

What Do Chaplains Really Do?

II. Interventions in the New York Chaplaincy Study

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ABSTRACT. The current study analyzes data from 30,995 chaplain visits with patients and families that were part of the New York Chaplaincy Study. The data were collected at 13 healthcare institutions in the Greater New York City area from 1994–1996. Seventeen chaplain interventions were recorded: nine that were religious or spiritual in nature, and eight that were more general or not specifically religious. Chaplains used religious/spiritual interventions, alone or in conjunction with general interventions, in the vast majority of their visits with patients and families. The types of interventions used varied by the patient’s medical status to some degree, but the pattern of interventions used was similar across faith group and medical status. The results document the unique role of the chaplain as a member of the healthcare care team and suggest there is desire among a broad range of patients, including those who claim no religion, to receive the kind of care chaplains provide.

KEYWORDS. Chaplaincy, interventions, pastoral care, religion, spiritual care

INTRODUCTION

O’Connor (2002) argues that chaplaincy needs to become more evidence-based—a view that is shared by Fitchett (2002b), Burton (2002), and Handzo (2002), who wrote commentaries for a special issue of the *Journal of Health Care Chaplaincy* on whether chaplaincy should become more scientific. O’Connor contends that pastoral care is already evidence-based to some extent since chaplaincy practice is heavily informed by case studies, which have a long and respected tradition in medical research. Indeed, Anton Boisen intentionally adopted the case study method from medicine as the basis of Clinical Pastoral Education (CPE) before Russell Dicks introduced the verbatim method (Gleason, 2004).

On the other hand, O’Connor (2002) correctly notes that case studies represent only one of several levels of research methods that make up a hierarchy with respect to their sophistication and the degree to which conclusions can be drawn from each. Randomized, double-blind clinical trials are at the highest level of research because they provide the strongest basis for making causal inferences (Flannelly et al., 2004). Although case studies, along with consensus

panels, serve a valuable purpose, they are the lowest level of the hierarchy, in part because it is difficult to generalize from a single case or even from a group of cases. Russell Dicks, one of the early pioneers of CPE, wrote an article about chaplaincy in the first volume of the journal *Pastoral Psychology*, in which he said “The sickroom is the mostly highly charged emotional situation in which the clergyman works and the hospital is the most complicated institution modern man has created” (Dicks, 1950, p. 50). To the degree this is true, it can be difficult to glean what chaplains do, and how they do it, from individual case reports.

Much of the published articles about professional pastoral care are narrative or expository in nature, describing what chaplains should or could do (see reviews by Flannelly, et al., 2003, 2005, 2006; Handzo, 2006; Handzo & Koenig, 2004). Much of the rest is case study-based (Handzo & Wintz, 2006; Hughes et al., 2007, Puchalski et al., 2006). While this evidence provides some support for professional pastoral care, the level of evidence is relatively low.

The next step up is cross-sectional research, which may simply entail observations of or correlations among different factors or variables. Such research can provide a better understanding of what chaplains do and how they do it, which can improve clinical practice and inform other healthcare professionals about the roles and functions of chaplains (Wilson, 2002). Large sets of observations are needed to detect patterns of behavior or activity, which may otherwise be obscured by individual differences or styles and the particulars of different situations. The larger a data set is the less likely it is that observed patterns are due to chance.

There have been only a few studies that provide evidence about pastoral care at this level of research sophistication. Our published studies of chaplains, to date, have observed pastoral care practices over several years at single hospital sites (Flannelly et al., 2003; Fogg et al., 2004). Both of these studies examined the pattern of referrals to chaplains and the populations they served. The earlier of the two also examined the kinds of interventions chaplains used with patients in terms of their religion and their medical status.

VandeCreek and Lyon (1994/1995) presented findings about chaplain contacts with patients, families and staff at three hospitals over a two-month period. However, that study did not look at pastoral care interventions other than worship services and sacramental functions. Gibbons et al. (1999) reported findings from a five and a half year

study of hospital chaplains in Australia. The data set contained over 42,000 chaplain-patient interactions coded in terms of 82 descriptors of the patient's feelings and concerns and the chaplain's interventions. Unfortunately, the article only presented a general summary of the frequency and percentage of the descriptors and the major themes they represented.

The current report is one of a series of studies to describe and analyze pastoral care encounters recorded by the clinical staff of The HealthCare Chaplaincy. While we know the database used for this report is now several years old, we believe it can serve as an historical control for more recent data, beginning to suggest both continuities and changes in pastoral care practice over time. It is our hope that these reports, besides providing important evidence for pastoral-care practice on their own, will also stimulate others to publish their own findings. As this higher order evidence accumulates, it will likely reveal patterns of pastoral care practice in various settings that can then be recognized as standards of practice.

METHODS

The study analyzes data from 30,995 chaplain visits with patients, families and friends that were collected as part of the New York Chaplaincy Study. The study was conducted at 13 healthcare institutions in the New York City area from 1994–1996. Ten of the participating institutions were hospitals, two were nursing homes; and one was a physical rehabilitation hospital. The chaplains also made about 1000 visits with staff during the course of the study, but these are not included in the present analyses.

Data were collected during two-week periods each year, but some of the healthcare institutions had two or more data-collection periods in some years. Professional chaplains, chaplaincy residents and students (hereafter referred to collectively as chaplains) recorded key information about their visits, including: whom they visited, the duration and number of visits, their interventions or other activities during the visit. The patient's religion and medical status were also recorded.

The individuals the chaplain visited (other than staff) were classified into three categories (or populations served) for the present study: (1) patient only, (2) patient with family or friends, and (3)

family or friends. The first and second categories were combined for most of the analyses.

At the end of a visit, the chaplain estimated its duration, using 5-minute intervals. The number of the visit was recorded as “1,” “2,” or “3.” All visits beyond the third were recorded as “3.” For the present analyses, these were classified simply as initial and later visits.

The chaplain’s activities were classified into 19 categories. The chaplains recorded all of the activities they performed during each visit. Seventeen of the nineteen activities were considered interventions and two were not. The two activities that were not deemed interventions were introducing ones’ self, and making a spiritual assessment.

We considered nine of the interventions to be religious or spiritual in nature, and eight to be general or not specifically religious. The eight general activities were:

1. crisis intervention;
2. emotional enabling;
3. ethical consultation/deliberation;
4. life review;
5. patient advocacy;
6. counseling;
7. bereavement, and
8. empathetic listening.

We realize that including empathetic listening as an intervention is controversial because as Gillman and his colleagues put it: “Any pastoral intervention assumes a caring presence, a compassionate heart, and continued active listening” (Gillman et al., 1996, p. 16). However, we also understand from clinical experience that empathetic listening, even employed alone, can have a therapeutic effect.

The nine religious/spiritual activities were:

1. hearing confession or amends;
2. faith affirmation;
3. theological development;
4. performing a religious rite or ritual;
5. providing a religious item;
6. offering a blessing;
7. praying;

8. meditation; and
9. other spiritual support.

Based on the combinations of different activities that chaplains performed, chaplain interventions were grouped together in some of the analyses as simply general, religious/spiritual and both.

Six categories of religious affiliation were recorded: Catholic, Jewish, Islam, Protestant, Other, and None. Twelve categories of medical status were used for the present study:

1. the patient died;
2. the patient was in the process of dying
3. the patient was in the end-stage of a disease;
4. the patient was in crisis or had a code;
5. the patient received a checkup;
6. the patient received a new diagnosis or prognosis;
7. the patient was being discharged;
8. the patient was going into surgery—pre-op ;
9. the patient was post-op/recovering from surgery;
10. the patient was receiving rehabilitation;
11. the patient was receiving treatment; and
12. other.

RESULTS

Overall, chaplains made patient assessments during roughly 48% of their initial visits and 44% of their subsequent visits with the same patient. They used empathetic listening in 71.6% of their visits. Because of the prevalence of this intervention, it was excluded from any analysis to avoid severe bias in the reported numbers.

Table 1 reports the extent to which chaplains performed assessments and interventions during initial and later visits. Specifically, the table shows the percentage of visits in which chaplains made assessments and interventions (excluding empathetic listening) with the different populations to which they minister.

The Chi-square test found a statistically significant difference in the percentage of times that chaplains made assessments and interventions in initial and later visits ($\chi^2(3) = 473.6, p < .001$). Looking at the two columns under the heading “All Three Populations,” one

TABLE 1. Percent of Initial and Later Visits in which Chaplains Performed Assessments and/or Interventions* with Different Populations

| | Patient Only | | Patient and Family or Friends | | Family or Friends | | All three Populations | |
|---------------------------------|--------------|-------|-------------------------------|-------|-------------------|-------|-----------------------|-------|
| | Initial | Later | Initial | Later | Initial | Later | Initial | Later |
| No Assessment or Intervention | 15.8 | 1.6 | 8.4 | 1.2 | 11.4 | 3.2 | 13.6 | 1.6 |
| Assessment but no Intervention | 15.5 | 12.0 | 12.2 | 15.6 | 18.0 | 25.2 | 14.7 | 13.7 |
| Intervention without Assessment | 37.2 | 57.3 | 44.1 | 52.4 | 40.1 | 40.6 | 38.7 | 54.5 |
| Assessment and Intervention | 31.5 | 29.1 | 35.3 | 30.8 | 30.5 | 31.0 | 33.0 | 30.2 |

*Interventions exclude empathetic listening, which was not included in the analyses because it was so widely used.

can see that chaplains performed no assessments or interventions in 13.6% of their initial visits. Chaplains recorded making introductions during 61.8% of these visits and engaging in empathetic listening during 40.9% of these visits, such that all initial visits that are listed as having no assessment or interventions involved introductions and/or empathetic listening. The percent of later visits with no assessment or interventions was only 1.6%. It is noteworthy that chaplains intervened in more than one third of their initial visits and more than half of their subsequent visits without doing any assessment.

The Chi-square test also indicated that chaplains responded differently to the populations being served, with respect to performing assessments and interventions ($\chi^2(6) = 264.2$, $p < .001$). This is mainly attributable to the fact that chaplains were more likely to intervene without making an assessment when they visited patients (with or without family or friends present) than they were when visiting with just family or friends.

Table 2 gives the percentages of visits in which chaplains used three broad categories of interventions with patients (with or without family or friends). The manner in which chaplains ministered to Catholics, Jews and Protestants was quite similar in terms of these three classes of interventions. Chaplains used only religious/spiritual ritual interventions in somewhat less than 60% of all visits and a combination of general and religious/spiritual interventions in

TABLE 2. Percentage Distribution of Different Types of Interventions used with Patients in Relation to Their Religious Affiliation

| Religious Affiliation | General | Religious/Spiritual | General and Religious/Spiritual |
|-----------------------|---------|---------------------|---------------------------------|
| Catholic | 7.1 | 59.8 | 33.1 |
| Jewish | 13.1 | 57.3 | 29.6 |
| Islam | 5.5 | 85.1 | 9.4 |
| Protestant | 9.7 | 56.1 | 34.2 |
| Other | 14.4 | 61.5 | 24.1 |
| None | 17.8 | 60.0 | 22.2 |

almost 30% or more of all patient visits. It is also noteworthy that the percentage of religious/spiritual interventions with those reporting no religion was in the same range as reported for religious patients. A single professional chaplain who is an Imam made more than 83% of all the visits to Islamic patients in the present sample.

Table 3 shows the percentage of visits with patients of different faiths in which specific religious/spiritual interventions were used. Overall, the pattern and degree of use of the different interventions was roughly the same across the different religious groups, including those who claimed no religion. Prayer was the most frequently used intervention with all patient groups, followed by blessings and faith affirmation. The high use of prayer with Islamic patients reflects the fact that the Imam in the study tried to visit patients once or twice a day during prayer time so he could pray with them. As the table shows, it was much more common to supply Jewish and Islamic patients with religious items than it was to do so for other patient groups. All of the hospitals had religious items available that are commonly requested by Jewish patients, such as Sabbath candles. Several also had religious items for Islamic patients, including the Qur'an, prayer rugs, prayer caps, and prayer shawls.

The sacrament of confession (or amends) is underutilized compared to what one would expect in a population that is heavily Roman Catholic. Lack of privacy clearly contributes to this result. More importantly, Roman Catholic rituals were normally handled in these hospitals by priests from a local parish and Eucharistic ministers, neither of whom were part of this sample.

General interventions differed across religious affiliation to some degree, but no systematic variation was found. The most common

TABLE 3. Percentage of Specific Religious and Spiritual Interventions used with Patients by Their Religious Affiliation

| Intervention | Religious Affiliation | | | | | |
|----------------------------|-----------------------|--------|-------|------------|-------|------|
| | Catholic | Jewish | Islam | Protestant | Other | None |
| Prayer | 59.1 | 40.8 | 76.9 | 58.4 | 45.3 | 45.9 |
| Blessing | 49.3 | 41.2 | 52.8 | 38.6 | 42.7 | 36.3 |
| Faith Affirmation | 29.4 | 28.9 | 15.1 | 35.8 | 18.8 | 9.5 |
| Theological development | 5.2 | 8.5 | 2.2 | 5.9 | 5.4 | 6.6 |
| Supplying a religious item | 5.0 | 16.8 | 16.1 | 3.9 | 1.4 | 0.1 |
| Religious rite or ritual | 6.0 | 2.1 | 0.6 | 2.0 | 0.1 | 0.0 |
| Confession or amends | 2.3 | 1.7 | 0.0 | 2.2 | 2.1 | 2.8 |
| Meditation | 0.7 | 0.4 | 0.2 | 0.5 | 1.2 | 0.6 |
| Other spiritual support | 6.5 | 10.5 | 6.3 | 7.3 | 12.5 | 16.0 |

general intervention was emotional enabling, which was used in 15.3% of all visits. The next most common was life review, which was used in 11.7% of visits. The other general interventions were used in 5% or less of all visits.

Table 4 shows the percentage distribution of the three broad categories of interventions used with patients (with or without others present) based on their medical status. The medical status categories are listed in descending order in terms of the percentage of visits that included only religious/spiritual interventions. The medical status category of discharge is excluded from the table because the number of visits involving religious/spiritual interventions is very low.

TABLE 4. Percentage Distribution of Different Types of Interventions used with Patients in Relation to Their Medical Status

| Medical Status | General | Religious/Spiritual | General and Religious/Spiritual |
|----------------|---------|---------------------|---------------------------------|
| Pre-op | 2.9 | 69.3 | 27.8 |
| End stage | 7.3 | 65.6 | 27.1 |
| Dying | 7.1 | 62.1 | 30.8 |
| Treatment | 8.7 | 60.1 | 31.2 |
| Post-op | 9.7 | 59.3 | 31.0 |
| Discharge | 11.4 | 56.3 | 32.3 |
| Crisis/code | 13.1 | 53.3 | 33.7 |
| Rehabilitation | 16.1 | 51.8 | 32.1 |
| Checkup | 39.1 | 30.0 | 30.9 |

Solely religious/spiritual interventions were used in over half the visits with patients except for patients receiving checkups and patients being discharged. There was an inverse relationship between the percentages of religious/spiritual and general interventions used. As the use of religious/spiritual interventions declined across the different medical categories, the use of general interventions increased resulting in a fairly constant use of interventions (27–34%) overall regardless of the patient's medical status.

The specific religious/spiritual interventions used with patients varied to some extent with the patient's medical status, as seen in Table 5. Overall, prayer was the most common intervention, regardless of medical status. Although prayer was widely used in all patient circumstances, it was most frequently used with patients who were going into surgery. Other circumstances offered a better opportunity for patients to be more reflective, as indicated by the increasing use of faith affirmation and theological reflection at discharge and during rehabilitation. However, these interventions were also relatively prevalent during times of Crisis/Code.

Prayers and blessings were the most commonly used interventions with patients who were dying or at the end stage of a disease. Although we combined faith affirmation and theological development in the table, it is worth noting that faith affirmation was from two to four times more common than theological development for most categories of medical status and it was six to seven times more common when patients were dying or going into surgery.

The performance of religious rites and rituals was very rare except during visitations with dying patients. As noted above, however, rites and rituals conducted by local priests are not included in the sample. Although there were a number of Rabbis in the study who were professional chaplains, the practices of outside Rabbis are also excluded from the sample. Confession and meditation were not included in Table 5 because both were infrequent, and other spiritual support was not included because it lacks specificity.

Table 6 presents the kinds of general interventions used with patients in relationship to their medical status. Emotional enabling, which was the most common general intervention, was used most frequently with patients in crisis or dying, and those going into and coming out of surgery. Life review was also commonly used with dying patients as well as those undergoing rehabilitation. As mentioned before, empathetic listening was reported in 71.6% of chaplain visits.

TABLE 5. Percentage of Specific Religious/Spiritual Interventions used with Patients by Their Medical Status

| Medical status | Religious/Spiritual Interventions | | | | |
|----------------|-----------------------------------|----------|----------------------|----------------|----------------|
| | Prayer | Blessing | Faith & Theology* | Religious Item | Rite or Ritual |
| Pre-op | 83.3 | 18.8 | 18.4 | 3.0 | 2.3 |
| End stage | 66.8 | 71.6 | 21.4 | 7.6 | 2.8 |
| Dying | 64.4 | 50.2 | 25.6 | 7.6 | 10.0 |
| Treatment | 49.3 | 47.2 | 34.9 | 8.5 | 3.4 |
| Post-op | 53.9 | 39.9 | 32.3 | 8.8 | 3.5 |
| Discharge | 46.0 | 47.7 | 46.0 | 7.9 | 1.0 |
| Crisis/code | 60.7 | 41.9 | 42.4 | 2.6 | 2.6 |
| Rehabilitation | 42.5 | 22.7 | 47.3 | 8.5 | 1.3 |

*Combines faith affirmation and theological development.

More directive interventions like counseling, ethical consultation and crisis intervention were much less common except with patients who were in crisis or dying. Naturally, the most frequent use of crisis intervention was when a patient was reported to be in crisis. Patient advocacy is not included in Table 6 because it reported for less than 5% of the visits in each of the medical status categories. The same was true for bereavement counseling except in the case of dying patients, which was used during 10.3% of visits.

TABLE 6. Percentage of General Interventions used with Patients by Their Medical Status

| Medical Status | Religious/Spiritual Interventions | | | | |
|----------------|-----------------------------------|-------------|------------|-------------------------|------------------------|
| | Emotional Enabling | Life Review | Counseling | Ethical Consultation | Crisis Intervention |
| Pre-op | 23.4 | 8.7 | 3.2 | 0.3 | 2.6 |
| End stage | 16.0 | 14.4 | 7.8 | 5.4 | 2.4 |
| Dying | 25.9 | 21.0 | 12.8 | 8.9 | 8.2 |
| Treatment | 20.3 | 16.1 | 6.8 | 2.2 | 3.6 |
| Post-op | 26.1 | 15.7 | 6.2 | 0.7 | 2.5 |
| Discharge | 22.3 | 14.4 | 7.0 | 1.4 | 4.3 |
| Crisis/code | 28.2 | 17.7 | 15.3 | 5.7 | 21.8 |
| Rehabilitation | 17.9 | 23.3 | 3.6 | 1.8 | 1.3 |

DISCUSSION

The current study represents the first published research to systematically document and analyze the actual interventions of chaplains in multiple healthcare institutions. VandeCreek and Lyon (1994/1995) documented chaplains' contacts with patients, families and staff at three hospitals but they did not examine chaplains' interventions with patients; other than religious worship and sacramental functions. Gibbons et al. (1999) collected a very large set of data about chaplains' visits and interventions but they present very little analysis of the data. Our own previous research on chaplain activities and interventions has been single-site studies (Flannelly et al., 2003; Fogg et al., 2004).

A number of authors have written about the secular and religious roles of chaplains (e.g., Foster, 1975; Lee, 2002) including Seward Hiltner (1951). A 1984 survey of hospital chaplains in Nebraska (Barger et al., 1984) found that chaplains tended to define themselves more in non-religious than religious terms, perhaps Barger and his colleagues suggest, "to legitimize their role in secular language" (Barger et al., 1984, p. 185). Lee (2002) sees the secularization of the profession as being necessary for demonstrating the relevance of pastoral care for all hospital patients. The present findings indicate that the chaplains in our study most commonly used spiritual interventions, and many of them have explicitly stated that they see their role as spiritual—not secular. The chaplains we spoke to believe those interventions, which we classified as general, non-religious interventions, in the present study, as spiritual. This view is also held by several of the authors. It is also possible that patients perceive any intervention as spiritual or religious in nature simply because they are performed by chaplains.

As standard practice in professional pastoral care has moved from a model featuring clergy visiting patients of their own faith group to multi-faith chaplains visiting all patients on a given hospital unit, questions continue to arise about whether those who specify their religion as "None" should be visited or whether this visit would be seen as an unwanted intrusion. These results seem to indicate that this patient group welcomes pastoral care and makes use of it to the same degree as patients who claim a religious affiliation.

Almost every patient experiences hospitalization as some form of crisis, traumatic or not. Thus, all kinds of fears, anxieties, confusion,

and uncertainties are present with the patient, and usually with the family. Until these are heard, identified, and experienced with the supportive presence a chaplain provides, the patient will have difficulty “taking in” not only what is being said by staff and physicians but sometimes, even medications. Hence, empathetic listening is a vital intervention because it allows the patient the opportunity to be heard.

Although for statistical reasons we did not include empathetic listening as an intervention in the tables, we recognize that listening is a vital part of the spiritual-care exchange. Chaplains are, in some sense, professional listeners. They often consider this ability to be their great gift [from God]. Listening is a positive action that does not go un-noticed by the patient, though a professional listener may come to take it for granted. The perception of being heard, which is experienced by the patient, is a therapeutic outcome. Listening strengthens not only communication between chaplain and patient but also shared trust and rapport. By employing both intense focus and emotional intelligence, chaplains can actively listen to patients’ concerns and in turn, patients will feel validated and understood. Enhanced communication of this sort may result in better patient care and more effective coping strategies.

The fact that empathetic listening was reported for over 70% of visits surely attests to its importance. However, since it is such a common intervention, to include it in the category of general interventions would have made it impossible to differentiate between situations in which such interventions were or were not used.

We began the presentation of our results by examining the extent to which chaplains reported making assessments. While Fitchett (1993a, 1993b, 2002a) and others (e.g., Pruyser, 1976) have long emphasized the importance of assessment in pastoral care, the present study is the first to ask whether chaplains make assessments of the patients they visit. The answer turned out to be somewhat more complicated than one might have expected. Before discussing the findings, however, we should mention that there are many ways in which a chaplain may assess a patient. Fitchett (1993a, 2002a) recognized nine types of assessments: implicit, inspired, intuitive, and idiosyncratic assessments; assessments based on traditional pastoral acts, assessments based on normative pastoral stances, global assessments, psychological assessments, and explicit assessments. Fitchett has said, “probably only a small portion of the pastoral care

[chaplains] offer is guided by a conscious assessment of spiritual need” (Fitchett, 1993a, 2002a, p. 14). Although we might expect chaplains in the present study to record an assessment when they made an explicit spiritual assessment, this is not necessarily the case. Discussions with some of the chaplains suggest that at least some of their assessments may have been intuitive or idiosyncratic.

It was not uncommon for chaplains to make no assessment or intervention during their initial visit with a patient. In some cases this appears to be because chaplains were simply introducing themselves to the patient and maybe telling patients about the services that were available. In other instances, the chaplain apparently introduced him/herself and then just listened.

It was equally common during initial visits for chaplains to make an assessment but not perform an intervention (other than listening). One reason for this is that the chaplain may determine what a patient’s problem is or seems to be, but does not think the patient is ready to address it. On other occasions, the patient may request a particular intervention for a later time, such as a prayer or a blessing, or the patient may request a religious item that the chaplains would bring to them on a later visit. With respect to visits with family, it is generally rare for family members to request an intervention for themselves unless they had met the chaplain earlier. Finally, chaplains may make an intervention without an assessment because a doctor, nurse or someone else may tell the chaplain to see a patient because he or she is having a particular problem.

Finally, these data were collected at a time when formal assessment was not stressed as a part of professional pastoral care in the way that it is today. Being able to do a spiritual assessment did not become a required competency for certification as a chaplain until 2004.

Certain circumstances tended to be associated with certain interventions, such as prayer with patients before surgery and those who were dying. Yet, prayer was the most common intervention for all categories of medical status. It should not be surprising that many patients want chaplains to pray with or for them when they are hospitalized, regardless of the nature of their condition. A national survey found that 35% of U.S. adults pray about health concerns and three quarters of those pray for wellness (McCaffrey et al., 2004).

Circumstances in which death or the possibility of death were less imminent were more likely to be associated with more reflective

spiritual/religious interventions. Among the general interventions, emotional enabling was the most widely used under all circumstances other than empathetic listening. Emotional enabling invites the patient or family member to share feelings, which chaplains see as windows or pathways to what lies beneath the surface, so this is a part of almost any pastoral interaction.

Life review was the next most common general intervention. Life review tends to occur whenever someone perceives life is changing or has changed dramatically and thus needs to be understood in a new light. Life review can help patients find meaning in their lives. In addition to reducing anxiety about death in terminally ill patients, life review has been found increase life satisfaction and psychological well-being among the elderly (LeFavi & Wessels, 2003). It is not surprising, therefore, to find life review used extensively with rehabilitation patients—along with reflection on faith and theology. The prevalence of faith affirmation over faith development confirms a basic assumption of pastoral care that, in a time of illness, people want to have their beliefs affirmed and their doubts eased rather than change their beliefs in any way.

Generally, chaplains are taught to be non-directive in their work—thus the prominence of empathetic listening and emotional enabling. However, in certain circumstances, such as crisis/code or imminent death, more directive interventions that may involve advice giving are appropriate and often requested. Thus, the relative prominence of counseling, ethical consultation, and crisis intervention during these times is consonant with good practice.

Although there were few distinctive differences in interventions with patients of different faiths, some spiritual interventions are more deeply rooted in some religions than others. Faith affirmation, for example, tends to be given more emphasis among some denominations or religions than others. Muslims would be more likely to affirm their allegiance or faith in prayer than in secular words, and it would very unlikely for them to question their faith openly. Specific words said as blessings are generally less common among Protestants than among Catholics.

The data on Islamic patients also point out the possible effect of the denomination of the chaplain on the pastoral care process. Much of these data were generated by visits from one Imam, whose ministry with Islamic patients mainly focused on praying with them at prayer time. Other chaplains were far less likely to pray with Islamic

patients. Looking at this coin from the other side, is the relatively low incidence of prayer with Jewish patients simply a result of Jews not wanting to pray or the chaplains visiting them were most likely not Jewish?

CONCLUSIONS

The current study presents some of the first published data on the interventions that chaplains actually make with a broad range of patients in a range of medical facilities. It is again noteworthy that the great majority of the interventions were religious or spiritual in nature, confirming the unique role for chaplains on the healthcare team and the desire of a broad range of patients, including those who claim no religion, to receive this kind of care. Overall, it was remarkable how similar the interventions were across faith group and medical status. It is important to emphasize that, while the patients in each case were presumably receptive to the interventions, nothing in these results evaluates the effectiveness of the chaplain's interventions or even makes any judgments about whether they were the most appropriate, given the patients' needs.

Although these data represent the work of a large group of chaplains in a number of facilities, all of those facilities are in the New York City area with a patient population, which is known to be somewhat conservative religiously. How generalizable these results are across other demographics is unknown. In a larger frame, the results only beg but do not answer the question of whether there is a normative pattern of interventions for chaplains or whether that is even a reasonable question to ask.

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