
- Allow the patient and family time to talk.
- With children they may not talk much but include them in the conversation if at all possible.
- Remember you are a **visitor;** respect personal boundaries.
- Do not sit on the bed!
- A large part of your work is to listen, use active listening skills. It is OK to repeat back what you heard for clarification or to summarize ("So what you are saying is…").
- Be aware of your own emotional state in the hospital.
- Seeing sick children can be very emotional for anyone.
- Be patient and sympathetic.
- Do not draw conclusions or judge anyone. No one likes it and it is never helpful.
- Do not try to have all the answers. A question you may face is: "Why did God let this happen?" Resist the urge to defend God, you are **NOT** God.
- Be careful about what information you give.
- Do not make declarations that you cannot prove. ("You'll be alright; you'll be out of here in a few days"). A terminal patient does not need to be lied to.

- Understand that healing may not always mean a cure.
- Some of us may only be made whole in the next life.
- Remember your faith is not the patient's or the family's faith.

No proselytizing! No preaching!

This is not your Sunday school class. If you feel the need to teach, your own church is the place for it!

*It is not fair to a patient. They are a captive audience. They cannot get away if they want to. Most people are too polite to kick you out even if they want to!

Caring Communication

- Your duty is to have caring communication.
- You communicate best by showing love and respect to everyone, even if they are not of the same faith tradition as you. **NEVER** put down any faith; it is not good spiritual care. If you put down their faith, most people take it personally and become offended. It's just not the proper thing to do! Especially when you are trying to make inroads and assist a person who is seeking spiritual support.

Concluding Your Visit

- Conclude your visit on a positive note.
- Do not give a phony sense of optimism.
- Express genuine concern for the patient and family.
- Do not make any promises ("I'll see you again, Lord willing" is ok)

VII. Effective Ministry in a Pediatric Setting

Understanding the special world of children and their families especially in the NICU, the Spiritual Care Provider is more effective if he or she understands the needs of patients and parents. The Hematology and Oncology units also have special needs unique to each one. Learning how to connect with the child, his life, his parents, and the social workers is very helpful. On the Rehabilitation units, physical and occupational therapies are a major focus.

CHILD DEVELOPMENT

Patient's Needs come first!

Ministry to children and families—Ministry in the context of a family

When given a diagnosis, families need support to come to grips with what they have heard.

They need your full attention, a supportive listening presence, not judgment or condemnation.

- **The most powerful medicine is to be totally present and focused as if no one else in the world existed at that moment. Your time with the patient and family should be brief but profound.**
- Radiate love and compassion
- Show sensitivity and acceptance
- Pray when appropriate
- It is OK to read or quote scripture when it is appropriate, but do not "force it in" or push it to make yourself feel more comfortable.
- You must learn to be comfortable while feeling uncomfortable.

When a person is dying or not doing well and family members are grieving and seem to be falling apart, be the calm in the midst of their storm.

In this hospital, we care for children from birth to age 20.

We also care for adult children with congenital disabilities who require pediatric specialists. Most of these patients already have had a history of treatment at this hospital.

A key to successful ministry at Children's Hospital requires some skills that we may take for granted. Every person who desires to do quality ministry at Children's Hospital must invest some time in learning and understanding child development.

When caring for children, it is always done in the context of the family. Even when no parent is present, the child still needs family support whether they are a newborn premature infant or an independent emancipated minor.

MINISTRY TO CHILDREN AND THEIR FAMILIES

Providing spiritual care to children is not like any other experience. There are limited resources available to most people that inform and guide their spiritual care with children and families.

1. Challenges of Providing Spiritual Care to Children

- Children are NOT miniature adults—they have special needs
- Children do not possess the vocabulary and communication skills of adults. They have challenges expressing concepts in ways that truly capture their emotions and communicate to adults what their specific needs are at times. Communication is a two-way street. Adults also have challenges communicating ideas and concepts in ways that children can understand and relate to.
- Children are still developing and learning—they rely on adults to guide them as they move toward maturity.
- Much of ministry occurs within the context of the family

- The family can have a positive or negative impact on the child. The presence of family members can be comforting and beneficial to a child, or the family could be a source of stress to a child.
- A stable family can help during a time of illness or crisis. Conversely, an unstable family unit can add additional stress during an illness or crisis.

Knowledge of family systems theory is important and helpful.

In the family unit, there are five categories of stressors that anyone may face.

The 5 Categories of Stressors are:

1. Loss
2. Chronically disturbed relationships
3. Events that change the family status quo
4. Events that require social adaptation
5. Acute traumatic events

   A crisis can arise from any source of stress. Stressors do not discriminate! Sometimes children are deeply impacted by these stressors and with the addition of illness, the crisis intensifies.

2. **Our Role Is to Help Children**

- Articulate their questions (children are naturally inquisitive and tend to ask questions during periods of heightened anxiety)
- Express their emotions
- Search for creative answers
- Connect with the community in meaningful ways
- Say good-bye if necessary

3. Ministry to Children Involves Building Effective Relationships

Keys to Building Effective Relationships With Children

- Make eye contact at the child's physical level
- Speak slowly, in a soft voice
- Introduce yourself using the name you want to be called by the child
- Explain your job/role
- Accept periods of silence
- Set limits regarding safety and fair play
- Keep humor at the child's developmental level
- Give a few minutes before your visit will end
- Let the child know when you will visit again
- Do not make promises (children do not forget)

4. Spiritual Care and Child Development

Quality spiritual care to children requires an understanding of child development! An awareness of stressors and difficulties of children can help you with your ministry.

Child Developmental Stages and Sensitivities:

a. Age 3 and under: separation and safety
b. Age 3-7 years: abandonment, punishment, and bodily harm
c. Age 7-13 years: loss of control, fears of death
d. Age 13-18 years: physical appearance, loss of peers, fears of dependency

5. **Spiritual Difficulties of Children**

   A. Loneliness/Abandonment/Separation

   Children develop *separation anxiety* at just a few months of age when they are able to recognize mother and can differentiate other people.

   Children react to protect themselves from abandonment and the possible loss of nourishment, warmth, and comfort.

   B. Anxiety/Fear

   Children experience anxiety and fear in response to environmental cues.

   Fear is a specific reaction to a specific stimulus (afraid of water).

   Anxiety refers to a more diffuse set of responses (children are generally anxious about doctor visits). ADULTS TOO! **Am I going to get a shot?**

   C. Guilt/ Shame/Self-blame

   Children associate actions with cause and effect (I did something bad, that's why my doggie died).

   They tend to see themselves as the cause, generating guilt without understanding that other forces are also at work.

   D. **Anger/Hostility**

   A child may experience anger because illness may rob them of a goal (I really hate staying in the hospital. I missed the party/Homecoming/Prom).

   A child may become angry as they feel personal boundaries have been violated.

E. Meaninglessness

Children ask a lot of "Why?" questions, as they struggle to find meaning. **This is the basis of spiritual care, to assist them on their journey to discover some answers.**

F. Grief

Children grieve the loss of many things. They desire to be like others and grieve the losses of things which tend to make them different.

They grieve the loss of opportunities

They grieve the loss of relationships.

In the U.S. 5% of children under the age of 18, **approximately 1.5 million** have encountered the death of a parent.

Children ages 10-14 are especially sensitive at this time of their development.

Children Are Disadvantaged Grievers

How children handle grief is based on their developmental stage.

Very young children (0-5 years) do not understand death to be irreversible. The only thing they grasp is that the person disappeared (Peek-a-boo with an infant). They grieve but do not fully understand why.

Children between (5-10 years) continue to clarify their concepts but still do not have full understanding of death and all its implications (concrete understanding, literal interpretation-i.e. an open casket–half visible person)

Children and the Cognitive Understanding of Death

Very young children (0-5 years) do not understand death as irreversible.

Children between ages (5-10) continue to clarify their concepts of death but are still confused at times. They might say, "When I die, my heart stops, I can't see, and I can't hear. But if I am buried, how will I breathe?"

We must remember in spite of a child's limited understanding of certain concepts, **children DO grieve.**

6. **Spiritual Care Providers Can Play a Significant Role in the Grief Process of Children.**

We can help by validating and clarifying feelings

We can be a source of comfort and support

Our purpose is to help children and their families to utilize spiritual resources, which promote health and wholeness, respecting the dignity of all persons, regardless of religious belief.

Specific Things We Can Do to Help Moderate the Grief Process

1. Educate the child and family (encourage honesty about death)
2. Help maintain routines as much as possible (encourage them to eat something when hungry)
3. Support family members—both parents and **especially siblings**
4. Do things that promote healthy coping and development in general

Good spiritual care encourages families to draw on faith.

Our role is to offer: spiritual guidance, emotional support, and compassion.

Remember: MINISTRY TO CHILDREN IS A PRIVILEGE. They have special needs that we must take time to listen and learn (children are amazing teachers).

Grief and Mourning *** Parents may be the focus here.***

- Be aware that children do die in this hospital and people will be in mourning at times.
- Also know that there are cultural differences in mourning (emotive styles, very private and personal styles, etc.)

What **NOT** to say:

- **At least you have other children**
- **You are young. You can have more children**
- **God doesn't make mistakes. He has a reason.**
- **God wants your baby more than you do.**
- **God needed another flower in his garden.**
- **He/she is a little angel now.**
- **It was God's will.**

Grief

- Grief is the feelings associated with the experience of loss.
- Mourning is the act or ritual one goes through during a time of loss.
- Grief can be private while mourning can be a form or ritual.

Confidentiality

- Everyone who performs service in a hospital is bound by the rules of HIPPA.
- Patient privacy must be respected.
- Violations can and will result in dismissal.
- It could also open you up to legal action by a family.

What We Do

- We help people connect with their spiritual resources in ways that promote health and healing.
- Helping people discover and use their spiritual resources in the service of their healing is part of the role of a spiritual care provider.
- Spirituality can be a tool for healing!

- Providing Spiritual Care is an honor and a privilege.
- Providing care in a pediatric setting is both challenging and rewarding.

VIII. Boundaries

SEE PPT—Boundaries and referrals. Spiritual Care Volunteers should also practice good boundaries by knowing when they are in a situation that may call for someone equipped with skills to provide specialized care.

REFERRALS-When should you refer???

- When patients expressed suicidal tendencies
- When a patient seems to disassociate with reality or may behaving erratically
- Overly angry or irrational patients
- When you feel the situation may be beyond your ability to handle

IX. Death, Grief and Loss

When you spend enough time in a Children's Hospital, you will encounter death, grief and loss. The role of the spiritual care provider acting as chaplain is to provide support to those who have experienced death, are in the throes of grief, or have experienced loss.

Some of the most powerful moments of ministry that we may have the privilege of being a part of is at the time of death. People tend to look for spiritual support during this time and the spiritual care provider can be a great source of comfort during what may be the most difficult time of a family's experience in the hospital.

Sometimes grief is the experience that we are asked to provide ministry to a family or an individual. Remember you are not there to "cure" grief. It is not something that needs to be "cured" at least not by humans in this life. Grief ministry is being present with people during the darkest of times. Psalm 23 comes to mind. "Yea, though I walk through the valley of the shadow of death…." The role of the spiritual care provider is to see to it that they do not walk through the valley alone. "For thou art with me." The verse is speaking of the Lord, and we are representatives of the Lord by our presence and our choice to be spiritual support.

X. Self-care

No doubt you may encounter some very difficult situations that may even shake your own faith. Do not go it alone. Seek help, speak with a staff chaplain to help you debrief. It is a good practice that will help you avoid compassion fatigue which is very real.

Know your own limits. No one can do it all. We are human and

subject to the effects of living in an imperfect world.

Take care of your own spirit. Do things that provide you with spiritual sustenance—make sure your soul is fed and nourished. If you are not being spiritually renewed, you will be overwhelmed. This takes team work. Use the resources available to you. And do things that feed, revive, recharge, and restore you for ministry.

This manual does not contain everything but was produced to act as a basic guide that can help you in your growing faith and spiritual development.

May God bless you as you seek to serve others.

XI. Spirituality and Religion

Identifying Spiritual Distress
The following symptoms indicate spiritual distress:

- Verbal questioning of the meaning of life and the purpose of illness
- Verbal questioning of one's own belief system (Why has God's let this happen? Why my child?)
- Withdrawal from, or loss of, relationships (no one visits me)
- Expressions of anxiety, anger and/or depression

Spiritual distress can be triggered by events such as:

- First admission to the hospital (or repeated hospital admissions)
- A devastating or terminal diagnosis
- Suicidal thoughts

Interfaith spiritual care
Spiritual development in children

XII. Communication and Listening Skills

Visitation Etiquette
Includes Boundaries
Understanding hospital jargon (codes, etc.)
The use of prayer—prayer communicates much

XIII. Ministry to Children and Families

Understanding the pediatric patient
Child development (see handout from Rene Assetta Guilbeau)
The Impact of Culture and Religion
Religious diversity

XIV. Death, Grief and Loss

Bereavement, grief, and mourning
Examine your own losses
The Art of Being a Healing Presence

Empathetic presence. Don’t do something, just sit there!
Planning your shift

XV. Mentoring, Shadowing, and Supervision

XVI. The Future
Active participation
Blessing and commissioning
Certification to provide spiritual care in Children’s Hospital
CAUTION—you have some knowledge but (Jedi not yet you are!!!)

APPENDIX C

COMPETENCIES OF A TRAINED SPIRITUAL CARE VOLUNTEER

COMPETENCIES OF A TRAINED SPIRITUAL CARE VOLUNTEER

An awareness of one's temperament, including strengths and limitations

A commitment to one's own continuing education and growth

Actions and attitudes that show respect and compassion for all persons

An ability to be a non-anxious presence in stressful situations

Self-discipline and respect for professional boundaries necessary to protect vulnerable populations

The ability to relate well to a wide variety of persons and age groups

Honesty and personal integrity

Good self-care and vital spiritual life evidenced by faith, hope, love, forgiveness, and joy

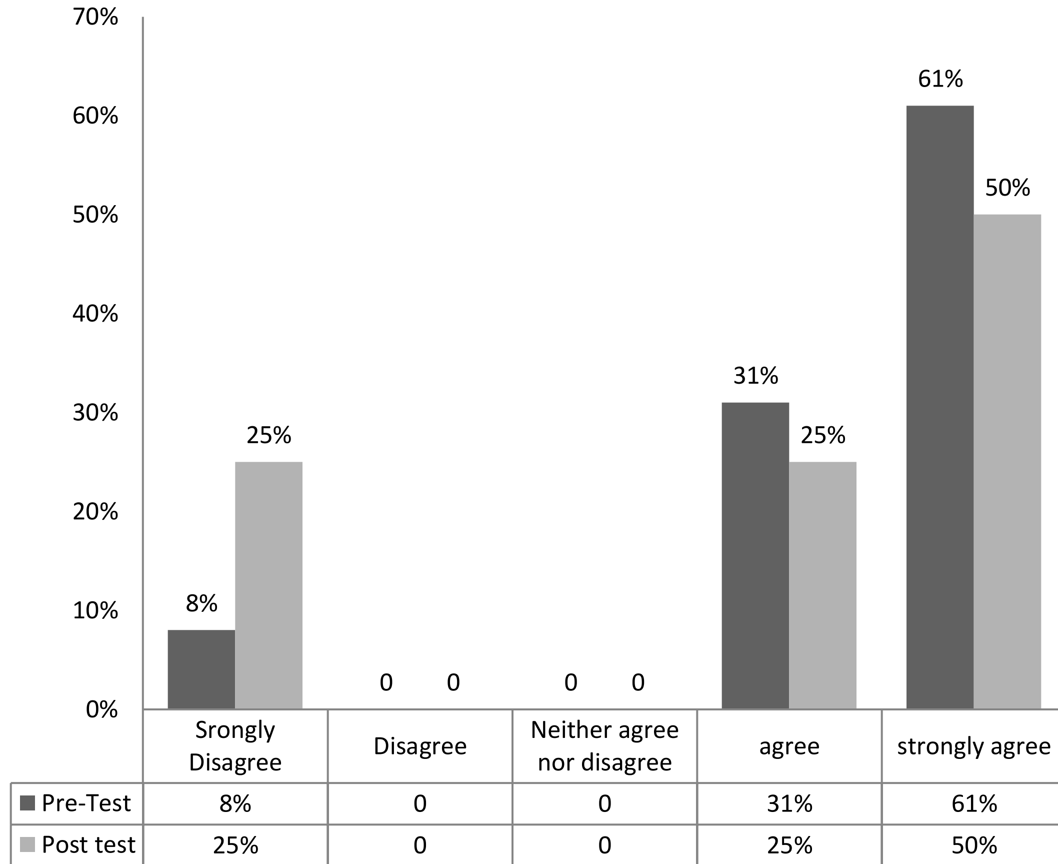
A respect and appreciation for the basic tenets, practices, holy days, taboos, and rites of diverse faith groups (including those who ascribe to no faith)

A respect for the confidentiality of pastoral conversations and the vulnerability of the persons in a hospital environment

An understanding of the role of the spiritual care volunteer and a commitment to the mission of the spiritual care volunteer program

APPENDIX D

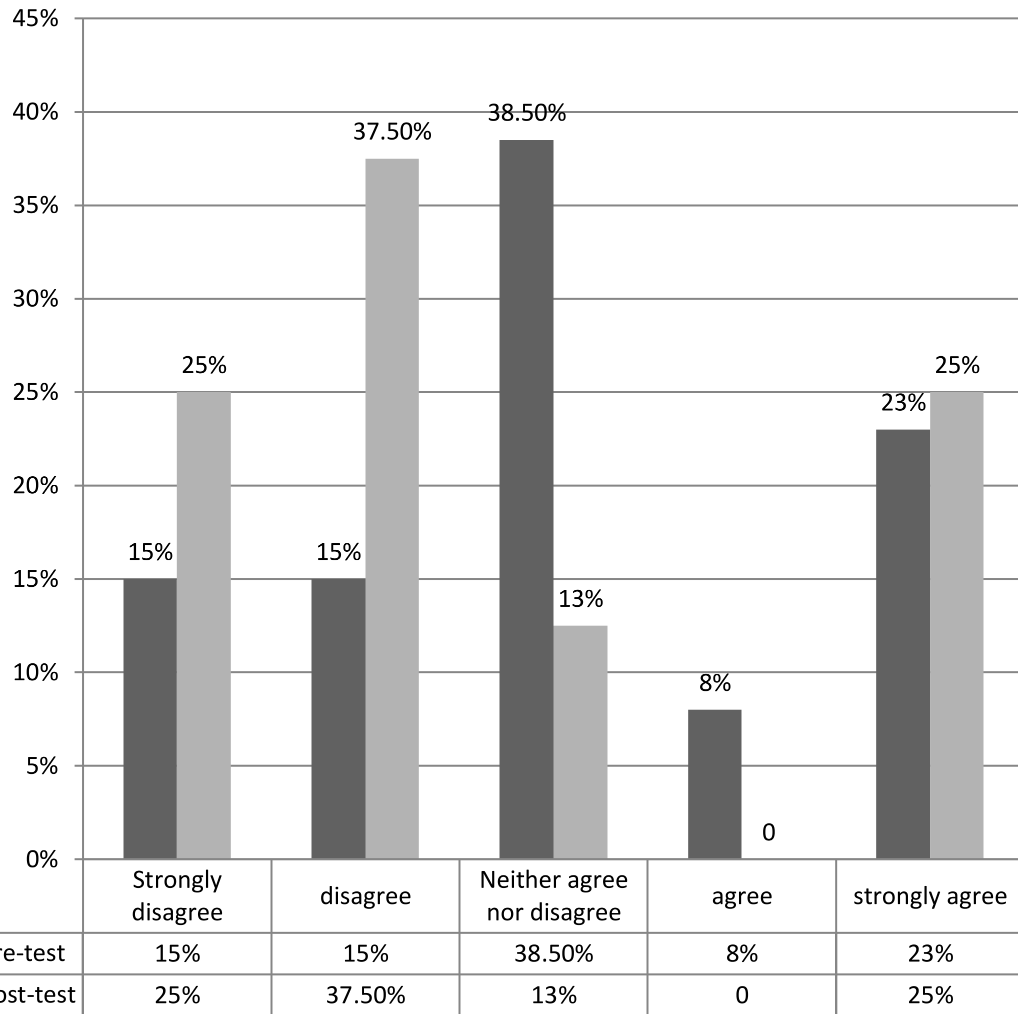
PERCEIVED IMPACT OF VOLUNTEERS



Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX E

PERCEIVED SPIRITUAL PROVIDER ROLE

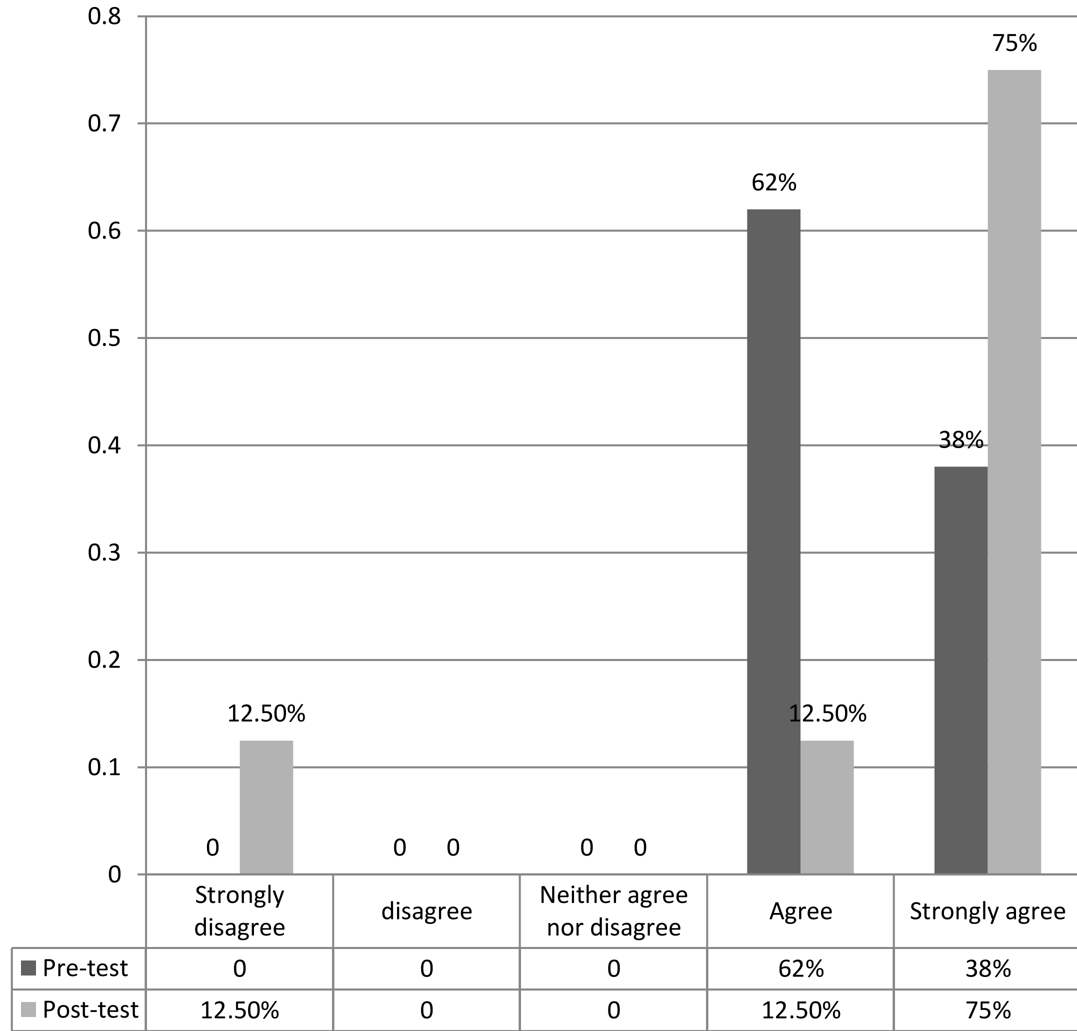


	Strongly disagree	disagree	Neither agree nor disagree	agree	strongly agree
Pre-test	15%	15%	38.50%	8%	23%
Post-test	25%	37.50%	13%	0	25%

Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX F

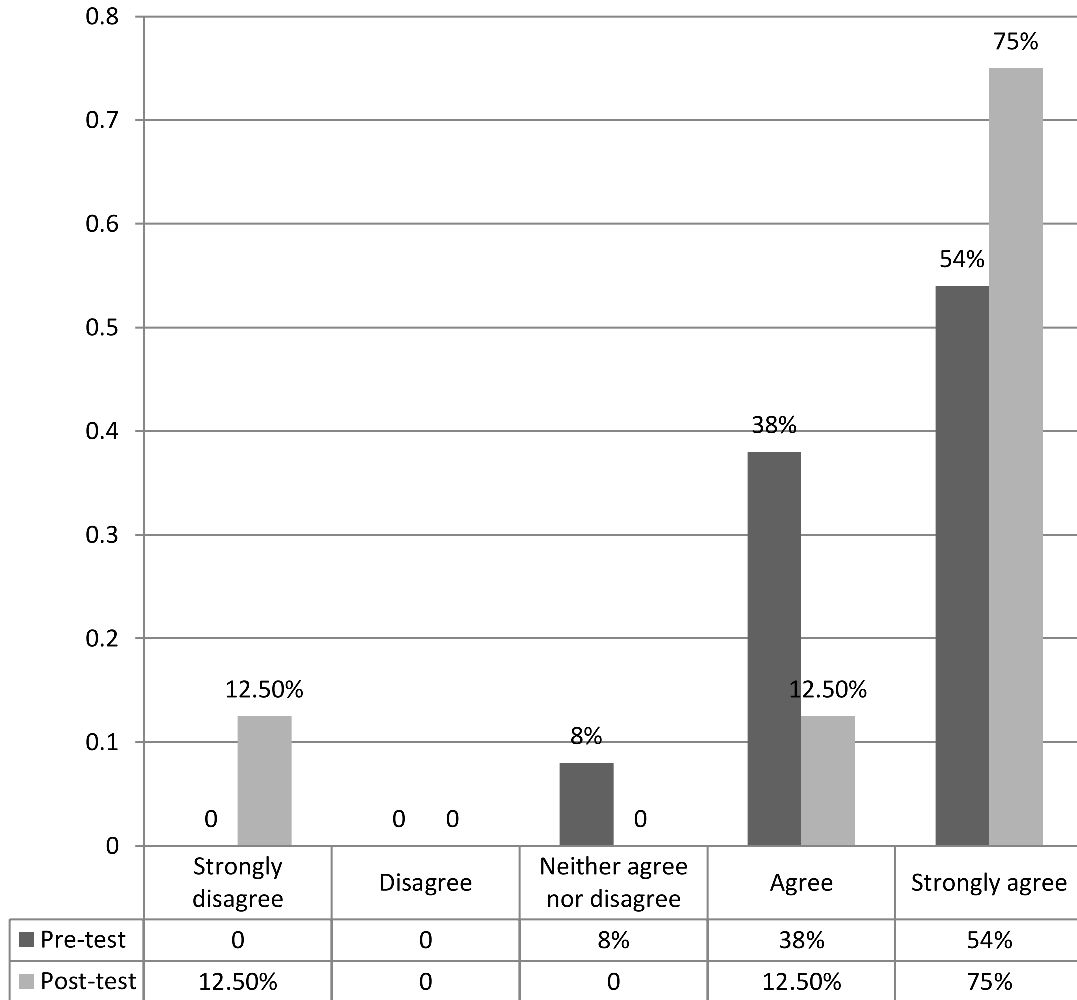
PERCEIVED PURPOSE OF SPIRITUAL CARE VOLUNTEERS



Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX G

PERCEIVED COMFORT WITH VISITATION

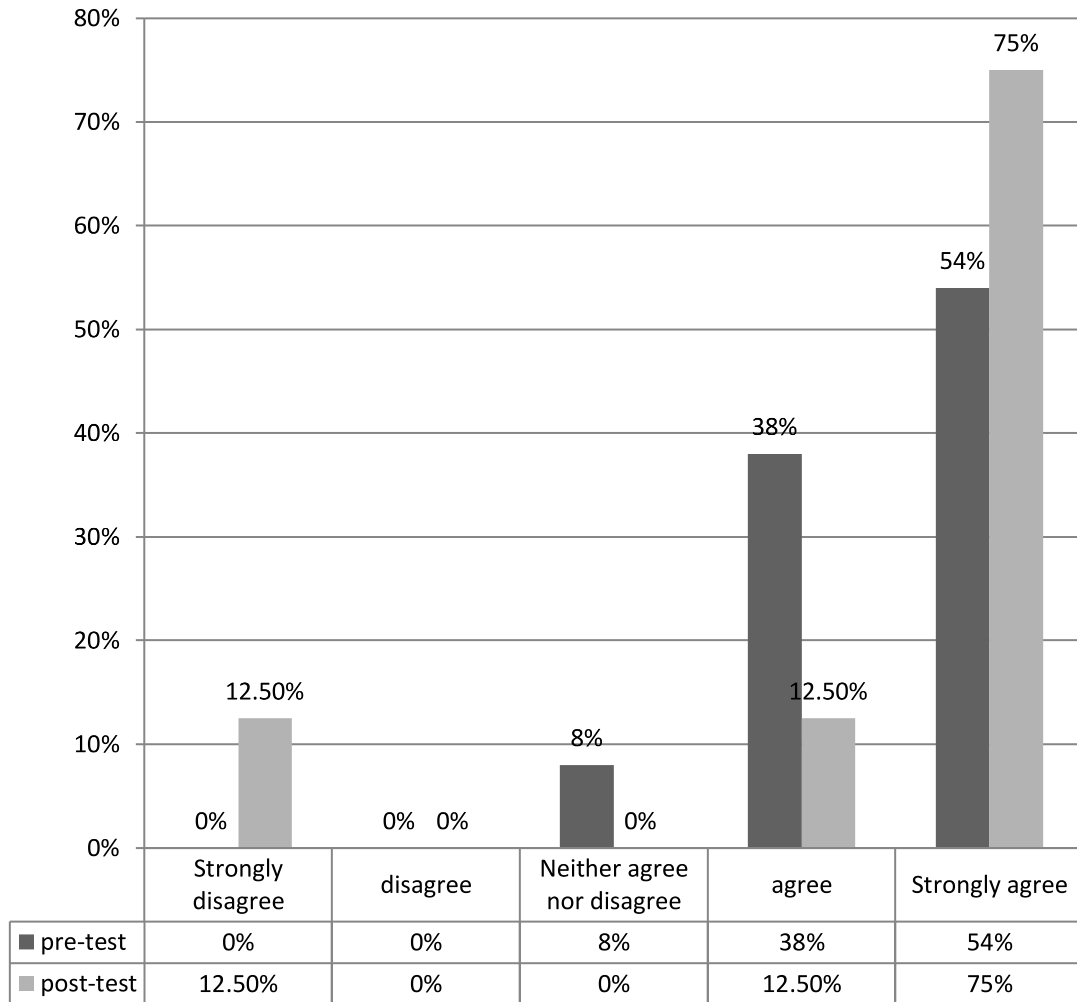


	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Pre-test	0	0	8%	38%	54%
Post-test	12.50%	0	0	12.50%	75%

Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX H

PERCEIVED COMFORT WITH PRAYING

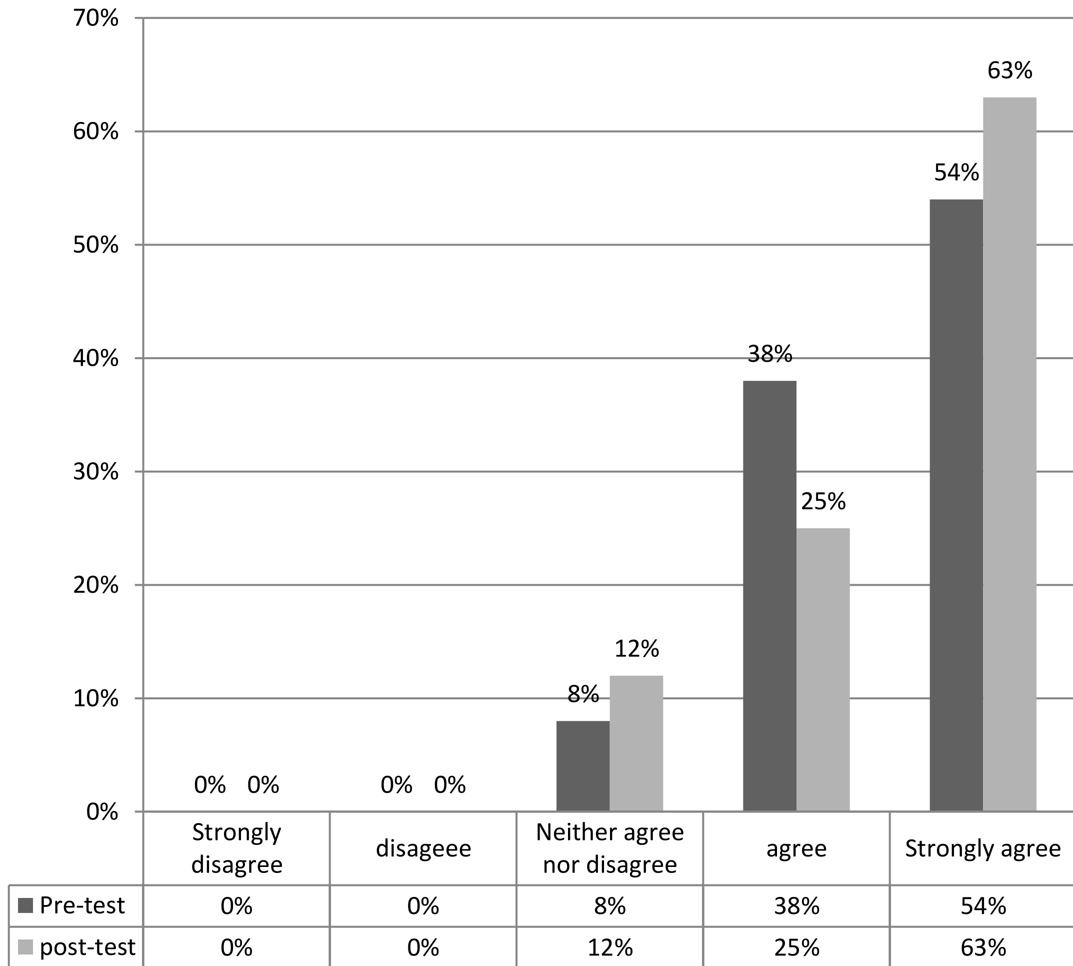


	Strongly disagree	disagree	Neither agree nor disagree	agree	Strongly agree
pre-test	0%	0%	8%	38%	54%
post-test	12.50%	0%	0%	12.50%	75%

Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX I

PERCEIVED COMFORT PROVIDING GRIEF CARE

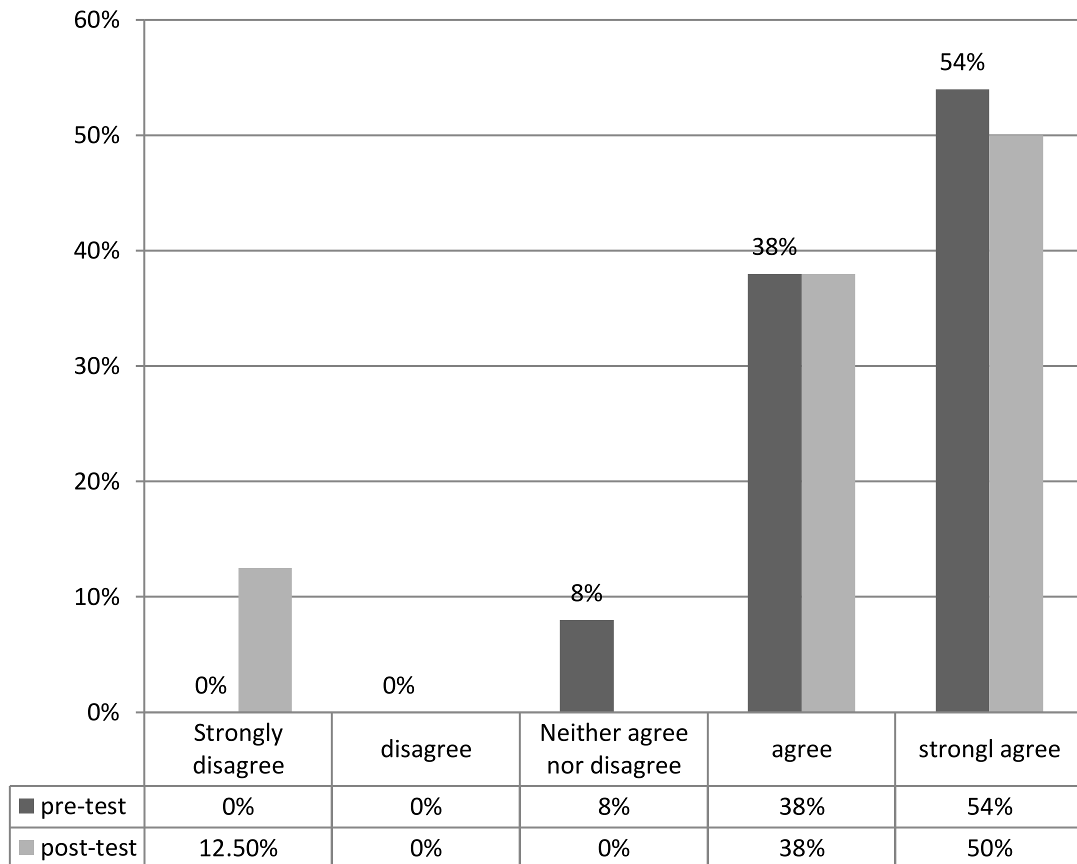


	Strongly disagree	disageee	Neither agree nor disagree	agree	Strongly agree
Pre-test	0%	0%	8%	38%	54%
post-test	0%	0%	12%	25%	63%

Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX J

PERCEIVED COMFORT WITH DIFFERENCES

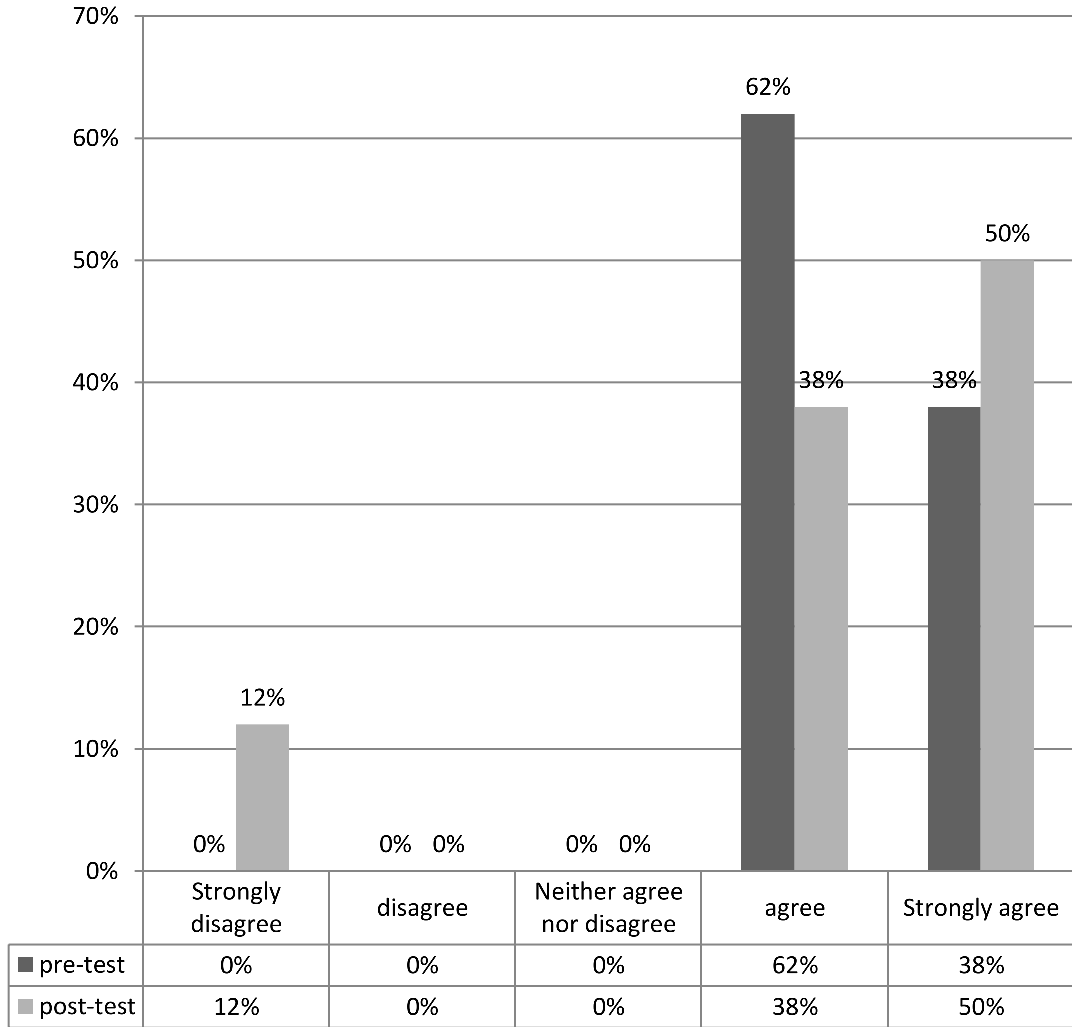


	Strongly disagree	disagree	Neither agree nor disagree	agree	strongl agree
pre-test	0%	0%	8%	38%	54%
post-test	12.50%	0%	0%	38%	50%

Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX K

PERCEIVED COMPETENCE IN PROVIDE SPIRITUAL CARE

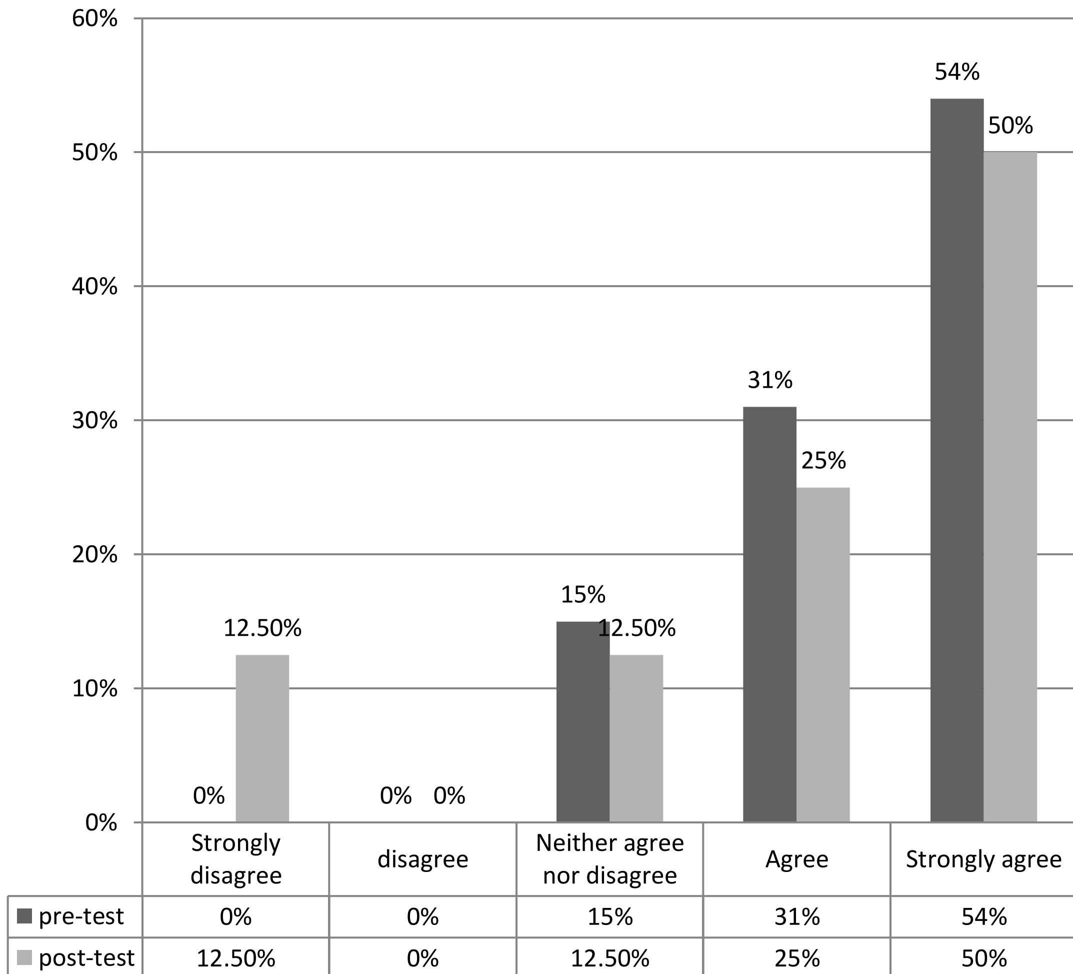


	Strongly disagree	disagree	Neither agree nor disagree	agree	Strongly agree
pre-test	0%	0%	0%	62%	38%
post-test	12%	0%	0%	38%	50%

Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX L

PERCEPTIONS REGARDING FREE EXPRESSION OF SPIRITUALITY

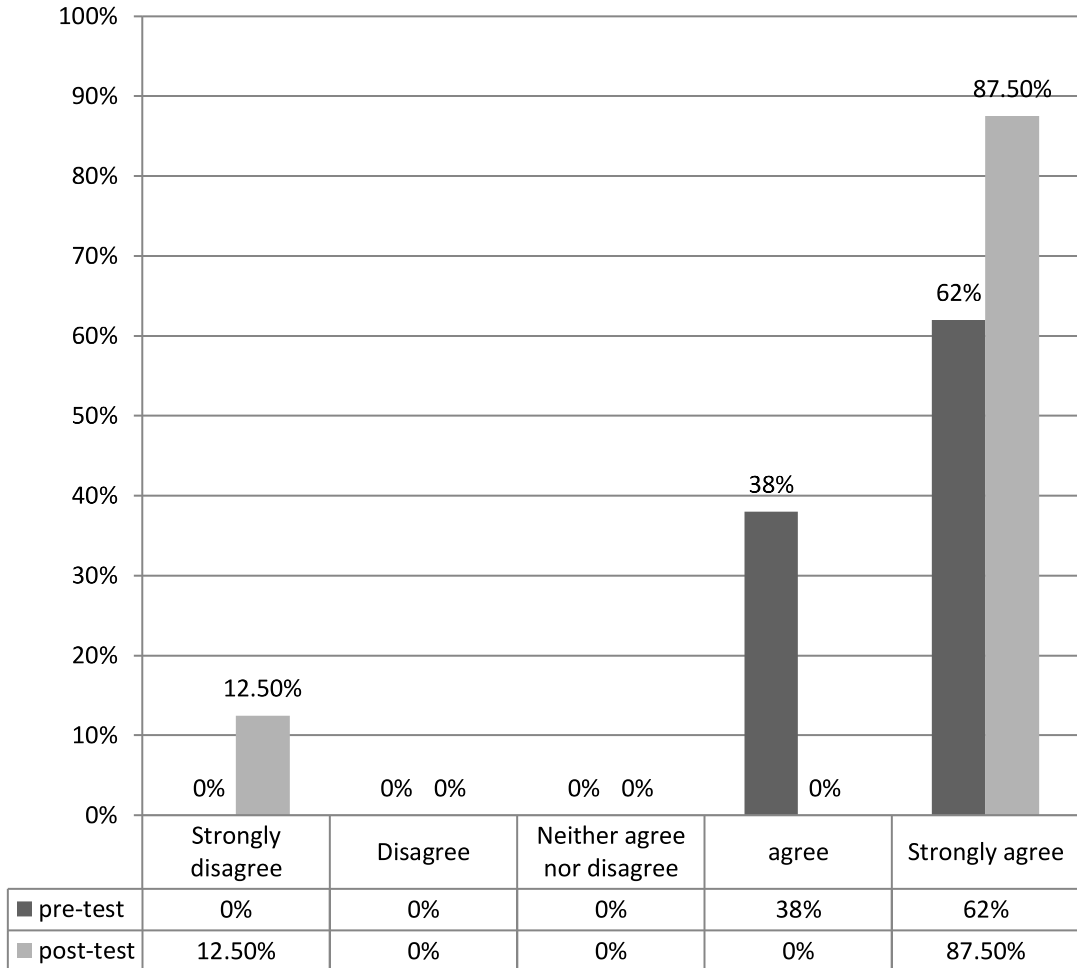


	Strongly disagree	disagree	Neither agree nor disagree	Agree	Strongly agree
pre-test	0%	0%	15%	31%	54%
post-test	12.50%	0%	12.50%	25%	50%

Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX M

PERCEIVED WILLINGNESS TO CONSULT CHAPLAIN



	Strongly disagree	Disagree	Neither agree nor disagree	agree	Strongly agree
pre-test	0%	0%	0%	38%	62%
post-test	12.50%	0%	0%	0%	87.50%

Pre-test surveys were answered by 13 participants.
Post-test results were answered by 8 participants.

APPENDIX N

SPIRITUAL CARE VOLUNTEER APPLICATION

Spiritual Care Volunteer Application

Please complete the application below which will be reviewed for consideration

First Name _________________ Last Name _________________________

Street Address ____

City____________________________ State ______ Zip Code ___________

Phone/Cell Number _________________________________

Email Address ____

Date of Birth ____

Occupation ____

Employer ____

Previous Volunteer Experience ____________________________________

Hobbies, Interests, Languages spoken _______________________________

Organizational Affiliations ____

Religious Affiliation ____

APPENDIX O

AVAILABILITY FORM

Name: ____

AVAILABILITY (PLEASE CHECK ALL THAT APPLY)

- ☐ **Sunday**
- ☐ **Monday**
- ☐ **Tuesday**
- ☐ **Wednesday**
- ☐ **Thursday**
- ☐ **Friday**
- ☐ **Saturday**
- ☐ **Morning (example 8am – 12pm)**
- ☐ **Afternoon (Noon – 4pm)**
- ☐ **Evening (4pm – 7pm)**
- ☐ **Overnight (7pm – 8am)**
- ☐ **On-call**
- ☐ **Emergency calls (only)**
- ☐ **Once a week**
- ☐ **Once a month**
- ☐ **Commit to providing a minimum of 50 hours of service during the course of a year**
- ☐ **I have read the enclosed guidelines for being a Spiritual Care Provider at Children's Hospital and understand that I may not evangelize, proselytize, or hand out any materials other than those provided by the Spiritual Care Department.**
- ☐ **I understand that it is my privilege to be a Spiritual Care Provider and it may be rescinded at any time at the discretion of Children's Hospital.**

Signed ____

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VITA

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Education:

2019	Doctor of Ministry in Chaplaincy from the Seventh-day Adventist Theological Seminary at Andrews University
2000	Master of Divinity (Chaplaincy emphasis) from the Seventh-day Adventist Theological Seminary at Andrews University
1992-1994	Attended Oakwood College (now University) pre-med studies
1990	Bachelor of Arts in Biology, Lafayette College, Easton, PA

Ordained:

2013	Ordained Seventh-day Adventist Minister by Southwest Region Conference and currently hold ministerial credentials from North American Division of Seventh-day Adventists located in Columbia, Maryland

Experience:

2002-present	Staff Chaplain, Children's Hospital-New Orleans
2004-2014	Pastor, Better Living Seventh-day Adventist Church, Houma, LA
2001-2002	Resident Chaplain, New Orleans Police Department

Professional Memberships and Activities:

2007-2013	Secretary -Seventh-day Adventist Healthcare Chaplains Association
2010-2014	Louisiana State Representative- Association of Professional Chaplains
2014-2016	Advisory Council At-large Member Pediatric Chaplains Network