

Early Samples of Ideal Intervention Paper Project (IIP) Reports from CPE Students

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| CONTENTS: | | Page: |
|------------------|---|-------|
| 1) | Ideal Intervention for patient's loss of personal independence | 1 |
| 2) | Ideal Intervention for patient, family and medical staff disagreement | 5 |
| 3) | Ideal Intervention for a non-receptive patient and family | 8 |
| 4) | Ideal Intervention for patient's family rejection of chaplain | 10 |
| 5) | Ideal Intervention for family problems | 11 |
| 6) | Ideal Intervention for family support after bypass surgery | 13 |
| 7) | Ideal Intervention for elderly patient's deteriorating condition | 16 |
| 8) | Ideal Intervention for feeling abandoned by and angry with God | 17 |
| 9) | Ideal Intervention for a disoriented elderly patient | 18 |
| 10) | Ideal Intervention for patients lacking social support system | 21 |
| 11) | Ideal Intervention for a patient in pain and suffering | 23 |
| 12) | Ideal Intervention for patients on ventilators | 26 |
| 13) | Ideal Intervention for anger with God | 27 |
| 14) | Ideal Intervention for early recognition of complicated grief | 28 |
| 15) | Ideal Intervention for patient despair | 31 |
| 16) | Ideal Intervention for patient's loneliness | 32 |
| 17) | Ideal Intervention for building a relationship with a terminal patient | 35 |
| 18) | Ideal Intervention for a child in severe pain | 38 |
| 19) | Ideal Intervention for hope in terminal illness | 45 |
| 20) | Ideal Intervention for elderly patient's frustration at hospitalization | 47 |
| 21) | Ideal Intervention for feelings of guilt or shame | 49 |
| 22) | Ideal Intervention for family divisiveness | 54 |
| 23) | Ideal Intervention for elderly frustration with long hospitalization | 60 |
| 24) | Ideal Intervention for low self esteem | 63 |
| 25) | Ideal Intervention for communicating across a language barrier | 65 |
| 26) | Ideal Intervention for feeling abandoned by God and family | 66 |

NOTE: Each sample uses the student's own formatting. Personal identifying information has been removed.

1) Ideal Intervention for patient's loss of personal independence (A1)

1. Summary Description

I was doing a follow up visit requested by the Chaplain who did an Initial Visit with this patient. The data I had prior to my visit is from the Log Note written by the aforementioned Chaplain. According to this Log Note the patient has a small brain bleed in the lower right side of the back of her head. Patient also has macular degeneration in both eyes. The patient does not remember any injuries to her head.

Prior to my visit with this patient, I was making other follow up patient visits. I prepared for this visit by reading the Log Note and making a few notations by her name on my list of patients to visit today. The patient is a Caucasian woman who is Roman Catholic.

It was already dark outside when I arrive at the patient's room. The patient is in the bed closest to the door. There is not a patient in the other bed. The room was dimly lit since only the light over her bed was on. Her TV was on but she had her back to the TV. The patient was lying on her left side. I did not see any evidence of cards, flowers, etc. The patient's bedside table was empty. There was a pillow or two on the chair that was beside her bed near the headboard. The patient was wearing a hospital gown. She has the sheet and blanket pulled up to just above her waist. There are no IV's or monitors present in the room.

2. Central Spiritual Care Issue Identifier

The central spiritual care issue identifier is the grief, loss and adjustment to diminished independence.

3. Brief Summary of Original Intervention

The patient's initial concern expressed to me is "Oh, I've been better." The patient then told me she has macular degeneration and inquires if I know what macular degeneration is. I respond I am familiar with macular degeneration and know some people who are dealing with it. I then say to her, "You said earlier you've been better," to get us back to our present conversation. The patient tells me she has blood on her brain and her doctor tells her it will take care of itself...no medical intervention is necessary. As our conversation continued, she told me she lives alone and one of her sons will be coming to stay with her. As our conversation continued, at one point I summarized what she had said thus far which led to her expressing that life is dismal. The patient then went on to elaborate on what she was finding dismal at that point in time.

C7: So your left eye is the worse eye and now you have more trouble than usual seeing out of your right eye because of the blood in your brain. And now you will need someone to live with you because you can't see very well. That's a hard place to be.

P7: It's dismal.

C8: Dismal....

P8: (The patient pauses for moment.) Life is dismal without my eyesight. I'm not looking forward to needing help at home. Both of my sons is going abroad on business. My daughter and her family are going on a cruise. Her son just got back from Iraq. When your job says you have to go, you have to go. I can't ask my daughter to cancel her cruise to come be with me. I hope my right eye goes back to where it was when this blood in my brain goes away.

C9: I hope so, too.

I was carrying one of the departmental pagers. The pager sounded shortly after this part of my conversation with the patient. I asked her if she would like a prayer before I left to attend to the page.

She indicated she would like a prayer. Before I prayed with her, I inquired about her religious tradition (she's Catholic). She tells me if she knew she was being transferred to the hospital she would have asked her parish priest to give her the Sacrament of the Sick before being transferred. I then asked her if a priest on staff had been to see her for the Sacrament of the Sick and if anyone has brought her Communion since she was admitted. She indicated she had had no visit for the Sacrament of the Sick or Communion. Her records did not indicate she was Catholic, so I made the change. I also wrote a referral for a priest visit so that she could receive the Sacrament of the Sick. This enabled her to connect to her religious tradition.

Expressed needs

The patient expressed her need to regain sight in her right eye. She also spoke of needing someone to stay with her once she is discharged from the hospital. Her son is moving in with her, but has work during the day. The patient also indicates life is dismal without having her eyesight and that she is not looking forward to needing help at home.

Perceived needs

My perception during this conversation with her is that she needs to talk about life with diminished eyesight and diminished independence.

Spiritual Assessment:

The patient's faith life is important to her. During our conversation, she spoke of her past practice of Daily Mass attendance.

The patient's faith community is an integral part of her life as is evidenced by her Daily Mass attendance. She is separated from this community which used to be part of her everyday life.

Her family community is evident from our conversation. As I wrote the Verbatim this IIP is based on, it dawned on me that perhaps she has some hesitancy about the son who is going to live with her after she is discharged from the hospital. I base this insight on her telling me where her other children are going. This comes after she tells me a little about the son who is going to be living with her after discharge.

The patient is struggling with finding meaning to her current situation in life regarding her diminished eyesight. I base this on her telling me "Life is dismal without my eyesight." Another struggle she shares with me is needing someone to live with her and help her with her self-care. She is used to taking care of herself and struggles with knowing she is experiencing some loss of this independence.

Explicit results of the interaction between the patient and myself are:

she opened up to me about her vision problems.

she revealed she feels life is dismal without her eyesight and that she is not looking forward to needing help at home.

I was able to make the connections necessary so that she can receive Sacrament of the Sick and Communion. She appreciated my checking in with her regarding Sacraments.

Implicit Results of the interaction between the patient and myself are:

by connecting with the patient's need for Sacraments she will feel a re-connection with her faith tradition.

The patient felt some of her concerns were listened to....she felt heard. (ex. my acknowledging her saying "It's dismal;" when I answered her question about knowing about macular degeneration then bringing the conversation back to her initial spoken concern of "Oh, I've been better.")

4. Ideal or Desired Intervention

My ideal or desired intervention focuses on the part of my conversation with her quoted in the *Brief Summary of Original Intervention* section of this IIP, particularly when she tells me:

Life is dismal without my eyesight. I'm not looking forward to needing help at home. Both of my sons is going abroad on business. My daughter and her family are going on a cruise. Her son just got back from Iraq. When your job says you have to go you have to go. I can't ask my daughter to cancel her cruise to come be with me. I hope my right eye goes back to where it was when this blood in my brain goes away.

In discussing this Verbatim with my peer group and Supervisor, their opinion regarding what some of the underlying dynamics and feelings expressed in the above paragraph by the patient are:

- ❖ grief and loss from diminished eyesight and children traveling
- ❖ loneliness with her children going out of town or the country with the exception of the son who is going to stay with her upon her discharge
- ❖ fear that blindness could be coming
- ❖ sadness with her current medical condition, separation from her church and her children

In light of the above insights from my peer group and Supervisor, my opinion of what the ideal or desired invention is to:

stay with the underlying dynamics and feelings expressed by the patient of grief, loss, loneliness, fear and sadness rather than moving to a more positive statement of hope about her right eye.

Some ways this Ideal Intervention might be achieved with this patient are:

- ❖ be open to and engage in conversation with the patient about ways she sees life as dismal with her poor eyesight assessing where she is in processing her fear about and grieving her loss of sight.
- ❖ ask her what it will be like for her to go home and need this son to live with her.
- ❖ wonder with her what it's like not to be able to attend Daily Mass anymore and does she have ideas about ways to stay connected with others who attend Daily Mass and/or arrange for a ride to church.
- ❖ encourage her to talk about her relationship with each of her children and how their absence has an impact on their relationship.

Each area of discussion listed above will ideally take place over the course of numerous visits.

Explicit results of the ideal or desired interventions are:

- ❖ The patient begins processing her loneliness about three of her four children going away during this time of need.
- ❖ She begins processing her grief about and struggles with life with diminished eyesight and diminished independence.
- ❖ She is able to determine ways she can stay connected with her faith community.
- ❖ She begins processing her fear(s) regarding the possibility of blindness.

Implicit results of the ideal or desired interventions are:

- ❖ She is able to determine ways to deal with her loneliness.
- ❖ She is able to come to terms with her new life situation of diminished eyesight and needing more assistance than previously in her self-care.
- ❖ Her reconnection with her faith community gives her support and strength to deal with this new phase in her life.
- ❖ She faces the possibility of blindness with courage and resolve to adjust and function as independently as possible

After Discussing This Ideal Intervention Paper With My Peer Group and Supervisor

Additional ways this Ideal Intervention might be achieved are:

- ❖ When encouraging her to talk about the relationship with each of her children and how their absence has an impact on their relationship to also particularly focus on her relationship with the son who is moving in with her.
- ❖ Engage her in a conversation about what she is missing with diminished eyesight
- ❖ Engage her in a conversation about ways she has previously coped with grief, loss and adjustment to diminished eyesight.

An additional Explicit Result of the ideal or desired intervention:

- ❖ There is a new configuration in the relationships with each of her children.

An additional Implicit Result of the ideal or desired intervention:

- ❖ She values her journey and her life.
-

2) Ideal Intervention for patient, family and medical staff disagreement (A2)

Central Issue Identifier:

- Conflict between patient's family and staff regarding treatment of teen age patient
- The patient's refusal to receive physical treatment and/or be admitted to a psych unit could possibly be a culturally determined resistant, yet the medical team will view him as noncompliant
- Disparity of expectations between medical team and family of patient
- Complicated grief (recent loss of husband, daughter, and car accident)

Problems and Needs of the Patient or Family, Initially Understood:

- Resolution of conflict

Problems and Needs of the Patient or Family, Ideally Understood:

- I would have hoped to know that each party needed to feel heard and understood.
- I would have hoped to understand that the patient's mother was crying out for help for her son and for herself as well.

Purpose of the Intervention, Initially Understood:

- My objective was to bring peace to a stressful situation; to eliminate chaos.

Purpose of the Intervention, Ideally Understood:

- I would hope in a future visit to be intent on facilitating dialogue between family and staff by listening to each party one-on-one (“de-triangulating”).
- My objective would be to clarify each person’s needs and wants to clarify hopes and increase understanding between parties.

Cognitive and Emotive Content of the Communications, Initially Understood:

(M = mother)

- M1 He needs help.
- M7 Nobody is listening.
- M14 That nobody is listening – my son needs help and nobody will get him help.
- M17 I’m just so tired. I don’t know what to do.
- M20/21 I just lost my daughter in February....I haven’t gotten over that yet.
- M22 And 3 years ago my husband died.
- M23 And I had a car accident last week.
- M35 Maybe you could help me talk to J.
- M37 (prayer) God, I need your help. I don’t know what to do with J. I need to talk to him and don’t know what to say. Help me to think straight...

Themes:

- Patient’s Mother is exhausted and having difficulty thinking.
- Mother feels unheard and opposed by staff.
- There is complicated grief and loss in her life: two deaths and a car accident within a few years.

Cognitive and Emotive Content of the Communications, Ideally Understood:

- I would have hoped to know that the patient’s core problems were feelings of invalidation and perhaps rejection, not only by staff, but by her own son.
- I would have hoped to understand that the patient’s fatigue was emotional as well as physical, struggling to hold her family together.
- I would have hoped to understand that the patient may have grief and loss in her life that is complicating the current situation.

Hoped-for Phases in the Visit, Initially Understood:

- I hoped that I could listen to involved persons’ dialogue.
- Intervene when helpful to clarify statements.
- Facilitate new understandings and possibilities for action.

Hoped-for Phases in the Visit, Ideally Understood:

- I would have hoped that I could create opportunities to hear each party express concern individually; to gather perspectives to determine the best intervention.
- I would have hoped to convey that I care about him/her.
- I would have hoped to facilitate dialogue between opposing parties after clarifying the basis for conflicts.
- I would have hoped to provide a sense of meaning and purpose (i.e., God’s presence), with an assessment of available resources (such as faith community – Bible study group)

Measurable Outcomes to be Achieve in the Visit, Initially Understood:

- I hoped to provide a calm, non-anxious presence in the midst of conflict.
- I hoped that there would be a resolution of conflict.

Measurable Outcomes to be Achieved in the Visit, Ideally Understood:

- I would have hoped to provide a calm, non-anxious presence in the midst of conflict.
- I would have hoped to be able to hear each person's story, individually.
- I would have hoped to model and facilitate dialogue on a deeper level of understanding.

Theological Reflections, Initially Understood:

- I perceived the patient's mother to be like the NT Phoenecian woman who asked for healing for her daughter, was rebuffed by Jesus, and continued pleading for help.

Theological Reflections, Ideally Understood:

- I would have hoped to understand that Jesus ministered primarily to the marginalized and would have heard this mother's cry for help.
- Jesus' response to his own mother when she asked him for help at the Cana wedding demonstrated his understanding of emotional boundaries. I was responding to others' expectations of me without clarification.

Cultural Implications, Initially Understood:

- I failed to recognize the racial dynamic in the conference room: one African American mother of an teen-age patient in a face-off with all white staff.

Cultural Implications, Ideally Understood:

- I would have hoped to have recognized that the mother was an African American woman who perceived that her voice was not being heard in a room full of powerful, white physicians and social workers – and chaplain, representing a powerful, though often chaotic system.
- I would have hoped to have understood the life struggles of African American women in her circumstances (unemployed, no college education, single parent), result in feelings of fatigue, rejection and loneliness due to the social forces that work against her.
- I would like to have understood that the patient's refusal to receive physical treatment and/or be admitted to a psych unit could possibly be a culturally determined resistant, yet the medical team will view him as noncompliant. It may have been helpful to consult with an African American Chaplain or Physician.

Further Understanding Upon Presentation of IIP to Group:

- The above actions would also slow down actions and help staff process the situation by helping them to be aware of their own needs.
- As a Caucasian Chaplain, I was perceived as powerful when ministering to an African American woman and held the possibility of overstepping her emotional boundaries.
- Unresolved grief and loss in the life of a patient or family member may result in conflict with the medical team over seemingly unrelated issues.
- A chaplain may find a patient to be more receptive to pastoral care *because* he/she is tired; there is less energy to hide feelings.

Resources Used Following Group Feedback:

- "The Legacy of the African-American Matriarch: New Perspectives for Pastoral Care" by Teresa Snorton. *Through the Eyes of Women*.
- "Triangles", *Family Evaluation* by Michael Kerr and Murray Bowen
- *Application of Family Systems Theory to a Work System: A Collection of Selected Papers*, by Michael E. Kerr, M.D.

3) Ideal Intervention for a non-receptive patient and family (A3)

I. The Purpose of the Activity: The purpose of this chaplain intervention is to provide pastoral care and spiritual support to a patient and his/her family who, through passive modes of communication, initially show signs of resistance to (or a lack of interest in) a chaplain's visit.

II. The Characteristics, Problems, and Needs of the Patient: This is a first time visit. Prior to entering the room, the chaplain had access to the following information about the patient: The patient is in his early sixties who presented himself to the emergency room the night before with chest pain and shortness of breath. Now a patient on the cardiac medical unit, the patient is due to have a cardiac catheterization test the next day and is awaiting a definitive treatment plan. The census indicates that the patient's denominational affiliation is Church of Christ.

Upon entering the room, the chaplain notices the following: The room is dark with the window blinds only slightly open and allowing in only a small amount of natural light. The patient is lying in the bed with the head end of the bed somewhat elevated. The patient is staring up at the television set, but there is no sound. Present with him in the room are two persons who identify themselves as the patient's wife and daughter. The wife is sitting in a chair immediately next to the patient typing on a computer keyboard. The daughter is sitting in a chair on the other side of the patient by the window reading what looks like a textbook. The initial responses of the patient and his spouse to the chaplain's introducing himself and inquiring into how the hospital patient's stay is going are politely chilly and include awkward glances between the two and terse clipped responses. An unnamed tension is present in the room. Is it shyness? Depression? Worry about the patient's health? Is one spouse angry at the other? Are they anti-religious? Have they a bad experience (or no experience) with a chaplain in the past?

III. The Cognitive Content of the Communications Involved: In this Ideal Intervention, the chaplain will not be intimidated by the patient and spouse's initial chilly reception. Short of being asked to leave, s/he will exercise care so as to not exit the room too quickly. The chaplain would introduce himself/herself on behalf of the pastoral care department and indicate that s/he is present to offer pastoral care and spiritual support in ways that hopefully will be beneficial to the patient's healing and recovery, and supportive to the family. Noting the patient's denominational background is Church of Christ, the chaplain can inquire into the patient/family's faith practices and what religious resources might be most meaningful to them during the course of this hospitalization. Would it be Prayer? The reading of Scripture? Communion? Spiritual guidance? A listening ear? Would they like their church to be notified? If terse passive responses and awkward glances continue, the chaplain can choose to confront this dynamic by gently and compassionately inquiring into its meaning with a tactfully worded question designed to illicit the patient and/or spouse to be more open with their feelings. If terse or passive responses continue, the chaplain might inquire, "I'm wondering if I've come at a bad time?" Throughout this Ideal Intervention, the chaplain remains Incarnational (that is, a sign of God's presence), self-defined, non-anxious, non-diagnostic, and perhaps even playful. An intentional effort will be made on the part of the chaplain to include the daughter as a part of the pastoral conversation.

IV. The Structure or Sequence of Phases in the Visit: :

a. *Phase One: The Chaplain's Own Spiritual Preparation:* This chaplain carries in his pocket a laminated card he frequently glances at prior to a visit – particularly if there is a hint that it might be an awkward or challenging one. One side of the card includes the following prayer: “Holy One, Grant us the strength and endurance for this day’s work. Grant us clarity of mind as we care for our patients. Grant us wisdom and help us to be sensitive to the one who is especially in need of our services. Place the right words in our mouths to soothe the hurting soul. May we show compassion and gentleness to all who cross our paths today. Amen.”

b. *Phase Two: The Gathering of facts:* This may be accomplished by a brief chart review of the medical history. Additional information and insight into the patient’s well-being may be garnered by visiting with the patient’s nurse and, if accessible, the patient’s doctor or other clinicians on the unit who have contact with the patient. Facts, of course, may also be gathered in the course of the Pastoral Conversation with the patient and family members.

c. *Phase Three (and throughout the Intervention) Direct Observations:* Once in the room, the chaplain observes the following during the course of the visit: The patient and family member’s appearance, posture, facial expressions, gestures, and mobility; the location and activation of medical equipment in the room; the use (or absence) of lighting; the presence or absence of flowers, gifts, mementos, pictures, cards; the emotional climate of the room; how the patient and family members interact with one another; meta communications; how language is used; voice tones; how silence is used.

d. *Phase Four: The Pastoral Conversation* (1) Brief introductory statement where the chaplain identifies him/herself and states as succinctly as possible the purpose of the visit; (2) A brief general inquiry into how the patient family member’s hospital stay is going – listening to the patient/family member’s stories and offering empathy; (3) Exploring with the patient and family members how/what religious resources might be beneficial to them through the course of the stay; (4) If patient and/or family member’s responses remain terse or chilly, gently exploring the meaning of such responses (5) Offering such spiritual resources as intuited or called for; (6) Closure: An expression of delight on the chaplain’s part in making the visit. Asking for feedback: Has this visit been helpful? Would the patient and/or family member like a follow-up visit?

V. *The Indicators of the Outcome Achieved in the Visit:* Indications that the purpose of the chaplain’s visit has been achieved include one or more of the following:

- (a) The patient and/or family members have identified to the chaplain specific religious resources that are helpful to them during the course of the hospital stay and are receptive to the chaplain partnering with them to explore these religious resources;
- (b) The patient and/or family members become open in disclosing the meaning behind their initially terse and chilly responses;
- (c) The chaplain has maintained appropriate pastoral authority and a non-anxious presence;
- (d) The patient and/or family members are able to identify how the visit has been helpful to them and/or are receptive to follow-up pastoral care;
- (e) The patient and/or family members assert that the services of the chaplain are not needed.

Other Supplemental Comments: In some cases, a patient and/or family members will remain passive, terse, chilly, and uninterested in the chaplain’s presence. When this remains the case, it is best to heed the counsel of Jesus offered to his disciples, “If anyone will not welcome you or listen to your words, shake off the dust from your feet as you leave that house or town” (Matthew 10: 14) and proceed on down the hall to visit the next patient.

4) Ideal Intervention for patient's family rejection of chaplain (A4)

A summary description of the original situation:

Patient was a 78 year old American White female who had been admitted for cardiac problem. Family present at the time of visit included patient's daughter, probably in her 50s, grand daughter, who may be in her 30s and two great grand children in their early teens. Chaplain was a Black African male. This visit was a referral for advanced directive. (This is a type of referral normally entered as part of the record during the admission process. Patients may not have necessarily asked for it or felt the need for it. These referrals, however, tend to provide a good way for Chaplains' initial contacts with patients, and many of them prove to be very good visits.) There was talking and laughter in the room just before I entered. Patient received chaplain well but the stern, angry looking face and body language patient's of grand-daughter signaled to chaplain that she disliked something that she was not willing to verbalize. After visit, which lasted less than 10 minutes, Chaplain asked nurse to check with family if there was something said or done they felt displeased. The feedback the family gave the nurse was that they did not need a chaplain.

Central Issue Identifier or Identifiers:

Unwelcoming behavior of family member towards chaplain in a visit family did not seem to need.

A brief summary of the original intervention:

Neither the patient nor family expressed any need. I perceived that patient would need the emotional and/or spiritual support having been newly admitted. I had hoped that the patient would be emotionally strengthened by my visit.

The Patient was surrounded by family members, which I took to be a sign of good family support. I did not assess patient's spirituality, but I deduce from her acceptance of a chaplain as a sign of her openness to spiritual care. I perceived from grand-daughter's stern, non-friendly and angry mood that there were other unknown issues. My immediate intervention was to invite her to express any misgivings she had. She refused to engage me. After a short while I took the next step to get her again to talk about what she was not feeling ok with. She again refused to talk with me. I had hoped that she would take my invitation and address any grievance she had.

Below is a section of the conversation relevant to understanding the "ideal" intervention.

("GD" is granddaughter, "D" is daughter, "P" is patient, "C" is chaplain

C1: My name is _____. I am one of the chaplains here in the hospital. Just checking to see how you are doing.

P3: I am doing ok.

C6: (Turning to the family) Are you the family?

D2: Yes

C7: Great family support!

C10: Mrs. X, is there any way I can be more helpful to you as Chaplain?

P5: No! Thanks. I hope they will not keep me here for long.

C11: I wish you speedy recovery. I would like to leave so that you could have some time with the family.

P6: Thank you for coming. (She shakes my hand.)

C12: (Turns to the family) Thanks very much for allowing me this short time to be with you. I came to see her because her name appeared in the system for a chaplain visit. It's been part of the admission process.)

GD1: Who put it in the system? Is it her nurse? (She asked angrily)

C12: As I said it may have been done during the admission process.

(She (GD) walks out in an angry mood. I came out and while I am rubbing my hands with alcohol I saw her talking with one of the nurses. As she walks towards me back into the room her face looks stern. I ask her if there is something she is not feeling good about. She raises her hand in a gesture that says a strong no. I go back to the nursing station and ponder over the whole thing. I thought I needed to be sensitive to this reaction of her, and should try again if she would allow me the chance to know what she does not like. If I have to apologize to her I would do so and not leave her angry. I go back to the room.)

C13: Hi! (Looking at grand-daughter) Can I have a word with you?

(She raises her hand in a strong no). ...

Ideal Intervention based on insights from peer and supervisory consultation:

In C1 when I said "Just checking to see how you are doing" I should have been specific that the visit was a system referral which is the source of my pastoral authority to do that visit. This would have set the stage for a rejection or acceptance of the visit by the family. Whatever was the outcome, it would have been satisfactory for both parties.

I should have avoided my comment in C7 "great family support" The fact that there are family members around the patient does not necessarily imply a great family support.

In GD1, when the grand daughter said "Who put it in the system?" I could have answered for instance "I hear that you are not expecting this visit but I am just responding to a request given by the system."

When the grand-daughter walked out angrily and on returning raised a hand signifying a strong "no" it should have been a sign to me that she does not want to communicate with me. I should not have gone back to try to engage her again.

5) Ideal Intervention for family problems (A5)

Central Issue identifier: The patient, a middle-aged woman had been admitted to ER after suffering all night with what was thought to have been "indigestion." The patient has muscular myopathy (?) and is on disability due to the constant pain.

Problems and needs of the patient or Family, Initially Understood: It was my understanding that the family and patient were members of some chaplain's congregation and that they wanted pastoral presences during this time. They have experienced the support of the church in the past and were hoping to receive that same sense of support during this time.

Problems and Needs of the Patient or Family, Ideally Understood: I would have hoped to have picked up on the controlling personality of the husband who was present. The ideal understanding would have been to

find out what it was this person was actually trying to “sell;” was it himself as a wonderful, loving, nurturing father and husband? As the husband talked, the wife and son were kind of off in their own worlds. The patient was resting on the bed in the room (but no doubt listening); why was it important for the husband to “fill” all the quiet space with his words? During this time the chaplain should have taken the time to “check-in” with the patient.

Purpose of the Intervention, Initially Understood: The Chaplain was paged by the chaplains’ office and notified that a Pastor from the church had called to let the chaplains know that a member of the church had been admitted to the hospital for “emergency surgery.” Purpose of the intervention was to provide a Pastoral presence and to pray with the family and patient prior to surgery, to be supportive of the family during this time.

Purpose of the Intervention, Ideally Understood: The initial purpose was not a bad understanding, however, the chaplain should have taken into consideration there may be more to a story than meets the eye. Do not assume that because people are members of a congregation that things are as they seem or as you hope for them to be. Be sure to engage other people in the room and pay attention to the body language of all involved. Why is the patient not interested in the conversation of the husband? Why does the child in the room not seem to listen to or engage in the conversation of the husband? Why can’t the husband look the chaplain in the eyes when talking? All of these things should be taken into consideration and brought up or at least acknowledged during the visit.

Cognitive and Emotive Content of the Communications, Initially Understood: I believe the husband needed to get some of what he was talking about (e.g. his feeling guilty about not showing sympathy) off his chest. Although he is a talker by nature, he needed to be able to express himself to someone outside the family.

(I understood that the husband was feeling guilty because he had not shown the patient the proper attention needed during her pain. The husband continually rubbed his wife’s foot or leg and became teary eyed at some time. The husband spoke highly of his son and appeared very playful with him, which seemed healthy but at times chaplain felt a bit uncomfortable with it.)

Cognitive and Emotive Content of the Communications, Ideally Understood: The husband was trying to “sell” himself to chaplain. He was controlling the conversation in an effort to not allow any time for questions or other observations. In order to be of help to the patient and family, I would have hoped I could have identified or acknowledged the husband’s need to be in “control,” not of just the conversation, but also of the life of his wife and son. I later found out that the wife is not happy in the marriage, but she is scared and is possibly being psychologically abused by the subject.

Hoped-for-Phases in the Visit, Initially Understood: I initially understood that the visit was helpful by allowing the husband only to verbalize what it was he was experiencing. He was able to “vent” some of his frustrations and it seemed that the family was able to be “together” during this particular time in the life of the family. Because of the monopolizing of the conversation by the husband, it was hard to tell if there was anything other than the “venting” that was accomplished.

Hoped-for Phases in the Visit, Ideally Understood: I ideally would like to engage the husband and the patient in the phases of helping as understood by Taylor: Involving, exploring, understanding and acting, while I the chaplain would attend to the needs of them both, respond to their involvement; help them to personalize what they were going through to bring about an understanding that would initiate their acting.

Measurable Outcomes to be Achieved in the Visit, Initially Understood: not sure I understand this.

Measurable Outcomes to be Achieved in the Visit, Ideally Understood: N/A

Theological Reflections, Initially Understood: “God is with us and knows just what we need.” I was providing the ministry of presence to this person that was in need of it.

Theological Reflections, Ideally Understood: although God is with us and knows just what we need, chaplains must not be so consumed in being a “listener” per se that all other elements of listening are ignored. Pay attention to body language, eye contact (or lack thereof) and particular words used, in this case the fact that the husband was a “sales man;” he led the chaplain to believe that was why he was talking so much, when in all actuality he was attempting to “cover something up” (this was found out after presenting the verbatim and then visiting the husband’s wife alone).

6) Ideal Intervention for family support after bypass surgery (A6)

Central Issue:

Family member supporting a patient (parent) following bypass surgery (Family of a religious tradition different than that of the caregiver)

Problems and Needs of the Patient or Family, Initially Understood

The patient in his eighties was an intensive care patient who had been admitted following a heart attack. He was sedated and on a ventilator, having gone through bypass surgery. The patient’s son needed support as he kept vigil with his father who was hanging in the balance between life and death. The middle-aged son was taking time off from his work to care for his eighty-year-old father. He also needed the freedom to draw upon his faith tradition as a source of strength and hope.

Problems and Needs of the Patient or Family, Ideally Understood

I would have liked to realize that the son may have needed to explore the hopefulness that he expressed regarding his father’s recovery. I would have liked to consider that perhaps he also needed to express his feelings about the fact that his mother had died at this same hospital years earlier. Such expressions may have addressed a need to speak with someone about the fear of losing his father. It would have been good to be more aware of the son’s apparent desire to establish some common ground between himself, as a Muslim, and me as a Christian, possibly reflecting a need to be treated with respect and kindness.

Purpose of the Intervention, Initially Understood

I was making rounds on the intensive care unit. My desired purpose with the son and his father was to offer pastoral support through prayer, empathic listening, and by exploring his faith as a source of nurture and guidance.

Purpose of the Intervention, Ideally Understood

In addition to the above stated purpose, I might have been more focused on providing an opportunity for the son to further express his hopes and fears. I would have done this by inviting him to expand on his comments (with statements and open-ended questions) instead of changing the subject. I could also have asked if he was affiliated with a particular mosque/worshipping community.

Had I been more aware of the interest the son was showing in establishing common ground between us, I could have become an advocate for him with other (non-Muslim) hospital staff. I might have done this by asking him how he was experiencing the staff's treatment of him and his father and if there were things being overlooked in relation to the customs of his family/tradition.

Cognitive and Emotive Content of the Communications, Initially Understood

Following are excerpts from the verbatim that reflect clues about the cognitive and emotional themes present.

C – chaplain, S – the son

- S2: He is doing better. He's on the respirator but he is really breathing on his own. They are probably going to take that tube out today.
- C3: That sounds like good news.
- S3: Yes, he's doing okay. He had a heart attack and they had to do bypass surgery. He is always very active and healthy.
- C4: He stays in good shape.
- S4: Yes. That's why this was a surprise. He is strong so he will get better.
- C5: And you are able to take the time to be here?
- S5: Yes. I am here every day. My brother comes too. He lives with my brother. He'll be coming soon. (Pause.) My mother died in this hospital.
- C6: Oh, she did?
- S6: Yes, she had a stroke. She was here for a few weeks. There was too much blood on her brain. We were here then, too.
- C7: How many are in your family?
- S7: We have three sisters, but they are still in the home country.

- S11: And are you a minister?
- C12: I am a chaplain with the hospital full time and I worship with a (denomination name) Church.
- S12: Oh yes. I know the (denomination name).
- C13: And you? Is there a faith community you belong to?
- S13: We are Muslim. But we are all God's children.
- C14: Yes, we are all loved by the same God.
- S14: Yes. There are so many stereotypes about what Muslims are like. But it is a political Islam that people see – the political Islam is not the true Islam. We pray in the name of Jesus.
- C15: You do?
- S15: Yes!
- C16: I didn't know that.
- S16: Many people do not know that, but we do. We believe that Jesus was the Son of God. Jesus did not have a human father. Mohammad did. So Jesus is the Son of God. There are Muslims who will not say that. But nobody can speak against Jesus. In (the home country), if anyone says anything against Jesus or Abraham or Mohammad, they can be sent to jail.
- C17: Really.
- S17: Yes. There are laws governing what people can say. (Pause.) I know the (denomination). I work in construction and there are (denomination) who work with me. Right now we are building a mosque in (city name).
- C18: Oh, you are? What do your (denomination) co-workers say about that?

In the segment from N2-N7, I initially understood that the son had expressed well-grounded hope, a sense of some insecurity because of the surprise of the heart attack, and sadness regarding the loss of his mother. In the segment N11-C18, I understood that he communicated some sadness and anger about some people's

perception of him as a Muslim. I also thought he expressed some tenderness for the (denomination) he was acquainted with (including me).

Cognitive and Emotive Content of the Communications, Ideally Understood

Having received peer group feedback, I might have brought more of an understanding of the underlying fear present in the son's conversation about his father and how the current emotions were connected with the loss of his mother. I also could have been more aware of the *present* anxiety about how they would be treated as Muslims by the hospital staff.

Hoped-for Phases in the Visit, Initially Understood

In between the two verbatim segments above, the son asked me to say a prayer before a short breathing test was performed on his father. I did so and then needed to make a decision whether to leave or stay a little longer. I stayed. My initial understanding of hoped-for phases in the visit included: an introduction and welcoming phase, a preliminary assessment phase, a soulful-spiritual connection phase, and a blessing phase. With the prayer it felt like we had the blessing phase but had not yet reached the soulful-spiritual connection phase, which was why I stayed and continued the conversation.

Hoped-for Phases in the Visit, Ideally Understood

After hearing feedback, I understand that the "soulful-spiritual connection" phase of our visit could have been deepened had I been more in tune regarding the unspoken fear the son was likely dealing with. And, quite likely, the fear of losing his father is a reflection of how deeply he loves him. Therefore, it would have been important to talk about both his love and his fear.

Measurable Outcomes to be Achieved in the Visit, Initially Understood

I hoped that, through our encounter, the son might have a sense of being noticed, heard, and cared for. I hoped that the sustaining power of his faith would be enhanced.

Measurable Outcomes to be Achieved in the Visit, Ideally Understood

As an expansion of the outcomes above, I would have wanted the son to feel like my presence offered a safe place for verbalizing fear and other uncomfortable emotions. And that he would have felt free to express his love for his father. I would have wanted him to have the assurance that we as staff would work together with him to provide care that would respect his Muslim context.

Theological Reflections, Initially Understood

When I saw the patient's name on the list and then met him and his son, I wondered what their religious affiliation might be. I thought, at first, that it might be (religion name). And so, when the son asked me to pray before I knew where they were coming from, I was intentional about leaving out "in Jesus name." What an interesting turn the subsequent conversation took! Apparently, the son had a less traditional understanding of Islam. I wonder how much of this came from living in North America amidst a prevailing negative attitude towards Muslims.

The son was a translator/messenger/caregiver for his father in the midst of his recovery from surgery in the hospital. He expressed a sense of dependence on God as he waited for signs of his father's recovery and stability. [While the respiratory technician and other clinicians were taking their measurements, it struck me – the mysterious nature of breath, the "ruach" (Hebrew for wind, spirit) that we all share. This breath that we can measure and sustain and lose but never create is a holy thing. It is something that connects us to each other and the animal world – something that makes us fundamentally interdependent, regardless of religious affiliation, and dependent on God the Spirit of Life.]

Theological Reflections, Ideally Understood

I might have seen that the son was approaching the edge of the “Void” – the place of loss, pain, disorientation, etc. – as he confronted the possibility of his father’s death. I have only a shallow understanding of the emphasis in Islam on Allah’s will, but enough to think that I might have pondered (alone or with the son), “when God’s will involves the loss of someone we love, where does our hope come from?” I might have remembered the regular prayers that are part of Muslim life and worship and could have asked about how these were a source of strength. The son expressed openness to and dependence upon God. I could have spoken with him about what he imagined Allah to be like, because this would have had a bearing on the manner in which he experienced loss and grief and hope.

7) Ideal Intervention for elderly patient’s deteriorating condition (B1)

The Purpose of the Activity

The purpose is a follow up visit after an initial visit during a medical crisis. The chaplain is to provide a supportive presence, and explore the meaning the patient has made out of the crisis and what spiritual needs she might have.

Characteristics, Problems, and Needs of Patient

The patient, in her seventies, had experienced a medical crisis in the midst of a long term deteriorating condition. She had improved since the crisis, and so was experiencing a reprieve in a condition that would worsen over time.

(She had had problems in the past with her lungs and she still smoked. She had had several heart stents put in during the previous year, and needed a triple bypass operation which her doctors said she should not have due to her overall health. She was in respiratory distress due to pneumonia, and was breathing with great difficulty even with a breathing support machine. I had prayed with her and talked with her husband during the crisis, but conversation with her had been limited due to the breathing mask.)

The patient was dealing not only with the effects of the current crisis, but also with her overall medical condition. Her medical condition was affected by how closely she adhered to a diet and her smoking. She had been married for more than fifty years, and her condition was affecting her husband. She did not seem to have a current church connection.

The Cognitive and Feeling Content of the Communications Involved in the Visit.

The crisis: The chaplain would encourage the patient to share her feelings about the crisis and her recovery. The chaplain would then investigate if or how the patient has made meaning of the event. If the crisis has caused a reassessment or change in attitude, the chaplain can explore how the patient will behave differently in the future.

Underlying health problems: The chaplain would encourage the patient to share her feelings about the deterioration in her health. Has she grieved her deteriorating health? What are her feelings about the future – despair? Hope? The chaplain would encourage the patient to talk about the future and would assess if this thinking was realistic or if the patient was in denial. The chaplain would encourage the patient to share thoughts and feelings about the effect of this illness on family members, relationships and daily life. The chaplain would inquire about the patient’s support system, and if there was not one, would encourage the patient to develop one.

The Structure or Sequence of Phases in the Visit.

Preparation and Introduction: The chaplain would prepare by recalling the first meeting and then taking a moment to center on God before entering the room. The visit would start with a reminder of the first meeting and an attempt to establish a closer connection. This might be done by mentioning something in the prior visit that seemed significant. It might be done by a genuine expression of concern for the patient and delight in the patient's improvement. As the connection is established, the chaplain would be able to move toward the purpose of the visit.

Assessment: There could be spiritual needs arising out of the crisis that the chaplain would evaluate. This might develop into spiritual needs related to the declining health of the patient and the effects on both her daily life and the life of her husband.

Meet Needs: The chaplain would attempt to meet the needs of the patient. This might involve prayer, being a caring listening presence, or helping the patient explore meaning that has arisen from the crisis.

Disengage: The chaplain then would wind up the visit and say good-bye. Any arrangements for another visit could be made at this time. After leaving, the chaplain would take time to reflect on issues and feelings that have arisen during the visit before moving on.

Indicators of the Outcome Achieved in the Visit.

- Connection established with patient
- Chaplain explored meaning of crisis with patient
- Patient articulated sense of meaning for the crisis
- Patient expressed feelings about the crisis
- Chaplain explored how patient's faith related to this
- Chaplain addresses patient's expressed spiritual care needs
- Chaplain asks about and encourages support system for patient
- Chaplain addresses other needs that were not verbalized
- Chaplain arranges any further visit

8) Ideal Intervention for feeling abandoned by and angry with God (B2)

A Summary Description of the Original Situation:

The patient had had a seizure. That was the reason for her being at the hospital. She also suffered from Muscular Sclerosis. I did not initially realize that she was emotionally unstable. I should have been more astute in my assessment and should have addressed this with the multidisciplinary team.

The patient was in her sixties and middle class. She was Caucasian and Roman Catholic.

When I encountered the patient she was slumped in her wheel chair. Her eyes were focused on the floor with her head tilted to the side. Her hair was disheveled and she had a blank stare. Her food was in front of her but she wasn't eating.

The Central Spiritual Care Issue Identifier:

The patient was angry with God due to loss of mobility and cognitive dysfunction. She felt abandoned by God.

A brief summary of the original intervention to include expressed and perceived needs:

The patient had a need to be listened to, understood, and heard. She wanted to express her anger and frustration with her situation. She also needed emotional and spiritual support.

The assessment was based on two brief visits with very little communication by the patient.

C: Chaplain P: Patient

P3: I am angry with God.

C4: Have you told God how you feel? (She just stared at me and then she put her hand on mine and shut down. I sat with her for a while. I thought that sometimes it is best to be silent and present.)

Next Visit

P10: I am in Hell and I do not know how I got here or how to get out.

P11: I used to be a social worker. I used to do what these people do. I used to be a runner.

C6: How about we focus on what you can do?

Summary of what should or could have been:

The patient was angry. She shut down after P3. In C6, I should have followed both leads by asking: Why are you angry with God and why do you feel crucified.

9) Ideal Intervention for a disoriented elderly patient (B4)

Central Issue

Disoriented patient and need for staff ministry

Problems and Needs of the Patient or Family, Initially Understood

The woman patient in her nineties on the nursing unit was crying out from her room for someone to help her, but received no acknowledgement from the nursing staff near her room. The patient was experiencing what seemed like an altered mental state, and felt that she needed help but was not receiving that support. There was also a concern for what the nursing staff was feeling, since there was no movement toward assisting the patient.

Problems and Needs of the Patient or Family, Ideally Understood

I would have hoped to know what the patient's status was prior to entering the room in order to better assess the situation. I would have liked to consider that there was an underlying reason that the nursing staff was not responsive to the patient's cries. Such information may have benefited the conversation allowing for the

opportunity to provide the patient with spiritual reassurance in her time of need, along with establishing a connection with the nursing staff to be an asset to the patient's over all health care.

Purposed of Intervention, Initially Understood

I was making rounds on the nursing unit when I heard the patient's cries. My intended purpose was to see if I could be of any help to this patient by helping her get what she was in need of and being a listening ear.

Purposed of Intervention, Ideally Understood

Along with the initially understood purpose, I would have liked to have an understanding of the different types of needs that the patient was expressing; i.e. the need for structure, the need for companionship, or the need for hunger. I would have liked to be a voice bringing familiarity to the patient to help her move through her disorientation. I might have offered pastoral support to the nursing staff as well, as they seemed frustrated with the patient.

Cognitive and Emotional Content of the Communications, Initially Understood

The following are excerpts from the verbatim show clues about the cognitive and emotional themes present.

P2: I dropped something on the floor. Could you get it?

C2: I don't see anything. What did you drop?

P3: My meals on wheels. Right there on the floor. (pointing at a piece or sliver of paper)

C3: This is just a piece of paper. (picking it off the floor and throwing it away)

P4: Oh... what time is it?

C4: Well it's about 4:30.

P5: I'm not dressed am I?

C5: No you are. You are dressed in what you should be.

P6: But I am in night clothes. Is it time for nighty night?

C6: Well in a while it will be night. But these clothes are fine for now.

P7: What day is it?

C7: Tuesday

P8: Tuesday at twenty after four. Meals on Wheels should be here soon.

C8: Your meal should be coming up.

P9: Will you check? Call my daughter.

C9: I can go check with the nurse about your meal.

(I left the room and went to find out from a nurse about meals and to see what information I could get about the patient. The nurse was short and didn't give me any information about the patient other than her meal would be there soon.)

P14: Oh, where am I?

C14: You are at the hospital.

P15: Oh I just took a nap and am all mixed up. Will they come get me and take me to a table?

C15: No, they will bring your food right in here. On that tray and you can eat your meal in bed.

P16: Okay. I see you are the woman of God. (pointing out my bible)

C16: I am one of the chaplains.

P17: You are truly blessed, highly religious. God bless you.

C17: Thank you.

In the first section P2-C9, I initially understood that the patient was not sure of where she was or what day it was; rather she was in a previous place searching and waiting for Meals on Wheels to be there. The second

section, P14- C17, I understood that she realized she was not making sense but also that she recognized the bible.

Cognitive and Emotional Content of the Communications, Ideally Understood

After receiving feedback from my peer group, I would have tried to reverse the roles of the giver and receiver with the patient as she was more in the role of giver instead of receiver. I could have taken more of a role in this role reversal by asking the patient questions about things that she recognized -- Meals on Wheels and the bible -- rather than having her ask question after question. Since the patient was not in her right frame of mind, I would have tried to explain where she was, along with utilizing the importance of calling her by name in order to allow her to focus on something familiar.

Hoped-for Phases in the Visit, Initially Understood

My initial understanding of hoped- for phases occurred between these two sections, where I went out to the nursing staff to ask questions regarding the patient's meals and condition; however, I received minimal information. I had hoped to have gained a better understanding of the patient prior to going back into her room to give her information about her meals.

Hoped-for Phases in the Visit, Ideally Understood

Having received feedback, I understand that regardless of the information that I could have gained by asking the nursing staff about the patient and her condition, I could have been more aware of her "hungers." These "hungers" were physical hunger, asking about her meals, spiritual hunger, mentioning that I was a woman of God, and social hunger, looking for her daughter. It would have been helpful to identify these "hungers" to help the patient gain some recognition of what was familiar to her

Measurable Outcomes to be achieved in the Visit, Initially Understood

I hoped that through my encounter with the patient that she heard a voice of reason and reassurance in her time of uncertainty. I also hoped that my asking the nursing staff questions would have been a way that they could have seen me as a valuable part to the patient's care and someone that they could vent some frustrations with.

Measurable Outcomes to be achieved in the Visit, Ideally Understood

Along with what I initially understood the outcome to be, I would have wanted the patient to feel God's presence with her in this time as well. That amongst the confusion she could have been assured that God was present with her.

Theological Reflections, Initially Understood

The theological and spiritual issues present were that the patient was in need of comfort, support, or healing. She was searching for this in anyway she could; by crying out she was searching for a source of aid. This situation reminded me of the story of the woman touching Jesus' garment. She knew that all she needed was to touch the hem of Jesus' robe and she would be healed. Similarly, this patient knew she needed help and in order to get that she cried out until some came to her side.

Theological Reflections, Ideally Understood

I might have seen the patient's situation in a different understanding if our conversation would have been more than a fix or heal situation. I have an understanding that what the patient was searching was healing, like the woman touching Jesus' garment. I could have spoken to her more about familiar things.

10) Ideal Intervention for patients lacking social support system (B5)

1. A summary description of the original situation:

This visit was a follow up visit initiated by a referral from the previous chaplain to see the patient. 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. The central spiritual care issue identifier:

Lack of support systems

3. 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 one of the chaplains here at the 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 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 lost 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 result of this interaction was that the patient asked me to leave. The implicit result 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 it 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.

4. 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 how 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 one of the chaplains here at the 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 could have developed that would end 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 seemed to require a gradual and sustained rapport being built if any lasting positive affects 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.

11) Ideal Intervention for a patient in pain and suffering (B6)

Central Issue Identifier

Undeserved suffering, both past and present.

Problems and Needs of the Patient, Initially Understood

I thought that the patient's problem was that he was uncertain about God's presence during his suffering and his daughter's suffering and death, as well as about the afterlife. I thought his need was for some concrete answers to these difficult questions to help ease his pain and understand his suffering.

Problems and Needs of the Patient, Ideally Understood

I would have hoped to know that the patient's problem was the pain and suffering he had dealt with for a long time. I would have hoped to know that his need was for someone to engage that suffering, rather than the surface questions he presented.

Purpose of the Intervention, Initially Understood

I had visited the patient a few weeks prior and he had presented some challenging questions about God's presence during suffering and the afterlife. His mental health had deteriorated immediately after that visit. He had regained his senses and I returned for this visit in order to better address his original questions. I had studied how theologians answered them before the visit. I wanted to ease his confusion and engage his questions.

Purpose of the Intervention, Ideally Understood

I would have liked to have addressed the emotions below the patient's questions, such as his suffering and the pain he still felt from his daughter's death. I would have hoped to empathize with this pain and allow him to explore it.

Cognitive and Emotive Content of the Communications

Excerpt:

P7: Alright. Well, my first question is, if there is a God, why does He make good people suffer? Like why did he make my daughter go through 2 years of hell before she died? (I'm thinking this is the same question from the first time I visited him) And you're going to say "I don't know." Just like everyone else.

C7: Hmmm. I might say that. It's a hard question to answer. And we talked about it the first time I visited.

P8: We did? Oh, well I still don't get it. She was a good person. She didn't deserve it. She spent 2 years with 4 big tubes in her chest and stomach. And it wasn't the leukemia that killed her either. She was strong and she beat that. But the radiation and chemo ate out her insides and killed her. So, why'd she go through that?

C8: Where do you think God was during it?

P9: Not there, because He doesn't exist.

C9: But what if He does and He was there?

P10: Well, then He's an asshole for not doing anything.

C10: It sounds like you're pretty angry at God, and it's ok to be that way.

P11: Yeah, I'm angry at Him. He took her and she'd never done anything wrong. She had hard times in her life, but she got through them.

C11: Well, what if God had been with her during the suffering and suffering with her?

P12: Nope, that's not possible. Then He'd have gotten all rotted out inside too and died. (I think to myself that Moltmann's ideas do work better with Jesus). If He was there and saw how bad she was hurting, He'd have to have done something.

C12: Hmmm, I don't know what to say.

Initially Understood

I thought that the patient was bringing up the painful emotions and memories in these questions to illustrate his confusion and doubt about God. I heard his statement that I would just say “I don’t know” as asking me to explore possibilities of God’s presence with him. I felt like exploring the mental questions he was bringing up and talking logically about this painful situation was helping him to explore his beliefs and feelings.

Ideally Understood

I would have hoped to see the opportunity for deeper empathy and exploration during this exchange. Particularly after P8 and P12, I would have liked to empathize and ask the patient to help me understand the pain he went through during these times. I would have liked to recognize that the patient was still dealing with grief and had a need to talk about his daughter’s suffering as it affected him emotionally. I would have liked to have seen the parallels the patient was drawing between his suffering and his daughter’s. I would have liked to have explored the “rotted out” phrase with him.

Hoped-for Phases in the Visit, Initially Understood

The phases I had hoped for during this visit originally were to guide the patient through potential understandings about God’s presence during suffering. I hoped to help him find an idea that gave him hope and allowed him to have faith. I hoped that by allowing him to find some way to have faith that he would find hope for his own health and what he was going through.

Hoped-for Phases in the Visit, Ideally Understood

After the presentation of this verbatim, what I would have hoped for in the visit changed dramatically. I would have hoped that I could have gotten down into the emotions the patient was experiencing and would have allowed him to explain and express them to me, as he had been dealing with them a lot. I would have hoped to gain an understanding of where he was emotionally and been able to just be present with him in that pain and uncertainty. I would have hoped that he would find hope in the fact that someone cared enough to get down in these emotions with him and not just deflect them or work around them.

Measurable Outcomes to be Achieved in the Visit, Initially Understood

One measurable outcome of this visit initially was that the patient would find a satisfying answer to his questions and be able to rebuild some faith from there. Also, that by answering these questions, we were able to get into his emotional pain and address it. I wanted him to feel like he could talk to me more deeply, so that my future visits would be more meaningful to him.

Measurable Outcomes to be Achieved in the Visit, Ideally Understood

My measurable outcomes changed after the presentation. Now I would have hoped that the patient would have felt like I had been able to experience and share the pain he was bearing for so long. I would have wished for him to feel free to explore his emotions with me. I feel like these would have led to my final outcome that the patient would have wanted to talk more deeply with me upon future visits.

Theological Reflections, Initially Understood

One theological assumption during this visit was that the patient was assuming that clergy should have more answers to questions of pain and suffering than saying “I don’t know” and that I should have said more. When I didn’t have answers, I did not have much more to offer him. One of my sources of theological reflection for this visit was the book of Job, particularly the idea that I was going to be more helpful if I got into the ashes rather than standing and answering questions. I had thought the patient was resistant to that idea. From reading Shirley Guthrie’s chapter on suffering in the Christian Doctrine, I learned that while we may not have many answers to these questions, it is important to not be negligent or apathetic toward “natural suffering.”

Theological Reflections, Ideally Understood

I would have realized my own resistance to getting into the ashes with the patient. I would have acknowledged my own resistance and tried to overcome it while exploring with the patient the pain he was experiencing. I would have hoped to know that his expectation for answers was not as important for me to meet as his emotional state at the time. I would have remembered that Jesus often offered actions rather than easy answers, as does God in the Old Testament. I would have hoped to keep in mind that Jesus also did not stand above the suffering of those who came to him, but got down into it with them before healing them.

Other Comments

It should be noted that the patient was a non-practicing Jew, which made turning to imagery or lessons from the New Testament difficult. Also, during this visit, his brother was present, which ideally would not have been the case. I experienced his brother as coping with the patient's pain through humor, which kept us close to the surface emotionally. The patient had always been open to prayer, though he didn't explain why. He was suffering from several conditions, including heart problems, MRSA, blindness, and becoming deaf as well. During visits between my initial visit and this one, he had been hallucinating, depressed, and confused.

12) Ideal Intervention for patients on ventilators

1. A routine visit to introduce chaplain services to a patient brought me to the room of a white woman in her 80s, listed as "Baptist." She was using a ventilator and had had, I believe, a tracheostomy.

CENTRAL SPIRITUAL CARE ISSUE: how to communicate with someone who cannot speak back.

3. Summary

When I entered the room I found a patient with a ventilator. Due to my unfamiliarity with assisted breathing (not intubation), when the patient began making strange (to me) noises I quickly prayed and then left.

C1 oh, you're on a vent. I didn't know. I'm ____, one of the chaplains.

P1 (patient makes noises like clearing her throat, but it is not clear to me what she intends.)

C2 I see. (I gesture to relax, don't worry.) I see you're on the vent and that you're Baptist. Would you like me to pray for you?

P2 (Patient nods and closes her eyes.)

C3 General prayer that pt. would know the presence of God and his peace.)

The following day, when I entered her room again, (by "mistake") I again realized I didn't know how to communicate and sought a nurse, who suggested "Paper and pen, but she's been talking". So I returned.

C4 I prayed with you yesterday."

P4 (Her eyes acknowledge and she nods)

C5 Do you have a favorite song?

P5 yes (spoken in a whisper)

C6 What is it?

P6 (verbal) In the Garden

C7 I think I know that. (We sing it together – she mouths the words when I fumble on the verse, but the chorus we “sing” together: “He walks with me and he talks with me and he tells me I am his own. And the joy we share as we tarry there, no other shall ever know.”

That is wonderful message for you.

P7 (She smiles and nods)

C8 (I lay my hand on her shoulder) May God Bless and Keep you.

4. Stop and think; there is no need to panic. Probably 75 % of our communication is always non-verbal. Find out what you can from the nursing staff about a particular patient. When speaking to the patient, ask yes or no questions. If patient can use hands, as this person could, find out if she can write a response. “Would you like me to stay a little while?” could have given me permission. Many different situations include the need to communicate with someone who does not speak. There are communication boards available in many settings. It would be helpful for a chaplain to be familiarized with these. There is a whole range of non-oral communicative devices available. Gestural systems include hand/head gestures, eye-blinks, facial expressions, written memos, as well as sign language. There are also gesture assisted tools, which involve graphic or electronic displays of symbolic systems, such as alphabet boards, or boards with pictographic symbols. Has anyone developed a “Pastoral care communication board”? What might be included in such a tool?

In this brief visit the chaplain made use of several powerful tools for communication. In the first visit, prayer was used in intercession. “Wherever two or three are together in my name, there am I.” Despite not being able to communicate easily, there was a “threefold cord which is not easily broken.” In the second part of the visit, the chaplain used her own experience as a music leader to try to find another point of contact and found the patient’s favorite song as a way to join together. Other Christian resources might include reading scripture or having a devotion together – especially if preceded by asking the patient if that would be agreeable.

While for many people being connected to a ventilator suggests a feeling a helplessness and very literally “not having a voice”, it is possible that one might be fully glad to be alive and functioning, so the task of the chaplain of ascertaining the unique realities of a patient through communicating with the available tools is the first step of providing pastoral care.

References:

<http://www.dinf.ne.jp/doc/english/asia/resource/apdrj/z13jo0400/z13jo0405.html> “Communicating with Nonverbal patients in India; Inexpensive Augmentation communication Devices”. Subhash C. Bhatnager and Franklin Silverman

International Ventilator Users Network (IVUN) Vol.9, No. 2, Fall 1995, Life with a Tracheostomy: A Personal Decision”. <http://www.ventusers.org/edu/valnews/val9-2.html>

13) Ideal Intervention for Anger with God (C1)

Summary

I was paged to the cancer floor at the hospital by the unit nurse. The patient and family had just received bad news that the patient was not going to get the aggressive treatment they had expected for her cancer. The family was Catholic, middle class, Euro-American consisting of the patient, a 54 year old female, her husband, her sister, and two sons. I felt comfortable with the racial, economic, cultural and religious dynamics in the room because I shared those experiences. Both the patient and her sister were nurses. The IV was beeping. The family was tearful when I arrived. I was asked to pray and I had prayed. I was leaving the room to get more tissue when the critical moment happened with the husband.

Central Spiritual Issue Identifier

The patient's husband was angry with God over his wife's cancer.

Problem and Needs of Patient and Family initially understood

I believed that the family and patient were sad over the bad news of an aggressive form of cancer treatment not being available to the patient and that they would need emotional and spiritual support.

Content of Communication initially understood

C: Chaplain H: Husband

(The husband has followed me out the door. We are standing in the hall across from the room. The door is still shut.)

H7: (Tears are rolling down his cheeks.) I am having a hard time with this. I am not perfect but I have done some bad things. But I have always been faithful to my wife. We have been struggling with her cancer since July. (I was surprised that she had not been fighting the cancer for a longer period.) She is a nurse. Since July our income is down by 11,000\$. It's been tough but we'll make it.

C8: This has been a struggle for you and it has been hard. I noticed that your family and you made the sign of the cross. Are you Catholics?

H8: Yes.

C9: Would you like to have a priest come to visit or bring communion. I think he is still in the hospital.

H9: No!(with some feeling) I am still angry with God over my wife's cancer. I don't understand why. (I am getting uncomfortable standing in the hall.)

C10: Would you like to talk in a more private place. We can find somewhere else to go.

H10: No, in fact I need to get going. I have to do something right away. I would like to talk to you if you can come back later.

C11: Okay, I'll be back. (Husband leaves the floor. I go back into the room)

Ideal Intervention Summary

After feedback from my peers and supervisor, I should have stayed with the husband in H9. I should have acknowledged his anger and journeyed with him down that path. Perhaps saying something like, "I hear your anger with God" or "Your wife's cancer has made you angry with God. Tell me more about that." would have been more helpful to him.

14) Ideal Intervention for early recognition of complicated grief (C3)

Central Issue Identifier:

- Patient's emotional instability due to recent suicide of patient's mother
- Complicated grief (patient history of abuse by father; father's death)
- Inappropriate boundaries expressed toward chaplain by patient

Problems and Needs of the Patient or Family, Initially Understood:

- I believed patient needed emotional and spiritual support due to recent suicide of his mother.

Problems and Needs of the Patient or Family, Ideally Understood:

- I would have liked to have understood the patient was in emotional/mental distress due to the news of his mother's suicide.

Purpose of the Intervention, Initially Understood:

- I believed that the patient needed emotional and spiritual support to help the patient cope with the tragedy of a family member's suicide.

Purpose of the Intervention, Ideally Understood:

- I would hope in the future to understand that the primary purpose of this visit was to assess the patient's spiritual needs and provide appropriate intervention, particularly referral to other specialties such as psychiatric counselors.

Cognitive and Emotive Content of the Communications, Initially Understood:

(P – patient; C – chaplain)

P2: (pt closes his eyes as if thinking; I prepare to leave, then pt speaks in a whisper, eyes still closed):
I've had some bad news.

C3: (I lean forward to hear patient better.) Bad news?

P3: My mother committed suicide two days ago. (Well – just put it right out there – no small talk – guess we're diving in! I feel a little shocked at the patient's forthrightness, though I already knew about his mother.)

C10: Is your father in your life?

P10: My mother shot and killed him.

C11: (Inwardly I gasp. I want to shout, "No wonder she killed herself!" but I take a deep breathe and let it sink in.) That must have been a terrible memory she carried.

P11: I was in a coma for 3 weeks.

C12: (Huh? Why is the pt jumping around?) A coma?

P12: My dad shot me in the head. That's why my mom shot him dead.

C13: How long ago did this all happen?

P13: 15 years ago.

C14: (What do I do with this tragic information? It is unbearable. I sit quietly.)

P14: My dad molested me until I was 17 years old.

C15: Oh. (The unbearable just got worse. Silence.) Did your mother know this was happening?

P15: Not at first. He started when I was 12. When she found out, she told him to stop. That's when he shot me.

P27: (Pt opens his eyes to a squint and looks at me sideways without moving his head.) Would you do me a favor?

C28: (I feel uncomfortable, without really knowing why. The words, "a favor" seem strange, and it seems that he is about to ask for something personal.) What would that be?

P28: My mother had a nickname for me.

C29: A nickname?

P29: When I was a baby, I didn't cry. I made a funny sound that my mom said sounded like a squeak. She called me squeaks.

C30: Squeaks?

P30: Yeah. (then extremely quiet, more than before) Could you just rub my arm for about 5 minutes and call me squeaks?

P35: Know what I really need?

C36: (Again, that sense of uncomfortableness creeps over me.) What do you really need?

P36: Would you hold me? (The pt breaks down into mind-boggling sobs that shake his entire body.)

P39: Do you have a tape recorder? Could you tape record the squeaks? I have a tape player and could listen to it.

C40: (I don't respond, but sit quietly thinking)

P40: Please. (tears trickle down his cheeks) I really need to hear some squeaks.

- I initially understood that the patient was in emotional and spiritual distress over his mother's self-induced death.
- As the visit progressed I learned that there was psychologically unprocessed family abuse both sexual and physical, with no spiritual resources.

Cognitive and Emotive Content of the Communications, Ideally Understood:

- The patient had an overwhelming need to be comforted beyond what I as a chaplain could offer.
- I would like to have understood that the patient was incapable of communicating his deepest needs.

Hoped-for Phases in the Visit, Initially Understood:

- I hoped that I could listen to the patient's distress, making a spiritual assessment of patient's needs.
- Intervene when helpful to clarify statements.
- Facilitate new understandings and possibilities for action.

Hoped-for Phases in the Visit, Ideally Understood:

- I would like to have known that I needed to prepare myself for such a visit by consulting with the staff and/or reading the patient's chart.
- To create a safe space for the patient to grieve.
- To preserve the dignity of the patient by recognizing his need to be comforted while enforcing personal boundaries.
- To help the patient connect with other practitioners of care and healing resources.

Measurable Outcomes to be Achieved in the Visit, Initially Understood:

- My goal in this visit was to be a listening presence, knowing that suicide is devastating to family members.
- I hoped to help the patient connect with God and community resources.

Measurable Outcomes to be Achieved in the Visit, Ideally Understood:

- To recognize the depths of the patient's spiritual despair and lack of spiritual resources.
- To connect the patient with psychiatric counselor.

Theological Reflections, Initially Understood:

- Only God could help the patient carry his unbearable burden. "Come unto me all you who labor and are weary and I will give you rest."

Theological Reflections, Ideally Understood:

- Jesus' words from the cross, "Forgive them for they know not what they do," could speak to the patient's inability to recognize the inappropriateness of his requests of me. That does not excuse the patient's actions, nor does it mean that I should remain in the situation.
- Referring a patient to a psychiatrist or social worker can be a means of extending grace to a patient.

Cultural Reflections, Initially Understood:

- The patient was more than a decade younger than me, but not a significant difference at this stage of life. He functioned much more immaturely, however. He was unemployed, financial situation desperate. We were both Caucasian.

Cultural Reflections, Ideally Understood:

- No new insights.

Further Understanding Upon Presentation of IIP to Group:

- My personal history (lack of boundaries in my family of origin and marriage) numbed me so that I was not prepared for the emotional issues that awaited me.
- I am the only person who can decide if a situation is appropriate for me.

References:

- Articles by *Methodist Employee Assistance Program*, "What you can do to ensure a safe workplace" and "More than Job Demands" distributed by PARS international provides information about employee self-care in potentially abusive or burn-out situations in the workplace.
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15) Ideal Intervention for patient despair (C4)

A Summary Description of the original situation

This was an 80 year old female patient diagnosed with ovarian cancer. She identifies herself as a Christian. She sees God as being close to her especially in difficult moments of her life. Her energy level was low. Her two month running illness made her "lose contact with family" as she says. On the other hand, she does not have a huge family circle.

The central spiritual Care identifier:

Despair

A brief summary of the original intervention

The Patient wanted to share with me her despair because of the length of time of her illness. There has the tone of despair coming through, but which later translated into hope, as we went into God talk. This was given a voice in the course of the verbatim conversation itself.

C: Chaplain P: Patient

C.12: What does God mean to you then?

P.12: God is a companion to me in life. He is always with me.

C.13: What about now? Where is he?

P.13: Even in my sickness God is there. His will for me is more important.

C.14: I do not seem to have anymore to say. What about sharing a prayer with me before leaving?

P.14: Fine.

C.15: let us pray: Father bless your daughter, who has been ill over a long period of time. Grant her the strength to move on so that she would be patient with the medical staff and allow her body to heal properly. We ask this in the holy name of Jesus, Amen.

What should or could have been done differently: An Ideal Intervention

C.14: I feel happy for you that you see God present in your sick condition. What about sharing a prayer with you as one way of being in touch with this God present at this very moment in your life?

P.14: Fine

C.15: Let us pray: Father, bless your daughter, who has been ill over a long period of time. Grant her the strength to move on so that she would be patient with the medical staff. Given her ailment, she may not heal properly. But we entrust all into your hands. May your will be done. We ask this through Christ our Lord, Amen.

16) Ideal Intervention for patient's loneliness (C5)

Part I – Summary of Original Situation

I encountered the patient while on usual rounds on a cardiac unit. Patient was an African-American female, in her late twenties. She was lying in bed with the television on. The room was bare – no cards, flowers or personal items were visible. It was a dark and gloomy day outside so the only light in the room was from the light over the patient's bed which added to the clinical feeling of the room. The patient's energy level seemed extremely low.

Part II – The Central Spiritual Care Issue

Loneliness

Part III – Summary of the Original Visit

As stated above, I encountered this patient as part of my regular rounds so I first introduced myself as chaplain and explained pastoral care services. The patient invited me to visit with her for awhile. I took a chair next to patient's bed. I asked how she was doing and she explained her physical symptoms and her experience of fear in not being able to catch her breath. The patient had a perceived need to talk and to be heard. I did not sense that the patient had a well developed spiritual life. No church connection was indicated in her file.

A portion of the original verbatim follows (C=Chaplain; P=Patient):

C2: How are you doing today?

P2: Oh, not good. I just started having trouble breathing. Even just moving around the house made it hard for me to find my breath.

C3: That must be a frightening feeling.

P3: Oh yes, it is.

.....

C6: So tell me about your family.

P6: There isn't much of one. My mom is staying with me right now. She's about all the family I have. My auntie came to see me, though. That was a surprise.

C7: So you and your auntie don't have a close relationship?

P7: We used to, but she got messed up with some stuff and we grew apart.

C8: It is hard to watch someone you love get into trouble, isn't it?

P8: Yes, it is. I think she's doing okay now, though. At least she seemed okay yesterday.

.....

I continued with a series of questions in an attempt to assess the patient's level of support.

.....

C14: What about friends? Do you have any girlfriends you can talk to?

P14: I used to have girlfriends, but since we got out of school, we've sort of grown apart.

C15: Do you want to rekindle those relationships?

P15: Not really. We are doing our own things now. We wouldn't have a lot in common now.

C16: What sort of work do you do?

P16: I do hair and makeup on the side.

C17: Is that what you went to school for?

P17: No. My cousin, she taught me how to do hair and stuff.

C18: Do you enjoy working with hair?

P18: Yeah, I do. I thought about going back to school for it.

C19: I always encourage people to do what they are passionate about. Maybe going to school would be a good thing for you.

P19: Yeah, I think I might.

I offered prayer and the patient was grateful. She invited me to come back whenever I could. I had a very brief visit the next day, but the patient indicated she felt quite ill and was not up for a visit. She extended her arms to give me a hug and we hugged goodbye. The next time I was on the unit, the patient had been released.

Part IV – Summary of What Should Have Been

The issue I presented to my peer group was how to gracefully get out of a visit that is lasting too long or not accomplishing anything. Immediately the group picked up on the fact that I was the one prolonging the conversation with a series of questions. The group also picked up on the patient's loneliness and isolation which they felt had left the patient in a depressed state. The group expressed their opinion that I did not explore her feelings in the original visit, encouraging her to talk about her sense of loneliness and depression which she obviously presented.

C2: How are you doing today?

P2: Oh, not good. I just started having trouble breathing. Even just moving around the house made it hard for me to find my breath.

C3: How did that make you feel?

.....

C6: So tell me about your family.

P6: There isn't much of one. My mom is staying with me right now. She's about all the family I have. My auntie came to see me, though. That was a surprise.

C7: Why was that surprising?

P7: She got messed up with some stuff and we grew apart

C8: When I hear you talk about your family, I hear some loneliness or sadness in your voice.

.....

C14: What about friends? Do you have any girlfriends you can talk to?

P14: I used to have girlfriends, but since we got out of school, we've sort of grown apart.

C15: How does that make you feel?

.....

C16: What sort of work do you do?

P16: I do hair and makeup on the side.

C17: Is that what you went to school for?

P17: No. My cousin, she taught me how to do hair and stuff.

C18: Do you enjoy working with hair?

P18: Yeah, I do. I thought about going back to school for it.

C19: Is there something stopping you from doing that?

Patient's actual need was for company to alleviate feelings of loneliness and isolation which were no doubt heightened due to her illness and resulting hospitalization. Questions should have been asked to determine her spiritual life, especially in light of her sense of loneliness. The best intervention with this patient would be active listening, allowing patient to lead the conversation yet picking up on the feelings behind the words.

17) Ideal Intervention for building a relationship with a terminal patient (D2)

Preparation

The patient, a widow in her early sixties with breast cancer that had metastasized to her bones, had entered a hospice program after living in a rehab center for over six months. All pts who enter hospice must have a spiritual assessment completed within 48 hours of admission. The purpose of these assessments is twofold. First, we are required to complete an assessment to be in compliance with hospice and Medicare standards. Because we are part of an interdisciplinary team, we can provide valuable insights on pt care. Second, it is a chance for the chaplains to meet the patient and begin to build a relationship. In addition, the information gathered is helpful to other chaplains as they attempt to build a relationship. I wanted to complete the spiritual assessment while taking the opportunity to build a relationship with a new pt. Because I am new, it was also a chance to meet and follow a pt from start to discharge.

Central Spiritual Issue: Building a pastoral relationship with a terminal patient.

Verbatim Dialogue

As I entered the room, pt was in bed, awake with her son, a young man about thirty sitting by her side, and two women (friends) sitting on chairs at the foot of the bed. The lights were off, but the patio doors were opened and a light breeze entered the room. The pt appeared to be awake and was reclining in her bed. She was speaking to her friends, though appeared confused.

P1: Hello there.

C1: Hi everyone (I looked around the room and noticed the visitors.) I'm one of the chaplains here at this institution. It looks like you have a room full of folks...do you mind if I talk to you for a few minutes? (knowing the Spiritual Assessment must be done, I hope they say yes).

P2: Sure, for a few minutes. I'm (name), and this is my son (name). These ladies are my friends (for the sake of time, I will focus on interactions with pt and son. Friends added to conversation, including talk of favorite TV shows etc). I'm kind of tired, so if you could make the visit short, that would help. Though I do appreciate chaplain visits.

C2: (feeling a little rushed) Thank you, this won't take very long. And I'm happy to come back when you have fewer visitors. So, you say this is your son?. Do you have any other family.

P3: Yes, I do.

S(on)1: Actually she has a "cheat sheet" on the wall. You may be able to get some information from it.

C3: Thanks, ok. I'll look at it and see what is there. Feel free to visit while I look it over.

P4: I have it there so everyone doesn't ask me the same dumb questions over and over.

C4: I'm sure it helps! There are many people who bombard you in the first 48 hours, I know. Thank you for letting me visit as well. (I read the list, where I learn how to pronounce her name, her age, diagnosis, the fact her husband died unexpectedly a few months ago. She has one son who lives in another city; his wife is a youth pastor, and they are expecting their first baby at the end of next month. The patient also does not like to be yelled at since her hearing is just fine. She has a dog who is very important for her).

Wow! That really does cover a lot of information. So, you have one son? (she nods yes. I become a bit anxious thinking what it must be like for him living so far away as an only child with a baby on the way). And, I saw your husband died a few months ago unexpectedly?

P5: Yes, (she tears up slightly)

C5: I'm so sorry to hear that. I can't imagine how hard this has been, to be sick and to lose your support in the midst of it.

P6: It has been very hard. I have breast cancer that has metastasized to my bones. It isn't in my brain. But I miss my husband dearly. This is my son (the son steps in as it becomes apparent his mother is very tired and confused).

S(on)2: She gets very tired. I'm here just for a few days. I have to go home tomorrow. I'm lucky to have support at home, my wife's church is great and they are helping us out.

C6: How are you doing emotionally? Losing your father a few months ago, and now having to place your mom in this institution?

S3: I'm hanging in there. We're just trying to get her settled. She can't be at home, and she isn't fit for the rehab at this point. She does have many friends, so we're trying to work something out. Our hope is to take her home.

C7: So, you are not planning to make this institution her last stay?

S4: No, because of her support system.

C8: (I explain our services to the son. The patient listens but closes her eyes often). Does your mother have a church?

P7: I like the Episcopal Church and the Methodist Church. They give me what I want, but have opposite views. So, I get a taste of everything. Several churches bring me communion. But, I don't have just one.

C9: (becoming annoyed that I have to ask specific questions for the form). Do you want us to list any church? We don't contact them or anything, but we would like to know if there is one church you want to affiliate with.

P8: not for now, just tell them I'm Christian. (closes eyes again. Conversation with friends occurs, information about the patient's tv shows, her lovely home, her flowers, etc)

C10: Well, I see that you may be getting tired. And, I certainly don't want to take time away from your friends. Can I say a prayer for you and visit again?

P9: Yes, I would like that. We can talk about things more, my husband and why I'm sick. I have breast cancer that is now in my bones.

C11: I would like to visit you too. Should I put down a request for 1, maybe 2 visits a week?

P10: Yes, 2.

C12: Alright. Let's pray. Lord, we thank you for the time her son (name) has been able to spend with his mother. We ask that you be with him in his travels. Help him to balance time with his mom and his wife. Watch over her and their baby. Be here Lord with this patient. Help her to find peace and rest in this place. Help the chaplains to be present. Guide her through her grief as she remembers her husband and his death. Amen.

P11: Thank you (holding my hand, and not letting go).

C13: That's what we're here for. I appreciate you letting me visit. I hope to come back and talk for a longer period of time. Maybe you can tell me about your husband and how his death is affecting you.

P12: I would like that. Thank you (still holding my hand)

C14: I'm sure you worry about your son too.

P13: I do. That's when he was a baby (pointing to picture of family at Christmas).

C15: Well, we are always available, so know we will stop by again, call us if you need (still holding my hand)

P14: Thank you. (closes eyes, continues to hold my hand, begins to drift off, lets go)

New insights gained as a result of peer interactions:

While it would be important to gather all the information needed for the required spiritual assessment, the chaplain may have been able to do this in a less formal manner. The chart offered for example was helpful, but did not build a relationship in the ways that asking questions would. A chaplain may ask the pt if it would be appropriate to come back at a later time when they were more settled in and did not have visitors (or at least non-family visitors). In addition, the chaplain may wish to ask more open-ended questions giving the pt and family time to answer in their own way. Finally, the pt should always be at the center of the

conversation if possible. Instead of asking family members questions, it may be helpful to address the pt more directly when possible.

(Below is an idealized version of this encounter.)

P1: Hello there.

C1: Hi everyone (I looked around the room and notice the visitors.) I'm (name), one of the chaplains here at this institution.

P2: Yes, nice to meet you. I'm (name). Hi, how are you today?

C2: Oh, I'm fine, thank you. It looks like you have some visitors. Would you mind introducing them?

P3: Sure, this is (name), (name), and over here is my son (name). I'm kind of tired, so if you could make the visit short, that would help. Though I do appreciate chaplain visits.

C2: Well, I wouldn't want to interrupt this visit, and I see you just arrived today. Would it be better if I came back another time?

P4: Would you mind? I think I'd like to visit with my friends. But they should be leaving in a while. How about 3:00?

C3: I'd be happy to come back and visit then. I just wanted to introduce myself and see what your needs and your family's needs are. Will your son be available?

P5: Yes, he should be. We'll visit more then.

(At 3:00 I arrive)

C4: Hello again, it's chaplain (name) again.

P6: Hello, thanks for coming back.

C5: no problem, is this a better time?

Son)1: Sure. I think it works for me and mom. Say, there is a "cheat sheet" on the wall. You may be able to get some information from it.

C6: Thanks, ok. I'll look at it and see what is there. (looking at the chart). You know this information is a great starting point, but I would like to talk with you about your emotions related to entering this institution. I'm guessing by the chart you must be a bit frustrated, being asked the same things over and over.

P4: I have it there so everyone doesn't ask me the same dumb questions.

C4: I'm sure it helps! What is it like to have to answer those questions over and over?

P5: It gets to be too much. I just have a little energy and I want to spend what I have with my family.

C5: Tell me about them, it says you have a son, and your husband died.

P6: Yes, (she tears up slightly) It has been very hard. I had breast cancer that has metastasized to my bones. It isn't in my brain. But I miss my husband dearly. This is my son, (The son steps in as it becomes apparent his mother is very tired and confused. She begins to drift off).

S2: She gets very tired. I'm here just for a few days. I have to go home tomorrow. I'm lucky to have support at home, my wife's church is great and they are helping us out.

C6: How are you doing emotionally? Losing your father a few months ago, and now having to place your mom in this institution?

S3: I'm hanging in there. We're just trying to get her settled. She can't be at home, and she isn't fit for the rehab at this point. She does have many friends, so we're trying to work something out. Our hope is to take her home.

C7: Wow! If I were in your place, I'd be overwhelmed.

S4: We are, it's hard to see her like this, and I feel so sad leaving my wife at home when she is due so soon.

C8: (addressing the patient) there has been so much loss recently for you. How do you feel about your grandchild being born in the midst of this?

P7: It's hard because I don't think I'll live to see him (pt cries, son and chaplain sit with her in silence).

C9: And you (addressing the son)?

S5: I feel torn about that too. I mean I'm happy to have a baby, but so sad that mom and dad will never meet him.

C10: You know, I'm an only child too, that would be one of my greatest fears. Losing my family and never having them meet my child.

S6: I feel support from my wife's church and family, but it doesn't replace mom and dad. (Pt drifts in and out, begins to look at chaplain again.)

P8: I'm glad you came by, but I'm so tired.

C11: Would you like some rest? Maybe we can talk another day?

P9: That would be nice. We can talk about things more, my husband and why I'm sick. I have breast cancer that is now in my bones.

C11: I would like to visit you too. Should I put down a request for 1, maybe 2 visits a week?

P10: Yes, 2.

C12: Alright. Bill, if you need any support, I'd be glad to set up a time to chat on the phone. Would that be helpful?

S7: Maybe, you can call. We'll see how things go. For now, if you would visit mom, that would be helpful.

P10: Could you say a prayer?

C13: Sure. Let's pray. Lord, we thank you for the time her son has been able to spend with his mother. We ask that you be with him in his travels. Help him to balance time with his mom and his wife. Watch over her and their baby. Be here Lord with this patient. Help her to find peace and rest in this place. Help the chaplains to be present. Guide her through her grief as she remembers her husband and his death. Amen.

P11: Thank you (holding my hand, and not letting go).

C14: That's what we're here for. I appreciate you letting me visit. I hope to come back and talk for a longer period of time. Maybe you can tell me about your husband and how his death is affecting you.

P12: I would like that. Thank you (still holding my hand)

C15: I'm sure you worry about your son too.

P13: I do. That's when he was a baby (pointing to picture of family at Christmas).

C16: He's still your baby, isn't he? (pt slowly nods yes and begins to sleep again,) Well, we are always available, so know we will stop by again, call us if you need (still holding my hand)

P14: Thank you. (closes eyes, continues to hold my hand, begins to drift off, lets go)

18) Ideal Intervention for a child in severe pain (D3)

I. INTRODUCTION

I enter the floor and went directly to the Charting Nurse to see if there were any patients she especially felt were need of pastoral care. She suggested two patients; one was a referral I already had on my list to see, and the other was a young Euro-American girl with a gun shot wound to the leg. The girl's father was planning a hunting trip with his son, the brother of the girl, so he was showing him gun safety. The son was holding the gun when the gun was fired; the gun was believed to be empty. The girl entered through the ER. The on call chaplain had answered this trauma but I was not previously involved.

Project Response

1. What could I have done differently to improve in this section?

I could have looked back into the charting notes to what the situation was when the patient first entered the hospital.

2. How can I apply the information I received on this section?

My becoming clearer in what information I have before entering the patient's room.

II. PLANS FOR VISIT

My preparation for this visit began earlier when visiting with the supervisor. It has been difficult for me to visit patients on this floor, because of anxiousness and the need for structure in visiting. So my supervisor and I set a plan in place. The plan said I would visit four patients a day on M-W-F. I began to feel a little more at ease knowing I could not finish this day without seeing my four patients. So I decided I would first visit with the Charge Nurse. She referred me to the girl and then proceeded to tell me the patient was in for an accidental gun shot wound. The nurse said the girl's family was there and they could use support. As I turned to go down the hall to the girl's room I saw two medical staff enter. My first notion was to come back another time, but then I thought the family might benefit from my visit even if the medical staff were there. I actually became anxious to enter the room so I was using the staff entering the room as an excuse not to go in. I was concerned I would not know what to say or do once entering the room. I was not sure how to address this type of situation. I became concerned for the patient as well as the brother who accidentally shot this child. The strategy I wished to employ for this ministry opportunity was being one who brings peace to this difficult time, also to be able to allow the family to speak about the situation. The feelings within me I was aware of were anxiousness to be able to do the right thing, and the feeling of curiosity. I had not dealt with this type of situation before, although I had heard of such things happening since I was a child, with my dad showing me how to properly handle a gun.

Project Response

1. What could I have done differently to improve in this section?

Since this was already an area I am working on I don't see any thing I could have done differently, although, I could have been up there a day or so sooner.

2. How can I apply the information I received on this section?

Continue to have a plan in mind when not just visiting an individual patient but also when first arriving on the unit. I know I must try to visit at least 4 patients on this unit. Also by asking the nurse about a patient if I see some flags come up before entering the room. I also now know I do just fine when going into rooms and units for initial visits.

III. OBSERVATIONS

When I came into the room I noticed there were several people in the room. There was the patient, who was asleep with her bed adjusted so that her head was lower than her feet and her left leg raised in a sling. The two nurses who had come in were working around her bed. The Dad and Mom were standing off to the side as well as the mom's sister. The paternal grandparents were in the room, the grandma was standing with the parents and the brother to the patient, while grandpa was standing by the bedside. There was an immediate sense of guilt/concern on the face of Dad and the brother. Also there were the non-verbal signals of helplessness among everyone, except Grandpa who stood by the patients' bed as the nurses began to prepare for the girl to go and have a PIC line put in. The girl began to SCREAM like I had never heard before and saying "OH GOD!" over and over as they began to lower her leg from the sling. It was at this time I noticed a large clamp attached to the girl's leg. Grandpa, an "ordained minister", was trying to comfort her by saying such things as, Jesus is with you Baby.

Project Response

1. What could I have done differently to improve in this section?

I could have improved by observing more after introducing myself instead of immediately feeling like I needed to talk to someone.

2. How can I apply the information I received on this section?

I could benefit from stepping back and observing for a moment after I introduced myself. This would help in knowing exactly where each person was physically and how they were dealing with the pain of the patient and their visual attitude to what was going on.

IV. THE CONVERSATION

C—Chaplain, P—the patient (patient, no speaking parts), D—Dad, B—Brother, G—Grandpa, M—Mom

C1- Hello I'm a Chaplain. (I introduced myself to the Dad and then to the rest of the family)

D2- Hello. The nurses are here because she is going down to have a PIC line put in.

C3- How is she doing?

D4- She is doing OK. Just in lots of pain.

C5- What happened? (I knew it was a Gun Shot Wound but not the details. I wanted Dad to talk about it if he would.)

D6- We are all hunters, so I was preparing my son for our next hunting trip. I handed the gun to him and he pulled the trigger. I thought it was empty!

C7- How is your son dealing with this?

D8- I told him it wasn't his fault it was mine for not emptying the gun, although he holds everything in.

(At this time the girl was in extreme pain and the nurses had lowered her leg, and were almost finished prepping her to leave the room. She was screaming while holding onto her mom's hand and saying "Oh God!!! Oh God!!! I want to go home!!! You could see in the face of the Dad the sadness he was feeling.)

G9- (Standing and leaning over the girl's bed and trying to comfort her by stroking her arm and speaking reassurance to her.) Baby it is going to be OK. Jesus is right here with you. Remember what we talked about? Can you tell me who is with you? Baby Jesus is here with you.

(I noticed the nurses were almost finished getting the girl ready to leave)

C10- (I leaned over to Dad) Would y'all like prayer before she leaves?

D11- Yes we would.

(I walked to one of the nurses and mentioned to her the family would like me to say a prayer before the girl leaves, but I will wait until she says it is a good time.)

C12- (I step over to the brother and got down on one knee I then put my arm around him.) Hi I'm a chaplain.

B13- (He stands close to me and says with a bit of anxiousness.) Hi.

C14- How are you doing?

B15- (With his head hung down) Fine.

C16- You care a lot for your sister, don't you?

B17- Yes.

(I would have liked to have interacted with the brother more, but the nurses were finished and ready to take the girl to get her PIC line)

C18- (I step up to the bed side while the girl was screaming and said to her) Hi I'm a Chaplain. I'm not going to poke you with anything; I'm going to pray for you.

G19- A the chaplain is going to pray for you.

C20- (To Mom.) AD is her name, right?

M21- (Tearful) Yes.

(I prayed for her and the family, and while as I was praying she stopped screaming and crying. The family expressed their thanks for coming by. As the nurses were pushing the patient out of the room I stayed and visited with the family, then walked with them to the elevator.)

Project Response

1. What could I have done differently to improve in this section?

First I could have written out the prayer I prayed so the team could better assess this special time. Also I could have looked at my note card for the name of the patient instead of having to ask her. I also could have asked the patient if there was anything specifically she would have wanted me to pray for.

2. How can I apply the information I received on this section?

I can apply this by seeing the positive in getting down on the level of the brother to talk to him. Although I didn't do this when talking to the patient, it would be helpful the next time as well as with anyone who is not standing. To make better contact with the mom by personally greeting her and briefly talking to her would have also been helpful in making better contact with the family.

V. PATIENT/ FAMILY EVALUATION

The family seemed to be very appreciative of my visit and seemed to be comforted by the prayer. The main concern I had, as I understood the family, were the feelings Mom and Dad had of guilt and helplessness. The Dad seemed to feel as though this was his entire fault and now he was in a place where he couldn't do anything to help. Grandpa seemed to feel as though he needed to be the strong one and the spiritual leader

during this time. Grandma was there to take care of and be concerned with the brother. The aunt was there to support the mom. The patient did not seem to care about anything except to get out of this place that was causing her so much pain and to call out to those whom she knew could help her: God and to her Mom. This patient and family seemed to have a great need for prayer and the need to be supported by others. The Dad seemed to be stuck at this time on feeling so much guilt.

Project Response

1. What could I have done differently to improve in this section?

Nothing I see.

2. How can I apply the information I received on this section?

I can apply this by understanding even in a family that seems to be of the same faith there is always different ways of allowing their faith to be expressed. I can apply this by taking note and being alert of those who externally seem to have everything together and a faith that is strong and more audible. Also even if the Dad said it was ok does not also mean the child would like prayer.

VI. CHAPLAIN EVALUATION

I seemed to bring in a non-judgmental attitude that cared for not only the patient but the family as a whole. I also brought prayer and a non-anxious presence. This was one of my learning goals, to deal with conflict and resistance within myself when making introductory visits: learning to make initial visits and learning how to think through the initial introduction before knocking on the patient's door; learning not to limit myself before and during visiting patients, but instead have "freedom with confidence." So I felt I met this goal. What I did on this visit was to assure myself I was going into this room, and that I had a ministry to offer this patient and family. This gave me confidence to follow through. I was helpful to the family by talking and showing specific concern for the Dad and the Brother. Also I made sure a prayer was made but I did not allow this need to get in the way of what the nurses needed to do. I was not as helpful when it came to Mom. I basically only greeted her and clarified the patient's name. I got stuck when the brother did not say anything other than give short answers to my questions. What I would do differently next time is remember the patient's name. The issue of this being a family accident makes it difficult to know how to go about ministering to each individual, but not neglecting the patient. At this visit I was not able to interact much with the patient because of the circumstances. With a family accident there is not only guilt, there could also be blame, and resistance from others.

Project Response

1. What could I have done differently to improve in this section?

I could have written more on the interaction with the nurse and my internal struggle as a chaplain.

2. How can I apply the information I received on this section?

Learn to accept compliments, and allow the positive words to motivate when struggling with a family. Also to pursue and face the areas I feel most threatened by, instead of allowing fear to prevent ministry to take place.

VII. PSYCHOLOGICAL REFLECTION

The feelings I observed within myself while being with this family was that of sympathy for the patient but more so for the Dad and son. Also there were the feelings, as I said before, of guilt and of shame.

The psychodynamics of this family seemed to be mixed. There was the dad who seemed to be carrying all of the weight and Mom who was hurting for her child, and there was grandpa who was trying to keep their faith in the forefront of the situation. There didn't seem to be any confusion, but there was sadness in all that was happening. My sympathetic feelings toward all those in the room seemed to help me be more effective because I also grew up with guns and could imagine something like this happening. Being a dad myself I knew Dad had to be hurting very deeply, and because of this I wanted to allow the Dad his space to talk.

Project Response

1. What could I have done differently to improve in this section?

I could have expounded more on the relationship of the Dad to his older son and the patient. Verify the difference between being sympathetic and being empathetic and how these could have been a positive or negative in this visit.

2. How can I apply the information I received on this section?

The information received on this section could be used to better recognize the psychodynamics between the family members, and then to visit with each individual person that was a part of the family. To not only focus on the Dad and the son. Even though words were spoken to each, I didn't allow any time for conversation. This could have been beneficial especially for Mom.

VIII. THEOLOGICAL REFLECTION

Before entering the room I was anxious and the scripture I embraced was Philippians 4:13, "I can do everything through him who gives me strength." Faith issues were raised only by the Grandpa, but were not said by anyone else, except by me when I offered a prayer. I had the sense that they were all people of faith, but I was not for sure. I thought of the Bible story of Jesus, in Mark 4 when he and his disciples were in a boat out in the middle of the ocean when a storm came up. The disciples were scared to death and Jesus was asleep. They woke up Jesus and he stood up in the boat and said "Peace" and everything became calm. This was what it was like when I began to pray and this screaming child, who was in extreme pain, quieted down. I had not had this happen before in my ministry, but on this day it happened with three different upset patients. I felt this was a God moment and he was saying I am and will use you to bring about peace in hurting peoples lives.

Project Response

1. What could I have done differently to improve in this section?

Recognized I need to be theologically aware when entering into the patients' room. Most of the time this reflection is not thought about until either leaving the floor or while writing the verbatim.

2. How can I apply the information I received on this section?

To take the action of bringing peace is not only in speaking but also in being there with the family. Understanding as a chaplain, peace is brought to those to whom we minister through all types of ways (touch, being a presence, not being there when [ministry of absence], and speaking). Jesus was peace in the boat, but the disciples did not recognize the peace they have brought. They had to have Jesus speak the peace.

IX. SOCIOLOGICAL REFLECTION

This patient seemed to have a good support group. There were several family members there, but I did not find out if there were any supports back home. The boy seemed to be empowered by both Mom and

Grandpa, by hanging on to mom's hand and by allowing Grandpa to speak encouragement and assurance to him. The family reminded me of my own family life and values when growing up. Were this my family, we would be acting very similar. This social group will help in the healing of the girl by the love, care, and attention she needs both while she is in the hospital and when she goes home. The community resource that might be helpful is a counselor to talk to the immediate family, helping them to work through this time, especially the Dad and Brother.

Project Response

1. What could I have done differently to improve in this section?

I could ask what community resources they had back home; and if they said they had none, help them in locating some, whether it is a counselor or a spiritual advisor who would be beneficial to them. Also discussing how this accident has affected their family dynamics, and see if there were ways of helping in this, especially in the Mom and Dad's relationship.

2. How can I apply the information I received on this section?

I could apply this information by asking the above type of questions at the proper time during the discussion, instead of assuming they would be resistant to any kind of psychological help because of where they come from.

X. PLANS FOR NEXT VISIT

I would like to see on the next visit Dad opening up more and for Mom to have an opportunity to join in the discussion. I also would like to have time with the brother and see if he wouldn't open up more allowing forgiveness to take place in all of their lives. I plan to revisit this family encouraging them to tap into their faith and emotions and ultimately allowing this healing to begin.

Project Response

1. What could I have done differently to improve in this section?

I could decide on a definite plan such as how to engage the entire family in discussion in a time of debriefing of the accident.

2. How can I apply the information I received on this section?

By implementing those things above and continue to follow up visits and having a plan each time I visit during the patients stay here.

XI. REASON FOR THIS VERBATIM

The reason I chose this verbatim was 1) because of what it took to make this visit, 2) because of the circumstances of the patient, accidental gun shot wound, and 3) because my familiarity with this type of family and using guns. What really grabbed me in this visit was the pain of the Dad (you could see it on his face), and the way the brother was dealing with this accident. What I can't let go of is the pain the girl was feeling as the nurses worked with her, and the screams of that pain.

I would like feedback on how I could best minister to this family when I return to visit. My learning needs to be that of listening and engaging the family to empty them of the pain.

Project Response

1. What could I have done differently to improve in this section?

There is not really anything I would do differently in this section.

2. How can I apply the information I received on this section?

Engaging the patient and family so that they will empty the pain is something that may take several visits so be prepared for, and to be aware that they may not ever want to address issues that would bring this release, at least while they are here at the hospital.

XII. INTERDISCIPLINARY TEAM EVALUATION

I was able to work with the Charge Nurse, as she told me briefly about the patient and then her referring me to the patient; also I worked with the nurses in the room facilitating a good place to be able to say a prayer with the patient and family.

Project Response

1. What could I have done differently to improve in this section?

I could have evaluated my actual interaction with each member of the team and to elaborate on the effect it had on my visit with this patient and family

2. How can I apply the information I received on this section?

To continue making the pastoral presence an important part of families who have a strong faith but not to ever over ride or get in the way of what the medical staff need to be doing for the health of the patient.

The Central Spiritual Care Issue Identifier

- To help the family walk through this difficult time (mental images, emotional pain, and the spiritual questions and struggles) and at the end of their journey look back and see the positive growth that has taken place in their lives, personally and as a family.

19) Ideal Intervention for hope in terminal illness (D4)

1. Summary description of the original situation:

This visit was with a married 53 year old female with a diagnosis of recurrent ovarian cancer. This was the fourth or fifth visit I had made to the patient. I had been referred to visit her as a terminal patient. In previous visits, we had talked some about her medical condition. She has a history of several gynecological and intestinal tumors and surgeries for them (if I remember right, she has had 6 or 7 surgeries as well as the surgery for which she is currently hospitalized). Her cancer was caught at a fairly late stage. She did not have chemotherapy before because of some misunderstandings between her and her doctor. She has a different doctor now. She expressed trust that he would be able to prescribe the right chemo mix to attack whatever cancer is left in her. She is very hopeful in the chemo working and trusting that God is going to heal her through chemotherapy. I did not want to quash her hope, but given what she told me and what her chart and nurse said, I wondered how realistic her hope is and how she would respond if she is not healed. I was hoping to be able to address that in this visit.

2. Central spiritual care issue identifier:

Hope in the face of terminal illness

3. Summary of the original intervention:

The visit began with some general greetings and introduction to the patient's husband, who I had not met before. One of the first things I noticed was that the patient was coloring in a coloring book. I asked her about it and she said that she was bored and it was keeping her mind occupied. She said that she was looking forward to being able to get out of bed later that day and to going home in a day or two. Then the following interaction took place.

C1: What is helping you to get through this time being confined to bed?

P1: I just keep trusting in God. He gets me through day by day.

C2: God gets you through day by day. I think I remember you saying the other day that you were trusting God to heal you through the doctor and chemotherapy too. It sounds like you have a strong belief in God and his healing power that is very important to you.

P2: Yes I do. I couldn't keep going without him.

C3: I wonder if you have thought about what it would be like if the chemo therapy does not get all the cancer.

P3: (She gets what I interpret to be an anxious look in her eye. She responds quickly and speaking quickly says) Oh no, I don't think negative thoughts. I just focus on the positive. God is going to heal me, I know he is!

C11: OK. So, you are just trusting God to heal you and not thinking about other options.

P9: (Still anxious) Yes. Please pray for me that God will heal me.

C12: Let's pray then (her husband, who had been reading the newspaper, holds one of her hands and I hold the other). God, we pray for your daughter right now. Please do bring your healing touch to her. Guide the hands of the doctor and others involved in her care. Give her the strength and patience to get through this and help her faith to remain strong. Amen.

4. Summary of what could/should have been

I think that the question about what it would be like if the chemo did not get all the cancer did not work well. Perhaps another way to talk to a patient that is hoping some treatment will cure them or prolong their life would be to say something like, "It sounds like you might still have some things you want to do in your life. Can you tell me about some of those things?" After hearing about those things, I might ask, "What, if anything, are you doing to accomplish among those things?" I might say something like, "I sure hope the treatment does give you some more time to do those things. None of us really know when we will die. I don't know when I will die. What are you doing right now to work on getting those things done?"

This kind of response would have stayed focused more on the present moment and on the hope of being able to do more things in this life.

20) Ideal Intervention for elderly patient's frustration at hospitalization (D5)

1. Typical Characteristics, Problem and Needs of the Patient

The patient was an African American woman in her nineties, widowed, mother of one male child. Her son is her primary caretaker. She appeared to be average height. with long gray hair, with a small frame. She was an inpatient in the hospital. Her admitting diagnosis was a reaction to prescription drugs for diabetes. She apparently had mismanaged her diabetes medication. She was a retired business woman and instructor. Her denominational affiliation was Baptist, although she was currently worshiping with another denomination's congregation where her son and daughter-in-law were members.

I encountered her while performing initial pastoral care visits on my assigned floor. She had been admitted earlier in the day. The patient was alone. The television was on, the patient was watching Oprah. There was one vase of flowers in the room. I entered the room by knocking on the open door; the privacy curtains were not drawn. There was no barrier between the patient and the open door. The patient very pleasantly, welcomed me into the room.

Thus, there were not immediate or specific indicators of the needs of the patient.

2. Desired Purpose of the Intervention

The purpose of the visit was to provide information about the resource of the Pastoral Care Department at the hospital as well as offering emotional and spiritual support to the patient.

3. Hoped-for Cognitive and Emotive Content of the Communications

Emotional Content

The patient talked with great passion as she unfolded the details of the core stories of her life.

The patient talked about her educational and vocational achievement with great pride.

Patient expressed her great love and appreciation for her son.

The patient exhibited racial pride and solidarity as she stated that she was proud of me for being a chaplain.

In the patient's prayer, the patient relieved that she was in need of encouragement and comfort, she stated: "Father God, thank you for this chaplain...you sent her to me...I was sitting here feeling a little low and about to cry myself because I was feeling sorry for myself. But you sent me this chaplain, you gave me somebody to be a friend to...you gave me the opportunity to encourage her and then I was encouraged too."

Spiritual Content

The patient expressed her deep and abiding relationship with God. The entrée into the patient's core life stories was when she stated, "Let me tell you this...I know what the Lord can do...." Clearly, the patient considered her relationship with God as the foundation of her life.

The patient operated in the Spiritual realm by naming our encounter as a Divine appointment. The patient stated: "Honey, don't you know you were sent here to me... You need a word from the lord I was sent here to give it to you."

4. Hoped-for Phases in the Visit

Introduction:

The chaplain introduced herself to the patient and begins to initiate a conversation by first asking informational question. As a rapport builds between patient and Chaplain, the chaplain begins to ask questions that elicited information found in the core stores of the patient's life.

Patient Expectations

The patient had no expectation of the chaplain at the time of the initial visit.

Concerns that surfaced During Visit:

The patient was feeling "sorry for herself" and voiced her frustration at being in the hospital.

Discussion/Support:

The interaction encompassed:

Giving voice to the reality and nature of the condition that brought her to the hospital.

Affirming that the hospital "intervention" would give her knowledge into the effects of her prescription medications for her diabetes.

Exploration of the impact of the patient's "core stories" on her faith journey.

Encouragement and support for the integrity of her life stage process.

Conclusion

Closing the initial visit with a shared prayer between the patient and the chaplain - this would empower the patient with the "gift of the lead." The patient is also participatory in providing her own comfort and engaging in her own healing process.

5. Measurable of the Outcome Achieved in the Visit

Indicator 1

The patient's emotional needs were met – Patient was able to verbalize the impact of visit on her changed emotional state.

The patient was presented with the opportunity to tell the stories that gave her life meaning.

By engaging in active listening, the Chaplain re-enforced and affirmed the importance of the patient's "core stories" in the development of her personhood.

Indicator 2

The patient's spiritual needs were addressed – as evidenced in the patient's offered prayer:

Father God, thank you for this chaplain...you sent her to me...I was sitting here feeling a little low and about to cry myself because I was feeling sorry for myself. But you sent me this chaplain, you gave me somebody to be a friend to...you gave me the opportunity to encourage her and then I was encouraged too. That's how you are God, always showing up and meeting

our needs. I thank you God. You have been so good to me. Bless this chaplain as she leaves tonight. May she have peace and keep her Lord, give her strength in Jesus name. Amen

Additionally, the patient's spiritual needs would have been met by further engaging her feelings of "feeling sorry for herself." Further exploration of her comment could have opened an avenue of emotions, thoughts and concern that were not initially expressed.

6. Theological Implications

The patient was a gift from God at the appropriate time. I believe by divine appointment messengers come into our lives no matter how brief, to manifest and express the love of God. Sometimes this message and the messenger is concealed by physicality or the message is convoluted, and we must seek the revelation. Or sometimes we never get the message or acknowledge the messenger. Sometimes we have too much static to hear the message. Often the message is blatantly clear. God's message of hope and love to me, spoken through Mrs. Lovie was blatantly clear.

Theologically, her life represents a steadfast journey faith. Her relationship with her God is the foundation of her identity. The patient would define herself as a faith-filled woman of God. She takes great satisfaction in the encouragement of others through the stories of her faith journey. Further Pastoral Care for this patient must extend to her the opportunity to further engage in a reflective process that would honor to the core stories of her life.

21) Ideal Intervention for feelings of guilt or shame (D6)

1. The Purpose of the Intervention

I went to the patient's room for an initial visit. It is hospital policy that every patient by his 3rd day or sooner would receive a visit from a Chaplain. During an initial visit, I inform the patient about the Chaplain resources available. The Chaplain's presence and speech should turn the patient's thoughts to God. It is the hope that the patient would be more God-aware. It is also a goal for the patient, if s/he chooses, s/he can verbalize his/her feelings, share personal history, burdens, and whatever joys or concerns s/he has. Another purpose would be for the patient to explore with the Chaplain the meaning made out of the crisis. If the patient is receptive to pastoral care, an offer to pray is made for the patient to accept or reject. The Chaplain is a sacrament of God's presence.

2. The Characteristics, Problems and Needs of the Patient

The patient is a lady in her seventies. She has sandy brown hair. Her hair is shoulder length. She is very thin, almost frail. She has had surgery for cancer 3 times. She has also had treatments for cancer, which have been tiring and relentless. Her cancer is currently in remission and she is here in the hospital for pneumonia. She had taken care of her chronically ill and terminally ill husband for a decade. Her husband passed away last year, I assume. She has a lot of guilt about not treating her husband's bone cancer, due to her husband's dialysis and diabetes, and generally poor health. She also has conflict with in-laws who blame

her for the lack of treatment for this terminal illness and her inability to cry at the funeral, calling her cold-hearted. She also has deep issues over her own salvation, if Jesus will take her, and if Jesus would abandon her.

3. The Cognitive Content of the Communication

a) The patient had deep feelings of what I would interpret as guilt and shame. She struggles with what I believe is low self-esteem and feelings of unworthiness. When her husband and relatives accuse her (out of their pain) of killing her husband, it deeply hurts her and she struggles deeply with moral issues of life and treatment. She has deep self-doubt and is plagued with the “what ifs”. What if he had chemotherapy? What if he was treated aggressively for his bone cancer? Was the doctor truly right in his assessment that the treatment would kill him? I believe she would want to ask God if she did the right thing. I believe that she would want to ask God if she is a good person, e.g., good enough to go to heaven. She questions if she is good enough to be accepted and in fellowship with.... She has issues of great loss.

She is cognitive and rational. She is aware of where she is in the hospital, the date and year. She can remember history, details of friends and family.

b) As Chaplain, I emphasize the experiential. I have a holy expectation that God will interact in my life and in the patient’s life. God is not an icon like Uncle Sam but a living God who is actively involved in people’s lives. Psychological or emotional care, but especially the Word and prayer, will change the supernatural world and the physical world. God can impact the life of the Chaplain and/or the patient’s life. The Chaplain’s visit is important because the Chaplain deals with the mystical and the supernatural as well as the physical. The focus of the visit is faithfulness and not what cannot be controlled.

4. The Structure or Sequence of Phases in the Visit

C = Chaplain is speaking

P = Patient is speaking

Italics = Chaplain’s internal thoughts

Introduction/Invitation: The first phase of the visit, the chaplain gives his name. He briefly explains the role of chaplains and begins to break the ice, trying to establish rapport and initial relationship with the patient. The chaplain will try to steer the conversation to the patient’s needs and burdens and away from his own. The chaplain will stay in the roll of the helper and not become the one receiving the help from the patient. The Chaplain invites the patient to meet God.

I knock on the open door.

C1: Hello, this is the Chaplain. Is it all right if I come in?

P1: Yes, come in.

C2: Hello. I am (name) a Chaplain here at the hospital. I wanted to let you know about the Chaplain resources. There is a Chaplain here 24 hours a day. Just let your nurse know that you want to see a Chaplain and we will come by and listen if you need to share and pray, if you would like.

P2: That is nice.

C3: How is it going?

P3: Not well I've got pneumonia and I have it very rough the last 10 years.

Confession: The second phase of the visit has the patient share what is most significant. *(There are many denominations and beliefs, but I have discovered that regardless of the diversity, allowing people to verbalize their feelings is therapeutic. Historically, confession has been part of the Roman Catholic Church for centuries. It is the Roman Catholic confessional that is the historical root of pastoral listening. The therapeutic value in confession for the patient is seen in the Scriptures in James 5:16. "Therefore confess your sins to one another and pray for one another so that you may be healed; the prayer of a righteous man is powerful and effective." This verse from James 5:16 has been a credo and formula for my hospital pastoral care.)*

C4: What happened to you that made the last 10 years so rough?

P4: My husband had a stroke and diabetes and cancer. I took care of him for 9 years. I also had breast cancer and had to have 3 surgeries and treatments.

C5: That is a lot of stuff. Which one of these burdens you the most?

P5: Taking care of my husband.

C6: What was that like for you to take care of your husband?

P6: It was very exhausting. He was mean to me a lot in the past. Then I had to shave him and bathe him and feed him. My husband said "sorry" again and he would cry. I love him. I am so glad that he said he was sorry. We were really close over those 9 years. It was meaningful to shave him. It was intimate. I really miss him.

C7: So he has passed away? What was that like? *[I felt proud. I went with a feeling question instead of a fact question.]*

P7: I didn't cry at the funeral. I couldn't cry. His family thought I was cold-hearted and didn't love him. I haven't cried since. I just couldn't. *[She is tearing up. I hand her a box of Kleenex.]*

C8: It is safe to cry now. When I was away in the military, my wife had a baby. She had a rough time. The baby was sick and my mom and grandma offered to help. I couldn't get home. I couldn't cry. I had to live. I was responsible for 4 men in my unit and they depended on me. I could cry and get myself killed or my men killed. I had to live and do what I had to do. You did what you had to do. You have to pay bills and eat and have responsibilities. This is a safe place to cry.

P8: *[She is crying now using Kleenex after Kleenex.]* I miss him so much. I didn't cry at the funeral. I didn't cry since. Now I can't stop crying.

C9: It is like a dam that holds those emotions. The emotional pain and loss does not go away. You just carry them around. It is healthy to let them out. *[I hope this crying is healing and not making things worse.]*

P9: Maybe I can get better now, and then I won't be so chronically ill. *[She continues to cry.]* The phone rings. She answers it. Hello honey. Can you call me back later? Thanks. I love you. *[She hangs up the*

phone.] I am so glad that you came by. My daughters both cried at the funeral but I couldn't. His family was mad and said that I was cold-hearted.

C10: I am sorry that happened. I can tell that you loved him.

P10: I have a lot of guilt. I keep praying, "Jesus, don't leave me." My husband had cancer and they could test him. The doctor said the bone marrow test would kill him and that he would never survive the test or treatment. He went to the nursing home just for some therapy but he cried and cried for 2 days. So I took him home. I was not leaving him. It was just for treatment. The nurse came to the home and did the therapy there with Hospice.

C11: That is what he wanted—to be home.

P11: Yes, he wanted to be home. [*She is still crying.*] Sometimes I feel guilty because we did treat him like I was tired of him but that couldn't be farther from the truth. I love him. Hospice concentrated on giving medicine for the pain and keeping him comfortable. A pastor was to help me with yard work and I asked him to talk to my husband. My husband gave his life to the Lord. He had such peace. He kept asking, "Mama, help me pray." I would tell him, just talk to him honey. I had a hard time talking about faith with my husband. I kept praying, "Jesus, don't leave me." I haven't done any miracles or anything great. I just raised my kids and took care of the family. I went to church but I haven't done anything great. [*The phone rings but she answers it.*] No, honey. Could you call me back in a few minutes? Dear, I am with the Chaplain. She hangs up the phone.

C12: I can tell you have a lot of hurts and loss. Would you like to continue to talk about your husband or your relationship to God.

P12: I don't want Jesus to leave me. Jesus please don't leave me. I'm sorry if I done wrong. I haven't done anything great.

Meeting God in Pastoral Resources: In the third phase, the pastor inquires and provides service that makes the patient feel closer to God. According to The Dictionary of Pastoral Care and Counseling, page 1288 says, "Trust expresses confidence in a helper's character and competence, trust anticipates help in discovery resources, overcoming difficulties and learning how to live responsible in the future." She is trusting me with her pain. It is my hope the patient will feel closer to God and experience God. There is a healing in just the confession. There is also healing in the Word, a mystical healing in the word. Although I do not quote the Scripture exactly or read from the Bible the word still mystical goes forth. There could be experience of God in communion, in song or Hymn.

C13: Jesus visited Mary and Martha at their house. During the meal, Mary sat at Jesus' feet. Mary was listening to Jesus worshiping Him and adoring Him. She was accepting the words and fellowship He was offering. Martha was doing all kind of works for God. She was worried about many things. Martha said to Jesus, "Don't you care that my sister left me to do all the work." Jesus' answer was that "Mary had chosen the better thing." She did the greater things by being a friend to Jesus and sitting at His feet than all of the work Martha was doing.

Let me put it this way I worked with the mentally retarded. They might be limited in what they can do, but they understand friendship. That is all that God really wants from us: friendship. We don't have to be rocket scientists to be friends with someone. We don't have to do great things for Jesus to accept us.

P13: My nephew was retarded. He had a rough 50 years.

C14: He knew what friendship was and love was, didn't he?

P14: Yes, he did.

C15: That is all God wants from us.

P15: I am so glad that you came by. This has been so good for me. I hope God takes me.

Meeting God in Prayer: The fourth phase is prayer. There is a spiritual world. Prayer is entrance into this mystical arena. Prayer will change the atmosphere of the room. Prayer brings in the presence of God. It is a face-to-face meeting with the Spirit. It is here that God changes us from the inside out. It is in this time, one can hear and speak with Jesus. The patient enters into prayer with God, a special sanctified talk, a conversation, set apart from his/her regular and ordinary talk. A holy talk to the Lord of the Universe, where the patient or chaplain brings burdens and concerns to the Lord and allows God's Spirit to supernaturally enter into the healing process.

C16: Would it be all right if I prayed for you?

P16: Yes, prayer is something that is always good.

C17: What would you like me to pray for you about?

P17: My health.

C18: Anything else?

P18: That God would take me. That Lord would look after my daughters.

C19: Anything else?

P19: No that is it?

C20: Dear Jesus I pray for this patient. I pray that your Spirit would comfort her. I pray, Lord, that you would give her strength and perseverance. Dearest Lord, please help her rest in your presence. Let her experience your acceptance in this room. I pray for her daughters that you would give them peace and that you comfort the daughters with terrible loss of their father. Lord, reassure her that she was a loving caring wife. Lord, help her to mourn her loss. Lord, begin the healing of her body and spirit today. I ask these things in your Name, Jesus. Amen

P20: Thank you. I feel better.

C21: You're welcome. I was glad to come by. I imagine your daughter will be calling again soon. I will come back tomorrow. Will that be all right?

P21: Yes that would be great. Thank you so much for coming. I really needed to talk to some one about my experiences and fears.

[The phone rings again.]

P: Hello Honey. No, the Chaplain was just leaving. *[She continues to talk on the phone.]*

I leave the room. I take a deep breath and see some more patients.]

5. The Indicators of the Outcome Achieved in the Visit

- a) The patient's thoughts are turned to God. The patient is more aware and conscious of God.
- b) The patient, through the Chaplain's visit feels God's care, love and active interest in the patient's life.
- c) The patient shares their burdens. Burdens include health issues, emotional pain and hurts from the past. The patient confessing things that have caused guilt, regret and shame. By so confessing, they are emotional and spiritually lightened. This emotional and spiritual care allows healing to happen more rapidly. This confession takes the wasted energy of guilt and worry and allows that energy to go to the patient's body for healing.
- d) The patient enters into prayer with God, a special sanctified talk, a conversation, set apart from their regular and ordinary talk. A holy talk to the Lord of the Universe, where the patient or Chaplain bring burdens and concerns to the Lord allows God's spirit to supernaturally enter into the healing process.
- e) The patient is glad the Chaplain came. The most successful visit includes all five steps. Less successful visits only would have 3 or 4 steps. The success or lack of success could be measured on a scale of 0 to 5 based on the number of steps the patients accomplish with the Chaplain's guidance.

6. Other Supplemental Comments

I would like to say that these 5 indicators of success cannot be forced on the patient like handcuffs. The patient has the right to refuse spiritual treatment or care at any point. I try to be aware of the non-verbal cues and not be aggressive but inviting and letting the patient determine how much pastoral care he or she needs. There is intimacy in God's Presence. If the patient is uncomfortable and doesn't wish to go farther or deeper or closer to God, I respect that. It is much like a date if the other person does not want to hold the other's hand; that is all right. Deep intimacy with God is just like deep intimacy with a person; it develops over time and is based on trust. For that trust with God to be built, it cannot be forced. I do not force intimacy with God. I believe the forcing of intimacy breaks trust. The first goal of the patient's thoughts being turned to God and/or the patient being more aware and conscious of God can be accomplished just by saying, "Hello. I am a chaplain here at this hospital." The Answer of "no" and "I do not need prayer or service of a chaplain" is always accepted.

22) Ideal Intervention for family divisiveness (E1)

Central Issue Identifier:

The patient was a teenage female patient with cystic fibrosis. She has frequent visits to the hospital with few visitors and little support from her family. Patient was currently dealing not only with her illness and being in the hospital but also with her divorced parents trying to make her choose which one of them she wanted to live with.

Problems and Needs of the Patient or Family, Initially Understood:

What I first perceived: I was aware that pastoral care did not involve giving advice but I truly believed that is what this patient needed.

Problems and Needs of the Patient or Family, Ideally Understood

What I learned from peer feedback would have been a more ideal pastoral intervention: This patient would not have needed advice, she would have needed someone to be with her through the yuckiness of her situation and she would have needed someone who could have helped her to explore how she might have felt about her given situation.

Purpose of the Intervention, Initially Understood:

I was brought to this situation by a concerned surgery transport employee who had met this girl the previous week and was very concerned about her situation. The employee told me that the patient was not going to live for very long and she (the patient) did not have any family or anyone visiting her. The employee was very saddened by the whole situation and she wanted me to go see the patient so that she had someone she could talk to about everything.

My desired purpose for the visit was to provide this girl with some support and some consistency. I knew that the nurses had visited with her each day, but I thought it would be nice for her to have someone else who had the time to talk to her about whatever it was that she wanted to talk about. My intention was to be there for her. I had heard a lot about the lack of family support that this patient had, and many people spoke about how bad they felt for her. I had heard she'd had a very bad day and it sounded like she needed some support. My goal was to provide whatever type of support she needed at the time. I even brought in a deck of cards in case she didn't want to talk at all, but just wanted to do something to get her mind off of what it had been on. The cards never came out of my pocket. She had plenty to talk about which was fine with me.

Purpose of the Intervention, Ideally Understood:

It would have been more appropriate for me to have been prepared to help the patient explore how she had felt about her situation. This would have helped her to have understood her life more and could have helped her to figure out what actions she needed to take in this situation to get her where she would have wanted her situation to have been. If I would have helped her to explore and understand it could have helped to make decisions on her own in future situations.

Key Points of Verbatim as Presented to Peers:

P5: I've had a really bad day.

(her eyes became blood shot and welled up a bit with tears)

C5: Oh really?

P6: Yeah my parents are divorced and they're doing this thing right now where they want me to decide who I want to live with, and my dad wants to talk to the attorney today. So he's saying that I have to make a decision today, and I just really don't want to.

C6: So you kind of feel like they're forcing you to make a decision that you're not ready to make yet?

P7: Yeah

C7: Well, are you able to go back and forth like one week one place and the next week the other place.

(I blurted this out because it was the first thing that came to mind. There are multiple reasons I should not have made this statement, one being that I know nothing about divorced families and how housing for the children is split up).

P8: No, I've said that in the past and neither one of them like that idea.

C8: Well it sounds like they are putting you in a really hard place having to make a decision between the two of them.

(both of us are nodding our heads)

P9: Yeah, I don't want to hurt either of their feelings. And you know, my dad doesn't want me to live with my mom because I get social security and my mom just takes that money and I don't see any of it. So if I lived with my dad, the social security would be sent to him and I would then get to have it but the thing is that, he's an alcoholic. So it's like, you know, he's an alcoholic and she's money grubbing.

C9: Well gosh that's got to be hard on you. It sounds like no matter who you were living with it would be pretty stressful on you.

P10: Yeah! I really don't want to live with either one of them. I really don't.

C10: Well, do you have any other family members like an aunt or uncle or anything like that who you'd be able to live with?

P11: Yes, my aunt.

C11: And how does she feel about all this?

P12: She said that I could come and live with her, that's who I was just on the phone with. But, I'm sure my parents won't like that idea either.

C12: How old are you?

P13: 17

C13 I forget, do you know if it is age 15 or 18 when a person can decide who they want to live with?

P14: 15. I've thought about getting emancipated. That's what my aunt wants me to do. And you know, I'm pretty independent and you know I basically am on my own any way, like when I had a car I was hardly ever at home. I was always on my own, but then I got in a car accident and ruined my car, so now I don't have a car anymore so that sort of ruined that for me.

C14 So it sounds like you're pretty used to living independently and relying on yourself. It sounds like you feel as though you're just ready to be on your own.

P15 Yeah, and the other week my dad like yelled at my boyfriend and called him bad names, and because of it my boyfriend broke up with me. We're still not back together, we're talking but we're not back together. My dad just got out of the hospital because he has depression and he had blood clots that he needed to get fixed. And so when he got back he wasn't able to do the yard work and things like that, so my boyfriend was doing it. And then my dad got drunk and called him like a worthless piece of crap or something. And ever since then, you know, my boyfriend broke up with me.

(the whole time she was speaking I was using accents and facial reactions)

C15 Well my gosh that must have really made you mad, cause it sounds like your dad sort of ran your boyfriend off.

P16 Oh yeah definitely!

C16 And it sounds like your boyfriend had been offering you a lot of support, and that you were really able to rely on him, and then that happened with your dad.

P17 Yeah he really has been so supportive in helping be figure out how to cope with my parents. And I haven't had many visitors, and my mom was supposed to come and visit me today, and she was supposed to bring my boyfriend (well you know, my ex-boyfriend) with her. But her car broke down on Thursday so she hasn't had a vehicle. But you know she has had ever since Thursday to find a different form of transportation and she...

C17 Hasn't found one

P18 Nope. And my boyfriend doesn't have a phone, so there's no way to get a hold of him to tell him she's not coming to pick him up. So he's just like, at his house, not knowing what's going on and waiting.

C18 Oh gosh, this all sounds so frustrating.

P19 Yeah

It's times like these when I just really wish someone would make the decision for me, you know; I just wish my mom or dad would say, "you have to come live with me, I'm not giving you a choice" That way I wouldn't have to choose between the two of them.

(At some point in the conversation I had asked if she had talked to the social worker about her living arrangements and she said, "yeah but she was like in and out in a couple minutes so we didn't really get to talk.")

C19 Well, you know, you're almost 18 years old and you sound very responsible and level headed for your age. It seems that you really know what to expect from other people and what to expect from yourself and, I just really encourage you to follow your heart on this. If you were to become emancipated then you would be expected to be able to fully make decisions on your own. And I think that you are completely capable of making those decisions. I know that it will be a very hard decision for you to make because you don't want to hurt anyone's feelings. But I think that you truly know who you want to live with, and who it would be best for you to live with. And based on what you've said, I don't think it sounds like you believe you should be living with either of your parents

P20 No, I don't

C20 So does that mean you feel it would be best for you to live with your aunt?

P21 Yeah I do. And my aunt has diabetes and so she's home like all day, and there are so many things that I could help her with.

C21 It sounds like you'd be able to help each other.

P22 Yeah. And with my health condition it is really important that I not be around cigarette smoke, and both of my parents smoke.

(My jaw dropped at that and I know I was shaking my head in annoyance and disgust)

C22 Well that's huge and it's enough reason in itself to live with your aunt, and you can even use it as an excuse to your parents if you need one. Your health needs to be the number one concern, and that is a huge issue.

(Pt was smiling and nodding in agreement)

C23 Inevitably one of your parents will say they will quit smoking, but you just have to say until then . . .

(Pt interrupts)

P23 Until then I can't live with you, yeah *(smiling and nodding)*.

(Earlier in our conversation she told me that one of the downfalls of living with her mom is that her younger sister, who is much bigger than her, will fight with her and hurt her, she's even thrown a chair at her. She told me a downfall of living with her dad was that when he drinks he's mean and she doesn't want to be around that. She told me the downfall of living with her aunt is that her social security check would not be sent to her unless her aunt got custody of her and her aunt can't afford to go to court for that.)

Cognitive and Emotive Content of the Communications, Initially Understood:

When I reflected on this interaction I realized that in C7 I tried to fix her problem because I really did not like that she was asked and practically forced to choose who she wanted to live with by her parents, who had not shown much of any support to her through her illness. In C10 my comment was made because I wanted her away from her parents, I saw no good had come to her from them. After P14 was stated I thought about how she had presented herself as an independent person the whole time she had been on the unit and I thought, *why not let her be on her own and away from the chaos of her parents? She deserves to not have to be around them.* After P15 I thought *what a jerk her dad is when he's drunk.* After P17 I thought *despicable, making excuses to not come and see your own daughter when she's in the hospital.*

Cognitive and Emotive Content of the Communications, Ideally Understood

After presentation of my verbatim I have realized that a lot of my comments were made out of frustration. I was mad at her parents for not giving her the care that everyone deserves. I have realized that these feelings of frustration appeared in C7. In C10 I have realized I was fed up with her parents. I have realized I was mad at her parents, and I did not want her to be forced to live with either of them when I felt neither of them were giving her the love and support she needed. I have realized that in C12 my feelings of "how dare they do this to her" came out. I have come to terms with the fact that I knew that one was allowed to choose who they live with when they are 15. I have realized that I may have been trying to be subtle when I presented it as a question in C12. I have realized that after P14 was stated I was thinking *she really has shown herself to be an independent person so why shouldn't she be. Her parents don't deserve to have her living with them.* I have now realized how much I related to this patient after P19. "I just wish someone would make the decision for me" is mantra of my own that I have been trying to grow out of for the past year. I have realized that I felt her feelings of being uncomfortable with her situation, and I felt I knew the "right" answer. I have realized that I wanted to give her my answer not only to make the decision for her (as she said she wanted someone to do) but because it would make me feel better if she were living with her aunt.

Hoped-for Phases in the Visit, Initially Understood:

My hoped for phases before presentation of this verbatim to the peer group were to have been of help to this patient, to have helped her to understand her own feelings on the situation, and to have made her feel comfortable to call for pastoral care services again in the future.

Hoped-for Phases in the Visit, Ideally Understood:

After presentation of this verbatim to my peer group I have realized that I may not have been clear on what “help” this patient needed. I have realized that I cast my own thoughts and feelings on her situation before I was able to help her explore her own. I have realized that this patient may feel comfortable calling for pastoral care services again, but that I did not give the best example of what pastoral care services are for. So she might seek them out for the wrong reason.

Measurable Outcomes to be Achieved in the Visit, Initially Understood:

I hoped the patient wanted to talk to someone. I wanted the patient to have someone to talk to about anything she needed to talk about. I hoped the patient appreciated the visit. I hoped the patient felt supported. I wanted the patient to feel she had a friend in pastoral care support. I hoped the patient felt comfortable calling upon pastoral care for future support.

Measurable Outcomes to be Achieved in the Visit, Ideally Understood:

After presenting my verbatim I have realized an important measurable goal would have been for her to have gained more understanding on her own feelings regarding her situation, and being able to state those feelings at some point. I have realized that an important measurable goal would have been for the patient to have felt heard and understood in the conversation. I have realized that an important measurable goal would have been for the patient to have realized that she does have a choice in this matter and that choices are a blessing. I have realized that I should not have tried to make the decision for her, but I could have encouraged her to not so easily give her options and choices away for someone else to choose.

Theological Reflections, Initially Understood:

My own theological beliefs said that people came into our lives and we went into other peoples’ lives at particular times and places. I believed we each had multiple experiences that equipped us to help and to be helped. I had never been in a situation even close to what this girl went through, yet I felt comfortable when we talked about it. I believed I had a place being in her room at that time. It made me feel purposeful. I thought it was possible that I let too many of my own thoughts show through, and that I may have given advice instead of helping her to explore the advice she would have given herself.

Initially, I believed that no theological or spiritual references had been made. God was not spoken of, and prayer did not take place. I did however try to guess her theological issues. I guessed that she tended to turn to God with a lot of questions. Her life was not the easiest and surely did not provide much support for her. I was sure she had questioned in the past, as anyone would, *why do I have to be sick like this, why does my family have to be so messed up?* These were the theological and spiritual reflections I had made before presenting my verbatim.

Theological Reflections, Ideally Understood:

Before presenting this verbatim I believed there had been close to no theological issues at hand. But after presenting this verbatim I have realized that there were many theological issues indeed. I have put names to the feelings she must have had. Feelings such as abandoned, rejected, defeated, deprived, cheated, robbed, afraid, sad, anxious, confused, alone; and although she had options in front of her, she probably still felt that she had no choice in the matter.

I have reflected on some Psalms, and Psalms 97 will speak to me with this situation in mind. It tells of God protecting and rescuing his people from the wicked, those who worship idols and such. I have realized that I felt the need to try and protect or save this girl from her parents. One who overindulges in alcohol and one who will do wicked things if it means getting money out of it.

23) Ideal Intervention for elderly frustration with long hospitalization (E3)

Category: Undiagnosed Illness

1. Typical Characteristics, Problem and Needs of the Patient

The patient was an African American married male in his seventies, father of two children, a son and a daughter. His wife is his primary caregiver. The patient was a career psychologist before retiring. His diagnosis when he was admitted focused in on his lack of stability when walking. However during his long hospitalization, he has seen his case baffle and frustrate not only himself, but the medical team as well. After two months of tests and various procedures during his hospitalization, he had recently underwent surgery.

The focus of this intervention is on the challenge that I had seeking closure when it looked like the patient would be transferred from the hospital to a care facility closer to his home. Due to his long hospitalization I have had numerous opportunities to visit this patient. In one particular visit I was taken off guard by the possibility of the patient being transferred elsewhere within one hour of my visit.

On the day of that particular visit I was planning to stop by to check in on the patient as I often had. As I approached his room I noticed that he was not in bed and at first incorrectly assumed that he had been taken from his room for another test. I was pleasantly surprised to find him out of the sightline of the doorway sitting up in a chair eating his breakfast. He answered my greeting and invited me to come in and sit down together.

2. Desired Purpose of the Intervention

The purpose of the visit was to originally check in on the latest update from the patient on his condition and to provide any further support that would be helpful. However the consistent concern of the patient during the visit honed in on his anxiety about the imminent transfer he thought he was facing.

3. Hoped-for Cognitive and Emotive Content of the Communications

Cognitive Content

The patient acknowledged the numerous resources available in his current setting.

The patient voiced his concern over the lack of resources at what would be his new location.

Emotional Content

The patient expressed clear feelings of anxiety about the transfer.

The patient acknowledged that this transfer would be logistically easier on the availability of his wife to be present with him. He expressed appreciation for her ongoing support.

The patient clearly expressed frustration about the transfer in his words, “not making progress” during his long hospitalization.

Spiritual Content

The patient was listed as a Protestant on the hospital census sheet.

The patient requested that I pray for him during the visit.

The patient gave voice to his view that in his words, “God is the One who helps me to keep going.”

4. Hoped-for Phases of the Visit

Introduction

The chaplain reconnected with the patient during his regular rounds. A rapport had been built over time to establish a sense of safety and confidentiality for the patient’s conversations with the chaplain.

Patient Expectations

The patient sensed that he would likely receive a visit that day due to the regular schedule of the chaplain which by this point was known to the patient.

Concerns that surfaced During Visit

The patient was feeling anxiety concerning his imminent transfer to a new care facility.

Discussion/Support

The ideal interaction encompassed what I would have done:

- Acknowledging the long hospitalization the patient experienced.
- Affirming the patient in the midst of his concern of a transfer.
- Exploring deeply the reasons for his concern.
- Affirming the care network of his family which could be in closer proximity to him as a result of the transfer.
- Encouraging the further discussion of the spiritual resources available to the patient regardless of his location.

- Blessing the patient with God's peace as the patient prepared for this process to unfold.

Conclusion

Closing out this follow-up visit took place through a time for prayer as the patient extended his hand to the chaplain as a signal of connectedness in sharing this moment together. The patient during this visit felt the freedom to take the gift of the lead as helpful to him to dig deeper into the reasons for his concerns and the resources that continued to be available to him. The chaplain in this encounter operates more like a guide to assist the patient in giving voice to his real concerns to assist the patient in transitioning to his next venue for care.

5. Measurable Outcomes to be Achieved in the Visit

Indicator 1

- The patient's need emotionally to give voice to his honest concerns assisted in his being able to move forward with his transfer.

Indicator 2

- The patient's understanding of the resources available to him grew as a result of the visit. The patient's appreciation for his family and the opportunity to call his spiritual resources into play helped reduce his anxiety over the perceived lack of resources that he would experience in his new care environment.

6. Theological Implications

The patient brought into focus the challenge for caring for long-term patients when a diagnosis leading to helpful treatment proves elusive. The suffering of a patient like him through his long course of many treatments points to the fact that there are limitations to the technological side of healing no matter how skilled the medical team may be. As human beings we are creatures with many skills, but the ultimate skillful One is God. As Creator, God blesses men and women with gifts to use. As each one acknowledges the gift he/she has been given, and acknowledges the identity of the Giver, a new focus of serving for a greater purpose and glory beyond oneself results.

7. Other Comments

Following my presentation of the above information to my CPE peer group I was encouraged to share some further insights concerning my interactions with this patient due to the length of the patient's hospitalization and the number of opportunities that I had to visit this patient.

The patient ended up not being transferred at the time of this visit. Shortly after my visit with him his condition worsened so that the transfer was not possible at that time. This continued to build the frustration of the patient and the medical team as his condition fluctuated. Eventually a few weeks later the condition of the patient improved to the point that a transfer prior to his subsequent readmission for another surgery occurred.

Due to the length of his previous stay, when the patient was readmitted for surgery to the hospital I was asked by the patient's family to come and pray for him as well as the family prior to his procedure. This helped for the blessing phase that I had earlier hoped to accomplish to happen. The poignancy of this time of blessing is that due to the course of events I had also had the opportunity to assist this patient with the Advanced Directive process in preparation for his surgery. Ironically, the patient continues on now in recovery as his process moves forward. The family has continued to request me to follow when possible.

In the time in which we live, where many patients' stay in a hospital is often numbered in days, rather than weeks, or in this patient's case months, the challenge of writing this ideal intervention is the tension between the real and the ideal. However, the process has been helpful to reflect on one of these earlier exchanges to see what could have been done differently for greater effectiveness.

The key learning in this process is that there are times when the care-giving capacity of the medical team is stretched beyond the norm. The chaplain as an embedded member of the team seeks to continue to bring care, comfort, and encouragement not only to the patient and his/her family, but to the medical staff as well.

24) Ideal Intervention for low self esteem (E5)

Summary:

This meeting took place in the cafeteria of the hospital, prearranged as a lunch between myself and an employee of the hospital. The cafeteria is noisy, crowded, with employees and guests having lunch. The smells of food are evident but not overwhelming in the dining room. I had met this man, approx. 40 years old, Caucasian, at a class held at the hospital for people interested in volunteering for pastoral care. He had attended for the entire 8 weeks but never volunteered due to a self-disclosed diagnosis of Asperger's Syndrome, a condition often associated with Autism. I have run into him in the hallway occasionally and we would talk of having lunch. We finally set a time and date. He was aware that I was well disposed toward gay persons and I was aware that he had a more literal understanding of the Bible. He also had poor social skills due to his diagnosis that often made people uncomfortable. I had observed this during our class time and after. He was always sincere when he communicated with anyone, which I appreciated. Our conversation had some odd twists which kept me alert.

Central Spiritual Care Issue Identifier:

Low Self Esteem

A Brief Interaction of the Verbatim Intervention

E=Employee C=Chaplain

E 8: Well, I'm gay and I find it easy to attend that congregation.

C 9: Well, that's great! I didn't know you were but I appreciate your honesty. .

E 9: I don't tell everyone because they already hate me.

C 10: Why would you say they hate you? You are very friendly and personable.

Summary of what could have been said:

E 9: I don't tell everyone because they already hate me.

C10: I hear a lot of pain in that statement...(silence).

A Second Interaction of the Verbatim Intervention

E 11: I have trouble keeping a boyfriend...I don't like to be intimate other than hugging and kissing.

C 12: You find it uncomfortable?

E 12: Yes, I do. I don't like to take off my clothes with another person. So it's difficult to find someone to love when I won't be able to please them. Who is going to want that?

C 13: I know some others who feel the same way. You may have to look for awhile though.

Summary of what could have been said:

E 12: Yes I do. I don't like to take off my clothes with another person. So it's difficult to find someone to love when I won't be able to please them. Who is going to want that?

C 13: Your question saddens me...(silence).

A Third Intervention of the Verbatim Intervention

E 14: Do you have someone?

C 15: Yes I do. We've been together almost 6 years and married over 2 years in the church.

E 15: Well, then we can only be friends.

C 16: Yes, I'm glad to hear you say that. I find cheating on partners a common occurrence in the gay community and I'm very much against it.

Summary of what could have been said:

E 14: Do you have someone?

C 15: Yes I do. We've been together almost 6 years and married over 2 years in the church.

E 15: Well, then we can only be friends.

C 16: I would like that if you would....(silence).

25) Ideal Intervention Paper for communicating across a language barrier (E6)

1. Summary of Original Situation

In the original situation, I was doing my regular rounds when I found myself in a room with an eight month old boy, attempting to connect with someone who did not speak the same language as I. I attempted to find some way to communicate with the Hispanic patient's mother, but was unsuccessful. The situation was further complicated because the patient was in isolation, so I was wearing gloves, a gown, and a mask, making me look like everyone else who walks through the door.

2. Central Spiritual Care Issue

How to minister to people when you do not speak the same language

3. Summary of Original Intervention

The way I resolved the original situation was to go back the next day with a person who spoke Spanish so the mother could at least know who walked into her baby's room yesterday. I knew one of the security guards for the hospital who had helped the chaplains in the past, so he and I went and explained the situation, who I was, and asked if there was anything I could do for them.

4. Summary of Ideal Intervention

a. *Wanting to do something for them*

Originally I asked if there was something I could *do* for the mother of the patient. I realize that I need to keep working on my introduction. I walk a fine line because I do not want to scare the parents whose children are in the hospital and because almost all of my patients go home in a day or two. Often I find that they want me to *do* something—play with their child, just have an adult conversation, etc..., but I need to realize that I also need to offer just presence. I could ask “Is this a good time for a visit?” or simply “How are things going today?”

b. *Language Barrier*

There are a few ways to bridge the language barrier (besides learning many languages!). There is a translation phone that is available, although it seems like a lot to get it out for an initial visit. There could be a sign on the door saying something like “language barrier,” “Spanish speaking” or “Español.” Another option would be to have a picture such as a telephone or a world map/globe. These options should indicate that we don't all speak the same language, not indicating an “us” verses “them” idea. It would also allow people to know and prepare before walking into the room so they are not put in a situation like mine.

Another way would be to carry around a card (or a few if there are several usual languages for patients at the hospital), stating who I am and what I can do for them.

26) Ideal Intervention for feeling abandoned by God and family (F1)

1. *Summary description of the original situation:* This pastoral visit takes place in an adult inpatient unit following the daily morning orientation/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. *Central spiritual care issue identifiers:* I experience the patient as feeling relationally isolated and abandoned – both from family and from God and very anxious.

3. *A Brief Summary of the Original Intervention:* Once seated, the patient tells me in an anxious, agitated, and aggressive fashion 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: "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.

4. *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.