

Additional *Brief* Samples of Ideal Intervention Paper Project (IIP) Reports

Selected and Compiled by Dr. John Gleason on 7/21/09, with additions:
(G-P) on 8/17/09; (Q-X) on 9/18/09; and Y-DD on 12/21/09

CONTENTS:	Page:
A) Shock at News of the Murder of a Loved One	2
B) Recently Divorced, Alleged Sexual Abuser, Homeless, Disabled Male	3
C) Patient Requesting Completion of an Advance Directive Form	3
D) Providing Appropriate Services for Dementia Patients	4
E) Sense of Hopelessness after Terminal Diagnosis	4
F) Care of Physician / Care of Self during a Medical Emergency	5
G) Suicidal Male Facing Unwanted Divorce	5
H) Anxious Psychiatric Patient Feeling Relationally Isolated and Abandoned	6
I) Caring for the Confused Patient	8
J) Son's Concern about Dying Father's Spiritual Status	9
K) Fetal Demise, with Nominal Catholic Parents Requesting Bedside Prayer	10
L) Belated Receipt of a Death Message	11
M) Lack of Patient Support Systems	14
N) Patient in Conflict with Hospital Staff Caregivers	16
O) Psychotic Patient Wishing No Contact with Family	17
P) Pain Plus Frustration with Hospital Medical Staff	18
Q) Rectifying a Mistaken Cremation	19
R) Caregiver Learning to Uncritically Accept Where Patient Is Spiritually	19
S) Management of Pastor/Parishioner Conflict; Vengeful Anger Unleashed; The Pastoral and the Prophetic Voices in Tension; Clash of Cultures	20
T) Confronting Codependency; Breaking Addictive Behavior with a Team Approach	21
U) Managing Self-Doubt Appropriately	22
V) Enabling Healing in a Situationally Psychotic Adolescent Female w/ Religious Ideation	23
W) Establishing Basic Trust	24
X) Becoming Directive in an Emotional/Spiritual Crisis	24
Y) Terminally Ill Patient with Little English from an Ethnic Pentecostal Community	25
Z) Terminally Ill Patient with Difficulty Communicating	26
AA) Elderly Female CHF Patient Finding No Meaning in Life and Wanting to Die	27
BB) Lonely, Obese Female Rehab Patient with Disconnection in Relationships	27
CC) Gay Bipolar Male with HIV and Alcohol Issues Feeling Rejected and Victimized	28
DD) Responding to Multiple Life-and-Death Issues Shared During a Spiritual Assessment Interview with a 33-Year-Old Caucasian Female, Including Suicidal Ideation	29

A) Shock at News of the Murder of a Loved One

1. Brief phrase stating the spiritual care central issue

(Examples of central issue identifiers are: 'feeling angry and abandoned by God,' 'hope in terminal illness,' 'coping with a fetal demise,' etc.)

Shock at News of the Murder of a Loved One

2. A description of the patient's circumstances, problems and needs for spiritual care

(This description can include information about the congregant/patient/client that is considered relevant for the choice of the best approach for providing spiritual/religious care: e.g. gender, ethnicity, age, religious preference, expressed or perceived need, family issues and social support, particular circumstances, and any other aspect that may be relevant for the spiritual care to be provided. For confidentiality, uniquely identifying information should not be included.)

As a community hospital chaplain on call, I met the arriving mother of a young adult African American male penal institution inmate who had been pronounced DOA upon arrival at the ER. The 40s-appearing mother was accompanied by two AA adult males in their 20s. They were as yet unaware of his death, but as we were meeting in the hallway the mother "read" my face and collapsed onto the floor in anguished wails. I enlisted the two men's help in assisting her to a small family room, where we provided creature comforts and I offered a prayer.

I acted as a go-between from the mother to staff and back, informing staff of her arrival and getting the MD to check in with her. Later, when the mother asked if she could see the body, I took her request to the staff, and relayed the word from the MD that this could not be done because of the required murder investigation procedures that would take some time. I also conveyed the doctor's advice to return home and stand by for further guidance on how to proceed. Throughout the process I stayed close by the mother and repeatedly expressed my sadness and regret at this horrific event and its impact. As they were leaving, I accompanied the mother and one young man to the exit. When the other young man drove up in their car, I assisted her in getting seated. As she was settling in she looked up at me and said, "Thank you."

3. A description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this patient

(E.g., a narrative description of how you would do the intervention (possibly differently) if given another opportunity. Write so that another practitioner encountering a similar situation could benefit from your insights. This description may include, at the discretion of the practitioner, reference to details of the original intervention that was provided in the encounter, but the primary interest should be on how the practitioner considers the intervention could have been best handled.)

In a similar situation I would: make a great effort to not get caught up in the flood of emotion, be sure to introduce myself and my role, learn the names of all three people and their relationships to each other, and use their names in my prayers if prayer is wanted, though with guidance from them re prayer content. I would elicit religious preference and the deceased's story. I would strongly negotiate with staff regarding viewing to allow grieving and prayer if desired. I would also suggest involving a pastor of their choice, encourage them to stay longer if desired, and provide a list of important contact phone numbers so that they could monitor the situation from home and know what they could do next.

B) Recently Divorced, Alleged Sexual Abuser, Homeless, Disabled Male

1. Statement of the Spiritual/Pastoral Care Central Issue (e.g., Feeling Angry and Abandoned by God; Hope in Terminal Illness, etc.)

Recently divorced, alleged sexual abuser of daughter, homeless, disabled 35 year old adult male.

2. Narrative Summary of the Actual Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description. Take confidentiality precautions.)

I introduced myself as the chaplain. I listened to the patient's story of being recently divorced; of how he wanted to be reunited with his wife; of how his three daughters meant the world to him; of how he attempted to commit suicide after by jumping off of a three story psychiatric building from which he had recently been released; of how he could no longer do construction work after breaking both arms and sustaining a head injury; of him having no source of income; of his wife having a live-in boyfriend who would not let him speak to his daughters. I read the Bible to him at his request. Re degree of helplessness, I think the patient would be 5/10.

3. Narrative Summary of the Ideal Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description of how you would do the intervention differently if given another opportunity. Write so that another practitioner with a similar situation could benefit from your insights.)

In addition to listening to the patient and reading the Bible passages to him that he requested, I would cautiously ask him about his alleged molestation of his daughter. I would also attempt to explore with him his feelings about being homeless and estranged from his family. Lastly, I would try to explore with him what he would do when he left our skilled unit.

C) Patient Requesting Completion of an Advance Directive Form

1. Statement of the Spiritual/Pastoral Care Central Issue (e.g., Feeling Angry and Abandoned by God; Hope in Terminal Illness, etc.)

Patient requesting completion of an advance directive form

2. Narrative Summary of the Actual Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description. Take confidentiality precautions.)

Patients are encouraged to complete advance directive forms.

3. Narrative Summary of the Ideal Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description of how you would do the intervention differently if given another opportunity. Write so that another practitioner with a similar situation could benefit from your insights.)

Use a script similar to "As your chaplain I would like to encourage you, as I do all my patients, to complete an advance directive form. This form allows you to name someone that you want to make medical decisions for you if the time ever comes when you are unable to do that for yourself. You can also state what kind of medical treatments you would want or not want if you could not tell us in person. Is that something you would be willing to do?"

(Key words are "encourage" and "willing." This script was actually used on an intensive care unit over a three month period and increased the completion rate of advance directives by over 400% as compared to

the previous three months, and has been named as a best practice by the Veterans Affairs National Chaplains Center.)

D) Providing Appropriate Services for Dementia Patients

1. Statement of the Spiritual/Pastoral Care Central Issue (e.g., Feeling Angry and Abandoned by God; Hope in Terminal Illness, etc.)

Providing appropriate services for dementia patients

2. Narrative Summary of the Actual Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description. Take confidentiality precautions.)

I am a chaplain providing a worship service experience for a group of residents in a dementia care unit. People are brought or come as they are able to the service. We come together as a worshiping community. I use music of familiar hymns, prayer, scripture, verbal explications and comments to lead the worship. Prayer is used to begin the service and create a sacred space. Music of old hymns is sung accompanied by my guitar. I read scripture from the lectionary making brief comments with a song in between. My comments are intended to elicit response from the participants as it is not a "sermon" but scripture with side comments. The hymns are often chosen by the participants. I close with prayer requests, a spoken prayer to include requests followed by Lord's Prayer. Verbal residents say thank you, smile, shake my hand, and make comments.

3. Narrative Summary of the Ideal Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description of how you would do the intervention differently if given another opportunity. Write so that another practitioner with a similar situation could benefit from your insights.)

Better intervention would include choice of songs, scriptures, language in prayer and themes in comments relative to the circumstances and capacities of dementia residents.

E) Sense of Hopelessness after Terminal Diagnosis

1. Statement of the Spiritual/Pastoral Care Central Issue (e.g., Feeling Angry and Abandoned by God; Hope in Terminal Illness, etc.)

Sense of hopelessness after terminal diagnosis

2. Narrative Summary of the Actual Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description. Take confidentiality precautions.)

Visited female, 35 years old, after having been told cancer of brain is inoperable. She shared her anger and desperation as she feels her life has really just begun. I listen carefully and ask questions to help explore her feelings so as to aid in the processing of this information. She asks me to visit again and she reaches out for me to hold her hand and I had a sense of providing support and comfort.

3. Narrative Summary of the Ideal Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description of how you would do the intervention differently if given another opportunity. Write so that another practitioner with a similar situation could benefit from your insights.)

I would reflect more on her body language and also review her chart to obtain more information about this patient. I would check in with myself to see if there is countertransference so as to determine how this information impacted me. I'd be more aware of the non-verbal communication.

F) Care of Physician / Care of Self during a Medical Emergency

1. Statement of the Spiritual/Pastoral Care Central Issue (e.g., Feeling Angry and Abandoned by God; Hope in Terminal Illness, etc.)

Care of Physician during a Medical Emergency

Care of Self during a Medical Emergency

2. Narrative Summary of the Actual Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description. Take confidentiality precautions.)

Called to be with family member while loved one has unanticipated reaction to operation and appears to be dying. Several doctors involved trying to save patient. Eight hours into the attempts to save patient several family members gathered now and thanked me for support. I went to bedside to record in patient's chart. One doctor approaches me. Others with nurses are still trying to save patient. The doctor who approached me asked how the family was doing and then told me the patient would die. I listened to the doctor and he repeated a couple of times the patient will die. It's hopeless. I replied "That sounds negative." The doctor said "I am always negative." I felt pity for the doctor and confused by the perseverance of the others, so I said "You need to work on that." The doctor said "I know" and walked back to join the other doctors. Later when I reflected I realized this was not a good pastoral response because it was judgmental and directive. I had lost sight of myself. I haven't seen the doctor since. I don't know his opinion.

3. Narrative Summary of the Ideal Spiritual/Pastoral Intervention (No more than two paragraphs of narrative description of how you would do the intervention differently if given another opportunity. Write so that another practitioner with a similar situation could benefit from your insights.)

I was feeling uncomfortable and consulted with a colleague. We worked out what was bothering me. If only I had accepted unjudgmentally his comment, checked in with myself about the impact his words were having on me, and suspended my feelings to explore them later. I likely would have said nothing, looked sad or scared and let go of the feeling that I needed to restore his hope. A self-check is especially important throughout an intense, long visit.

G) Suicidal Male Facing Unwanted Divorce

1) The Situation

The patient is a 35 year old male who is a fireman. His wife had an affair. He forgave her and met with the adultery partner. She doesn't want to work the marriage out. They have two children. He doesn't want the children raised without a father. They went to counseling. He confessed that he didn't do his part during the counseling. He mentioned that PTSD was a problem for him. Now, he wants to work it out. The patient came into the psychiatric unit because of suicide thoughts. She is Roman Catholic. The patient said he feels closer to Buddhism.

The patient wants the marriage to work out now. He did not work hard at counseling before, perhaps, because he did not think that the marriage would end up in divorce. Divorce seems imminent now. The patient would rather die than face divorce and loss of his children.

2) The Actual Intervention

I affirmed his choice to live to come into the hospital. I suggested that he had two choices: (1) divorce and go on; or (2) to work hard at getting his wife's affection and commitment back. I suggested the book by James Conway, "When One Wants Out" for his relationship problem. I also suggested that he find ways to manage stress, find someone to talk to, and, perhaps, see a professional counselor.

3) An Ideal Intervention

Many people who deal with PTSD need professional help. The patient should have been encouraged more to find professional help. The book mentioned by James Conway deals well with the subject of one partner wanting out and what the remaining partner should do.

H) Anxious Psychiatric Patient Feeling Relationally Isolated and Abandoned – Both from Family and from God

1) Summary description of the original situation:

This pastoral visit takes place at the adult inpatient psychiatric unit following the daily morning orientation and community meeting. The patient is a divorced female in her early 50's with a clinical diagnosis of schizophrenia and depression. During the meeting, I observe that the patient is teary and agitated. Immediately following the meeting, the patient approaches me in guarded fashion and asks if she could sit down and talk to me. Once she is seated, the patient's posture indicates that she is alert and eager to converse – at first, aggressively so. She is well-groomed and dressed casually, but attractively. I experience the patient as paranoid, delusional, and very anxious. She verbalizes her feelings of shame at being in a psychiatric unit. Her use of language suggests that she is well educated and, indeed, in the course of our conversation, she tells me she has a Bachelor's degree. The patient's religious background is unknown except that in the course of the conversation she says, "God means everything to me. . . Without God there is no peace." She also raises the issue of theodicy when at one point she laments, "Chaplain, I'm a good Christian and I've tried to live a good life; I haven't done anything to deserve this."

2) A Brief Summary of the Original Intervention:

Once seated, the patient tells me in an anxious, agitated, and aggressive fashion me that she is in the wrong place. She's not depressed, she says, but is in need of surgery. The patient asks if I can be influential in getting her moved from the mental health unit to a medical surgery floor in the main hospital. The patient proceeds to tell me that "The CIA have planted mind control devices in my brain through the use of a sniper rifle" and the "I need to have them surgically removed." A piece of information I considered especially important was her going on to tell me that that these devices cause "divorces ...separates families . . . [and] breaks the hearts of children." With tears rolling down her cheeks, she tells me, "I want freedom from this abuse." My first intervention is not to say anything, but rather just be with her for a few moments. I reach for a box of Kleenex and hand her a tissue to wipe the tears.

After drying the tears, the patient continues with an exchange comparable to the one I have described above. Only this time, she adds, "Chaplain, I'm a good Christian and I've tried to live a good life; I haven't done anything wrong to deserve this You're the only person that can get me out of here." This time, I acknowledge her pain by saying how it affects me: "Janet, it saddens me to see you in such pain." In

response to a third plea to get “me out of here,” I acknowledge that I can’t do that, but wonder with her whether, “maybe we could come up with something that could take the edge off your anxiety you’re feeling right now.” The patient does not respond to this suggestion, so I continue with an empathetic, “It’s not fair – what you are going through right now,” followed by the suggestion, “I’m wondering if God could help alleviate some of the pain you’re experiencing right now.” The patient grows a bit calmer with this intervention and responds by saying, “Oh, God means everything to me; without God there is no peace.” I ask her if “it would help for us to pray together?” When she offers her approval, I then ask, “How would you like me to pray?”

Her answer reflects her tendency to talk indirectly and generally – as if she really isn’t talking about herself: “I want you to pray that God will get rid of this destructive technology that is infecting our world . . . our children . . . our home; pray for our President, our leaders – that they will do something about this evil technology.” I indicate that I will do that, but I also ask if I can pray for her specifically, that God will set her free “from this evil technology and give you some peace.” With tears running down her face, she says in a calmer, but still desperate voice, “Oh, yes, please, Chaplain, anything.”

I offer a prayer offering healing, hope and encouragement. I honor her prayer requests as she has identified them and use her language in the course of my prayer – especially the language about getting the destructive technology out of her head. At the conclusion of our prayer, the patient thanks me for seeing her. The pastoral visit is concluded.

3) What would an ideal/desired intervention/desired intervention look like in light of peer/supervisory feedback?

Pastoral work with schizophrenic patients at their most delusional/paranoid point is often anxiety-evoking in the inner world of the care giver and thus whatever interventions are offered, it begins with monitoring one’s own anxiety and making certain one doesn’t truncate the visit too quickly because of it. This is the first lesson I learned in presenting this case study. The second lesson I learned in presenting this case – and it subsequent visits with schizophrenic patients – is that just because they are paranoid or delusional doesn’t necessarily mean that they are incapable of making meaning or reflecting upon their experience. Often they are quite insightful.

With these two lessons in mind, a more desirable intervention would have been to go ahead and invite the patient to make meaning at the two places in our visit she most gives evidence of feeling abandoned. One place this occurs is when she talks about the “mind control devices” destroying children and home life and causing divorces. It is surely a reasonable interpretation to suggest that she was speaking of how her own illness had impacted her family life. It may have been fruitful to fashion an intervention that attempted to explore this. At the very minimum, I might have inquired along the lines, “What are your family relationships like right now in light of your being here?”

The second place the patient gives evidence of feeling abandoned relates to the theodicy issue – when the patient says, “Chaplain, I’m a good Christian and I’ve tried to live a good life; I haven’t done anything wrong to deserve this.” It wasn’t a bad intervention for me to say, as I did, “...it saddens me to see you in such pain.” It just didn’t go far enough. I could have given her the opportunity to voice in more detail her feelings of abandonment. One way of exploring these feelings with her might have been to read one of the laments from the Psalms. Another possibility might have been to invite her to verbalize or write out her own lament. Either of these interventions would have been ways for me to validate the patient’s feelings of abandonment as real and be with her in that pain.

Whereas depression is a mood disorder, schizophrenia, as I understand it, is primarily a thought disorder that often results in the kind of anxiousness and agitation manifested in this patient. Given this patient’s anxiety, another intervention I might have tried would have been some form of meditation practice. When the patient, for instance, suggested that, “without God there is no peace,” I might have invited the

patient to select a phrase such as, "God is my peace" to focus and meditate upon as a way of relieving some of the anxiety. I've subsequently done this with some schizophrenic patients with some success.

I) Caring for the Confused Patient

1) Summary Description – Original Situation

The visit with this particular patient took place as a result of ministry within an ICU setting in a local hospital. The patient was a 48 year old white male who had recently become a double amputee, with both legs having been removed at the mid-thigh area. The particular procedure was to remove the diseased portion of his second leg, his first leg having been removed a couple of years earlier.

Due to the patient's condition, the visit took place in a full isolation room that required the chaplain to wear the mask, gown, and gloves that are required for that type of room setting. In order to go into the room it is necessary to open and close a glass sliding door that is the marker for the boundaries of the isolation garb.

The patient was a steelworker by background and had worked with his hands most of his life. He had a very strong upper body that was an assist to him due to his disability. On the particular day of the visit, the patient was coming off sedation though still taking pain medication to assist him in his recovery process. The patient was intently watching the news on television when the chaplain happened to stop by to visit him.

2) Brief Summary of the Original Intervention

As the chaplain encountered the patient, it quickly became evident that the patient was experiencing a sense of confusion in what he was verbally communicating to the chaplain as well as other members of the medical team. The patient early on in the visit made the connection that the sliding glass door for his room was a phone booth that his family members would be making phone calls from in order to make arrangements for his wheel chair that the patient would eventually need when he would leave the hospital.

The chaplain tried to make connections with the patient as this confusion became evident. The patient became more lucid for a few moments and talked about the loss of his legs. The chaplain affirmed this with the patient. During this portion of the visit, the patient began to move around in his bed using his upper body to maneuver. This effort caused concern to the chaplain due to the patient's condition. The chaplain encouraged the patient to lay back down which the patient complied and began to rest again. However, after this the patient began to experience a time of confusion again.

The patient then looked puzzled at the chaplain and wanted to remember who the chaplain was. When the chaplain reintroduced himself, the man smiled and admitted that at first he thought the chaplain was another friend of his with the same first name. The patient then commented that the chaplain had more hair than his friend to the laughter of both of them.

The visit concluded after the chaplain joined the patient in watching a couple of news stories being broadcast on the patient's hospital television. The patient thanked the chaplain for the visit and welcomed him to return anytime.

As a result of the initial visit the chaplain returned to visit the patient again in the next couple of days. In the next visits, the patient again expressed confusion about the identity of chaplain as well as details concerning his condition and next steps in his process. The chaplain noted from the patient's chart information that others within the medical team had also been challenged in their care for the patient due to his confusion.

3) Brief Summary – Ideal Intervention

The two key moments to further engage the patient in a more ideal way would have taken place during first, the patient's comments about the loss of his legs. The chaplain could then potentially explore how this loss was affecting the patient's sense of the future. The patient was certainly going through a time of intense transition in his life. This interaction would have potentially been helpful for the patient to not only talk more about how this loss was affecting him but would have helped to engage him further at the emotional level.

Second, the chaplain in an ideal intervention would have explored more about the patient's friend whom he was a mistaken identity for. To have engaged the patient with a phrase such as, "I am glad that I remind you of him, but that's not me." This could have then been followed with a helpful question, "How did you meet your friend?" or some other question that would help the chaplain learn more about the patient's story.

The key issue to make this encounter ideal is to find caring ways to engage the patient even in the midst of the moments of his confusion. It is certainly a challenge to allow verbal confusion to be a bridge to further understanding and as a result more effective pastoral care.

J) Son's Concern about Dying Father's Spiritual Status

1) The Situation

Had a call from ICU that there was a son there with a terminally ill father who wanted to see the chaplain. His story was that he was the DPA and having read the living will, decided he could not allow his father to die unless he was sure of his salvation. Initially this seemed like a medical ethics issue.

2) Actual Intervention

Met the son and his wife. Told them that as the chaplain I was not in favor of forcing people to say words they did not support. Patient had been asleep but I agreed to talk with him, but told the family I was not into secrets and that they he could agree to talk with me or throw me out. Explained to him who I was and that I was there because his son had some concerns about his spiritual well being.. Asked the dad what his faith was and he said he was a lapsed Lutheran. I asked if he felt OK with God and he said yes. Son was not pleased. So I asked if he had done the Lutheran confession in a while and would he like to do so. He agreed. "we confess that we are in bondage to sin... etc. Finished....the son was not pleased.

So I invited the son outside the room and asked what this was about... he said, "When I die, I want to see my father again and I'm worried that he won't be there." So I asked what words he needed to hear, and he said, "that I accept Jesus as my Lord and Savior

So I said, what about if you explain your concerns to your father and let me get out of the middle and I would wait outside. Son explained that he loved his father and wanted to see him again and that it would be important for him to hear those words. Dad understood his son's concerns, said the words, and the son agreed to be his DPA under those conditions.

3) Ideal Intervention

What started as a medical ethics situation became a family issue and a difference in faith perspective, but then was transformed into a love matter. In a more ideal intervention I would be more open to the possibility of the realities just described, thereby being more able to "tune in" sooner and be of help perhaps more effectively.

K) Fetal Demise, with Nominal Catholic Parents Requesting a Bedside Prayer Service

1) A description of the patient's circumstances, problems, and needs for spiritual care:

The patient was aware that her infant was not alive in her womb. She was waiting for her water to break to receive her child. The patient had been informed that this would be another three (3) to four (4) hours. Present in the room were her husband, who was at the foot of the bed, the best friend of the husband, who was 12 ft. from the patient's bed, and a six (6) year old niece.

The problems were how to address the intimate feelings and needs of the patient in the presence of a diverse group in age, relationship, and spiritual needs.

2) Brief phrase stating the Spiritual Care Central Issue:

Though the patient was uncomfortable in a church setting, both, she and the husband, requested a prayer service in her hospital room (with the child).

3) A description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this patient:

Upon reflection and given the opportunity again, I would explain options and not leave the question open-ended. This creates clarity and the patient doesn't have to work too hard. Secondly, I would omit the "the God love ya". Prayer is an important element in this process. However, her feeling and thoughts may not be embracing God's love at this time.

The background information that I consider useful for understanding the appropriateness of the proposed intervention of the particular needs of this type of patient/client could be better understood in the articles cited herein:

Weiss L, Frischer L, Richman. "Parental adjustment to intrapartum and delivery room loss. The role of a hospital-based support program." ClinPerinatol. 1989 Dec;16(4):1009-19

[Abstract:] Perinatal loss prompts a unique bereavement for parents and their families that is unlike the mourning process experienced at the death of other loved ones. The Support Center for Perinatal and Childhood Death has developed a comprehensive program to provide support, counseling, and information to families who experience miscarriage, stillbirth, fetal anomalies, and therapeutic abortion for genetic or congenital abnormalities. The impact of perinatal loss is felt not only in the real loss of the wished-for child but also in the loss of self-esteem, the role of parent, and the loss of confidence in the ability to produce a healthy child. The emotional experience of miscarriage or stillbirth creates an atmosphere of despair and confusion for families anticipating a joyous event. The presence of a support counselor and medical caregivers at this time can help parents to navigate the crisis surrounding the loss in ways that promote a healthy grieving process and avert pathologic adaptations. Prenatal, intrapartum, and postpartum counseling opportunities are afforded to families as the situation and parental needs dictate. Services also are extended to other family members, with particular attention to surviving siblings who might be vulnerable to the consequences of unresolved or unacknowledged grief. Grief is experienced as a long-term process, which frequently emerges fully after discharge from the hospital and lasts well beyond the interest and stamina of supportive family members and friends. Support groups, which meet the specific needs of families who experience perinatal loss, contemplate subsequent pregnancy, or face the prenatal decision to terminate a genetically or congenitally compromised pregnancy, have been run successfully for a period of several years. Beyond the experience of intrapartum loss in the delivery room, the experience comes full circle for families who enter the delivery room again with a subsequent child. The expressed need for support in acknowledging the rekindled memories of prior loss at this poignant time are matched only by

parents' needs to find reassuring ways of differentiating healthy newborns from the memory of those who died. It is often at the time of the subsequent birth that the memory of the lost child can take its proper place in the family. Stein expresses the essence of grief work and resolve: Mourning is not just feeling sad. It is the specific psychological process by which human beings become able to give up some of the feelings they have invested in a person who no longer exists, and extend their love to the living. Mourning is hard, emotional work.

Related articles:

"Family pediatrics: report of the Task Force on the Family." [Pediatrics. 2003]

"The effects on the family of miscarriage, termination for abnormality, stillbirth and neonatal death." [Child Care Health Dev. 1995]

"Meeting the needs of parents around the time of diagnosis of disability among their children: evaluation of a novel program for information, support, and liaison by key workers." [Pediatrics. 2004]

"Parents' experiences of midwife-managed care following the loss of a baby in a previous pregnancy." [J Adv Nurs. 2002]

"Grief and perinatal loss. A community hospital approach to support." [J Obstet Gynecol Neonatal Nurs. 1985]

L) Belated Receipt of a Death Message

1) Known Facts

I received the referral from the day time chaplain who was on call that the patient had received some news that was not good and that a visit would be good.

2) Preparation

I had made a note of the name and the name sounded really familiar. Since this was my unit, I know that I had visited this patient before. I had an idea of who the patient was, but was not for certain. When I got to the unit, I stopped by the nurse's station and the nurse had stated that the patient had just found out that his son had died. I have had other conversations with the patient, because he was in ECU from heart surgery. On the initial conversation, he was hoping he could go home in a week after finishing his medication. He was hoping that his time would be short in ECU, so that he could go home

3) Observation

When I walked into the room, the patient was watching television in his chair. His mannerism seemed like that he was down and not really enjoying watching the show that was on. He was wearing his glasses and the lights were off in the room. He was also had on a blanket.

4) Pastoral Conversation

Patient- P Chaplain- C

C1- (knocking on door) I am just stopping by to see how things are going

P1- Things are not going so well

C2- Why do you say that

P2- (sense of frustration)- I found out that my son died last week of AIDS

C3- (taken back)- I am sorry to hear that, and you sound angry

P3- (Frustrated)- not it is not that

C4- (Timid)- so are you frustrated?

P4- (Frustrated along with a little anger)- I did not find out about my sons death till this morning when a family member called. They asked me if I saw today's paper and I said that I hadn't. That is when they told me that my son had died. The boys mom said that she would tell me the news when it would happen.

(A moment of silence as I collected my thoughts)

C5- Do you know of the funeral plans yet?

P5- No not yet, the body is undergoing an autopsy and no one really knows of the plans that he had made. (Frustrated) You know, if I was not in here, I could have found out earlier. I have could have been out with my people and they could of found out sooner. I could have said bye to him one last time.

(Paused to process information and the noise of the television filled the room)

C6- (Curiosity)- Why do think that you did not find out till now?

P6- The boy's mom has had a drug and alcohol problem and she needs to really get her life straightened out. I am not sure why I didn't find out till now.

(Short pause)

P7- I am getting tired now, I think that I am going to take a nap

C7- I am sorry for your loss and I hope your day gets better

P8- Thank you

5) Self-critique

I was a little frustrated that I could not find a direction of where to go with the conversation. There seemed to be several different directions that I could have gone with the conversation, especially exploring the frustration with family, not being able to be out of the hospital and ultimately his death. I had a sense that he knew that the death was coming, but death is still never easy to deal with. I noticed that I used silence to cope with my own issues. I did not know where to go with the conversation, so instead of pressing on, I did not say anything. I found that the television may have promoted the silence. I felt like I was stuck between two worlds, of trying to provide patient care and what was being broadcasted on the television.

When I found out that the patient's son had AIDS, it made me feel uncomfortable, because I assumed that he was a member of the gay community. I am still somewhat uncomfortable dealing with that issue, mostly because of my personal background and beliefs that a homosexual life style is wrong. There is a sense of frustration on my part that I am uncomfortable around the issue of homosexuality. There will be more in my theological reflection on this, but how do I not let the issue of homosexuality take away from my patient care, or keep allowing me to become timid in patient interaction and care. There is another thing that really caught my off guard, and that is I assumed that the patients son was gay, because he had AIDS. I found out in a later conversation that the patient's son was not part of the homosexual community. I realized that assumption can be very destructive in patient care, especially when the assumptions are not correct

6) Spiritual Assessment

The assessment of the patient is that the patient is frustrated over not knowing that his son had died. It seems to be that he questioned a little why his family or his sons mom did not tell him of the news or keep him informed. It seemed like there was some avoidance with the family was letting the newspaper tell the patient of his sons death. There is also the frustration of being in the hospital. With previous conversations that I have had with the patient, he was an active person. He was a professional roofer and now with his medical condition, he will be most likely on disability. So there could be some coping issues that the patient is facing, because he has to change his lifestyle because of his medical condition

I sense that there is also some frustration with being in the hospital. At the date of the reported conversation, the patient has been in the hospital for about ten days. The hospital seems to be an unplanned thing and to a point it is becoming an inconvenience. It is inconvenient because he was not able to find out information about his family situation, or be with people or do things that he enjoys.

7) Theological reflection

I know that the patient's son having AIDS was not important to the story, but I let myself be consumed by it. The question is that how do I care for patients that have a different life style than I do. For those who may have that different lifestyle, I should not let it consume my thoughts or be weirded out by it. I want to see those people as Jesus does, which is someone who He has created and loves very much. According to my value system, sin is sin, no matter if it is someone who is a part of the homosexual community, or who is living with their significant other and they are not married. Still, somehow, I create this classification of sin, that there are some sins that are either better, or more tolerable than others. I can tolerate the extramarital affairs, but someone living in a committed homosexual relationship kills me. I need to learn how to put my biases aside and through God's grace treat people with dignity.

Another thing that I realized is that I was making assumptions about the patient's son. In other words, I was just as guilty because I was jumping to conclusions that were not healthy ones and unproven. After, it made me mad that I had jumped to that conclusion. I know that when people jump to conclusions about me, it makes me mad, and frustrated that they did not get the chance to know me to know who I really am. In the end, it made be a little sad; because I did something that I do not want people doing to me.

8) Plan:

Continue to visit with patient and build relationship so that there is an opportunity to work through the grief and possible life change issues of not being able to work anymore.

9) What I would do differently (Ideal Intervention)

One of the things that I learned from my peers is the idea of being emotionally present. During my visit, I was more about seeking the facts instead of being emotionally available. One of the things that I was trying to do during the fact finding session is that I wanted to fix the patient problems. I do not think that fixing the patients problems right then and there would have been the most useful thing to do. The most useful thing that I could of done, was to just sit with him and try to understand where the patient was coming from. If I could of changed anything, I would have been emotionally available to the patient. Being emotionally available to the patient would have helped tremendously.

One example of this is the conversation of C4-C5 and P4-P5. Along with being more present, I should have watched my projection of what the patient was feeling. I thought that he was frustrated and I know I would have been frustrated, but projecting it to the patient is not good. When the patient corrected me on his feelings, instead of asking for what the funeral plans were I should have explored what his feelings were. One of the ways I think that I could have corrected myself is not only giving validity to the emotions and dealing sitting with him for awhile. I wish I would of used silence a little more so I could be a little more emotionally present.

Another thing that I need to keep on realizing is my unchecked biases. Not only do I need to keep my biases in check, but to make sure that they are not interfering with patient care. When someone believes something that is different than me, there tends to be either a wall that gets put up and my mind runs wild with assumptions, or I debate those things with people. In the hospital setting I have notices that I tend to put up the wall and have my mind run wild with assumptions. I am learning to find out where those assumptions come from, and how they affect my ministry. It is also learning to deal with them in a healthy way so that I can minister to people without them getting in the way.

One of the ways I think that I can help check my biases is realizing that I have them. The more I am aware of them, the more of an opportunity I have to deal with them. When I am doing patient care, I have to triage in the information that the patient is giving me. I have to figure out what is really important and what is just fluff information. When I have figured out what is fluff, I will have to put that information aside and not have it be the main focus and put it away.

M) Lack of Patient Support Systems

1) A summary description of the original situation:

This visit was a follow up visit initiated by a referral from the previous chaplain. Patient is a 25 year old single female Caucasian. Patient is uncertain where she is at with her spirituality. She classified herself as a Christian when admitted. Patient was somewhat disheveled in her appearance (hair uncombed). Patient seemed to be somewhat lethargic (her lunch was uneaten, her food remained next to her on her tray, rather than being pushed away so that she could have more space to color) spending what energy she had towards coloring in a coloring book. Her voice was fairly monotone and conveyed a sense of hopelessness. Her personality seemed to convey a sense of being distant and guarded. Psychosocially there was a sense that her social development was slowed as she processed and exchanged information slowly. There was a sense of ambivalence in her interactions with me as she exhibited a mixture of wanting a chaplain in the room but at the same time pushing me away. The room was bright with the shades open. There was only a meager amount of personal belongings in the room, nothing seemingly present that she had received from someone else during her stay.

2) Summary of the original intervention:

I found myself heavily influenced going into the visit from the vast amount of information in her chart from previous pastoral care interventions. The general consensus was that she seemed to be having issues with her parents as well as dealing with some anger issues that may have stemmed from abuse. I also took note that a psych evaluation had been ordered. The perceived needs of the patient that I identified were to develop stable healthy relationships with others and to explore whether or not some type of spiritual identification may be present as well. Also identified was her need to obtain hope and stability amidst the chaos that she identified and the anger that she expressed. It was my perception that she had not benefited much from the previous attempts that other chaplains had made to help her in this area. The she-saids and the I-saids of the intervention were as follows:

C1: Hi I'm Rick one of the chaplains here. (As I entered the room I noticed that the patient had recently received her lunch although it seemingly had not been touched. She was coloring in a coloring book as I entered the room).

P1: Hi

C2: Oh, I didn't realize you just got your food, I don't want to keep you from eating, would you like for me to come back?

P2: No, it's Ok, I'm not really hungry. (Patient seemed content to continue coloring)

C3: Do you like to color?

P3: Yes, it relaxes me. I had a really nice nurse last night. She brought me these things when I told her I liked to color.

C4: That's great! Are you going to give one of your pictures to the nurse that brought the books to you?

P4: Yeah, she was very nice...I really felt like I connected to her.

C5: That's neat, she sounds like she is very nice. (slight pause) I wanted to stop by and see if there is anything that you need and to see how you are doing. (Patient's eyes began to well up)

P5: Not very well, my life is full of chaos. (Patient tells me that I can sit down in the chair next to her bed) I don't know where to begin. (Patient seems to retreat into her coloring, visible tears are now seen. Patient becomes quiet).

C6: (After a period of silence) Do you want to talk about the chaos in your life?

P6: I just don't know what you can do for me? I mean unless you are specifically trained in these areas (she seemed to assume that I knew specifically what her challenges were).

C7: Ms. (patient), I am not sure exactly what areas you mean. I do want you to know that I am here to support you spiritually, to pray for you if you like and to help support you by listening to any concerns you have if you wish to share them.

P7: I just don't know where I am at spiritually. I'm not sure what you can do for me. What do you want from me? (I sensed that the patient's attitude had changed drastically from inviting me to sit down to now becoming almost hostile towards my presence).

C8: Ms. (patient), there is nothing that I am seeking from you. As chaplains we are here to help you any way we can. It's up to you if you want to share with us. (patient has no response...she is noticeably distraught and has loss any eye contact with me that she once had)

C9: (After a long period of silence) Ms. (patient) would you like for me to pray with you? (patient shakes her head no). (Another long period of silence) (In an effort to put control back into the hands of the patient I then asked her) Ms. patient you shared with me that you had a female nurse that you really liked, would you prefer maybe to have a female chaplain come visit you? (nothing, another extended period of silence) Ms. (patient), I want to respect your feelings, would you prefer that I leave you alone at this time?

P8: Yes, please do!

C10: Know that we will hold you in our prayers and if you would like to have us come back to visit, just let your nurse know. Blessings.

The explicit results of this interaction was that the patient asked me to leave. The implicit results of the interaction was that the patient before physically asking me to leave had already pushed away my pastoral presence by viewing me to not be specifically qualified or trained in the areas of her perceived needs. Implicitly as well may be a further sense of hopelessness by the patient as yet another person had come and gone and she was no better off than before the visit.

3) The ideal or desired intervention:

Given the insights that I obtained during my original presentation of this verbatim to my group, I would have focused more on residing with the patient where she was at (coloring with her?) and seen if the conversation I initiated in regard to how she was doing would have originated from her instead during this time of simply being with her. The other key issue would have been to explore more fully the positive attachment she had made to the nurse, as this was a positive support system for her, which could be seen as a breakthrough. To see what this ideal intervention may have looked like with these proposed changes, I have made changes to the dialogue from above in bold and in italics below.

C1: Hi I'm Rick one of the chaplains here at St. Vincent hospital. (As I entered the room I noticed that the patient had recently received her lunch although it seemingly had not been touched. She was coloring in a coloring book as I entered the room).

P1: Hi

C2: Oh, I didn't realize you just got your food, I don't want to keep you from eating, would you like for me to come back?

P2: No, it's Ok, I'm not really hungry. (Patient seemed content to continue coloring)

C3: Do you like to color?

P3: Yes, it relaxes me. I had a really nice nurse last night. She brought me these things when I told her I liked to color.

C4: That's great! Are you going to give one of your pictures to the nurse that brought the books to you?

P4: Yeah, she was very nice...I really felt like I connected to her.

C5: *That's great did she color with you?*

P5: *No she just brought me the stuff to color with and talked to me for awhile.*

C6: *Would it be OK if I colored with you?*

P6: *Sure, I guess so. Here take these.*

C7: *Thanks. I think it's really neat how you made such a great connection with that nurse. Can you tell me a little about her.*

P7: *Yeah. She was really nice. It's like she didn't want anything from me. She just enjoyed being with me and got me these things to color with.*

C8: *Cool. She just hung out with you then.*

P8: *Yeah, it was kind of nice, just being with someone. Them not wanting anything from me. Not being angry with me. Just letting me be me.*

C9: *You have a lot of people not letting you be you?*

P9: *Mainly my parents. Things just aren't right there. My life is full of chaos. You probably wouldn't understand.*

C10: *You're right. I may not. I do know what it's like when people don't understand me very well, it kind of messes things up.*

P10: *Yeah it's that, but a lot more than that. Things just go on that shouldn't.*

C11: *I gotcha. Were you able to talk about any of this with your nurse friend?*

P11: *Yeah, a little bit.*

C12: *Anything that I can help support you with? Anything spiritually that you are struggling with?*

P12: *I really don't know where I am at spiritually, but I may talk to you about it sometime.*

C13: *That would be great. Would it be OK if I stopped back tomorrow and hung out with you again?*

P13: *Sure. Maybe you could bring me something new to color with.*

C14: *I'll see what I can come up with. I'll see you tomorrow.*

P15: *Bye.*

The explicit results of this ideal intervention would be that a bridge of rapport was developed that ended with the patient welcoming me to visit with her again. The depth of her issues with her parents and her lack of other support systems seems to require a gradual and sustained rapport being built if any lasting positive effects of the pastoral care interventions will take place. The implicit results of this ideal intervention include adding another person to the patient's life (in addition to the nurse) who simply resided with her where she was at and did not ask much of her. At the heart of this is the potential to mend and heal in regard to the chaos and the "things that aren't as they should be" in her present relationships.

N) Patient in Conflict with Hospital Staff Caregivers

The patient is feeling neglected and angry about it, hurt by not being listened to or taken seriously, frustrated because of being misunderstood and exhausted from constantly fighting for what she believes should be given.

This 54 y-o female married Caucasian patient was raised Jehovah's Witness, no current faith claim, but identifies culturally as Jehovah's Witness, and is pondering religious questions. She is demanding and

challenging and because of that comes across as needy of attention. This patient is also insightful and blunt about her insights, which makes her come across as forward. In combination with her demanding attitude, this makes her come across as rude. There is a long history between the patient and staff, resulting in the staff taking a posture of protection against their perception of her neediness and rudeness by avoiding her, working with her only as much as necessary. This is obvious to the patient, turning her rudeness to criticism. Another result is that staff members do not listen to her when she describes symptoms they are not expecting, and diagnosis and treatment is delayed.

Three primary areas of improvement were identified in the verbatim presentation:

- 1) Simply staying with the patient so that she could be heard was a dramatic step forward for this patient. What more is needed is affirming that what she expects is reasonable, what she gets is not reasonable, and most importantly, that the way she experiences it (her distress) is valid. I would do that by responding to her story at appropriate places in the same way that she did, e.g. "that's rough," or "that's not right," or "how awful!" Being someone who validates her emotions without saying "I know how you feel" will help her realize someone actually cares about her and what she is experiencing. At one point she asked me to tell her what I heard and I paraphrased her story back to her, but my paraphrase was very functional. Next time I would complete the paraphrase by including the feelings I "heard" from the patient at each point in the story.
- 2) At one point a dietician had come in to collect the patient's lunch tray, not realizing that the patient still had a tray that was not what she wanted. When the patient told her she had requested a different tray, the dietician left without speaking. I then spoke for the dietician, which would be heard by the patient as defending her, even though there truly was a problem with the patient's lunch. Next time I would let the dietician speak for herself (or not, as in this case) so as to avoid appearing to take sides against the patient.
- 3) There is a need to advocate for the patient without accelerating the conflict. In the verbatim, I spoke to the Charge Nurse and the dietician. Next time I would draw on three areas of discussion in those conversations:
 - a) I would discuss a transition in my own feelings when I would take sides for both the patient and the staff, to demonstrate to the staff not only the validity of the patient's feelings, but that I can also identify with how the staff feels.
 - b) The patient had complimented two nurses attending her that day in contrast to those who had attended her the night before. I would use this contrast to demonstrate that the patient is willing and able to discern between good care and bad care, and she is not just condemning everyone who tries to serve her.
 - c) I would raise "Press-Ganey" statistics to characterize the patient as a gift who keeps the hospital successful and the staff working, and who provides feedback in person instead of afterward.

O) Psychotic Patient Wishing No Contact with Family

1) A description of the patient's circumstances, problems and needs for spiritual care.

The patient is suffering with psychosis including delusions. She refuses to accept she is ill and resists the attempts of the staff and her family to help her. She believes she is married to a man in Great Britain. The family alleges her "husband" has manipulated her into giving him \$60,000 from her retirement fund. Her mental status includes tangential thinking and restricted or flat affect. She is currently taking anti-psychotic medications. This patient has received regular pastoral visits from two different chaplains. She is a 50's, Caucasian female. She has never been legally married and has no children. She identifies herself as

Roman Catholic and that her “husband” and “spiritual advisor” (another man in Great Britain who is colluding with her “husband”) are Roman Catholics.

2) Brief phrase stating the spiritual care central issue.

The patient stated she wished to cut off all contact with her family and that she “hates” them for they have done to her (placing her in institutional care and assuming guardianship).

3) A description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this patient.

I listened to her complaints and intentions to cut off contact with her family. Since she had previously identified herself as a Roman Catholic I invited her to consider that her family was only trying to help her and that Jesus had directed his disciplines to forgive others because hate kills the soul. She accepted this redirection and restated her desire to cut off her family forever, however she would now only cut them off from “at least a year”. She then asked to pray the Lord’s Prayer.

I believe this intervention was effective and appropriate though due to her mental status it is difficult to assess it’s effectiveness in modifying her behavior or thinking. The patient has since deteriorated in her condition and has been transferred to a higher level of care. She continues to request regular meetings with the pastoral care staff.

P) Pain Plus Frustration with Hospital Medical Staff

1) A description of the patient’s circumstances, problems, and needs for spiritual care

The patient was a 74 year old widowed woman with acute cholecystitis and pancreatitis and COPD. She also had a history of depression. The patient expressed both physical and emotional pain, embodied in the groaning sounds that she would occasionally make. After nine days in the hospital, she was anxious to go home. The patient was also frustrated and upset with the care provided by the medical staff at the hospital. As far as her needs for spiritual care, she seemed to need someone to listen to her express her feelings. The patient also appreciated prayer, which I knew from previous visits with her.

2) A description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person

Unbeknownst to me, the patient was on her bedpan when I entered the room; the bedpan was hidden under the sheets. Consequently, my visit was soon interrupted by the arrival of a nurse, who asked me to step out while she cared for the patient. During this time, I heard the patient yell out in pain. The nurse was not very gentle in her response to the patient’s discomfort. In an ideal intervention, upon re-entering the room after the nurse was finished, I would have taken some time to reflect back the pain I had overheard the patient express. I would give her an opportunity to talk about her feelings regarding her hospitalization and the medical staff. I would have tried to be more accepting of the silence in the room, rather than fill it with lots of questions. When the patient made groaning sounds, an ideal intervention would be to acknowledge this expression of pain and invite the patient to talk about it.

An ideal intervention would also include an opportunity for prayer. I would ask the patient if she has particular prayer requests and incorporate them into a vocal prayer, along with other concerns expressed during the pastoral visit. Knowing that the patient is Catholic, I would ask her if she would like to conclude the prayer by saying the Our Father together, being sensitive to the particular language (e.g. “trespasses”

rather than “debts”) that she uses as a Catholic patient. I would be open to continuing to visit with the patient after the prayer in case it intensified her thoughts and feelings or prompted new ones.

Q) Rectifying a Mistaken Cremation

1) Description of the client’s circumstances, problems and needs for spiritual care:

As the hospital chaplain, I was called to the laboratory to assist with a dilemma. There had been a still-born who had been taken for a post mortem. The pathologist mistakenly cremated the baby which had been the standard practice in his past employment. The parents had wanted to bury the baby instead.

I agreed that we needed to tell the parents immediately that there had been a mistake but that we would do our best to rectify it so they would still be able to have a graveside service. I went with the pathologist for support while he explained his error.

I shopped downtown for a suitable container for the cremains and found a blue porcelain container (the boy was male) that had red and yellow flowers on the side. I also had a matching floral arrangement made. The pathologist was able to gather the cremains together, and the maintenance department was able to glue the lid closed.

Later that afternoon, we were able to present the family the way we had resolved this and I was able to provide a brief service and memorial prayer at the bedside when we gave the family the ashes and flowers.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

The family felt that we had gone beyond what they had expected and were grateful for the effort we had put into correcting the mistake. Thus, the intervention was considered a success.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

The Golden Rule

R) Caregiver Learning to Uncritically Accept Where Patient Is Spiritually

1) Description of the patient’s circumstances, problems and needs for spiritual care:

This chaplain was called to be with a hospitalized 60s widowed Protestant small town mid-America Caucasian female just after her son died in the same hospital while in emergency surgery from an accident on the job. She calmly iterated a series of losses she had experienced in her life: pastor- father’s early death, other children’s deaths, husband’s death, et al., concluding with “I guess I was supposed to go through these things or I would not have had to.” After I commented with a quizzical expression about this unquestioning faith she calmly but firmly added, “Well, the Lord has seen me through, hasn’t he? And he’ll see me through this.”

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

This patient was my teacher in that she was living proof of mature, adults of faith being completely accepting of what life brings. If I had this visit to do over again, I would have tried to begin from a truly neutral, open-ended pastoral stance. That is, I would have been better prepared to accept her where she was spiritually, not where I would have been in her circumstances. I had imposed my doubts upon a genuinely doubt-free woman of faith, causing her to have to explain her beliefs at a time when all attention and caring should have been focused upon meeting her where she was, namely, in a state of sweetly child-like trust and acceptance.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

John J. Gleason, The Four Worlds Model of Spiritual Assessment and Care, *Journal of Religion and Health*, 38:4, 1999. 305-317.

Paul Tillich, *Dynamics of Faith*, N.Y.: Harper, 1957. 52-53.)

S) Management of Pastor/Parishioner Conflict; Vengeful Anger Unleashed; The Pastoral and the Prophetic Voices in Tension; Clash of Cultures

1) Description of the parishioner's circumstances, problems and needs for spiritual care:

J was in his late fifties, an ex-marine high school principal, lay minister, husband and father of two avant-garde young adult children. The military discipline was prominent in his attitude and behavior. Following 9/11 and prior to President Bush's decision to invade Iraq, it became clear that J was a rabid patriot who believed the US could do no wrong and it was time to gain revenge for the terrorists' attack. He attended, with his family, a special worship service to commemorate 9/11 on the second anniversary. He was less than pleased with the suggestion that the US might be in any way culpable and need to confess any corporate sins (e.g. greed, power-mongering, ethnic/religious bigotry, etc.). God bless America because we deserve it! Vengeance is mine (says J)! He would have led a Christian crusade against the Muslim "infidels," given the chance.

Six months later, on a Sunday when the pastor took a strong stand against the anticipated preemptive strike against Saddam Hussein, J walked out of the service and confronted the pastor with loud public insults and the declaration that he would never return to the church. When the pastor attempted to contact him for reconciliation, he refused the gesture and ceased any communication. He subsequently moved his family's membership to another church in town.

J seemed to want the gospel wrapped in the American flag and the pastor either to share his political point of view or be silent on the subject. His intolerance for any other perspective was unacceptable and interfered with his spiritual sense of well-being. Biblical perspectives that challenged him to consider love, respect, grace and tolerance were not considered relevant.

The challenge for the practitioner was how to be pastoral as well as prophetic. The pastor's confrontation of corporate sin interfered with J's core values of an "eye for an eye," patriotism and pride in the US military. His rigid and narrow interpretation of selected Old Testament scriptures justifying his position on war interfered with his capacity to relate to the pastor or be open to invitations for dialog. The pastor failed to engage J in self-reflection and openness to the Gospel's emphasis on love, forgiveness and brotherhood of humankind.

2) Description of most appropriate and effective spiritual care intervention for this person:

Anticipating the divisive and controversial nature of the topic, the pastor would have been wise to engage small groups of persons in the church, prior to any public proclamation, for study and biblical reflection to provide opportunity for persons to express their opinions and prepare the context for a series of sermons on the Christian's response to national catastrophe and crisis. The pastor could have offered a bible study of some of the texts for justifiable war theory as well as some of the issues related to the topic. It might have helped to invite J, and others of his political persuasion, to make a presentation of their position in the context of a study series so that he might have felt he had been heard, even if not endorsed by the pastor.

The pastor was ineffective in defusing the growing hostility for the six months between the 9/11 commemoration service and the sermon denouncing the President's plan for invasion. J was allowed to gather bits of resentment until it burst like a thunder storm on the March Sunday morning. The pastor failed to seek intervention early in the process until it was too late to reconcile the relationship. Early intervention would have included naming and claiming the anger J felt toward the pastor, modeling patient tolerance and listening to J's position and invitation for John to engage in a study with the pastor of the issues. Neither J nor the pastor attempted to engage in dialog at the early stages of the process. Conflict resolution may have required a third party's intervention.

T) Confronting Codependency; Breaking Addictive Behavior with a Team Approach

1) A description of the parishioner's circumstances, problems and needs for spiritual care:

The situation concerns a recently widowed woman in her late seventies in the congregation I serve as a bi-vocational pastor. An alcoholic son in his mid fifties had lived in the basement apartment of her home and had not held down a job since graduating from college. Her late husband was reluctant to confront the situation, but would occasionally farm out work to the son from his construction business or have him work on the family's stock portfolio. The son would rationalize this into a delusion that he was being productive and financially dependent. He had become alienated from his two older brothers, both of whom were married with families and had good jobs. One brother is a recovering alcoholic. The widow resented that her husband had left her with this situation. She would occasionally talk with me about all this.

I would usually encourage her to get active in Al Anon and get support as she worked on breaking the cycle of enabling between her and the son. (An Al Anon group met in the church.) I also would refer her to a professional interventionist I knew. At first she was reluctant to take action, as she knew that meant she would have to confront the son to get help for himself and move out of the house. I think that part of her delay in taking action was that she was still working on the grief of losing her husband. Finally, she reached the point where she was ready, and she contacted the interventionist. An intervention was scheduled. As pastor to the family, I was invited to participate. The son initially refused to seek help, angrily packed his things and moved in with a friend. That lasted only one night, and the next day he went into treatment. To make a long story short, he has not been a happy camper, but he did complete treatment and is working. While not enthusiastic about his recover, he is none the less in compliance. He still occasionally calls his mother to put the squeeze on her. "I can't believe you would do this to your own son", etc. Some times she gets hooked by this, but with the help of Al Anon and or an occasional phone call to me or the interventionist, she is able to get a better perspective and move on.

She has anger at the husband for leaving her with this situation and mixed feelings with the son for not growing up, yet attachment and reluctance to let him go, and fear of separation from the other two sons due to their anger at their brother and at her initial reluctance to confront the situation. It has been interesting and enlightening to listen to the evolution of this woman's theology as she has had to struggle with the fact

that God does not enable us in the situations we place ourselves, yet gives us direction we may not at first wish to follow, but does sustain us when we follow a difficult path toward hope.

2) A description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

I learned a lot in this experience. One is to trust the process, to not get too far ahead of the person, but give them (her in this case) time and be there when they are ready. I felt honored to be included with the family in the intervention.

This situation has had a positive impact on the congregation, a small church of 25-30 active members. Two sisters of an alcoholic brother learned of the situation and contacted the same interventionist. That did not turn out as well, and the brother seems to be headed toward a painful death related to his drinking. While saddened, they are satisfied that they made the attempt. The widow and the sisters have become active in the AI Anon group that meets at the church.

The interventionist, a personal friend, and I have reflected on the possibility that of the hand of providence led me to be pastor of this congregation so that the resources needed by this situation would be available.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

Co-Dependent No More, by Melanie Beatty

Involvement of a professionally certified interventionist

AI Anon and other 12 step support groups

An appropriate biblical parallel is the story of the prodigal son and the father's recognition that he had to let the son go. If you love something, let it go. If it returns, it is yours to keep. If it does not, it never was.

U) Managing Self-Doubt Appropriately

1) Description of the client's circumstances, problems and needs for spiritual care:

A female 50ish married Caucasian female Ph.D. college adjunct faculty member expressed her hesitancy to complete a several-years-long research project and submit her manuscript for possible publication.

The caregiver matter-of-factly reminded her that she was no longer a student, that she had a well-documented track record as an accomplished teacher, and that the worst thing that could happen upon submission of the manuscript would be to receive a rejection slip. He further suggested that she have a prioritized list of other publishers ready, and be ready to submit to the next one on the list on the same day that a rejection slip might arrive.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

The intervention was deemed a success by virtue of the facts: 1) that shortly thereafter she completed and submitted the work, 2) that the manuscript was indeed accepted by the first publisher, and 3) that she later reported the intervention to have been something of a turning point in her career and life.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person.

Contemporary Growth Therapies: Resources for Actualizing Human Wholeness by Howard Clinebell (Nashville: Abingdon, 1981) offers an invaluable survey of those counseling approaches which are committed to maximizing human wholeness (book jacket quote).

V) Enabling Healing in a Situationally Psychotic Adolescent Female with Religious Ideation

1) Description of the patient's circumstances, problems and needs for spiritual care:

A Caucasian 14-year-old female was admitted to the adolescent unit of a psychiatric hospital suffering from emaciation and delusions, including: the end of the world is at hand, the second coming of Christ is near, and she had conceived of the Holy Spirit and was to give Virgin Birth to a child.

Her parents had divorced when she was five, and she lived with her mother and younger brother. She was an active member of a large Christian church and avid reader of religious literature. Unsure of her mother's love, torn by her father's attempts to lure her toward him, rejected by peers, denying her sexuality, she refused to go to school, and, ultimately, to eat. Given the religious ideation, in my role as the unit chaplain I was given a prominent role in the treatment process, and framed my work with her using several terms in Viktor E. Frankl's logotherapy.

A phrase that came to her in the midst of her out-of-contact period was "God is love; love is God." I never pressed the literal meaning. The phrase was honored as a touchstone (exploring height psychology). She discovered that one of the meanings of her refusal to eat was resistance to her mother's "clean your plate." With this insight, she was able to use that energy toward getting released from the hospital (mobilizing the defiant power of the human spirit). She also saw her attempts to reunite her parents as futile, and shifted her goal toward being a teenager becoming a woman (finding the personal life task). She began to answer her own question, "Is this effort worth it?" with a "Yes" (filling the existential vacuum). She was expected to choose which parent to live with. We talked about alternatives, and she finally decided she needed her mother the most (resolving value conflicts). Early on she decided that the hospital was worse than home. Once committed to going home she became more willing to eat and to address her fears of going to school (actualizing the self in responsible commitment). From the first hours of her hospitalization she was able to choose her attitude, which was horror at the way her own behavior had brought her near death and into an inpatient psychiatric unit. From this stance she began to exercise her freedom to choose behaviors which would move her toward her immediate goal of getting out of the hospital (exercising human freedom).

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

The interventions and the healing relationship were deemed successful because: 1) Midway through her hospitalization her mother visited. They simply walked among the trees and enjoyed the day. She spoke of this visit joyously as her beginning to get acquainted with her mother. 2) She was discharged from the hospital to the care of her mother. 3) Over many years in exchanges of Christmas greetings with me she sent photos and descriptions of her growing and seemingly happy family.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

Viktor E. Frankl, *Man's Search for Meaning*. N.Y.: Washington Square Press, 1968.

John J. Gleason, Lucy and Logotherapy: A Context, A Concept, and A Case, *Voices* 7:1,23, Spring 1971.

Robert C. Leslie, *Jesus and Logotherapy*. Nashville: Abingdon, 1965.

W) Establishing Basic Trust

1) Description of the client's circumstances, problems and needs for spiritual care:

A 31-year-old Caucasian widowed mother of boys 14, 11 and 10 and a daughter 7 had undergone bariatric surgery a few months previous to seeking counseling, but at 4'10" still weighed 190 lbs. at the time of her first counseling interview. Her presenting problem was infatuation with a 20-year-old single male who had befriended her and her children by providing rides to and from worship services and other church events. She had not learned to drive.

Raised by a teenage mother and laborer father in a siblingship of six, pressed into marriage by pregnancy, left by her problem drinker husband's sudden death to raise her children alone, the client presented a dramatic picture of an individual emotionally and spiritually starved for caring kinds of nourishment. After several sessions she succinctly stated her vulnerability: "I need to be needed--I guess that is the reason I can't say no."

She rather quickly transferred her attachment from the 20-year-old to me, as evidenced by her citing my authority in various situations, "My counselor says for me to..." and by expressing her attraction to me. Her sharing of that attraction was received with appreciation and with the assurance that the counseling structure was a safe place to be cared for.

Within this context I gradually encouraged her to take greater responsibility, with some success.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

This counseling was deemed successful because: 1) She gradually replaced "My counselor says..." with "I said..." in several situations. 2) In one of her last counseling sessions we celebrated her purchase of a car and her growing relationship with an employee of the service station where she purchased gasoline.

Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

Erik H. Erikson, *Childhood and Society*. N.Y.: Norton, 1950. Chapter 7.

John J. Gleason, *Growing Up To God: Eight Steps in Religious Development*. Nashville: Abingdon, 1975. Chapter 3.

X) Becoming Directive in an Emotional/Spiritual Crisis

1) Description of the client's circumstances, problems and needs for spiritual care:

A 28-year-old Caucasian married male seminary graduate was called to his first ministry as the full-time single-staff pastor of a congregation that had mission status for its entire nine year existence because its members had not been able to become self-supporting. The call actually came from the mother church, and the mandate was clear: get the mission into self-supporting status and constituted as a church as soon as possible.

The young pastor worked diligently at that task, and within months the mission celebrated its financial independence and new church status. He was called as permanent pastor. The work was deemed a success by most measures, but near the end of his third year the pastor had become exhausted and depressed. As yet another Sunday approached he realized that he could not bring himself to step into the pulpit to preach one more sermon. He told his wife he would announce his resignation instead. She urged him to at least share his crisis with a trusted fellow pastor before doing so. He agreed.

The pastor called his friend and shared his story and his intention to resign. Without hesitation the friend said, "Do not act when you're this depressed!" The words struck home as the pastor realized for the first time that he was indeed depressed. The friend suggested that he contact his lay leader, simply say he would not be in the Sunday services, to make other arrangements, and that he would be in touch shortly. He did this, and with his wife spent the weekend away, reflecting on the situation and on possible futures.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

The pastor returned to work after the weekend and continued in that ministry for several more months. In that time he applied to a clinical pastoral education program and was accepted for a one-year chaplaincy internship. He later understood the friend's willingness to speak the truth in love as a turning point in his life and ministry.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

G. Lloyd Rediger, *Coping with Clergy Burnout*. Valley Forge: Judson, 1982.

Y) Terminally Ill Patient with Little English from an Ethnic Pentecostal Community

1) Description of the client's circumstances, problems and needs for spiritual care:

At 5.15am I was called by a senior nurse to attend to a terminally ill middle-aged male patient from a non-English speaking European country. The patient had collapsed in the night and was not expected to recover. He was moved from the ED to a ward. His Latin American wife spoke some English. They were unable to contact their church and asked for a protestant chaplain to attend for final prayers.

I arrived at the patient's bedside on the ward and found the wife, her daughter (the patient's step daughter), son-in-law, and two female church members there. The nurse said they were anxious that they saw "the right chaplain".

After questioning by the wife as to which church I was from, she and the church members seemed satisfied with my answers and were happy for me to pray for the patient. I asked the type of prayer but was not understood so prayed the 23rd Psalm and prayers letting the patient go into the arms of God and blessing. Each time I mentioned the words 'Jesus' or Holy Spirit' the wife and church members agreed loudly. They said their pastor was coming and again questioned me about my church, and then said thank you and

blessed me. I left after telling them where the Chapel was located. Language was an issue so a simple question took time to be understood. Later, I arranged for another chaplain to visit as the patient was still alive late that afternoon. The patient died soon afterward and no further chaplaincy requests were received.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

Ideally I would be aware of the language difficulties before I went and would be able to bring a prayer or a Scripture reading in the language required. I would have had with me a small cross which I could have given to the wife. I should have asked for and then charted the name and contact details of the pastor so that if necessary I could have contacted him/her.

A multi-faith group of chaplains suggested various practical things that would have involved *ritual* rather than *words*. For example, the patient may have been anointed, or the family could have been offered communion. When blessing the patient, each family member and friend could have been asked to lay hands on the patient, either together or individually. If done individually, they could have kissed the patient or said a few words or blessed the patient. It was generally recognized that ministry *in extremis* can only be poignant and simple.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

Multi-faith major incident/emergency box (contains requirements for death/serious illness from major faith communities)

How to be a Perfect Stranger, ed by Stuart Matlins, Arthur Magida, Skylight 2003 1-8993361-67-5

Z) Terminally Ill Patient with Difficulty Communicating

1) Description of the client's circumstances, problems and needs for spiritual care:

The chaplain assumed the patient's agitation was because he was in pain. However, when the patient denied he had pain the chaplain began to ask more creative questions and offer practical help, suggesting prayer, touch, dealing with physical needs and low energy and generally relying on intuition, observation, and finding areas in which to comfort the patient emotionally around his isolation from his family and physically around getting nursing care to increase his comfort.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

The intervention confirmed:

... offering a menu of simple choices such as a prayer or choice of reading was better than asking open ended questions that took too much energy to answer;

...using a kind, sensitive and supportive approach rather than one which encouraged the patient to articulate his negative feelings;

...including the patient more in what goes into the prayer as well as using intuition to communicate the need for healing relationships; and

...being part of the interdisciplinary team and knowing background about the patient's progress might have helped the chaplain discern patient needs more quickly.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

None given

AA) Elderly Female CHF Patient Finding No Meaning in Life and Wanting to Die

1) Description of the client's circumstances, problems and needs for spiritual care:

Summary: The chaplain, making rounds in the ER, visited a 90 year old female patient that was brought to the ER with complaints of dyspnea due to fluid in her lungs as a result of congestive heart failure. The patient revealed that she was Russian Orthodox, but that she was having doubts about believing in God due to the existence of suffering and death in the world. The patient expressed that she was not an atheist, but that she did not believe in God according to Christian thinking. She also stated that she wanted to die because of her advanced age and, more importantly, because she could not find any meaning in her life. The patient also stated that she was tired of seeing other residents in her nursing home die.

Actual Intervention: Upon entry into the patient's room, I joked with the patient to establish a connection. The patient told me that I look very young and I told her the same even though she was 90 years old. The patient asked me to explain my views about God. Hesitantly, I explained some basic Christian theology concerning God as the Holy Trinity. As I thought, my explanation seemed to have little effect on the patient's attitude. After the attempt to explain God theologically, I affirmed the patient's statements about God, a meaningless life, and seeing others around her die by using statements such as "you see others die" and "uh hmm."

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

Ideal Intervention: Joking with the patient helped to establish a better connection to lead into discussion about the patient's thoughts and feelings. Explaining theology was not very helpful. The patient's question about God might have been reframed and redirected with the chaplain asking that the patient tell him her views about God. Next, the chaplain should have investigated the patient's feelings of meaninglessness. It would have been helpful for the chaplain to be curious about how the patient reached a level of disconnection with God and with others. The answer might come from asking the patient about when she had meaning in her life or if she ever felt that there was meaning in her life. Lastly, prayer may have been helpful to strengthen the patient's wavering faith.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

No books or articles were suggested.

BB) Lonely, Obese Female Rehab Patient with Disconnection in Relationships

1) Description of the client's circumstances, problems and needs for spiritual care:

The chaplain received a consultation to visit 33 year old woman at the rehab facility. The woman requested the consultation because she stated that she was feeling depressed and lonely. After several attempts to find her, the chaplain finally made contact. She stated that she is never in her room because she tries to keep busy in order to distract herself. Further, she associates with others at the facility, many times against her will, so as to please them. The patient revealed that she has a troubled family history ever since her father died from a massive heart attack and as a result of her own disabling medical problems. The patient stated that though she is frustrated with the behavior of her family members towards her, she hides her feelings behind a smile. The patient also revealed that she is in constant physical pain, but that she hides her pain so that those around her will not abandon her if she was to complain.

During the first few minutes of the visit, the chaplain revealed to the patient that he shared the same nationality as the patient so as to build a common connection. The patient expressed some of her concerns related to her medical condition and family history and the chaplain affirmed the patient's worries and pain as well as the amount of time she had already spent at the rehabilitation facility. The chaplain did not enter into the emotional pain that the patient's brother caused by making fun of her morbid obesity. The chaplain responded to the patient in order to clarify and better understand her statements and expressions so that she might reveal more of herself. When the patient stated that she hides her pain the chaplain realized that she may be hiding her physical pain even as they spoke. The chaplain asked the patient to be more honest by expressing her pain and stated that he was not going to abandon her because of her pain. The chaplain began to lose attention and focus when the patient began to speak at length about extended family issues.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

Revealing the connection of a common ethnic background was helpful and allowed for an easier conversation. The chaplain's affirmation of the patient's medical condition and family history allowed the patient to know that the chaplain was attentive to her story. The chaplain might have explored the complicated relationship that the patient had with her brother and the reasons that she allowed him to make fun of her obesity even while in the rehabilitation facility. Affirming the patient's pain and rejection was helpful for reducing tension in the room so that the patient might more easily express herself. Ideally, the chaplain would've set boundaries to stay focused on the patient's current experience and avoid long explanations of family history. Finally, it would've been better to end the visit before attention was lost and come back to the patient on another visit to hear more of her story.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

No books or articles were suggested.

CC) Gay Bipolar Male with HIV and Alcohol Issues Feeling Rejected and Victimized

1) Description of the client's circumstances, problems and needs for spiritual care:

The patient had returned to the psych unit in a deteriorated state (thinner, unshaven, swollen ankles) after only being gone for one and one-half weeks. Two primary themes emerged in the interview:

a) He was feeling victimized. Since his discharge he had experienced the death of his father and the distancing behavior of his mother and other family members. (He had previously been rejected by his male friend and others.)

b) He was feeling safe in the psych unit environment, the only place where he could find people willing to listen to his concerns.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

a) Try to help him get unstuck from feeling victimized. Instead of saying “I can’t imagine how hard that was for you”, I could have said something like, “Can you tell me about one thing in your life that makes you happy?”

b) Ask him about his son. How would he feel about contacting him? Offer to work with the staff to see if there would be any way to make that connection, hopefully thereby diminishing his feelings of rejection and loneliness.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

No books or articles were suggested.

DD) Responding to Multiple Life-and-Death Issues Shared During a Spiritual Assessment Interview with a 33-Year-Old Caucasian Female, Including Suicidal Ideation

1) Description of the client’s circumstances, problems and needs for spiritual care:

The patient readily shared her physical discomfort, her financial challenges as a laid-off person, her history of drug addiction, her trying to raise her daughter properly (including church), and her belief that the Bible supports suicide by citing the Bible story of Samson (esp. Judges 16:30).

The interventions included listening presence, intentional eye contact, and affirming and validating the patient. Her need included confessing her thoughts of suicide to the chaplain.

2) Description of what the practitioner, upon reflection, considers would be the most appropriate and potentially effective spiritual care intervention for this person:

At the first suggestion of suicidal ideation, stop the patient and explain the chaplain’s responsibility to share such information with other staff for the welfare of the patient. Invite the patient to proceed with that in mind.

Examples of ideal responses: So are you praying for enough strength to die? Are you chained to any pillars? (ref. Samson story) Is it that God knows you are going to die and you are praying for God to give you strength? Do you see yourself in this story? (Samson)

These examples are given so the chaplain can journey with patients where they are by following the themes of the patient’s questions, responses, and dialogue. Seeking to understand the metaphors being used by the patient is of utmost importance.

3) Background information that the practitioner considers useful for understanding the appropriateness of the proposed intervention for the particular needs of this type of person:

Share suicidal content with at least one staff member as a precaution against acting out and as an opportunity for further exploration.

Judges 16