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Chaplaincy Inclusion in Hospital Interdisciplinary Teams and Its Impact on Chaplains' Well-Being

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
2018

Abstract

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by

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MS, University of Maryland Baltimore County, 2009

BS, University of Maryland Baltimore County, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Health Services

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Abstract

Healthcare providers may impede the delivery of spiritual and emotional support to patients and their families by healthcare professional chaplains if they misunderstand how to effectively use chaplains, who often prefer to be engaged sooner than they are. This issue prevents highly trained, board-certified professional chaplains from providing services, thereby impacting the quality of patient care. The purpose of this phenomenological study was to examine, through the lived experiences of professional chaplains, the extent to which chaplains feel that others perceive them as valued members of an interdisciplinary team (IDT), as well as to determine how team inclusion may impact chaplains' physical and emotional well-being. An adaptation of the antecedents and outcomes of inclusion theoretical framework was used. Research questions were developed to elicit to what extent professional chaplains perceived that they were valued members of IDTs and what impact inclusion had on their well-being A semistructured interview protocol with open-ended questions was used with 9 board-certified professional chaplains in the northeastern region of the United States.. Data were analyzed through coding and comparison of significant responses into units of meaning to reflect the phenomenon of participants' experiences. Key findings revealed that inclusion did have an impact on the well-being of chaplains, and its impact was perceived as positive. This study may contribute to positive social change by helping to initiate training and education programs for healthcare organizations that work with and employ professional chaplains to effectively integrate chaplains into IDTs, ensuring more timely evaluation and care planning for patients and their families to achieve greater wholeness and healing.

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Dedication

This dissertation is dedicated to my Lord and Savior Jesus Christ, and to my paternal and maternal grandparents, parents, uncle, wife, and children. I cannot thank the Lord enough for what He has done, past, present, and what is yet to come.

A special feeling of gratitude to my loving parents, Mr. Kenneth Osita, G.O.N., BArch, and Mrs. Patience Eyiuche Nzegwu, BSN, RN, whose prayers and words of encouragement helped me stay the course.

In admiration, I also dedicate this dissertation to my late paternal grandparents, Mr. Lazarus and Mrs. Sophie Nzegwu, and maternal grandparents, Mr. George and Mrs. Patience Onyido, who laid a strong family foundation. It is with great joy that I represent the Nzegwu family of the late Mr. Lazarus and Mrs. Sophie Nzegwu as the first doctoral-level male PhD recipient.

With great appreciation, I dedicate this work to my dear late Uncle Lawrence "Larry" Uchenna Nzegwu, my namesake, who by the grace of God made it possible for my dad and his family to enjoy many opportunities in the United States. My Uncle Larry motivated me to be the best I could be and to not let any obstacles keep me from achieving my goals. I learned a great deal from his life that he shared with me, and for that I'm thankful. I also dedicate this work to my dear and loving late Aunt Dr. Christie Ifeoma Okeke, M.D., who involved me in her family practice at an early age.

Lastly, I dedicate this work to my wife and children. Being a husband and father is one of the greatest joys of life. I pray that my achievement is a springboard that you will use to go further and do even greater works. To my wife, children, Godchildren, and children in the Lord, I love you.

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This dissertation could not have been possible without my Lord and Savior Jesus Christ, whom I am forever indebted to and grateful for.

I would like to acknowledge my committee. My chair, Dr. Bewley, thank you for your support and joining me on the rest of this journey to the finish line. To Dr. Griffin, thank you for your insights and sticking with me from the beginning to the end. To my URR, Dr. Cain, thank you for your timely feedback. To my first former chair, Dr. Suz, thank you for your all-around support and sharing your experiences with me. To my second former chair, Dr. Carmoney, thank you for your intangible advice and reminding me of the most important things in life. Lastly, thank you to Dr. Tammy Root, who gracefully addressed my obstacles to this accomplishment.

I am thankful and grateful to all the organizations and participants who partnered with me and volunteered their time to provide their insightful input, and I pray this work helps to further chaplaincy's place in healthcare and the greater community.

An exceptional basketball team in 2016 lost their final game of the championship round, and their reigning MVP stated that even though they did not win the championship, you can still win at life. Achieving this great milestone in my life is one of many wins for me in life. I am a champion!

Finally, I would like to thank all my family, friends, and church family who have poured into me and who have helped me to be the God-fearing man I am today. This work could not have been without your support of love, prayers, encouragement, and presence along the way.

Table of Contents

ii

List of Tables

List of Figures

Chapter 1: Introduction to the Study

In 2010, the Patient Protection and Affordable Care Act (referred to as the Affordable Care Act [ACA]) was signed into law by President Obama (Shaw, Asomugha, Conway, & Rein, 2014). Under the ACA, the "focus" is patient centered, involving holistic care of the whole person mentally, socially, and physically (Cliff, 2012). In addition, The Joint Commission (TJC), a nonprofit nongovernmental organization whose mission is "to continuously improve healthcare for the public, in collaboration with other stakeholders, by evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value" (The Joint Commission, 2016), is helping to improve healthcare for the public by inspiring its stakeholders such as hospitals to focus on and address patients' cultural and personal values, beliefs and preferences, and religious and spiritual care (Cadge, Calle, & Dillinger, 2011; The Joint Commission, 2015). The healthcare industry recognizes the position of hospital chaplain as the primary spiritual-care professional (Chang et al., 2012; Jankowski, Handzo, & Flannelly, 2011) on an interdisciplinary team (IDT).

There are approximately 5,000 board-certified professional chaplains (Doblmeier, 2015) employed within the U.S. public and private healthcare system. These men and women provide essential nonmedical support and healing to patients each year as well as counseling to other healthcare staff (Koenig, 2012). As such, professional chaplains are members of hospital IDTs, yet they often face inclusion challenges, which potentially jeopardize the quality of patient care (Russell, 2014). Current literature lacks information about the extent to which professional chaplains feel included on hospital IDTs and the

impact of their inclusion perceptions on their physical and emotional well-being; therefore, it is imperative that an examination be conducted on these healthcare providers for a better understanding. This study investigated the extent to which professional chaplains feel that they are viewed as productive members of IDTs and how their perceptions regarding inclusion impact their physical and emotional well-being.

A better understanding of these highly skilled spiritual care providers may benefit patients and their families, in that it may promote more active involvement of professional chaplains in care planning and evaluation processes. In turn, this involvement may result in the spiritual and emotional needs of patients being addressed in a proper and timely way.

Chapter 1 opens with background information and a summary of the research literature related to the perceptions of professional chaplains on healthcare teams. In addition, Chapter 1 provides a statement of the problem that was the catalyst for the need to investigate the inclusion of professional chaplains on IDTs and the impact of inclusion on their physical and emotional well-being. I then present a discussion of the purpose of the study, followed by the research questions that operationalized the theoretical framework and underpinned the study. In a section on the nature of the study, I provide the rationale for the selection of a qualitative research design. Discussions of definitions and assumptions follow. The scope of the study is defined, followed by a description of the delimitations and limitations of the study. Finally, I identify the significance of the study and how it may contribute to advancing either or both practices and policies of professional chaplaincy, outlining the study's implications for social change.

Background

Various published studies have provided descriptions of chaplaincy's role within healthcare; this literature helps to describe the nature and scope of a chaplain's healthcare-team involvement. The provision of spiritual care over the last decade in the United States has shifted from religious communities to healthcare organizations (Swift, Handzo, & Cohen, 2012). Chaplaincy services in hospitals generally begin with a referral from a healthcare provider such as a nurse or physician (Swift et al., 2012; Winter-Pfandler, Flannelly, & Morgenthaler, 2011). Patients from all religious backgrounds are assessed (Koenig, 2012) using a spiritual assessment tool to gauge their spiritual care needs (LaRocca-Pitts, 2015; Trancik, 2013). Chaplains then provide spiritual care and evaluate outcomes (Proserpio, Piccinelli, & Clerici, 2011). Prayer, presence, and listening are forms of spiritual and emotional care (Cadge et al., 2011; Lyndes et al., 2012; Nolan, 2011). In addition to serving patients, chaplains address the spiritual needs of family members and hospital staff (Koenig, 2012; Taylor et al., 2015). The current literature provides information about chaplains' role, the services they provide, their contribution to healthcare teams, and settings where they provide their services, but this literature falls short of providing any evidence concerning how chaplains perceive their involvement on healthcare teams and what impact that these perceptions of involvement may have on their physical and emotional well-being.

Healthcare chaplaincy scholars have speculated that there is a positive correlation between spiritual care and health outcome (Farber, 2014; Russell, 2014). Recent studies have provided empirical evidence for the relationship between the two variables (Farber,

2014; Russell, 2014). There is little research regarding professional chaplains in healthcare and patient-centered care (Cadge et al., 2011; Russell, 2014). Studies in the disciplines of management and workplace diversity help to underscore the potential significance that inclusion may have for a chaplain's physical and emotional well-being. In reference to management, Shore et al. (2011) stated that poor inclusion could lead to psychological, emotional, behavioral, and health issues. In addition, poor inclusion could be exacerbated when the unique characteristics, perspectives, and knowledge of individuals are ignored (Shore et al., 2011). Chaplains bring unique skills to IDTs, such as empathetic listening and spiritual counseling (Cadge et al., 2011). Chaplains, in comparison to other IDT members, constitute a minority group whose members require special attention to ensure their integration within IDTs.

A national survey conducted on 35,000 Americans found that 77% had a religious affiliation and 55% said that they prayed daily (PEW Research Center, 2015). Of those surveyed, approximately 23% claimed no religious affiliation (PEW Research Center, 2015). In the midst of stressful life events, people (including those with no religious affiliation) are likely to engage in religious activities (HealthCare Chaplaincy, 2011). Piotrowski (2013) suggested that all humans are spiritual regardless of religious affiliation or lack thereof.

While physicians use medicine to relieve suffering, chaplains can relieve spiritual suffering through the provision of spiritual care (Piotrowski, 2013). This study was needed to ensure that professional chaplains who are specifically trained to deliver spiritual care can do so effectively and bring holistic healing to patients and their

families. More specifically, this study was needed to identify "best practices" and barriers associated with the inclusion of professional chaplains on IDTs. Finally, it was needed to better understand their level of inclusion on the IDT and how it impacts their physical and emotional well-being.

Problem Statement

In 2008, various healthcare chaplaincy leaders were assembled by the Commission on Quality in Pastoral Services, a division of the Association of Professional Chaplains (APC), a nonprofit professional association dedicated to the advancement of healthcare chaplaincy, in order to develop unified standards of practice for chaplains (APC, 2016). This initial collaboration produced the Standards of Practice for Professional Chaplains in Acute Care Settings, which the APC adopted. One of the key standards that directly related to the ACA was Standard 7: "Respect for Diversity: The chaplain models and collaborates with the organization and its interdisciplinary team in respecting and providing culturally competent patient-centered care" (APC, 2016). Subsequently, Standards of Practice for Professional Chaplains in Long-Term Care Settings and Standards of Practice for Professional Chaplains in Hospice and Palliative Care were developed and adopted by the APC in 2012 and 2014, respectively. These three sets of standards of practice showed more similarities than differences and served as a catalyst for change, necessitating a consensus for standards of practice irrespective of setting. In 2014, professional chaplains from various healthcare settings assembled by the Commission on Quality in Pastoral Services developed the Common Standards of Practice, which were accepted and approved by the APC board. In the newly developed

Common Standards of Practice, Standard 7 reads, “Respect for Diversity: The chaplain models and collaborates with other care providers in respecting and providing sensitive care regardless of diverse abilities, beliefs, cultures or identities” (APC, 2016). The existing literature lacks research explicitly addressing the chaplain’s inclusion in an IDT and the chaplain’s role concerning patient-centered care.

According to Farber (2014) and Russell (2014), healthcare chaplaincy scholars have speculated that there is a positive correlation between spiritual care and health outcome. New studies have provided empirical evidence for the relationship between the two variables (Farber, 2014; Russell, 2014). However, there is little research regarding professional chaplains in healthcare and patient-centered care (Russell, 2014). In a study conducted by Russell (2014), the results revealed that the provision of “pastoral care” suffered because most physicians misunderstood or lacked the knowledge needed to effectively use chaplains. Furthermore, Russell reported, chaplains preferred to be engaged sooner in the care of patients so that they might provide patients and their families “greater wholeness and healing” while lessening the burden of extensive patient care on providers. This issue prevents highly trained and board-certified professional chaplains from providing spiritual and emotional care, which ultimately impacts the quality of patient service (Russell, 2014).

Purpose Statement

The purpose of this phenomenological study was to examine, through the lived experiences of professional chaplains, the extent to which chaplains feel that others perceive them to be valued members of IDTs and to determine how these their

perceptions concerning inclusion may impact their physical and emotional well-being. Identification of factors that influence these experiences is essential to the development of programs or policies that assist them in flourishing and in improving patient care.

Professional chaplain inclusion is vital to healthcare because it fulfills the ACA and TJC recommendations for healthcare organizations to address the holistic needs of patients (Cadge et al., 2011; Patient Protection and Affordable Care Act, 2010), improve patient health outcomes (Blanchard, Dunlap, & Fitchett, 2012), and ensure health care quality for organizations that employ them (HealthCare Chaplaincy, 2011).

Research Questions

The following four research questions guided this investigation of the lived experiences and perceptions of professional chaplains and their inclusion within IDTs, as well as the impact of this inclusion on their physical and emotional well-being.

RQ1. With regard to their organization's climate, leadership, and practices, what are the perceptions of professional chaplains about their inclusion on the IDT?

RQ2. With regard to the perceptions of professional chaplains about their inclusion on the IDT, how does it affect their physical and emotional health status?

RQ3. What are best practices for full inclusion on the IDT?

RQ4. What are barriers to full inclusion on the IDT?

Theoretical Framework

The theoretical framework for this phenomenological study was an adaptation of the antecedents and outcomes of inclusion developed by Shore et al. (2011), illustrated in Figure 1, and was grounded in knowledge about workgroup inclusion and diversity within the field of management. The antecedents and outcomes of inclusion framework was based on the optimal distinctiveness theory (ODT) developed by Brewer (1991) within the field of social psychology. ODT, as Brewer described it, explores "human needs for validation and similarity to others (on the one hand) and a countervailing need for uniqueness and individuation (on the other)" (p. 477). Brewer explained that individuals have a need to balance between being similar to others and maintaining uniqueness (Brewer, 1991). This proposition is supported by Brewer's other findings that humans have a fundamental need to belong by maintaining healthy relationships that provide a sense of connection, preventing isolation that can occur for a sole individual (Brewer, 1991; Pickett, Silver, & Brewer, 2002). The theory provided the inclusiveness climate, inclusive leadership, and inclusiveness practices as constructs and boundaries to support this phenomenological research design. Lastly, the theory's constructs were operationalized by the research questions. Further explanation and details on the theoretical framework and its constructs are provided in Chapter 2.

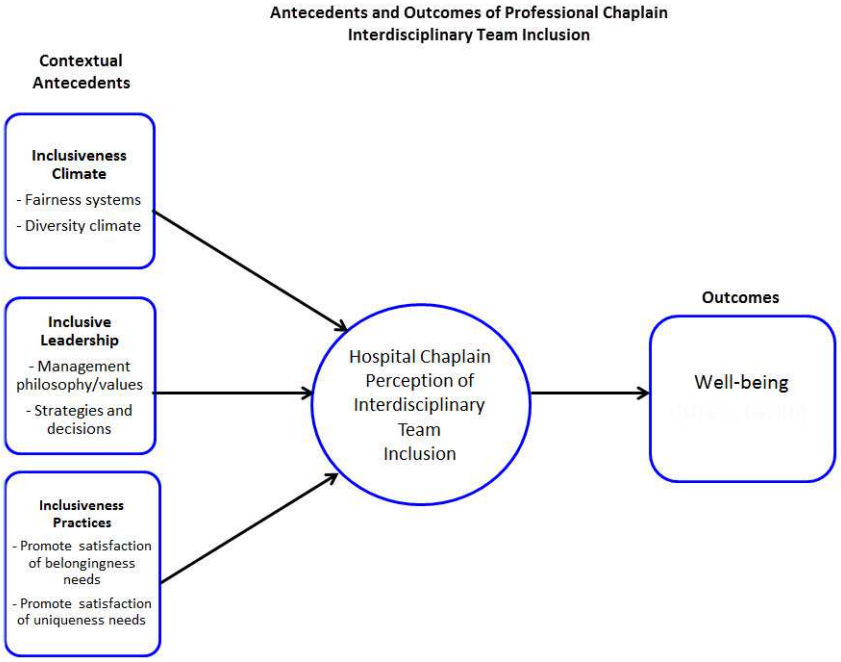

Figure 1. Theoretical framework. Adapted from "Inclusion and Diversity in Work Groups: A Review and Model for Future Research," by L. M. Shore, A. E. Randel, B. G. Chung, M. A. Dean, K. H. Ehrhart, and G. Singh, 2011, *Journal of Management*, *37*, p. 1276. Copyright 2011 by Sage Publications. Gratis use with permission from Sage.

Nature of the Study

A qualitative form of inquiry was conducted, and more specifically, a phenomenological research design was used. The rationale for using this methodology was driven by the need to thoroughly investigate the phenomenon and obtain rich descriptions of the lived experiences of professional chaplains on IDTs, as well as their perceptions of inclusion and inclusion's impact on their physical and emotional well-being. Phenomenological research designs aid in understanding and interpreting the lived experiences of participants within a specific context (Moustakas, 1994).

The key concepts investigated in this study were inclusion, well-being, organizational climate, organizational leadership, and organizational practices.

Specifically, inclusion, as it relates to this study, is the extent to which individuals perceive themselves as esteemed members of a team (Shore et al., 2011). According to Chou, Chu, Yeh, and Chen (2014), "well-being is a complicated concept" (p. 116). Scholars agree that well-being is subjective, describing it as *subjective well-being* (SWB) (Chou et al., 2014). For the purpose of this study, the dimensions of wellness (Garcia, 2015) were used to provide an operational definition of physical and emotional well-being. *Physical well-being*, as defined by Garcia (2015), involves "recognizing the need for physical activity, healthy foods and sleep," and *emotional well-being* is defined as "coping effectively with life and creating satisfying relationships" (p. 6). *Organizational climate* describes the environment of an organization based on its policies and procedures. *Organizational leadership* describes the internal organizational processes that are demonstrated by an organization's leader. Lastly, organizational practices describe the actions of the organization operationally (Shore et al., 2011).

Data were analyzed using descriptive coding, then codes were assigned to words or short phrases. Topics were generated and then indexed and categorized into themes (Saldaña, 2014). Meanings were extrapolated to investigate and better understand the lived experiences of the participants. Definitions of key terms that are both relevant and particular to this study and field of study are provided in the next section.

Definitions

This section introduced and defined key concepts and terminology pertaining to this study to ensure a common understanding.

Inclusion: The degree to which an employee (chaplain) perceives that he or she is an esteemed member of a workgroup (interdisciplinary team) through experiencing treatment that satisfies his or her needs for belongingness and uniqueness (Shore et al., 2011).

Inclusive leadership: Leadership with internal organizational processes that create inclusion and are demonstrated by the leader (Shore et al., 2011).

Inclusiveness climate: An environment where policies, procedures, and actions of the organization promote fair and consistent treatment of all groups, especially those that have fewer opportunities (Shore et al., 2011).

Inclusiveness practices: Practices that facilitate inclusion within a group (Shore et al., 2011).

Interdisciplinary team: A healthcare team composed of healthcare providers from separate disciplines who provide care during a single patient visit (Jessup, 2007).

Patient-centered care: Patient care that is patient-centered takes into consideration a patient's access to care, values and preferences, coordination of care, information, communication, education, physical comfort, emotional support, involvement of friends and family, and preparation for discharge and transitions in care (Balik, Conway, Zipperer, & Watson, 2011).

Professional chaplain: A multifaith (e.g., Christian, Muslim, etc.) board-certified chaplain who holds a college degree, is credentialed or commissioned by a religious organization, and has completed two or more supervised clinical pastoral education trainings and one full year of postgraduate employment in chaplaincy (Koenig, 2012).

For the purposes of this study, the term *professional chaplain* is synonymous with *healthcare chaplain*.

Spiritual care: Care provided to address nonreligious concerns involving existential and emotional experience (Candy, 2012). For the purposes of this study, spiritual care also represents the provision of pastoral care.

Assumptions

In this study, it was assumed that the professional chaplains selected would provide honest, accurate, and insightful responses to the interview questions. This assumption was necessary in order for the study to avoid respondent bias, which would have distorted the findings of the study. It was also assumed that the lived experiences of the selected professional chaplains were important to the study. The rationale for this assumption was that experiences would be best expressed by the individuals who had experienced the phenomenon. Lastly, it was assumed that the method and traditional concerns of reliability, generalizability, or validity would not distract from fully exploring the phenomenon throughout the data analysis.

Scope and Delimitations

After the passage of the ACA, patient centered-care became a focal point in healthcare; this approach includes addressing the patient's needs for spiritual and emotional care (Cliff, 2012). Professional chaplains are specifically trained to provide spiritual and emotional care (Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014). There is a lack of current research that provides any evidence of how chaplains perceive their involvement in healthcare teams and what impact this involvement may have on their

physical and emotional well-being. Shore et al. (2011) defined *inclusion* as "the degree to which an employee perceives that he or she is an esteemed member of the workgroup through experiencing treatment that satisfies his or her needs for belongingness and uniqueness" (p. 1265). In order to investigate the degree of involvement of professional chaplains within the healthcare team, I focused in this study on their perception of their inclusion and its impact on their physical and emotional well-being.

Chaplains in healthcare represent various ethnic, religious, age, and gender demographics (HealthCare Chaplaincy, 2011). Professional chaplains receive 1,600 hours of supervised training (Swift et al., 2012). They work in various types of healthcare facilities, such as community hospitals, academic medical centers, integrated delivery systems, freestanding hospitals, and specialty hospitals (HealthCare Chaplaincy, 2011). Professional chaplains generally get provisioned with computer access in their places of work (Goldstein, Marin, & Umpierre, 2011). For this study, professional chaplains of various ethnic backgrounds, religious faiths, ages, genders, and specialties who were proficient in the English language were considered. The professional chaplains selected for this study were also currently active professional chaplains who were working and had been employed within their respective hospitals' IDTs for at least one calendar year, which was arbitrarily selected because there is little or no known research supporting a specified minimum length of employment for professional chaplains. One year should provide sufficient time for professional chaplains to become well acclimated to their organizations and enable them to provide rich descriptions of their lived experiences. All acute hospital healthcare organizations that professional chaplains

worked for within the Maryland and District of Columbia area were included for consideration. All participants had completed the requirements to be board-certified professional chaplains. Professional chaplains who were not actively working, were not board certified, and/or had less than one full year of experience were not considered for this study. Nonprofessional chaplains (e.g., clergy, volunteer chaplains, etc.) did not fit the criteria for the study and were not considered. Lastly, nonprofessional chaplains were eliminated from the study because they had not completed the rigorous requirements for board-certified professional chaplains: certification by a healthcare chaplaincy association; completion of 4 years of college, 3 years of divinity school, and 2 or more years of clinical pastoral education; and an oral and written board examination with endorsement or commissioning from their denomination after 1 year of full-time practice (Koenig, 2012; Russell, 2014).

This study investigated the perceptions of inclusion of professional chaplains within IDTs and how their perceptions of inclusion may impact their physical and emotional well-being. *Negotiated order* is a theoretical framework developed by Anselm Strauss that helps to describe the negotiations that take place in an organization, such as those involving the definition of work, how it is done, who does it, how it is evaluated, and when it is necessary to reassess it (Allen, 1997). Employees' perceptions are partly influenced by their organization. The rationale for not selecting this framework was that it did not help to answer the research questions or provide a sufficient way to capture a participant's physical and emotional well-being. Institutional logics, a framework developed by Thornton, Ocasio, and Lounsbury (2012), was also considered for this

study because it helps in describing the behaviors of individuals and their organization within an institutional context. This framework not only describes how behaviors are regulated within this setting, but also provides opportunities for action and change. The rationale for not selecting this theory was that it did not provide the means to capture a participant's well-being as it relates to physical and emotional dimensions, focusing instead on individuals' belief systems and how they inform their interactions with other individuals (Thornton et al., 2012).

There are perceived limitations regarding the transferability of this study. It may be perceived that the findings of this study may be applicable to various settings in which chaplains work, as well as to nonprofessional chaplains or various chaplain teams. However, the findings from this study are not intended to be transferable.

Limitations

Phenomenological study designs present limitations such as the subjectivity of data, inability to completely prevent researcher bias, and those involving the need to present data in a way that is usable (Van Manen, 1990). Dependability is a limitation due to the subjective nature of the data, which makes it challenging to replicate a study with similar participants in a similar environment (Van Manen, 1990). Credibility is another limitation, due to the generally small sample sizes used (Patton, 2014). Additionally, transferability is a limitation because the data cannot be generalized to other similar environments (Van Manen, 1990). Participants need to be interested but also may have personal challenges in expressing themselves, such as English as a second language, age, health, or interview anxiety (Van Manen, 1990). Social desirability bias is a limitation

that is inevitable in social science research that involves gathering self-report data, in that the participants may respond in a way that they feel is socially acceptable (Nederhof, 1985). Finally, although I initially proposed the use of an independent researcher, I did not involve such an individual in this research study due to limited availability. As Saldaña (2014) posited, an independent researcher should be able to partake in qualitative research in the same capacity as a primary researcher, such as in interviewing participants.

Researcher bias and reactivity are two factors that could have influenced study outcomes (Maxwell, 2012). To address researcher bias, interview transcripts were validated by participants, allowing them to verify what they intended to say in order to avoid selecting data that favored me as the researcher (Maxwell, 2012). To address reactivity bias, it is first necessary to note that this influence cannot be eliminated but must be understood and used responsibly (Maxwell, 2012).

Reasonable measures were taken to address the limitations of this study. First, to best address dependability limitations, explicit detail was provided within the methods section of the study (Shenton, 2004). To best address credibility limitations, I employed saturation to conclude data collection (Simon & Goes, 2011), used well-established and adopted research methods, developed a relationship of trust prior to data collection with the participants' organization involved in the study, and used iterative questioning (e.g., probes), thick descriptions (Shenton, 2004), and member checks (Shenton, 2004; Van Manen, 1990). To best address transferability limitations, I used thick descriptions to allow readers to make their own best judgments as to whether the study can be applied in

a similar environment or not (Shenton, 2004). To address any personal participant interview issues, all interviews were recorded with permission by informed consent of the participants and transcribed with verification against the recording, then validated by the participants. Finally, to address social desirability bias, two methods were incorporated: careful wording of interview questions and a creative way to introduce the research (Ipsos MORI, 2012).

Significance of the Study

To create a true patient-centered culture, healthcare organizations need to promote interdisciplinary collaboration (Cliff, 2012; Russell, 2014). This study examined the perceived level of integration of professional chaplains on the IDTs of hospital care settings based on the lived experiences of the participants. More specifically, this study identified "best practices" and barriers associated with the inclusion of professional chaplains into care teams. Finally, I explored the impact that chaplains' level of inclusion had on them and how this impacted their physical and emotional well-being.

This study may serve as a catalyst for organizational reform by shedding light on issues related to the inclusion of professional chaplaincy within IDTs. More specifically, it is hoped that the findings will increase team awareness of the role and impact of professional chaplains in meeting the spiritual and emotional needs of patients, spur timely and appropriate involvement of professional chaplains in the provision of holistic care, and create or revise internal policies that better align with the aim of accreditation to ensure the active inclusion of hospital-based chaplains into the interdisciplinary team model. Equally important, the study provides an understanding of the physical and

emotional impact that professional chaplains feel based on their perceived level of team inclusion. This study contains several implications for social change. With attention focused on this topic, patients and their families may benefit from professional chaplains being actively involved in care planning and evaluation processes. In turn, this involvement may result in addressing the spiritual and emotional needs of patients in a proper and timely way.

An emphasis on the need to include professional chaplains on the interdisciplinary team would serve the best interest of society. According to a Gallup poll finding, more than 9 out of 10 Americans believe in God (Newport, 2011). The study reflected a 95% confidence level and a margin of error of $\pm$ 4 percentage points (Newport, 2011). With such a significant portion of the population believing in God, it would stand to reason that many would want to study the active inclusion of professional healthcare chaplains in IDTs charged with meeting their patients' holistic needs. Finally, it is believed that the findings from this study will serve as a catalyst for future empirical studies that will advance the healthcare chaplaincy profession.

Summary

Chaplains offer a unique opportunity to help healthcare organizations fulfill ACA and TJC patient-centered recommendations to treat the whole patient, which includes addressing their emotional and spiritual care (Cadge et al., 2011). The majority of the available research on chaplains in healthcare has been directed at services that chaplains provide, how they provide them, their role, and more recently, evidence-based research

on the efficacy of their services, leaving a gap in the literature regarding how inclusion may impact them and their well-being.

The passage of the ACA in support of patient-centered care underscores the importance of the need to investigate professional chaplains and their inclusion on IDTs and what impact this inclusion has on their physical and emotional well-being. A better understanding of this topic may benefit patients and their families by supporting professional chaplains' active involvement in assessment and treatment plans. Thus, this involvement may bring about the best, most timely provision of spiritual and emotional care services.

The literature review that follows in Chapter 2 provides background and synthesis of current literature regarding chaplains in healthcare, chaplains and their integration on healthcare teams, and the challenges that chaplains face. More specifically, it addresses how involved in healthcare teams chaplains are and how inclusion may impact their physical and emotional well-being. An adaption of the antecedents and outcomes of inclusion framework was applied to the literature to illustrate the current state of chaplains within healthcare teams.

Chapter 2: Literature Review

Introduction

Professional chaplains are specially trained to deliver spiritual care, but their level of inclusion on healthcare teams may hinder their provision of spiritual care, causing the quality of patient care to suffer (Russell, 2014). The purpose of this phenomenological study was to examine, through the lived experiences of professional chaplains, the extent to which they felt that others perceived them to be valued members of IDTs and to determine how these perceptions may impact their physical and emotional well-being in hospital settings located in the Maryland and the District of Columbia area.

Current literature indicates that the potential for chaplains to deliver spiritual care is based on competing external factors such as role ambiguity by other healthcare providers, discretion over referrals by other healthcare providers, and higher patient-to-chaplain ratios (Galek, Flannelly, Greene, & Kudler, 2011; Hall, Shirey, & Waggoner, 2013; Swift et al., 2012). At the discretion of physicians and various other providers, chaplains may be summoned when patients are dying or in need of spiritual support, but they are rarely called to address broader issues such as patients and family members dealing with negative feelings or psychosocial issues (Winter-Pfandler et al., 2011). Chaplains in some settings receive referrals (Swift et al., 2012). Nurses are among the primary providers who refer to chaplains on behalf of patients (Winter-Pfandler et al., 2011). In some healthcare organizations, the ratio of patients to chaplains is overwhelming, and a spiritual assessment of each patient is not possible (Blanchard et al., 2012). Various leaders of healthcare organizations give the role of chaplain less

consideration (Proserpio et al., 2011). Swift et al. (2012) posited, that there is a direct correlation between a chaplain's ability to perform effectively and full healthcare team integration.

Chapter 2 provides a synthesis of the research literature as it relates to the inclusion of chaplains in healthcare teams and its impact on their physical and emotional well-being. A detailed description of the iterative literature search process, key search terms, and databases used is provided to aid in the replicability of this research study. A review of the theoretical framework and the foundational theory is given, and the constructs that support the research are also discussed. In addition, a review of factors from the current literature that relate to the research study is given. Lastly, from the current literature, significant themes are summarized and explained, along with a plan to address the perceived gap in the literature and how this study fits into the existing body of literature.

Literature Search Strategy

A literature search conducted on the research topic provided articles for the literature review identified in ProQuest Central, ProQuest Health & Medical Complete, and ProQuest Nursing and Allied Health Source (a full listing of databases and search engines used is provided in Appendix A). The scholarly peer-reviewed articles identified for this review were published over the last 5 years and in the English language. The key search terms used for the literature search were as follows: *pastoral care*, *chaplain*, *interdisciplinary*, *antecedents and outcomes of inclusion*, *optimal distinctiveness theory*, *organizational climate*, *organizational leadership*, *organizational practices*, *inclusion*,

well-being, and *wellness* (a full listing of key search terms and combinations of search terms used is provided in Appendix B). The literature search identified 129 articles, 78 of which were selected and used for the purposes of the literature review.

The 78 articles selected and used were characterized as qualitative or quantitative, with the majority being qualitative in nature. An initial key search term showed that there were various articles that could possibly relate to the research topic. The search process relied heavily on combinations of key search terms (e.g., hospital AND pastoral care OR chaplain) to narrow the results in order to identify germane scholarship. Filters were then set to narrow the results further. The filters used were limited to search for works published in the past 5 years, works in the English language, and scholarly (peer-reviewed) journals and articles. The article titles in the results were read to ascertain to what degree they related to the research topic. Lastly, abstracts were read to determine to what degree the articles related to the research topic, and then I made a decision to select or reject the articles.

Theoretical Foundation

Introduced in Chapter 1, the theoretical framework for this study was an adaptation of the antecedents and outcomes of inclusion framework developed by Shore et al. (2011) and illustrated in Figure 1. The theory is grounded in the knowledge of workgroup inclusion and diversity within the field of management. The authors developed the theory based on Brewer's ODT (Brewer, 1991; Shore et al., 2011). ODT was developed by Brewer (1991) within the field of social psychology. ODT, as Brewer described it, explores "human needs for validation and similarity to others (on the one

hand) and a countervailing need for uniqueness and individuation (on the other)" (p. 477). Brewer explained that individuals have a need to achieve balance between being similar to others and maintaining uniqueness. This proposition is supported by Brewer's other finding that humans have a fundamental need to belong by maintaining healthy relationships that provide a sense of connection, preventing isolation that can occur from being a sole individual (Brewer, 1991; Pickett, Silver, & Brewer, 2002). Based on Brewer's ODT definition, the authors built upon it and derived their framework of inclusion to conduct a review of inclusion and diversity literature. Shore et al. (2011) defined *inclusion* as "the degree to which an employee perceives that he or she is an esteemed member of the workgroup through experiencing treatment that satisfies his or her needs for belongingness and uniqueness" (p. 1265). From the authors' literature search, an extrapolation of potential contextual factors and antecedents, and outcomes were reported as having the potential to determine one's perception of inclusion. Contextual factors (e.g., climate, leadership, and practices) create the "stimuli" that aid individuals in developing their perceptions (Shore et al., 2011). Unlike the existing literature, the authors focused strictly and solely on belongingness and uniqueness. Shore et al. (2011) posited, that inclusiveness climate, inclusive leadership, and inclusiveness practices are contextual factors that may contribute to perceptions of inclusion. These three constructs help in formulating the concept of inclusion. In developing this framework, the authors highlighted several potential outcomes of inclusion, such as better relations with group members and supervisors, job satisfaction, intention to stay, job performance, organizational citizenship, organizational commitment, well-being,

creativity, and career opportunities for diverse individuals (Shore et al., 2011). According to the authors, this framework provides a platform for future research. This platform was the platform that I, as the research practitioner in this research study, used to investigate the outcome of well-being as it relates to the inclusion of professional chaplains on IDTs and the impact of such inclusion on their physical and emotional well-being. Although there are no existing studies using this theory, the available literature provides studies using the constructs of inclusiveness climate, inclusive leadership, and inclusiveness practices, on which it was developed.

Inclusive Climate

According to Shore et al. (2011), an *inclusiveness climate* is an environment where policies, procedures, and actions of an organization adhere to fair and consistent treatment of all groups, especially those whose members have fewer opportunities. Chaplains may be considered a minority group within IDTs and could benefit from an inclusive climate. Studies conducted over several years by the American College of Healthcare Executives (ACHE), a healthcare management association, found that there are still perceived disparities based on race and ethnicity in healthcare workplaces (Athey, 2015). Chaplains, compared to other providers, could be considered a minority group with fewer opportunities, given that their profession has only been professionalized for a little more than a decade (HealthCare Chaplaincy, 2011). Chaplains are the only specialized spiritual care and emotional support providers on healthcare teams (Jankowski et al., 2011), and the chaplain-to-patient ratio in healthcare organizations is generally minute (Galek et al., 2011). A study conducted on inclusion in workplaces

found that programs that motivated inclusion received positive perceptions in terms of diversity climate (Wolfson, Kraiger, & Finkelstein, 2011). While chaplains may be few, inclusive organizational climates may help their perception of inclusion.

If chaplains are considered a minority group within the IDT, they are underrepresented. Membership in a traditionally underrepresented group defines diversity (Bond & Haynes, 2014). The workforce has become increasingly diverse (Downey, Werff, Thomas, & Plaut, 2015). Downey et al. (2015) reported that the results in their workplace diversity study revealed that organizations should foster an organizational climate that is inclusive of diverse individuals in order to maximize diversity. The hospitality industry is a specific work industry with an increasingly diverse workforce (Madera, Dawson, & Neal, 2013). A study conducted by Madera et al. (2013) revealed that managers benefit from a diverse climate. A diverse group such as chaplains would most likely benefit from an organizational climate that supports diversity.

Organizational climates could potentially affect the way in which chaplains practice. In a study on nurses and organizational climate conducted by Roch, Dubois, and Clarke (2014), qualitative results showed that poor organizational climate negatively affected nurse practices within the IDT. Challenges included other IDT members not being able to define their role, having their contributions devalued by other IDT members (e.g., physicians), feeling overwhelmed by workload, and facing ambiguity about their role (Roch et al., 2014). In contrast, another study on the collaboration between healthcare providers showed that a supportive work environment helped interdisciplinary

collaboration (Kobayashi & McAllister, 2014).The provision of spiritual care by chaplains could be negatively or positively impacted based on an organization's climate.

Based on the aforementioned studies, an inclusive climate plays a vital role in this research study because it may help to investigate the environment in which professional chaplains work and provide their services. An inclusive climate may either support or hinder a chaplain's practice.

Inclusive Leadership

Inclusive leadership begins with internal organizational processes that create inclusion and are demonstrated by the leader (Shore et al., 2011). A chaplain director or healthcare administrator may need to demonstrate an inclusive behavior. Direct supervisors are leaders who directly manage employees, and their behavior needs to reflect the organization's inclusion values (Shore et al., 2011).

Healthcare management demonstrates how inclusive leadership garners a positive response from employees. The results from a 2014 ACHE survey on diversity inclusion in healthcare indicated that increasing diversity in senior leadership, offering residencies, and offering fellowships were highly favored by respondents (Athey, 2015).

A group of leaders share in contemporary leadership (Baker, 2014). Organizations benefit from using a diverse body of leaders. Inclusion also makes for a more collaborative workplace (Baker, 2014) and is a must in the modern organization (Katz & Miller, 2014). In a case study conducted on disability inclusion, Devine (2012) noted that a "top-down" approach was effective as followers modeled leaders. Leaders of a faith-based community in another study found that the most critical variable was their

commitment to inclusion (Griffin, Kane, Taylor, Francis, & Hodapp, 2012). Organizations are recognizing that leaders need to have an urgency toward change and be different because they influence the organization first toward change (Katz & Miller, 2014). From their organizational work experience, Katz and Miller (2014) found seven ways in which a leader could transition to a more inclusive leadership style. Katz and Miller stated that employees should be approached as allies, cared about and held accountable, partnered with to cocreate a workplace, encouraged to make problems visible and solve them at their root cause, encouraged do what is right and challenge the status quo, guided, coached and taught; and finally allowed to interact and develop trust.

Inclusive leadership was vital to this research study because leaders have a strong influence on the perception of inclusion among their employees (Shore et al., 2011). By investigating inclusive leadership in this study, I sought to better understand how a hospital's leadership influences the perception of professional chaplains within IDTs.

Inclusiveness Practices

Inclusiveness practices are practices that facilitate inclusion within a group (Shore et al., 2011). Inclusiveness practices, as Shore et al. (2011) posited, support belongingness and uniqueness needs. Shore et al. argued that belongingness and uniqueness are precursors to perceptions of inclusion and benefit any organization's effort to improve practices that may improve outcomes due to inclusion. Also known as *optimal distinctiveness*, it describes how an individual attempts to reconcile between his or her sense of belongingness and uniqueness within the group (Brewer, 1991, 1993). In a diversity study conducted by Wolfson et al. (2011), results showed that a diverse

climate had a positive relationship with improved race relations (between White and non-White employees), empowerment, and organizational commitment. Chaplains are unique because they are the only spiritual support experts on IDTs (Jankowski et al., 2011). Inclusive practices may ensure that professional chaplains' unique services are understood and that they have a sense of belonging as members of IDTs.

The importance of inclusiveness practices in this study was that they directly impact the influence of an organization's employees (Shore et al., 2011). Investigating inclusiveness practices for this study aided in identifying how an organization's practices shape a professional chaplain's perception of his or her inclusion.

Well-Being

According to Chou et al. (2014), "well-being is a complicated concept" (p. 116). Scholars agree that well-being is subjective, describing it as subjective in nature or using the term *subjective well-being* (SWB; Chou et al., 2014; Diener, 1984; Kirsten, Van der Walt, & Viljoen, 2009; Rodríguez-Muñoz & Sanz-Vergel, 2013). Well-being or wellness is composed of many dimensions. For the purposes of this study, I have used the term *well-being*. Well-being is multidimensional, and the number of dimensions varies from author to author (George & Taylor-Gooby, 1996; Horton & O'Fallon, 2011; Horton & Snyder, 2009; Nita, 2015; Wood et al., 2011). The consistent and prominent dimensions of well-being across various authors are physical, emotional, spiritual, intellectual, social, and environmental (Garcia, 2015; George & Taylor-Gooby, 1996; Horton & O'Fallon, 2011; Horton & Snyder, 2009; Wood et al., 2011). The central concept of this research study was well-being with a specific focus on physical and emotional well-being

dimensions. For the purpose of this study, *physical well-being* was defined, with reference to the work of Garcia (2015), as "recognizing the need for physical activity, healthy foods and sleep," and emotional well-being was defined as "coping effectively with life and creating satisfying relationships" (p. 6).

Previous studies on well-being and work-related environments are well documented but were generally conducted as cross-sectional studies (Chughtai, Byrne, & Flood, 2015; Duffy, Allan, Autin, & Douglass, 2014; Dunlop, 2015; Elovainio et al., 2015). Well-being has been explored in relation to mental health (Wood et al., 2011), medical laboratory (Narainsamy & van Der Westhuizen, 2013), health center, hospital (Kanste, 2011), and private enterprise (Chou et al., 2014) settings. Further, well-being has been explored at an occupational level, with research focusing on shop assistants, nurses, administrative staff, software engineers, lawyers, consultants, blue-collar workers (Meier, Semmer, & Gross, 2014), and physicians (Elovainio et al., 2015).

As aforementioned, Shore et al. (2011) suggested inclusiveness climate, inclusive leadership, and inclusiveness practices as contextual antecedents that may contribute to perceptions of inclusion, which impact various outcomes such as well-being. Previous studies have supported the use of an antecedents of well-being framework (Pereira & Coelho, 2013). In previous studies, antecedents of well-being varied, encompassing subjective well-being (Chou et al., 2014; Pereira & Coelho, 2013), work engagement and emotional exhaustion (Chughtai et al., 2015; Kanste, 2011; Kozusznik, Rodríguez, & Peiró, 2015), burnout, employee engagement, and occupational stress and job satisfaction (Narainsamy & van Der Westhuizen, 2013).

The significance of using this theoretical framework is that it aligns with the focus of the research study about the "inclusion" of the individuals being investigated. Previous chaplaincy research, which closely related to this study, focused on collaboration (Powell et al., 2015), or the role of chaplains on healthcare teams (Fitchett et al., 2011; Kobayashi & McAllister, 2014), rather than inclusion. The collaboration related studies focused on how chaplains function alongside other healthcare team members. Other conceptual frameworks in other fields such as social work and business administration were considered, but neither held a high goal of "inclusion" as did the selected theoretical framework. The theoretical framework most suited for this study is the "antecedents and outcomes of inclusion" (Shore et al., 2011) framework. The antecedents and outcomes of inclusion model is a framework developed by Shore et al., previously used to study perceptions of inclusion and diversity in the field of management (Shore et al., 2011).

The antecedent and outcomes of inclusion framework and its constructs inclusiveness climate, inclusive leadership, and inclusiveness practices help to frame the environment that possibly contributes to the chaplain's perception of their inclusion. Furthermore, this framework coupled with a phenomenological research design has the potential to help better understand the deeper meaning of the impact of inclusion on the chaplain's physical and emotional well-being. The constructs of the theoretical framework are operationalized in the research questions to gather self-report data from professional chaplains and their lived experience.

Chaplains in Healthcare

The evolution of chaplains from local religious establishments to an integral member of the healthcare team has spanned over several decades (Handzo et al., 2014). According to Doblmeier (2015), there are about 5,000 board certified professional chaplains in North America. The American Hospital Association (AHA) states that within the United States, chaplaincy services are provided in more than two-thirds of the hospitals (Winter-Pfandler et al., 2011). Chaplains consist of a variety of faiths, professions, and backgrounds (Shackleton, 2012). Some chaplains enter chaplaincy as they feel led by God (Feldstein, 2011), taking roles or positions such as ordained clergy, counselors, teachers, social workers, psychologist, or enter into full-time ministry. Chaplaincy requires faith, demanding much of a person spiritually and physically; because of this demand, not everyone can be a chaplain (Adrian, 2013). Chaplains reside in various healthcare settings such as hospitals, hospices, palliative care and government subsidized Veteran Affairs health system (Kobayashi & McAllister, 2014; Margaret & Lee, 2011; Yan & Beder, 2013).

Requirements for Professional Chaplaincy

Chaplains within the healthcare team are professional chaplains who are board certified (Koenig, 2012). Board certification and supervised training are mandates for professional chaplaincy (Koenig, 2012). In order to fulfill the requirements of a board-certified professional chaplain, a chaplain must be certified by a healthcare chaplaincy association, successfully complete four years of college, three years of divinity school (generally a Master's of Divinity degree from an accredited theological school), two or more years of clinical pastoral education (with 1,625 hours of clinical supervision in

counseling), an oral and written board examination with endorsement or commissioning from their denomination after one year of full time practice (Koenig, 2012; Russell, 2014). Certification is conducted by one of the five major (or equivalent) certifying healthcare chaplaincy associations, Association for Clinical Pastoral Education (ACPE), Association of Professional Chaplains (APA), Canadian Association for Pastoral Practice and Education (CAPE), National Association of Catholic Chaplains (NACC), and National Association of Jewish Chaplains (NAJC) (HealthCare Chaplaincy, 2011). The Association of Professional Chaplains (APC) is one of the most prominent associations for chaplaincy in the United States, which many chaplains have a membership (Fairweather, 2011; Koenig, 2011; Shackleton, 2012).

The Standards of Practice for Professional Chaplains

Chaplaincy grew as a profession through the development of standards of practice (LaRocca-Pitts & Overvold, 2011), certification and training, establishing itself beyond traditional settings. In 1940, Russell Dicks was the first to develop and propose standards for professional chaplains (HealthCare Chaplaincy, 2011). Over several decades, the standards of practice for professional chaplains evolved but still reflect the chaplain's responsibility to the hospital and care of the patient.

Professional chaplains assume a general workflow, which reflects their standards of practice across various settings when engaging in patient care. Generally, they begin with a spiritual assessment of the patient using a spiritual assessment tool. There are various spiritual assessment tools that aid in understanding a patient's spiritual health at the time of admission or throughout the care process (LaRocca-Pitts, 2015; Lennon-

Dearing, Florence, Halvorson, & Pollard, 2012; Trancik, 2013). Once the assessment is complete, they create and implement a plan of care. The spiritual health status of the patient is documented (Goldstein et al., 2011). The chaplain continues to work in collaboration with other healthcare providers, respecting them and their diverse abilities while promoting the spiritual wellness of the patient (Association of Professional Chaplains, 2016). The chaplain will also ensure they are adhering to ethical practices as affirmed in the APC Code of Ethics and other codes as required by their health organization where they are employed (Association of Professional Chaplains, 2016). The chaplain throughout care ensures all patient, legal and health organizational records remain confidential and upholds all federal and state regulations and rules (Association of Professional Chaplains, 2016). Chaplains generally follow this basic workflow across various settings, which reflect their standards of practice.

The Role of the Chaplain in Healthcare

Traditionally, the role of the chaplain focused on addressing religious and spiritual needs through prayer and concerns such as death and dying of the patient, family, friends and their local ministry (Proserpio et al., 2011; Trancik, 2013; Winter-Pfandler et al., 2011). In this role, the chaplain provides their support to all patients and family members regardless of their faith practice or lack thereof (James, Cottle, & Hodge, 2011). In contemporary healthcare, chaplaincy expanded beyond the hospital setting to include hospices and palliative care. In these cases, their role is more pronounced on specialty teams such as the hospice IDT where they disseminate information (Sibbald, Wathen, Kothari, & Day, 2013) collaborate, encourage, and provide conflict

management. The role of the chaplain also expanded to include patient safety and advocacy, crisis intervention, ethical consultation/deliberation, life review, patient advocate and counselor (Feldstein, 2011; Maddox, 2012). In their expanded role, chaplains like their fellow healthcare team members, also access patient medical records and document in the patient's electronic medical record (EMR) or paper chart (Goldstein et al., 2011). The scope of the chaplain's EMR access provides them a user account with the access level of a social worker which allows them to create patient notes such as spiritual assessments (Goldstein et al., 2011).

Chaplains provide various support services to patients, families and the staff of their respective health organizations. Chaplain services include spiritual and emotional support, bereavement counseling, and mediation (Nolan, 2011). The aforementioned services were described by chaplains as wholeness, presence, and healing (Cadge et al., 2011; Lyndes et al., 2012; Nolan, 2011). Chaplains bring wholeness through prayer, provide a presence through listening, and heal through emotional support (Cadge et al., 2011; Lyndes et al., 2012; Nolan, 2011). To the patient, the chaplain serves as a faithful companion (Maddox, 2012), comforter, presence, storyteller (Feldstein, 2011), especially during difficult medical circumstances. To the family, chaplains serve as a mediator between patients, families, as well as the healthcare team (Sibbald et al., 2013). To fellow staff members chaplains also provide counseling, debriefing, and moral support (Lyndes et al., 2012; Russell, 2014). According to Willis and Limehouse (2011), nurses are known to be one of the primary staff consumers of chaplain services, which help nurses recoup from their sometimes very emotional and draining work. Chaplains may be

valuable to healthcare organizations. According to Winter-Pfandler et al. (2011), a national survey of hospital directors in the United States was conducted, and results showed they held chaplains and their services in high regard especially in providing spiritual and emotional support at periods of grief and death. Chaplain services reach a broad group potentially making them more highly sought after.

Chaplains Within the Healthcare Team

According to Swift et al. (2012), there was a shift from religious affiliation and authority in western countries in the mid-twentieth century. Chaplains responded to this shift by expanding their faith understanding to meet the needs of more patients (Swift et al., 2012). Within the healthcare team, chaplains are considered the primary spiritual care professional (Jankowski et al., 2011).

Chaplains and the Interdisciplinary Team

Contemporary healthcare in the United States favors the use of IDTs, as Villagran and Baldwin (2014) defined, it is a team of expert healthcare providers from various disciplines coordinating care by information sharing and joint decision making for the best health outcome for patient-centered care (Kapo, Crawford, Jeuland, & Blatt, 2015). The foundation of an IDT is its diversity of expert providers, which supports the notion that various expert healthcare providers with their expertise and background can better address more complex health issues (Kapo et al., 2015; Nancarrow et al., 2013). Included in the IDT are physicians of various specialties, nurses, social workers, chaplains and other various staff members.

Chaplains may be a symbol of patient advocacy. On the IDT, hospital chaplains advocate on behalf of the patient and their psychosocial and spiritual needs. The chaplain brings knowledge and expertise about psychosocial and spiritual matters (Margaret & Lee, 2011). Various members of the IDT hold communication meetings with families as they partner with the patient's family to develop a customized plan of treatment to address the patient's health issue (s) (Goldsmith, Wittenberg-Lyles, Ragan, & Nussbaum, 2011). Chaplains take part in these meetings and ensure patient, and family desires are met, such as religious practices (Taylor et al., 2015). As a patient advocate, chaplains support the patient on the IDT and in some meetings that involve families of the patient.

In addition to patients and families, hospital chaplains also provide spiritual care and support to team members. As a member of the IDT, chaplains are considered both formal and informal spiritual advisors and group mediators making hospital chaplains an essential cohesive component of the healthcare team (Taylor et al., 2015). On the one hand, a spiritual advisor, team members relied on chaplains to provide spiritual guidance and encouragement (Willis & Limehouse, 2011). On the other, a group mediator, hospital chaplains manage team conflict and provide individualized spiritual care (Willis & Limehouse, 2011). In high-stress environments such as healthcare, hospital chaplains can be a source of spiritual calm and psychosocial euphoria for patients and staff.

Chaplains provide additional expertise to the IDT. Chaplains generally address the spiritual needs of patients (Powell et al., 2015). The effectiveness of the IDT comes from utilizing expert healthcare providers with varied expertise and professional roles in coordinated care (Villagran & Baldwin, 2014). As Villagran and Baldwin (2014) posited,

the makeup of each member such as their training, expertise, background, and affiliation produces the outcome of the team's collaborative goal. Interdisciplinary teams compiled of expert providers are necessary to address complex patient health conditions (Klipfel et al., 2014; Leclerc et al., 2014; Tremblay et al., 2014). Chaplains and the spiritual support they provide is a unique contribution to patient care in conjunction with their IDT members.

A chaplain as a member of the IDT may benefit other health providers. From a holistic perspective, Savel and Munro (2014) posited, in addition to addressing patient psychological needs, their spiritual needs should be addressed, which is often forgotten. As a nurse and physician, Savel and Munro (2014) state being aware of the patient spiritually may remind healthcare providers of their own spirituality or to find it and provide more focus on the patient. Spiritual awareness may also allow them to discern whether the patient needs a referral for chaplaincy services (Savel & Munro, 2014). Lastly, healthcare providers being spiritually aware can better understand why patients prefer and do not prefer certain medical services (Savel & Munro, 2014). Spiritual awareness could add another dimension to healthcare providers and their referring to chaplains.

An IDT may best support chaplains and the services they provide. The provision of spiritual care can be complex (Leclerc et al., 2014). Through an interdisciplinary, holistic approach, hospital chaplains can better address these complex psychological and spiritual needs of patients as well as their families (Leclerc et al., 2014). As Myers (2014) conveyed, there is mounting evidence on the positive outcomes of caring for a patient's

emotional and spiritual needs, giving chaplains a unique opportunity to make a valuable contribution. Being part of the IDT may allow chaplains to be most effective in their delivery of services allowing them to contribute to patient care in conjunction with other IDT members.

Other Members of the Interdisciplinary Team

Interdisciplinary teams are a collaboration of various healthcare providers with various specialized skills and backgrounds (Kapo et al., 2015). The various types of healthcare providers depend on the healthcare setting. Generally, the IDT is comprised of physicians, nurses, social workers, and chaplains. In some models of team-based care, physicians and nurses are categorized as 'active caregivers,' while social workers and chaplains are in the 'basic supportive caregivers' category, followed by 'community support' such as staff and family members (Ueno, Ito, Grigsby, Black, & Apted, 2010).

According to Villagran and Baldwin (2014), IDTs consist of a hierarchy structure and are generally directed by physicians. IDTs that have multiple physicians, typically delegate the senior physician with team lead responsibility (Sibbald et al., 2013). In a study conducted on IDTs by Sibbald et al. (2013), results showed team lead physicians typically took responsibility to obtain and implement new health research, although it is deemed the responsibility of each member. This demonstrates the influence physicians may have on the IDT. Physicians may also take the lead in care planning meetings with other IDT members (Goldsmith et al., 2011). Some studies show that patients do appreciate physicians inquiring about their spiritual needs (Pearce, Coan, Herndon, Koenig, & Abernethy, 2012), which may lead to physicians involving chaplains for

spiritual assessment (Lyndes et al., 2012). Physicians may lead on the IDT as one of the primary providers of patient care.

Interdisciplinary teams typically include nurses. Nurses communicate developments of the patient's care between healthcare providers (Klipfel et al., 2014). Nurses are caring and compassionate individuals that are committed to providing the best quality of care possible (Ndoro, 2014). Nurses in the Sibbald et al. (2013) study were noted as very knowledgeable and trustworthy. Compared to other healthcare providers, nurses generally have the most patient contact, which allows them to build relationships with patients (Ueno et al., 2010). This supports the notion about nurse communication skills in handling patient developments. In some healthcare settings, nurses are the primary sender of referrals to chaplains (Winter-Pfandler et al., 2011). Nurses tend to work in a complementary manner with chaplains; one reason possibly is that a portion of their training includes spirituality (Winter-Pfandler et al., 2011). Nurses play a great role as a communicator on the IDT and are essentially its glue with an abundance of patient care information.

Interdisciplinary teams generally have social workers as a secondary care provider or patient representative (HealthCare Chaplaincy, 2011). Like chaplains, social workers provide their services to patients holistically (Cadge et al., 2011). The roles of the social worker and chaplain can be challenging to distinguish at times but is distinguishable. The role of the social worker is distinguished by the needs they address for the patient, such as housing and lively upkeep (e.g., bills, child care, appointments, etc.)(Cadge et al., 2011). Social workers assist patients between transitions of care for the e.g., hospital to

home while ensuring patient satisfaction is met and costs are kept low (Margaret & Lee, 2011). Like a chaplain, social workers may provide spiritual support and emotional care services (HealthCare Chaplaincy, 2011; Koenig, 2012), but in a study conducted by Cadge et al. (2011), a physician stated chaplains can provide spiritual support more readily because social workers sometimes cannot, due to their overbearing practical duties pertaining to housing and lively upkeep (Koenig, 2012). Social workers provide referrals for chaplains (Jankowski et al., 2011), and maybe a preferred provider to do so because of how well they collaborate with chaplains. Some physicians feel it is not their position to send referrals for chaplains but desired the task be left to social workers (Cadge et al., 2011). Social workers and chaplains generally work well together as members of the IDT (Lyndes et al., 2012).

Interdisciplinary Versus Multidisciplinary Team

Contemporary healthcare in the United States has shifted towards a team-based approach with various approaches being used to best address the needs of the patient, who is at the center of care. Various team-based approaches were used and documented, but the majority of terms which describe them are not well understood. They were used incorrectly or interchangeably, while each team-based approach is different from the other (Jessup, 2007; Leclerc et al., 2014).

The terms “interdisciplinary team” and “multidisciplinary team” are commonly used interchangeably but are quite different. A multidisciplinary team consists of various healthcare providers of various disciplines who treat a patient “independently” using their care plan (Jessup, 2007; Leclerc et al., 2014). Interdisciplinary teams, consist of various

healthcare providers of various disciplines similar to a multidisciplinary team, but who "collaborate together" to treat a patient "at the same time using a jointly created" patient-centered plan (Jessup, 2007; Leclerc et al., 2014).

The primary distinction of true interdisciplinary teams is the shared responsibility of collaborative decision-making and health outcomes for patient-centered care (Jessup, 2007). The goal of the IDT is to coordinate patient-centered care amid the complex healthcare environment of an organization such as roles, structures, and regulations (Villagran & Baldwin, 2014). It is also believed the use of inter-professional healthcare providers better addresses more complex health issues (Tremblay et al., 2014). As complex as the environment in which an IDT operates in, the process itself is complex as various healthcare providers collaborate sharing expertise, knowledge, and skills for the goal of achieving the best patient-centered health outcome (Nancarrow et al., 2013). The goal of IDT collaboration is demonstrated in the patient-centered care plan which reflects the input and expertise of various healthcare providers (Parrott & Kreuter, 2011).

Multidisciplinary teams involve the work and collaboration of various healthcare providers, but the primary distinction of this team-based approach is the independence of the collaboration (Ndoro, 2014). The various healthcare providers of a multidisciplinary team will treat the same patient with their patient-centered plan independent or without awareness of other healthcare providers' actions (Parrott & Kreuter, 2011). This team-based approach allows the various healthcare providers within the team to improve communication, improve collaboration, added skills increasing access to care, better decision making and flexibility. Increased job satisfaction and well-being are another

advantage and benefit of a multidisciplinary team (Ueno et al., 2010). The limitations of this team-based approach are poor communication, lack of trust, misunderstood roles and responsibilities, unclear goals or objectives, poor action plan, poor leadership, limited participation in decision making and power issues (Ndoro, 2014). Lastly, decision-making can be hampered because of the independent nature of collaboration that occurs on a multidisciplinary team (Ndoro, 2014).

Some healthcare organizations have transitioned from the multidisciplinary-based team approach to an IDT based approach (Ndoro, 2014). Each organization would need to assess the applicability of either team-based approach for their organizations as each approach has its disadvantages and advantages depending on their varying organizational factors. Both are great team-based approaches, but differ in the fact the IDT makes more efficient use of human resource collaboration.

Factors That Lead to Successful Interdisciplinary Teams

Teams may be only as effective as they are built and rely heavily on the initial design, which can help to predict their success. Various factors contribute to a successful interdisciplinary team, which can be derived from successful teams. Various factors that contribute to successful interdisciplinary teams are provided by the review of literature.

Communication. Healthcare providers within the IDT coordinate their actions in a hectic healthcare environment as well as communicate their perspective observations, concerns or pose any questions they may have for the betterment of the team and the care they provide the patient (Villagran & Baldwin, 2014). Communication is the number one factor that attributes to a successful IDT (Ndoro, 2014; Ueno et al., 2010; Villagran &

Baldwin, 2014). Various studies described this communication as “respectful” (Klipfel et al., 2014), “competent” (Goldsmith et al., 2011), “practical, robust, interdisciplinary and outcome-oriented” (Real & Poole, 2011). Communication is the backbone that helps the various healthcare providers in the IDT to create meaning for effective patient-centered care (Villagran & Baldwin, 2014). The superior quality of an exceptional IDT is an effective communication plan amongst members and dedicated team meetings for information sharing and learning (Kapo et al., 2015; Margaret & Lee, 2011). To create an exceptional IDT, requires planning, dedication, and continual development (Kapo et al., 2015).

Teamwork. Teamwork may be essential for successful interdisciplinary teams. As a member of an interdisciplinary team, having a fundamental understanding of each member's expertise and approach to care, helps members to facilitate offers for help and how they can better complement each other (Ueno et al., 2010). Teamwork helps to create a supportive team climate within the interdisciplinary team. Underpinnings of teamwork demonstrated interaction, interdependence, boundedness, commonality and motivation (Real & Poole, 2011).

Emotional intelligence. Emotionally intelligent interdisciplinary teams may also be deemed successful. Emotional intelligence effectively enhances collaboration among team members, patients, and their families. Emotional intelligence is comprised of self-awareness, self-management, social awareness, and social skill, which also enhances the teamwork factor (Nancarrow et al., 2013). Individuals within the IDT who exude these characteristics foster an environment conducive to trust and valued feedback (Nancarrow

et al., 2013). Addressing any lack of emotional intelligence can help to overcome burnout and emotional stress of team members (Galek et al., 2011; HealthCare Chaplaincy, 2011)

Expertise and cognitive intelligence. Expertise and cognitive intelligence are factors that may contribute to a successful interdisciplinary team. It is vital in order to get the full benefit of an IDT approach to have varied expertise which aid in the joint collaborative decision making and patient-centered care (Nancarrow et al., 2013). It can be entirely overlooked, but sometimes being an expert does not qualify as a healthcare provider to be cognitively intelligent. Recruitment should focus on healthcare providers who exemplify competence and personality to support patients and the initiative of the IDT (Nancarrow et al., 2013). Quality patient-centered care is provided with documented health outcomes and any feedback received is used to help improve quality of care (Nancarrow et al., 2013). Having these qualities aid in avoiding role ambiguity (Real & Poole, 2011).

Leadership. Positive leadership and management attributes may be strong components that attribute to successful interdisciplinary teams. The leadership should exemplify one that has a clear vision and mission for the team and listens, supports and supervises (Nancarrow et al., 2013). Leadership also provides better team communication (Villagran & Baldwin, 2014). The reliability of a healthcare team struggles with inconsistent or nonexistent leadership (Klipfel et al., 2014).

Training. Interdisciplinary teams that are successful may provide training, development and be rewarding. Training is essential, rewards are awarded, recognition is

given, and there are career growth possibilities (Nancarrow et al., 2013). These teams also ensure the appropriate resources and procedures are in place to uphold and support the vision (Nancarrow et al., 2013). Training provides an improvement in team collaboration which strengthens a team (Kapo et al., 2015). Technology allows training to be carried out in various ways such as through simulation (Klipfel et al., 2014). Training is the hallmark of a good, solid team (Tremblay et al., 2014).

Shared mission. Successful interdisciplinary teams may share a mission and vision (Edmondson, 2003). Interdisciplinary teams with a shared mission and vision retain the buy-in of their various healthcare providers which allows for more ease of collaboration, which shapes the delivery of patient-centered care (Ueno et al., 2010). It is also important to note the mission and vision should be clear (Nancarrow et al., 2013). As Nancarrow et al. (2013) posited, it is essential for the continued success of an IDT to regularly plan time to improve through development and maintenance of these factors.

Factors That Contribute to Less Successful Interdisciplinary Teams

Many organizations strive for exceptional interdisciplinary teams, but they are not always realized (Real & Poole, 2011). While various expert providers are on an interdisciplinary team, it does not guarantee that it is an expert team (Klipfel et al., 2014). The factors that contribute to a less successful IDT are factors that would generally stymie a successful interdisciplinary team. Identifying and improving on these factors may improve less than successful interdisciplinary teams.

Poor communication. Lack of communication may be a primary concern and contributor to a less than successful IDT. Goldsmith et al. (2011), states that healthcare

providers do not receive training in communication or interdisciplinary group communication. Miscommunication may cause a break down in collaboration. Ineffective communication amongst the healthcare providers on the IDT puts patients at risk for medical errors, being uninformed while the healthcare providers miss opportunities to maximize treatment and improve health outcomes (Villagran & Baldwin, 2014). If the communication issues are not addressed, it can lead to patient safety issues, medical errors, and other adverse events (Real & Poole, 2011). As Real and Poole (2011) suggests, beyond just sharing information, complex healthcare teams such as the IDT require greater cohesion and communication that leads to a constructed meaningful task or goal.

Poor leadership. Poor leadership may also contribute to a less than successful interdisciplinary team. Without suitable leadership the structure of the team is not stable, giving way to an unclear mission, insufficient time, excessive workload, and lack of administrative support that impedes collaboration (Nancarrow et al., 2013). Poor leadership also contributes to a lack of boundaries, blurred roles, role confusion which ultimately leads to stress and tension for teams (Real & Poole, 2011).

Poor conflict resolution. Lack of conflict resolution strategy is a factor that may directly impede collaboration amongst the various healthcare providers on the interdisciplinary team. The work of the IDT is complex and made up of various disciplines with different expertise, interpersonal conflict impedes collaboration and increases the potential for medical error (Nancarrow et al., 2013). Interpersonal conflict negatively affects coordination within the interdisciplinary team. While conflict can be

beneficial in bringing awareness and leading to solutions to issues, they may never be realized if there is no conflict resolution strategy in place (Kapo et al., 2015). Given that IDTs involve varied healthcare providers, with various specialized training, their collaboration can be complex. Their diversity is beneficial to patient care but can also cause conflict, but as Kapo et al. (2015) posited, conflict well managed may provide opportunities for the growth and improvement of the IDT.

Lack of training. Lack of training may hinder an IDT's cohesion and ability to provide adequate patient-centered care. Lack of training or education is a factor that impedes improvement to patient care (Sibbald et al., 2013). It is important for leadership to provide adequate training and education to keep the IDT up to date with advancements in care for more optimal patient-centered care (Sibbald et al., 2013). Training helps unify teams, and without stability, the team suffers (Tremblay et al., 2014). Addressing training needs may lead to more successful teams.

Poor collaborative environment. An environment that is not conducive to an IDT may debilitate team members' effectiveness and potentially impact patient care provided. The lack of a safe environment for an IDT can be detrimental to the collaboration of various healthcare providers and patient-centered care (Villagran & Baldwin, 2014). Those within the team who have less influence defer to those who have more influence, self-censorship occurs and fear of marginalization (Villagran & Baldwin, 2014). This issue impedes the potential for added input to decision-making for patient-centered care. The lack of an IDT encouraging environment curtails the learning ability of the team (Jessup, 2007).

Lack of emotional intelligence. An IDT that lacks emotional intelligence may obscure various healthcare providers within the team from effectively functioning. Unfortunately, the lack of emotionally intelligent healthcare providers within an interdisciplinary team is sometimes sacrificed for more cognitively intelligent members (Ueno et al., 2010). Lack of emotional intelligence can also lead to IDT members supplanting, contradicting or repeating the work of other members with no interest in understanding the expertise of other members (Ueno et al., 2010). Burnout and emotional stress are sure for teams that lack emotional intelligence (Galek et al., 2011; HealthCare Chaplaincy, 2011). It is important to address these factors as they critically impact the success of an interdisciplinary team.

The Impact of Poor Team Inclusion

Poor inclusion on a team can cause harmful psychological, emotional, behavioral health outcomes for those who are not properly integrated (Shore et al., 2011). As Nancarrow et al. (2013) stated, there are challenges when working on a healthcare team of various healthcare providers where conflicts occur between professional roles and expertise, planning and decision-making all while attempting to create a patient-centered plan. The various healthcare providers in one research study noted that they were providing the information but no information or transfer of it was reciprocating back (Sibbald et al., 2013). As previously aforementioned, a shift from religious affiliation and authority in western countries in the mid-twentieth century contributed to chaplains expanding their services and meeting patients in hospitals that had no religious community (Swift et al., 2012). Chaplains who provide spiritual care in secular

environments endure stress due to lack of role definition, the secular environment and poor communication with colleagues (Winter-Pfandler et al., 2011). Shore et al. (2011) argue that individuals who work in teams where their unique characteristics are ignored, such as their perspective, knowledge, and information would add to their feelings of exclusion. Chaplains have unique characteristics (e.g., empathetic listening, spiritual and ethical counselor) (Handzo et al., 2014), if ignored could cause chaplains to have feelings of exclusion.

Unfortunately, poor team building and team alignment according to Ueno et al. (2010) is common for healthcare teams. Team building and team alignment underscore the need for various healthcare providers within a team to have an understanding of the expertise of their colleagues. Without team building and alignment, it may cause anxiety, conflict and an ineffectively functioning team. It is necessary that team members have training on the differences of their understanding to better engage in informative and helpful team discussions, which builds trust and effective communication for better patient centered-care (Ueno et al., 2010). A functional team environment may produce a team with fluid discourse.

Evidence-Based Care

Skeptics for the use of spiritual care in healthcare, state whether there is evidence to support its benefits. Some debate whether chaplains at all should even have a scientific approach to their delivery of spiritual care (Proserpio et al., 2011). There is not enough evidence-based research on spiritual care to definitively support the confident claims of its use in healthcare. The services of a chaplain are empirical in nature, and

some chaplains have shied away from research seeing it as a waste of time, but now necessary as they must solidify their work as healthcare organizations face tighter budgets (Myers, 2014). The lack of evidence-based research in chaplaincy has led to a call to chaplains to engage in research (Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014; Kestenbaum et al., 2015). To promote more evidence-based spiritual care research, various research experienced professional chaplains have created research guides and documents to ease their professional chaplain colleagues into research, providing for them a blueprint. One notable resource is the is the published handbook "An Invitation to Chaplaincy Research: Entering the Process" funded by the John Templeton Foundation (Myers, 2014). Chaplains agree that evidence from research can help support their delivery of spiritual care, tell their story and build their case as productive members of the healthcare team (Fitchett, 2011).

Before the push for evidence-based research for spiritual care in order to assess the benefits of spiritual care, reliance weighed heavily on patient and family satisfaction surveys, quality improvement initiatives and audits (Hall et al., 2013). When patients received spiritual care, patient satisfaction survey results were generally positive (Hall et al., 2013). The professionalizing of chaplaincy may promote better standards and the delivery of spiritual care. In existing literature, research and biomedical evidence in the United States is helping other healthcare professionals to recognize the benefits of spiritual care on patient experience including interaction with healthcare professionals and services, patient recovery, health outcomes, safety, and clinical interventions such as surgeries (Doyle, Lennox, & Bell, 2013; Russell, 2014).

Summary and Conclusions

Chapter 2 began with a restatement of the problem, the potential impact of inclusion on professional chaplains, followed by the purpose of the study, to investigate the inclusion of professional chaplains on the IDT and what impact it may have on their physical and emotional well-being. A description of the literature search strategy was provided, including the terms and databases from where current literature was extrapolated to form the literature review. An adaptation of the antecedents and outcomes of inclusion framework developed by Shore et al. (2011) theoretical framework was presented along with its origin, a description of its theoretical propositions and assumptions appropriate in the application of the theory. An explanation was provided for how the theory relates to the research study and how the research questions build upon it. The literature review provided current literature on relevant major themes as they relate to professional chaplains, their inclusion and well-being: chaplain requirements, standards of practice, the role of the chaplain, chaplains and healthcare teams, positive and negative factors concerning teams and evidence-based care.

While several studies highlighted the collaboration and utilization of professional chaplains, few research studies targeted their inclusion, and how it may affect their physical and emotional well-being. The need for research on the inclusion of professional chaplains is necessary to serve as the genesis for organizational reform by shedding light on issues related to the inclusion of professional chaplaincy within the IDT in hospitals.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological study was to examine, through the lived experiences of professional chaplains, the extent to which they felt that others perceived them to be valued members of IDTs and to determine how this perception of inclusion might impact their physical and emotional well-being in hospital settings in the Maryland and District of Columbia area. As aforementioned, identification of factors that influence these experiences is essential to the development of programs or policies that assist chaplains in flourishing in the provision of emotional and spiritual care to patients and their families.

In Chapter 3, I describe the research design and the rationale for its selection for the study. An explanation of my role as the researcher in the study is provided. A sufficient description of the study's selected methodology, including the identification of the population and sampling strategy, is given. Data collection instrumentation and its source are identified, with validation for how it helped to answer the research questions. Procedures for the recruitment of research participants and data collection procedures are described. My plan for data analysis, including the use of software and coding procedures for each type of data collected, is identified. Issues of trustworthiness and the reasonable measures taken to safeguard research participants in accordance with National Institutes of Health (NIH) ethical standards are described.

Research Design and Rationale

The following four research questions helped in investigating the lived experiences and perceptions of professional chaplains regarding their inclusion within IDTs and its impact to their physical and emotional well-being.

RQ1. With regard to their organization's climate, leadership, and practices, what are the perceptions of professional chaplains about their inclusion on the IDT?

RQ2. With regard to the perceptions of professional chaplains about their inclusion on the IDT, how does it affect their physical and emotional health status?

RQ3. What are best practices for full inclusion on the IDT?

RQ4. What are barriers to full inclusion on the IDT?

In this phenomenological study, I sought to investigate the lived experiences of professional chaplains, the extent to which they felt that others perceived them to be valued members of IDTs, and how their perceptions of inclusion might impact their physical and emotional well-being. The central constructs of this study were organizational climate, organizational leadership, organizational practices, and physical and emotional well-being. Specifically, *inclusion*, as it related to this study, was the extent to which the individuals perceived themselves to be esteemed members of their teams (Shore et al., 2011). The term *organizational climate* describes the environment of an organization based on its policies and procedures. *Organizational leadership* describes the internal organizational processes that are demonstrated by an organization's

leader. Lastly, *organizational practices* describe the actions of an organization operationally (Shore et al., 2011). *Physical well-being* was defined by Garcia (2015) as "recognizing the need for physical activity, healthy foods and sleep," and *emotional well-being* was defined as "coping effectively with life and creating satisfying relationships" (p. 6).

Phenomenology was the research tradition selected for this research study. My rationale in choosing this tradition was that phenomenology provides the capability to capture the lived experiences of participants. Moustakas (1994) posited that phenomenological research investigates an individual's lived experiences. Patton (2014) furthered this supposition by stating that the lived experiences of individuals shape their world perspective. Phenomenology is not limited to the lived experiences of individuals alone. Van Manen (1990) postulated that phenomenology also allows the researcher to investigate and understand the lived experiences of a homogenous group of individuals who have shared a phenomenon. The qualities of the phenomenology research tradition supported this study. Phenomenological research traditions complement qualitative research designs, in that they focus on a holistic experience opposed to just an aspect of individuals' experiences, they permit first-person accounts in the form of interviews, the lived experience plays a major role in understanding human behavior as part of scientific evidence, and they aid in developing questions and problems that reflect the passion and dedication of the researcher (Moustakas, 1994). In these ways, phenomenology supported the qualitative research design of this study. Compared to the measurements and scores that quantitative designs produce, phenomenology provides a broader array of rich

descriptions to provide a better understanding of an individual's lived experience (Moustakas, 1994). The phenomenology research tradition and its various qualities complemented this study.

Role of the Researcher

As a research practitioner, I assumed the role of interviewer. As an interviewer, I was the sole data collector and provided analysis of the data. In qualitative studies, the researcher generally serves as the instrument in addition to providing an analysis of the rich descriptions inherent in the collected data (Maxwell, 2012). To my knowledge, I had no personal and professional relationships with any of the professional chaplain participants or any supervisory or instructor relationships involving authority over them.

Using a qualitative research design has the potential for researcher bias. As the qualitative instrument, it is possible that the researcher in such a design will affect the findings due to his or her perspective and personal experiences (Maxwell, 2012). I made my best effort to remain objective throughout the study, especially during data collection and data analysis processes, by employing bracketing. Bracketing aids in ensuring that researcher biases are properly managed throughout a study, particularly in the data analysis process (Chan, Fung, & Chien, 2013). In addition, I employed member checks. This technique, as Lincoln and Guba (1985) stated, allows those from whom data were originally collected to validate the data. The qualitative techniques of bracketing and member checking were employed to manage researcher bias.

No ethical issues or concerns arose during the research study. As the researcher, I did not incur any ethical issues such as any conflicts of interest in relation to my role and

work environment. This research study was not conducted in my work environment and posed no conflicts of interest. Each participant received a gift (valued up to $5) for this research study to show appreciation of his or her time. To address ethical issues relating to the use of an incentive, I documented it in the informed consent letter, explaining that a gift (valued up to $5) would be given to each participant to express appreciation for his or her time (NIH, 2008).

Methodology

Participant Selection Logic

The population for this study consisted of board-certified professional chaplains currently employed and working on IDTs in hospitals within Maryland and the District of Columbia area. This study used a chain sampling strategy. A chain sampling strategy emphasizes the selection of information-rich participants for in-depth analysis (Patton, 2014). A chain sampling strategy also provides the researcher with an opportunity to select participants who meet the selection criteria in order to obtain adequate and sufficient data (Patton, 2014). Professional chaplains were selected based on the following selection criteria. For the purposes of this study, professional chaplains of various ethnic backgrounds, religious faiths, ages, genders, and specialties who were proficient in the English language were considered. The professional chaplains selected for this study were currently actively working and had been employed within their respective hospitals' IDT for at least one calendar year, a period that I arbitrarily selected because there is little or no known research supporting a specified minimum length of employment for professional chaplains. All acute hospital healthcare organizations in

which professional chaplains worked within the Maryland and the District of Columbia area were included for consideration. All participants had completed the requirements to be board-certified professional chaplains. In order to establish that prospective participants met the selection criteria, professional chaplains were screened through their respective hospital websites, and information on any additional criteria not verifiable by the websites was requested from the participants directly. For this study, nine participants were recruited. Small sample sizes, even as small as one selected purposely, are typical of qualitative research (Patton, 2014). Generally, the number of participants for phenomenological research ranges between one and 10 (Starks & Trinidad, 2007). In this type of research, the sample is small but is more focused than a larger sample (Onwuegbuzie & Daniel, 2003). Data saturation was employed in the research study and was the determinant for the number of participants. Data saturation occurs when a researcher's constructs represent the phenomenon and no further data collection is necessary (Simon & Goes, 2011). Publicly available hospital websites and hospital brochures in chapels were used to identify, contact, and recruit participants for this study. More details are provided in an upcoming section of this chapter. The sample size was dependent on when saturation was achieved during the data collection process. Sample size is contingent upon the researcher finding out what he or she is investigating (Patton, 2014). Saturation occurs when no new themes are generated and the researcher begins to see themes reemerge (Seidman, 2013).

Instrumentation

As the researcher, I served as a data collection instrument in this study. Additional data collection instruments included a semistructured interview protocol with open-ended questions (Appendix E), a handheld audio voice recorder, the meeting service freeconferencecall.com, and a researcher journal. The data sources were the interviews. In qualitative studies, the researcher is typically an instrument (Maxwell, 2012). An interview protocol ensures that the researcher is efficient in the use of allotted interview time (Patton, 2014). A handheld audio voice recorder was used with the consent of the participants to record the interviews, and the meeting service freeconferencecall.com was used to record interviews that were conducted over the telephone. Having multiple collection methods increased the chance of obtaining an adequate response rate (Seidman, 2013).

The research study was conducted using a researcher-developed interview protocol (Appendix E) instrument. An interview protocol is intended to assist in querying participants for reconstruction of their experience so that the researcher can explore the meaning (Seidman, 2013). The interview guide provided a semistructured beginning with an introduction, as well as an icebreaker, interview questions, probes, a conclusion, and debriefing. The basis for instrument development was the review of the literature. Steps were taken to identify a published instrument, but none were suitable that could uniquely address the research questions. Face, content validity, and alignment of the interview protocol instrument to answer the research questions were established by having them vetted by three subject matter experts. The three subject matter experts were

doctoral-level board-certified chaplains who reviewed and aided in establishing the sufficiency of the interview protocol instrument to answer the research questions. In order to establish sufficiency of the instrument to answer the research questions, the subject matter experts were given a copy of the problem statement, purpose statement, interview protocol, research questions, and validation rubric for expert panel (VREP; Appendix F). Each of the subject matter experts reviewed the provided material against the VREP criteria (clarity, wordiness, negative wording, overlapping responses, balance, use of jargon, etc.; a full listing is available in Appendix F). Each criterion was scored between 1 and 4, with 1 indicating *not acceptable/needing major modifications*, 2 indicating *below expectations/some modifications needed*, 3 indicating *meets expectation/ no modification needed but could be improved with minor changes*, and 4 indicating *exceeds expectations/no modifications needed*. The first subject matter expert gave a score of 2 for the "overlapping responses" and "relationship to problem" criteria; all other criteria scored 3 or 4. The first subject matter expert advised that Interview Questions 3 and 4 were overlapping and interview question 1 could be more discrete. To remediate the instrument using this feedback, I revised question 1 by using more discrete verbiage and combined questions 3 and 4, bringing the number of interview questions down from 11 to 10. Subject Matter Expert 1 approved of the revisions. The revised instrument was then given to subject matter experts 2 and 3, who scored it under the various criteria with a combination of 3s and 4s. The instrument was finalized with no further alteration. The aforementioned process was used to establish sufficiency of the data collection interview protocol instrument to answer the research questions.

In Table 1, the interview questions are shown in alignment with the research questions, constructs, and variables associated with this phenomenological qualitative study investigating the inclusion of professional chaplains on IDTs and inclusion's impact on their physical and emotional well-being.

Table 1

Alignment of Interview Questions

Interview questions	Research questions	Constructs & variables
IQ1, IQ2, IQ3, IQ4, IQ5, IQ6	RQ1	Inclusiveness climate Inclusive leadership Inclusiveness practices
IQ7, IQ8	RQ2	Physical well-being Emotional well-being
IQ09	RQ3	
IQ10	RQ4	

Procedures for Pilot Study

Prior to the main study being conducted, a pilot study was conducted. A participant sample of 10-20% for a pilot study is reasonable (Simon & Goes, 2011). The pilot study consisted of two professional chaplain participants as a pretest of the interpretation of the interview questions within the interview protocol. The procedures used for the pilot study were the same as reflected in the main study. Recruitment of the pilot study participants was conducted using a recruitment e-mail (Appendix D), consent to participate in the pilot study was validated using an informed consent letter, and the interviews were conducted using the interview protocol (Appendix E). As identified in

the main study, the pilot study used the same data collection and analysis procedures as outlined in the next section.

The purpose of the pilot study was to pretest the interview questions within the interview guide to ensure that they could be easily understood by the participants, to obtain rich descriptions from the participants, and to assess the feasibility of my method for the main study. A pretest serves as a mini version of a main study and improves the study's opportunity for success (Polit & Beck, 2008). The pilot study was conducted apart from the main study, and the results of the pilot study were not included in the main study.

Procedures for Recruitment, Participation, and Data Collection

After receiving approval from Walden University's Institutional Review Board (IRB; approval number 09-28-16-0311050, expiration August 29, 2018) for this research study, I conducted recruitment. Generally, the hospitals provided the qualifications and tenure of their hospital-employed professional chaplains on their public websites and/or in chaplain service brochures provided in the hospitals, in addition to department contact information. Contact information from websites and/or flyers was obtained; specifically, I documented contact information for the manager of the chaplains and potential professional chaplains who met the criteria for the study. Gatekeepers such as the manager of the professional chaplains will likely govern access to the participants (Seidman, 2013). An e-mail with the recruitment flyer (Appendix D) was e-mailed to each potential participant's hospital department's manager requesting the possibility of participation. On the same day, I followed up the e-mail with a call to the manager

indicating a request for participation and referring to the e-mail sent. If there was interest in participation in the study, the outcome of the conversation was e-mailed to the manager to confirm and document the discussion. The necessary steps indicated by the manager during the conversation (e.g., obtain IRB approval from the hospital) were taken. Once the requirements of the hospital had been met, I e-mailed and notified the manager. Additionally, I requested that the manager provide the office number and e-mail (if not provided on the public hospital website) of professional chaplains who were willing to participate. From here, through participant contact information, I worked to identify the interview mode (face to face or phone), as well as a possible day and time for the interview. On the day of the interview, before the interview began, I provided the participant (by e-mail in the case of a phone interview) with the informed consent form to read and sign.

If the manager did not agree or have an interest in involving their professional chaplains to partake in the study, they were thanked for their time, and further communication was discontinued. Recruitment steps were repeated with other possible participants from other hospitals within the Maryland and D.C. area.

The interview protocol (Appendix E) was used to interview and collect data from professional chaplain participants. Data were collected at the professional chaplain's hospital located in Maryland or D.C. or by phone interview. Data collection continued until saturation was achieved. The duration of the interviews ranged between 20 and 45 minutes. Data were recorded using a hand-held recording device or recorded by using freeconference.com teleconference meeting service for phone interviews and with the

consent of the participant. Upon completion of the interview, per debriefing procedures on the interview protocol (Appendix E) all professional chaplain participants were thanked and informed that they will be contacted and provided with a summary of their responses for validation and requested for a follow-up if necessary. All participants were assured that their responses would be kept secure and confidential and used only for the purpose of this study unless otherwise approved by the participant. If a follow-up was necessary, the participant was contacted using their primary (work number) or secondary (e-mail address) contact information. An agreed upon time and location or phone conference was scheduled with the participant to hold a follow-up interview.

Data Analysis Plan

Qualitative analyses of the data were conducted using a phenomenological approach. The analysis of the data consisted of organizing it into meaningful categories, content comparison, and interpretation. Data were collected inductively to align the content analysis with the framework. The following four questions were investigated:

RQ1. With regard to their organization's climate, leadership, and practices, what are the perceptions of professional chaplains about their inclusion on the IDT?

RQ2. With regard to the perceptions of professional chaplains about their inclusion on the IDT, how does it affect their physical and emotional health status?

RQ3. What are best practices for full inclusion on the IDT?

RQ4. What are barriers to full inclusion on the IDT?

The research questions helped to gain a better understanding of the lived experience of professional chaplains, their IDT inclusion, and its impact on their physical and emotional well-being. This inquiry about one's experience provides a rich understanding of their perception of the phenomenon (Van Manen, 1990). Acquiring a description of one's past experiences provides an in-depth understanding and meaning of the phenomenon experienced (Moustakas, 1994). To code interview responses and identify themes, QSR NVivo 10 qualitative data analysis (QDA) software was used. Similar responses were categorized to generate codes and themes for this study. In-depth notes and comments help to identify codes and themes (Shosha, 2012). Notes and comments were documented during the interview to help with the identification of codes and themes. Any discrepancies in data were verified by using a comparison between the participant's responses and coded themes. Should there have been any inconsistencies suspected, current research would have been be used to enhance emerging themes (Shosha, 2012).

Each chaplain's interview transcript was analyzed as ascribed by Colaizzi's strategy in the following seven steps: (a) transcribed and surveyed to gain an understanding of the content; (b) extracted significant statements by the professional chaplains as they related to research questions; (c) interpreted and formulated meanings from extraction of significant statements by the chaplains as they related to research questions; (d) categorized of the formulated meanings organized into categories clusters of themes and themes; (e) integrated the discoveries of the study into a thorough depiction of the lived experiences of professional chaplains regarding their inclusion on

the IDT, their perception of inclusion and how it may impact their physical and emotional well-being; (f) conceptualized the key discoveries of every professional chaplain's response; and lastly, (g) validated of the descriptive discoveries from the study should be validated with each professional chaplain participant (Speziale, 2011). Should there have been any discrepant cases, they were re-analyzed, and explanations for the particular cases were provided.

Issues of Trustworthiness

Credibility

To establish credibility for this study, the following techniques were employed, data saturation, developed a relationship with the participant's organization, iterative questioning, transcript validation, and member checks. The sample size for this phenomenological study may be relatively small; data saturation was utilized to determine when the sample size was adequate and credible. Phenomenological studies are typically conducted using small sample sizes (Patton, 2014). When the researcher, as the interviewer begins to hear and see repeated data reported, they will have reached saturation (Lincoln & Guba, 1985). When data saturation was achieved, a credible sample size for the study was identified, and participant recruitment ceased.

Relationships of trust were developed with the professional chaplains' organizations. Shenton (2004) recommended prior to the first data collection a visit take place at the organization where the participant is located. The researcher must balance this relationship and not allow it to compromise the study (Lincoln & Guba, 1985). A

provisional visit to each professional chaplain's organization was made and was objective about interaction with the organization and its potential participants.

During the data gathering, iterative questioning was used. The use of probes helps to draw out more detailed information from the participant (Shenton, 2004). Probes data helps the participant to provide a more lucid description of their experience (Speziale & Carpenter, 2011). Probes were utilized in the interview protocol to better extrapolate informative detail from professional chaplain participants surrounding their lived experiences.

To ensure the credibility of the data collected and the results, transcript validation, and member checks were applied. Once the interview process was concluded for each interview, I transcribed the data and provided a copy in a reasonable time to each professional chaplain participant to review. At the completion of the study, the results were provided to each participant to ensure the essence of their experience was reflected. Various research scholars agree that member checks significantly increases the credibility of qualitative studies (Lincoln & Guba, 1985; Van Manen, 1990). To improve the credibility of the data for this research study, transcripts were validated, and the results of the study were member checked by each participant.

Transferability

To aid, if any, the possibility of transferability, thick descriptions were applied to ensure the study was sufficiently detailed. Thick descriptions provide the reader a concise narrative of the phenomenon under study with sufficient detail (Patton, 2014). As an observer, I collected interview notes with detailed thick descriptions. This was

beneficial, as it related to this study to investigate the impact of inclusion on the participant's physical and emotional well-being. Shenton (2004) posited that the results of qualitative studies are not transferable to other similar contexts, because of relatively small samples sizes that only pertain to a specific number of participants and environments. Thick descriptions will allow the reader to make their own judgment if the study is applicable in a similar context or not (Shenton, 2004). Thick descriptions were applied to enhance the detail of the research study and to allow the reader to decide if it may be applicable for their purposes or not.

Dependability

To ensure dependability of the study, steps taken to complete the study were documented in clear and concise details. The researcher should report the study in precise detail so it can be a model for future studies should the reader desire to replicate it (Shenton, 2004). Qualitative techniques were applied to ensure credibility (e.g., Saturation, and member checks). Lincoln and Guba (1985) postulated that a researcher who employs credibility techniques essentially ensures dependability. A combination of thick descriptions and credibility techniques were used to ensure the dependability of the research study.

Confirmability

To ensure confirmability of the study, I remained objective and used the reflexivity technique throughout the study. In order to be reflexive, the researcher must be aware of and attentive to their cultural, political, social, linguistic and ideological origin themselves and their participants (Patton, 2014). For the purposes of this study, I

maintained an attitude of systematically being attentive to their own cultural, political, social, linguistic, and ideological background throughout the study's procedures to completion.

Ethical Procedures

Ethics, as it relates to human research participants is very important. Harm and atrocities against humans in 20th century research experiments led eventually to the establishment of the IRB (Seidman, 2013). The events that surround this unfortunate period in history provides the necessary background for understanding current established ethical procedures in protecting human subjects in research. As the researcher, I completed training in "Protecting Human Research Participants" provided by the NIH, which included a historical review for the established ethical procedures and a scored assessment of my understanding of them. All ethical procedures were adhered to in order to protect human subjects in this research study to the best of my ability.

An agreement was established allowing me to gain access to professional chaplain participants for interviews. Local IRBs will require informed consent prior to conducting research (Seidman, 2013). Each participant was provided with an informed consent letter that contained the contact information for Walden University's IRB Chair whom the participant could contact if they had any concerns regarding the study and how it was conducted. The informed consent letter also provided the participants with the researcher's contact information with an open invitation to call and or e-mail with any questions or concerns before, during, or after signing the informed consent letter. Lastly,

the informed consent letter also adhered to NIH's "Protecting Human Research Participants" guidelines (NIH, 2008).

Upon IRB approval, I interviewed the professional chaplains for the purposes of this research study. The participants for this study were treated with utmost professional respect. IRB approval for this research study was applied for and obtained (number 09-28-16-0311050 and expiration August 29, 2018) through Walden University's IRB. Written and or IRB permission was obtained from each participant's hospital, as necessary. Researchers intending to conduct research with human subjects must obtain IRB permission before commencing research (NIH, 2008). The recruitment materials were well detailed with information about the research study. Any concerns related to data collection activities were handled ethically. Potential participants had the right to refuse taking part in this study, and they were not solicited again. Any participant could withdraw from the study at any time without reproach as stated in the informed consent letter. If any potential participants had additional questions in addition to the information provided in the recruitment e-mail (Appendix D) or informed consent letter; I was available by phone or e-mail to answer their questions. As the researcher, I adhered to all NIH ethical practices and ensured participant data were de-identified when used in the study and secured. The informed consent letter re-iterated the de-identification of the participant's identifiable information. In addition, the consent letter informed participants their data were secured. The research data for this study are stored in an office laptop and electronically password protected and other than I the researcher, my dissertation committee had access to the data. Upon completion of the study, all paper documents

(e.g., notes, interview notes) were scanned and converted to digital format. Paper documents were then shredded in the researcher's home office shredder. Lastly, all data were compressed into the .zip format, electronically password protected and secured on the researcher's laptop for five years (personal communication, March 9, 2016) then permanently deleted.

Each participant was given a gift (valued up to $5) to show appreciation for his or her time. Per Walden University's IRB, a gift valued below $5 is suitable in exchange of participant's time and is not considered unduly influence (personal communication, March 8, 2016).

Summary

In this chapter, I reintroduced the purpose of the study followed by the rationale for the phenomenological study. An explanation for the role of the researcher was given with an explanation of any possible biases and ethical issues applicable to the study. The methodology for the selection of participants was described. A description was provided of the instrumentation to be used for data gathering and its sufficiency to answer the research questions. Details explaining procedures for recruitment, participation, and data collection were explored followed by the plan for data analysis. Issues of trustworthiness were discussed such as credibility, transferability, dependability, and conformability relate to qualitative research. Lastly, I delineated the ethical procedures adhered to throughout the study and how data at the completion of the study were handled.

In Chapter 4, a summary of the collected data with detailed descriptions is provided. Metadata for the study, setting, and demographics will be explained. A

description of the data collection is provided followed by the process for data analysis. A description of the evidence for trustworthiness as it relates to credibility, transferability, dependability, and conformability is provided. Lastly, the results of the study are presented and displayed showing how the results address each research question, and any discrepant cases or nonconfirmed data are addressed.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to examine, through the lived experiences of professional chaplains, the extent to which they felt that others perceived them to be valued members of IDTs and to determine how inclusion may impact chaplains' physical and emotional well-being. The following four research questions helped in investigating the lived experiences and perceptions of professional chaplains, their inclusion within IDTs, and such inclusion's impact on their physical and emotional well-being.

RQ1. With regard to their organization's climate, leadership, and practices, what are the perceptions of professional chaplains about their inclusion on the IDT?

RQ2. With regard to the perceptions of professional chaplains about their inclusion on the IDT, how does it affect their physical and emotional health status?

RQ3. What are best practices for full inclusion on the IDT?

RQ4. What are barriers to full inclusion on the IDT?

In this chapter, I describe the pilot study, research setting, demographics, data collection, data analysis, evidence of trustworthiness, and final study results. The chapter closes with a summary.

Pilot Study

A pilot study was successfully conducted in February 2017 after I had obtained Walden University IRB approval (number 09-28-16-0311050, expiration August 29, 2018). Simon and Goes (2011) posited that prior to conducting a main research study; a researcher should conduct a pilot study with a participant sample of 10-20% of the total main study sample to test interview questions and to resolve any issues. Two professional chaplains were recruited for the pilot study through the same procedures used in the main study. The two pilot study participants were recruited using the recruitment e-mail (Appendix D), consent to participate in the pilot study was achieved using an informed consent letter, and the interviews were conducted using the interview protocol (Appendix E). The pilot study was successfully completed. Data were analyzed through the same process used in the main study, which was helpful in eliciting rich and thick descriptions. No modifications to research instruments or data analysis procedures were required. At the conclusion of the pilot study, I deemed the interview questions adequate to answer the research questions by obtaining rich descriptions during the pilot study, and no alterations of the interview questions within the interview protocol were necessary. I conducted the pilot study prior to the main study, and its results are not reported in the main study.

Setting

The phenomenological qualitative research study was conducted beginning in March 2017 and ending in February 2018. Interviews were conducted face to face and by teleconference. The face-to-face interviews were held in the participants' natural work setting, which allowed for comfortable and undisturbed interviews. Interviews were also

carried out using a teleconference call line for the convenience of the research participants, allowing them to be in a setting they preferred and ensuring that they were fully available without disruption. At the time of the research study, no personal or organizational conditions existed that influenced the participants.

Demographics

The research participant sample consisted of nine full-time-employed professional chaplains in a hospital healthcare setting. Two of the participants were female, and seven were male. The participants were actively working for their healthcare organization and were employed full-time as board-certified chaplains, with cumulative experience with their current and/or past organizations ranging from at least 1 year to 24-plus years. The chaplains' job titles included Chaplain, Chaplain Manager, and Chaplain Director. The characteristics of the chaplain participants are listed in Table 2.

Table 2

Participant Characteristics

Participant	Job title	Time employed with organization	Board certification	Time BCC with past org.	State
Participant 1	Chaplain mgr.	2+ months	BCC	10+ years	DC
Participant 2	Chaplain	5+ months	BCC	2+ years	DC
Participant 3	Chaplain dir.	1+ year	BCC	--	MD
Participant 4	Chaplain	1+ year	BCC	--	MD
Participant 5	Chaplain dir.	1+ year	BCC	--	MD
Participant 6	Chaplain mgr.	4+ years	BCC	--	MD
Participant 7	Chaplain	13+ years	BCC	--	DC
Participant 8	Chaplain dir.	17+ years	BCC	--	DC
Participant 9	Chaplain dir.	24+ years	BCC	--	MD

Data Collection

Data were collected from nine chaplain participants from Maryland and Washington, DC. Each participant met the study's delimiting factors, in that they were board-certified chaplains who were actively working full time and had spent 1 or more years in their current organization or their previous organization. The participants consisted of two females and seven males. Once Walden University's IRB approval (number 09-28-16-0311050, expiration August 29, 2018) was given, I scheduled in-person and teleconference phone interviews with each participant. For in-person interviews, each participant was handed the consent form. For teleconference phone interviews, participants were e-mailed the informed consent form. Prior to each interview starting, I reminded the participant about the goal of the study and the estimated length of the interview, and I gathered demographic information such as number of years employed with the participant's organization. Informed consent forms were reviewed and signed by all participants without issue. Data collection began in March 2017 and ended in February 2018. During each interview session, I used a semistructured interview protocol containing open-ended questions (Appendix E) to investigate the phenomenon of the participant's experience. I gathered data at most participants' work locations (in a closed-door office) through a single interview that generally lasted 20 to 45 minutes. In addition, I gathered data via a teleconference line in a single interview for some participants, with these interviews lasting 20 to 35 minutes. Data were recorded using a handheld voice recorder for face-to-face interviews, four participants total. For the teleconference-line interviews, the free service freeconferencecall.com was used to

record interview sessions, five participants total. There were no unusual circumstances during the data collection phase of the research study. I was able to conduct the study as described in the methods section of Chapter 3 without issue.

Data Analysis

Data analysis was conducted using Colaizzi's strategy, manual coding, and QSR NVivo 10 qualitative data analysis (QDA) software. Transcription of the raw recorded interview data were completed and provided to each participant for validation purposes. None of the nine participants requested revisions to their original transcripts. The participant-validated electronic transcripts were then manually coded and reviewed several times for reoccurring ideas and patterns as they related to the research study. Once the transcripts had been validated, I organized participant responses to the interview questions by categories, which helped to consolidate the meaning of the phenomenon of my four research questions. Participant responses that directly pertained to the investigation of the study were extracted. These responses were coded and reorganized into their respective categories. The electronic transcripts were then uploaded into NVivo 10 for further analysis, reapplying the manual codes. To move inductively from coded units to a broader representation of themes, I bracketed the data using the adapted theoretical framework (Figure 1). The adapted theoretical framework provided the theoretical lens with which I further analyzed the data. The adapted framework constructs influenced the organization of the descriptive codes into the themes and categories generated. Listed below are the themes generated from the organization of descriptive coded raw interview transcript data.

Theme: Religious Inclusive Organization

- Support of chaplains in mission and vision (5 of 9 [56%])
- Religious diversity embraced (6 of 9 [67%])
- Religious diversity resourced (6 of 9 [67%])
- Religious diversity reflected in chaplain staffing (3 of 9 [33%])
- Chaplains provide education on religious diversity (4 of 9 [44%])

A table capturing this theme and its associated codes is located in Appendix G.

Religious Inclusive Organization and related codes were applied to participants' descriptions of an environment in which the organization was welcoming and accommodating toward the various religious backgrounds of not only patients, but also staff. Participant 3 stated, "Very strongly we are a very diversified organization, respecting every person's culture, religious background, gender, and ethnicity."

Theme: Supportive Leadership

- Support for chaplaincy (6 of 9 [67%])
- Provision of additional full-time chaplains (2 of 9 [22%])
- Provide chaplaincy department resources (2 of 9 [22%])
- Extend decision making to chaplains (3 of 9 [33%])
- Chaplain's role recognized (4 of 9 [44%])

A table for this theme and its associated codes is located in Appendix H.

Supportive leadership and related codes were described by participants as having the backing of their organizations' leadership. Participant 4 stated, "From my own

perspective I think the hospital cares about hospital ministry. How? Because they give us the resources we need to work with."

Theme: Valued Team Member

- Contact chaplains (e.g., referrals, calls, etc.; 9 of 9 [100%])
- Recognition of unique religious & spiritual skills (7 of 9 [78%])
- Involved in interdisciplinary team meetings (7 of 9 [78%])
- Included in various committees (ethics, boards, etc.; 6 of 9 [67%])
- Respect for chaplain input (7 of 9 [78%])
- Included in hospital workflow (4 of 9 [44%])

A table of this theme and its associated codes is located in Appendix I.

Valued Team Member and related codes were described by participants as being called because IDT members recognized the chaplain to be the best fit for the delivery of the spiritual and emotional care service needed by the patient. Participant 5 stated,

> The way they consult us, what they call us about, what they consult us about. You know different cases they bring to us for us to inform them about. That reflects the fact that they know that we have a unique contribution so the specific questions reflect that perception from them and referral too, referrals that they give us, cases.

Theme: Well Integrated

- Feel positively about integration (7 of 9 [78%])
- Treated fairly (2 of 9 [22%])
- Respected (5 of 9 [56%])

- Trusted colleague (5 of 9 [56%])

A table for this theme and its associated codes is located in Appendix J.

Well Integrated and related codes were applied to participants' descriptions of a "feel good" sense of oneness with other members of the IDT. Participant 7 stated, "So it feels like a big family, different branches but we are connected they do all the good referral to us and go to us for some help."

Theme: Integration Positively Impacts Physical & Emotional Well-Being

- Positive impact on physical & emotional well-being (6 of 9 [67%])
- Physical well-being tied to emotional well-being (6 of 9 [67%])

A table for this theme and its associated codes is located in Appendix K.

Integration Positively Impacts Physical & Emotional Well-Being and related codes were applied to participants' descriptions of the feeling they experienced in relation to their perception of their IDT inclusion based on the accumulation of information on the climate, leadership, and practices of their organization. Participant 5 stated,

> It's very nurturing and supportive actually. I feel very nurtured and supported and you know it sends good vibes to my emotions because once I feel nurtured, supported, and welcomed ... Positive, emotional, physical they all go hand in hand.

Theme: Perceptions of Inclusion

- Contacting chaplains (e.g., referrals, calls, etc.; 5 of 9 [56%])
- Inviting chaplains to interdisciplinary team meetings (5 of 9 [56%])
- Including chaplains on committees (ethics, boards, etc.; 4 of 9 [44%])

- Treatment as a fellow colleague (3 of 9 [33%])

A table on this theme and its associated codes is located in Appendix L.

Perceptions of Inclusion and related codes were applied to participants' descriptions of actions taken by the healthcare team or organization that improved their sense of inclusion. Participant 6 stated,

> Well I'd say yes. I mean the fact that that I get daily reports from the units and the patient care coordinators for the patients on the various floors are willing to meet with me and go over whatever might be going on with certain patients on their floors. I'm invited to be part of the rounds, if I have time to be rounding with them on the units. I'm included in things, you know I'm part of the loop, but also at a more administrative level as well I'm part of the management forum and invited to that. You know, I have a voice, if I have something to say, I'm on various committees in the hospital. All of these things integrate me and make me feel valued here as a chaplain, but also as an individual.

Theme: Perceptions of Noninclusion

- Poor communication (5 of 9 [56%])
- Not valuing chaplain (5 of 9 [56%])
- Excluding from interdisciplinary team meetings (4 of 9 [44%])
- Not treated as a fellow colleague (3 of 9 [33%])

A table on this theme and its associated codes is located in Appendix M.

Perceptions of noninclusion and related codes were applied to participants' descriptions of others ignoring the chaplain or indicating the intention to not act when the services of the chaplain were needed. Participant 3 stated,

> What would make me feel less integrated at least from my own perspective is a situation where we are not valued, where we don't belong to any of the mentioned interdisciplinary teams or committees that I mentioned where there is not enough budget to fund the department and where we are treated as second class citizen, 'if I may use that expression,' and so those things would really make me feel that the organization does not really care about spiritual care and where spiritual needs of the patient and staff are not taken seriously so but that is not my experience in my organization so that being said should these things be lacking I would feel not valued if you like, not integrated into the system.

During the data analysis, I did not incur any discrepant cases. No discrepant cases occurred, and therefore there were no discrepant cases that were part of the data analysis. No discrepant cases were incurred during the research study.

Evidence of Trustworthiness

Credibility

To establish and increase credibility for this research study, I implemented saturation, developed relationships with the participants' organizations, and employed iterative questioning and member checks. The sample size for this phenomenological research study was estimated at up to 10, which is a relatively small sample. Saturation was used to reach a sample size that was adequate and credible for the study; this

occurred when I began to hear and see repeated data reported (Lincoln & Guba, 1985), ending at a sample size of nine. Prior to gathering data, I established relationships with participant organizations as recommended by Shenton (2004) to gain participants' trust. In addition, I used iterative questioning or probes to elicit more drawn-out, detailed information from the participants (Shenton, 2004). Once the interview data were collected, transcribed, and later coded, I verified the data by allowing the participants to review their transcripts. No revisions were requested. I conducted member checking with participants by providing them with the results of the study to ensure that they were accurate and resonated with their experiences (Lincoln & Guba, 1985). Each participant confirmed that the results resonated with their experiences.

Transferability

To allow the reader to make their best judgment on transferability, I utilized thick descriptions. Thick descriptions were utilized to provide sufficient details in the research study to allow the reader to make their judgement if the study is applicable for their purposes or not (Shenton, 2004).

Dependability

To achieve dependability, I documented the research data in clear and concise details using rich and thick descriptions. Documenting using rich and thick descriptions allows the reader to replicate the study should they desire to do so (Shenton, 2004).

Confirmability

To achieve confirmability, I remained objective and reflexive throughout the research study. During the research study, I was aware of and attentive to my own biases

by implementing bracketing. Throughout the study, I maintained an attitude of systematically being attentive to my own cultural, political, social, linguistic, and ideological background.

Results

Four research questions were used to investigate the lived experiences and perceptions of professional chaplains and their inclusion within the IDT and its impact on their physical and emotional well-being. The constructs organizational climate, organizational leadership, organizational practices, inclusion, physical and emotional well-being provided the theoretical framework and research lens for the research study. The raw interview data were coded and organized into themes respectively. Research questions three and four are without constructs as they were questions used to elicit responses from participants to garner a census on what may hinder or could promote inclusion as it related to the research study. The research questions and their associated themes were provided below.

Research Question 1

With regard to their organization's climate, leadership, and practices, what are the perceptions of professional chaplains about their inclusion on the IDT? In order to address this question, I divided it into six interview questions that generated four emergent themes. Religious inclusive organization emerged as the overarching theme describing how the chaplains perceived their organization's climate. Participant 6 stated,

> "We're a nonprofit hospital. We encourage sort of a holistic approach to chaplaincy as well as to healthcare in general. That is that we are non-denominational, we are totally welcoming and open and inclusive."

According to Wolfson, Kraiger, and Finkelstein (2011), in a study conducted on inclusion in the workplace found organization's that promoted inclusion had a more positive perception of diversity climate. Participant 3 stated similar sentiments,

> "Very strongly we are a very diversified organization, respecting every person's culture, religious background, gender, and ethnicity."

The inclusiveness of a climate, its policies, procedures, and actions of an organization adhere to fair and consistent treatment of all groups especially those that have fewer opportunities (Shore et al., 2011). Supportive Leadership emerged as a theme describing how chaplains perceived their organization's leaders. Participant 5 stated,

> "One-hundred percent support. Right now we're trying to capitalize on that support to expand the department, but I'm getting one-hundred percent support from the leadership above me and yes I give one-hundred percent support to the chaplains and residents in the program."

Shore et al. (2011) posited leaders should reflect inclusive values. Participant 3 stated,

> "My organization being a religious organization believes in the holistic care of every patient and even the staff that works for the organization. That being said, that means that spiritual care is part and parcel of that holistic care, so they promote that to the optimum."

According to Katz and Miller (2014) one of the seven ways a leader could be more inclusive is to approach employees as allies and show care for them. The theme "Valued Team Member" emerged and described the practices chaplains felt that made them feel valued. Participant 8 stated,

> "They're very; our clinical teams are very open and accepting of the presence of chaplains. We participate in rounds, we participate in family meetings, participate in ethical consults, the team typically will keep us informed when we're working with patient of family about what's going on."

Belongingness and uniqueness are precursors to perceptions of inclusion and benefit any organization's effort on improving practices that may improve outcomes due to inclusion (Shore et al., 2011). Participant 1 recollected their past experience and stated,

> "The staff has always relied on the chaplain, especially in terms of recognizing the uniqueness of what we do that literally anything that happens that brings the entire hospital community together begins with the ministry of a chaplain offering a reflection or doing a prayer."

The theme "Well Integrated" is the emergent term derived when the chaplains reflected on their over perception of their integration. Participant 2 stated,

> "I felt like I was a member of the care team and that they were quick to accept me as a member of the team and rely on me for various aspects not just for patient and family care, but for care of staff as well. Which is big, what I see as a big part of our ministry here at the hospital as well, it's not just families and patients, but staff as well."

Research Question 2

With regard to the perceptions of professional chaplains about their inclusion on the IDT, how does it affect their physical and emotional health status? This researcher question was addressed by dividing it into two interview questions that generated one emergent theme. It generated “Integration Positively Impacts Physical & Emotional Well-being” as the emergent theme that reflected the chaplains’ perception of the positive impact they felt their IDT inclusion had on their emotional and physical well-being. Participant 8 solidified this theme and stated,

> “Significantly. I think, not I think I know. I think there’s nothing for frustrating for professional chaplains than feeling misunderstood, overlooked, the value of what we can help the team achieve in terms of complete care of patients and families and how we can assist patients and families towards a better quality of healing. If those things are not recognized, then that is a huge emotional drain. You feel like you are always swimming upstream and exhausting...I think in the same way that as your emotional well-being is more balanced, your physical well-being is more balanced."

Garcia (2015) posited physical and emotional well-being as dimensional concepts and their importance as they make up ones person.

Research Question 3

What are “best practices” for full inclusion on the IDT? The emergent theme which encapsulated the chaplains’ perception of what makes them feel integrated was “perceptions of Inclusion”. This theme was formulated by various codes such as

contacting chaplains, inviting chaplains to interdisciplinary team meetings, including chaplains on committees, and treatment as a fellow colleague. Participant 2 encompassed this notion and stated,

> "I feel like we're fairly integrated; it's the telephone calls from staff. They are obviously thinking we need, if I am not on the unit, they "I need you, can you come visit this family?" It's the constantly putting in the referrals. It's not uncommon for me to come in everyday and have 2 or three referrals waiting for me. And so its things like that. We also do a routine staff support event. It's every other week, and so they are constantly "are we having it today? Are we having it today? Are we having it today?" So they're including me in because they realize we're here for them as well. So it's being integrated on multiple levels and the care of the patient and families and then their own care."

Research Question 4

What are "barriers" to full inclusion on the IDT? The emergent theme which encapsulated the chaplains' perception of what makes them feel less integrated was "perceptions of noninclusion". This theme was formulated by various codes such as poor communication, not valuing chaplain, excluding from interdisciplinary team meetings, and not treated as a fellow colleague. Participant 6 eloquently stated,

> "What would make me feel less integrated would be not in the loop of information about patients and conditions and also things that might be going on, on the unit. You know with shift changes there are always new personalities coming on and sometimes you might have a doctor or hospitalist who takes a

> different treatment plan for a patient then what was agreed on the day before and I might have been part of that discussion and then I might not be part of a discussion on a new treatment at night and then I found out about it the next day and I'm going well wait a minute we were going to do this, I can see where that would probably make me feel a little disenfranchised, but it doesn't really happen, but very, very rarely."

During data analysis of the research study, I did not incur any discrepant cases. No discrepant cases occurred and therefore there were no discrepant cases that were part of the data analysis or results. No discrepant cases were incurred during the research study.

The constructs organizational climate, organizational leadership, organizational practices, inclusion, physical and emotional well-being provided the theoretical framework and research lens for the research study. This adapted theoretical framework influenced the emergent themes and is shown in Figure 2.

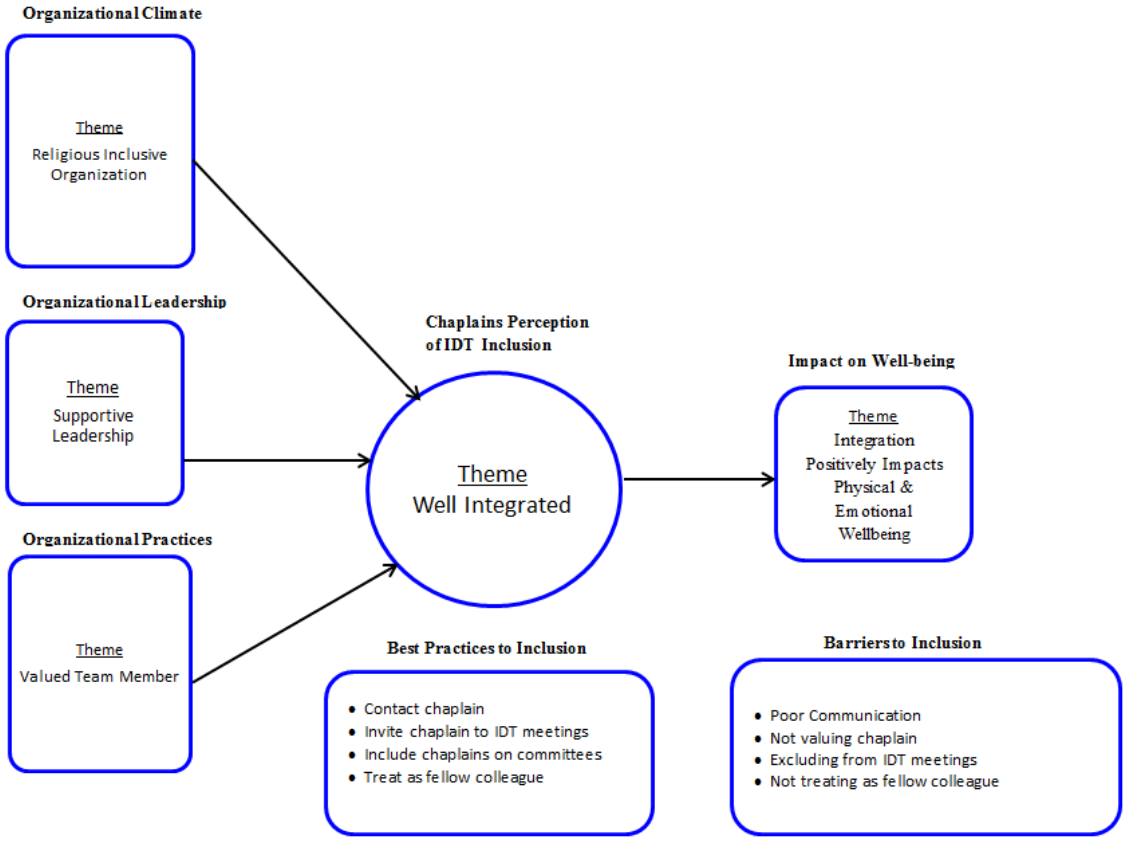

Figure 2. Results of the study.

Summary

In summary, the four research questions were used to investigate the lived experiences and perceptions of professional chaplains and their inclusion within the IDT and its impact to their physical and emotional well-being. The research questions helped acquire rich and thick descriptions from the professional chaplain participants. The emerging themes that addressed the research questions were religious inclusive organization, supportive leadership, valued team member, well integrated, integration

positively impacts physical & emotional well-being, perceptions of inclusion, and perceptions of noninclusion.

This chapter provided an overview of the pilot study, setting, demographics, data collection, data analysis and lastly a summary of the results of the study. In this chapter, I described the pilot study, research setting, demographics, data collection, data analysis, evidence of trustworthiness, and results. In chapter 5, I provided an interpretation of the findings, describe the limitations of the study, provide recommendations for further research, and lastly discuss implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological study was to examine, through the lived experiences of professional chaplains, the extent to which they felt that others perceived them to be valued members of IDTs and to determine how inclusion may impact their physical and emotional well-being. The rationale for using a phenomenological research design methodology was driven by the need to thoroughly investigate the phenomenon and obtain rich descriptions of the lived experiences of professional chaplains on IDTs, their perceptions of inclusion, and inclusion's impact on their physical and emotional well-being. Phenomenological research designs, according to Moustakas (1994), help in understanding and interpreting the lived experiences of participants within a specific context. A review of the literature showed that much of the available research on chaplains in healthcare has been directed at services that chaplains provide, how they provide them, their role, and, more recently, evidence-based research on the efficacy of their services, leaving a gap in the literature regarding how inclusion may impact them and their well-being. Identification of factors that influence these experiences is essential to the development of programs or policies that assist chaplains in flourishing and improving patient care.

Key findings from the study revealed several prominent themes, which may be helpful in gaining a better understanding of the inclusion of chaplains on IDTs and inclusion's impact on their well-being. First, three constructs—organizational climate, organizational leadership, and organizational practices—helped to create the context for

the chaplains' perceptions of their inclusion, generating three prevalent themes: religious inclusive organization, supportive leadership, and valued team member. Based on this context, chaplains were able to reflect on their perception of their integration, generating the following theme: well integrated. This process was then followed by investigating how their integration affected their well-being, generating another theme: integration positively impacts physical & emotional well-being. In order to provide practical ways in which chaplains' inclusion could be supported and ways to overcome obstacles of noninclusion, chaplains were asked questions on ways to promote inclusion, generating an emerging theme—perceptions of inclusion and ways that did not promote inclusion—generating the emerging theme of perceptions of non inclusion.

Interpretation of the Findings

The findings of this research confirm the contexts in which chaplains work in relation to organizational climate, organizational leadership, and organizational practices. This research study extends knowledge in the discipline on chaplain inclusion and the impact that inclusion has on chaplains' well-being, in addition to providing information on best practices for and barriers to chaplain inclusion.

In this research study, participants' perceptions of their organizational climate generated the theme of religious inclusive organization. This theme was linked to findings that are consistent with the research literature, in that chaplains generally work in places where organizations embrace the religious diversity of their patient and staff populations, as well as diversity in the faith of the chaplains they hire (Cadge et al., 2011). According to Goldstein et al. (2011), chaplaincy has been reflected in the mission

of organizations and consistent in their mission and vision, especially in the case of religious-affiliated hospitals. Organizational leaders have an understanding that patients have a religious need, and they support chaplains in meeting that need (Koenig, 2012).

Participants' perceptions of organizational leadership derived the theme of supportive leadership. The literature supported this theme from the perspective of an organization's leadership context. Leaders in various organizations support their chaplains and are considerate in decision making as it relates to chaplains, inviting their input (Russell, 2014). The literature indicates that chaplains still feel that they are a lower priority when it comes to their organizations' budget (Myers, 2014). Some research has shown, however, that chaplains obtained adequate resources pertaining to their job role (Fitchett et al., 2011).

The participants' perceptions of organizational practices as they related to their experiences generated the theme of valued team member. As Swift et al. (2012) posited, chaplains are noted by other healthcare professionals to have specialized skill in spiritual support, which lead them to be contacted, generally by referral. As the chaplaincy profession has evolved, other healthcare professionals have become more receptive of it (Hall, Shirey, & Waggoner, 2013). Chaplains, as members of healthcare teams, have been included in various groups such as ethics committees; these invitations are evidence of the chaplain's role as a trusted colleague alongside other healthcare professionals (Willis & Limehouse, 2011).

This research study extended knowledge in the discipline on chaplains' inclusion and the impact that inclusion has on their well-being. Well integrated emerged as the

theme encompassing participants' perception of their overall inclusion. The participants were able to reflect on how inclusion impacted their physical and emotional well-being. The theme that emerged was integration positively impacts physical & emotional well-being. Chaplains asserted that while their integration experiences varied, they were generally positively impacted. These findings imply that IDT inclusion does have an impact on chaplains emotionally and physically, and as noted by participants, this impact is positive overall.

The adapted antecedents and outcomes of inclusion theoretical framework (Figure 1) was created and used to elicit participants' perceptions of chaplains' inclusion and its impact on their well-being. Three contexts were used—organizational climate, organizational leadership, and organizational practices—as the contexts that participants would reflect on, and, based on their reflection, tie into their perception of their inclusion and how it impacted their well-being. The findings imply that IDT inclusion does have an impact on chaplains and their emotional and physical well-being. Overall, chaplain participants were positively impacted by their inclusion. These findings led to the simple reasoning that the contexts that surround chaplains—organizational climate, organizational leadership, and organizational practices—affect their perceptions of their inclusion, which could impact them positively or negatively. The effects of chaplain inclusion were summarized succinctly by Participant 8:

> Significantly, I think, not I think I know. I think there is nothing more frustrating for professional chaplains than feeling misunderstood, overlooked, the value of what we can help the team achieve in terms of complete care of patients and

families and how we can assist patients and families towards a better quality of healing. If those things are not recognized, then that is a huge emotional drain. You feel like you are always swimming upstream and exhausting. I think in the same way that as your emotional well-being is more balanced, your physical well-being is more balanced.

Limitations of the Study

There were several limitations associated with this descriptive phenomenological research study. The research study was limited by time and financial resources. As a student practitioner, I had limited availability and finances. To address this limitation, I employed time management and budgeting of resources for the research study.

For this research study, I was the sole research practitioner. I conducted participant interviews, gathered the data, and completed the data analysis. To reduce researcher bias and increase the credibility of the study, I provided participants with the transcripts of their interviews for their validation, and there were no requests for revisions. In addition, I member checked results of the study and provided them to each participant. All participants confirmed that the results resonated with their experiences.

Lastly, the research study used a small sample size. A small sample size can limit credibility and transferability. To increase credibility, I employed stratification, only selecting participants who exactly matched my participant criteria (Seidman, 2013), and I determined that saturation had been achieved when it occurred to me that themes reemerged. Transferability is subjective in nature, and readers will need to decide whether the research study is applicable to their environments.

Recommendations

The purpose of this phenomenological study was to examine, through the lived experiences of professional chaplains, the extent to which they felt that others perceived them to be valued members of IDTs and to determine how inclusion may impact chaplains' well-being. For future study, a comparison could be made to investigate whether there are varying degrees of inclusion among secular or nonsecular organizations that employ professional chaplains. This could help both secular and nonsecular organizations better implement spiritual and emotional care to meet the needs of all staff and patients.

This research study revealed best practices in and barriers to the inclusion of chaplains on IDTs. This information on best practices and barriers could be used by various organizations that employ chaplains to improve chaplain team inclusion in an effort to ensure the appropriate and timely delivery of spiritual and emotional care to patients.

According to Kobayashi and McAllister (2014), chaplains, in addition to working at hospitals, are employed in various healthcare settings such as hospices, palliative care, and the government-subsidized Veteran Affairs health system. Future studies could assess the inclusion of chaplains in various employment settings.

Implications

Positive Social Change

This research study has the potential to influence society positively. At the family level, patients and their families could benefit from the close and active involvement of

professional chaplains in care planning and evaluation processes. The review of literature indicated that many Americans have a religious affiliation. The close involvement of chaplains in patient care may result in the proper and timely delivery of spiritual and emotional care to patients to bring about wholeness and healing. A practical implication of this would be to include professional chaplains in the workflows of their IDT colleagues, which would ensure an increase in their inclusion. At the organizational level, this study could provide the blueprint for leaders to better establish and sustain chaplaincy integration within various healthcare teams or settings. Programs could be developed based on the study's results concerning best practices and barriers to inclusion. Other healthcare professionals who work with chaplains could benefit from this study, in that it may give them a better understanding of how to best interact with chaplains and ensure that these colleagues are well integrated. The experiences of the participants could be a launching point for an informative bridge-building discussion between professional chaplains and other health professionals in their organizations. A practical implication of this would be to create mandatory training in conjunction with other organizational training that provides an overview of the role of the professional chaplain and how to involve them in patient care planning. By implementing these various practical implications for social change, there is the potential for the organization that uses them to evolve their inclusion of professional chaplains.

For this research study, there were no methodological or theoretical implications. There is a potential empirical implication. The research study used a concise method that aligned with the study. An adapted theoretical framework was used to address a gap in

the literature pertaining to the inclusion of professional chaplains on IDTs. Finally, the study has the potential to influence other empirical studies, thereby advancing professional healthcare chaplaincy.

This research study provides information on best practices and barriers to chaplaincy inclusion that could support the practice of chaplaincy in the team or organizational involvement. The themes identified for best practices and barriers to inclusion could be a blueprint or guide to the creation of inclusion programs in healthcare organizations that employ professional chaplains, ensuring that chaplains who provide spiritual and emotional care to patients are well integrated.

Conclusion

The provision of "pastoral care" often suffers because most physicians misunderstand the roles of chaplains or lack the knowledge to effectively use them. In addition, chaplains have indicated that they would prefer to be engaged sooner to provide patients and their families "greater wholeness and healing" (Russell, 2014). Such issues prevent highly trained and board-certified professional chaplains from providing spiritual and emotional care, which ultimately impacts the quality of patient service (Russell, 2014). The purpose of this phenomenological study was to examine, through the lived experiences of professional chaplains, the extent to which they felt that others perceived them as valued members of IDTs and to determine how inclusion may impact their physical and emotional well-being. Identification of factors that influence these experiences is essential to the development of programs or policies that could ensure chaplain inclusion and thus benefit patient care.

The research questions investigated the perceptions of chaplains concerning their inclusion and its impact on their well-being. Key findings of this research study imply that the perceptions that chaplains have of their inclusion have an impact on their emotional and physical well-being, and the research study revealed that the impact of inclusion on their well-being was generally positive. In addition, key findings provide information on best practices in and barriers to the inclusion of professional chaplains. There is a need for professional chaplaincy inclusion, and I recommend further empirical research in this area. The social change impact of this research study may reside in its use as a guide for the creation of inclusion programs for organizations that employ professional chaplains to ensure their proper integration and availability for care planning and timely delivery of spiritual and emotional care to patients. Ensuring proper and timely inclusion of chaplains may help patients reach greater wholeness and healing that might not be achieved by physical medicine alone. Literature has shown that patients value having their religious beliefs honored at the time of care. Satisfying this need could help healthcare organizations to achieve greater patient satisfaction.

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Appendix A: Accessed Library Databases and Search Engines Used

Academic OneFile
Business Insights: Essentials
Business Source Complete
CINAHL & MEDLINE Simultaneous Search
CINAHL Plus
Digital Access to Scholarship at Harvard (DASH)
EBSCO
ERIC and Education Research Complete Simultaneous Search
ERIC-Educational Resource Information Center
Expanded Academic ASAP
General OneFile
Google Scholar
Health & Wellness Resource Center
John Wiley & Sons Database
JSTOR Journals
MEDLINE
MedScape
Ovid Nursing Journals
Political Science Complete
ProQuest Central
ProQuest Health & Medical Complete
ProQuest Nursing & Allied Health Source
ProQuest
Health Sciences
PsycINFO
Psychology Databases Simultaneous Search

Appendix B: Full List of Key and Combinations of Search Terms Used

antecedents and outcomes of inclusion
chaplain
hospital AND pastoral care OR chaplain
inclusion
inclusion AND hospital AND pastoral care OR chaplain
inclusion AND team
interdisciplinary
interdisciplinary AND pastoral care OR chaplain
optimal distinctiveness theory
organizational climate
organizational climate AND "well being"
organizational climate AND management
organizational climate AND stress
organizational leadership
organizational leadership AND "well being"
organizational leadership AND management
organizational leadership AND stress
organizational practices
organizational practices AND "well being"
organizational practices AND management
organizational practices AND stress
pastoral care
team AND pastoral care OR chaplain
well being AND "work related" AND physical AND emotional
well being AND pastoral care OR chaplain
well-being
wellness
“dimensions of wellness”

Appendix C: Gratis Reuse

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SAGE

Title: Inclusion and Diversity in Work Groups: A Review and Model for Future Research:

Author: Lynn M. Shore, Amy E. Randel, Beth G. Chung, Michelle A. Dean, Karen Holcombe Ehrhart, Gangaram Singh

Publication: Journal of Management

Publisher: SAGE Publications

Date: 07/01/2011

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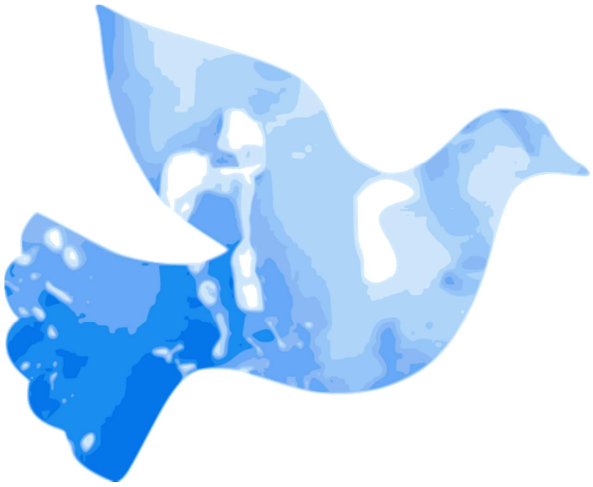
Appendix D: Recruitment E-mail



Doctoral Research Study

Professional chaplains in hospital interdisciplinary teams (IDTs).
Hello, my name is Chike ("Chee-kay") Nzegwu, a doctoral student in Health Services at Walden University, conducting a research study related to the effect of professional chaplain integration in hospital IDTs in Maryland, Virginia, and D.C.

I am seeking professional chaplains to interview face to face or by telephone that speaks English, actively working and board certified. The interview time span may last between 45-60 minutes. At any time during the interview, the research participant may withdraw if he or she feels uncomfortable with the content of the interview process.
The Institutional Review Board (IRB) approval number from Walden University for this study is 09-28-16-0311050 and expires on August 29, 2018. If you are interested, please contact me.

Chike ("chee-kay") Nzegwu
Doctoral Health Services Candidate
Walden University
College of Health Sciences
Chike.nzegwu@waldenu.edu
(xxx) xxx-xxxx

Appendix E: Interview Protocol

Interviewee's Code Name: _____
Hospital Name: _____
Date: _____ Time: _____

Introduction: Thank you for agreeing to participate in this study. My name is Chike Nzegwu a doctoral student at Walden University. The goal of this study is to understand the effect of integration of chaplains in hospital IDT. (The IRB approval number). Inform the participant the interview may last 45-60 minutes. Administer ice breaker conversation, if needed (Tell me a little about yourself, how many years a professional chaplain, what led you to want to become a chaplain, advice to others considering chaplaincy, PBS Chaplain short film).

1. What is your opinion about the consistency of policies, procedures, and actions of your organization as they relate to you as a chaplain?

2. What is your opinion on your organization's diversity culture as it relates to chaplains?

3. What is your opinion about your hospital's leadership & management decision making as they relate to you as a chaplain?

4. What is your opinion about your hospital's leadership & management values as they relate to you as a chaplain?

5. What are ways your IDT demonstrates your belonging to the team as a chaplain?

6. What are ways your IDT demonstrates your uniqueness to the team as a chaplain?

7. With regard to the previous questions, how do you feel about your overall integration as a chaplain on the IDT?
    Probe:

8. Based on how you stated you feel about your integration on the IDT, how does it affect your emotional well-being?

9. Based on how you stated you feel about your integration on the IDT, how does it affect your physical well-being?

10. Are there any particular things that are done or could be done which make you feel well integrated on the IDT?
    If yes, Probe: What specifically has been be done?
        Probe: What specifically could be done?

11. Are there any particular things that are done or should not be done which make you feel less integrated on the IDT?
    If yes, Probe: What specifically has been be done?
    Probe: What specifically should not be done?

Conclusion: Thank you for taking the time to meet with me, as a sign of appreciation for your time here is a (gift valued up to $5).

Debrief: Once I transcribe your interview, I will send it to your e-mail address for your verification. Can you please verify your e-mail address for me? If a follow-up interview is necessary I will also let you know in this e-mail. Please also remember as stated in the informed consent letter your their data will be kept secure and confidential.

Appendix F: SME Expert Panel

Interview Protocol Validation Rubric for Expert Panel - VREP©

By Marilyn K. Simon with input from Jacquelyn White

Criteria	Operational Definitions	Score **1=Not Acceptable** (major modifications needed) **2=Below Expectations** (some modifications needed) **3=Meets Expectations** (no modifications needed but could be improved with minor changes) **4=Exceeds Expectations** (no modifications needed)				**Questions NOT meeting standard (List page <u>and</u> question number) and need to be revised.** ***Please use the comments and suggestions section to recommend revisions.***
		1	2	3	4	
Clarity	• The questions are direct and specific. • Only one question is asked at a time. • The participants can understand what is being asked. • There are no *double-barreled* questions (two questions in one).					
Wordiness	• Questions are concise. • There are no unnecessary words					
Negative Wording	• Questions are asked using the affirmative (e.g., Instead of asking, "Which methods are not used?", the researcher asks, "Which methods *are* used?")					
Overlapping Responses	• No response covers more than one choice. • All possibilities are considered. • There are no ambiguous questions.					
Balance	• The questions are unbiased and do not lead the participants to a response. The questions are asked using a neutral tone.					
Use of Jargon	• The terms used are					

	understandable by the target population. • There are no clichés or hyperbole in the wording of the questions.					
Appropriateness of Responses Listed	• The choices listed allow participants to respond appropriately. • The responses apply to all situations or offer a way for those to respond with unique situations.					
Use of Technical Language	• The use of technical language is minimal and appropriate. • All acronyms are defined.					
Application to Praxis	• The questions asked relate to the daily practices or expertise of the potential participants.					
Relationship to Problem	• The questions are sufficient to resolve the problem in the study • The questions are sufficient to answer the research questions. • The questions are sufficient to obtain the purpose of the study.					
RQ1-Measure of Construct: A: (Inclusiveness climate**)**	• The interview protocol adequately measures this construct. **Operational definition:** An environment where policies, procedures, and actions of the organization adhere to fair and consistent treatment of all groups especially those that have fewer opportunities (Shore et al., 2011). (RQ1-IQ1-IQ2)					
RQ1-Measure of Construct: B: (Inclusive leadership**)**	• The interview protocol adequately measures this construct. **Operational definition:** Leadership with internal organizational processes that create inclusion and is demonstrated by the leader (Shore et al., 2011). (RQ1-IQ3-IQ4)					
RQ1-Measure of Construct: C: (Inclusiveness practices**)**	• The interview protocol adequately measures this construct. **Operational definition:** The practices that facilitate inclusion within the					

	group (Shore et al., 2011). (RQ1-IQ5-IQ6)					
RQ2-Measure of Construct: D: (Physical activity**)**	• The interview protocol adequately measures this construct. **Operational definition:** Recognizing the need for physical activity, healthy foods and sleep (Garcia 2015). (RQ2-IQ7)					
RQ2-Measure of Construct: E: (emotional well-being**)**	• The interview protocol adequately measures this construct. **Operational definition:** Coping effectively with life and creating satisfying relationships. (Garcia 2015). (RQ2-IQ8)					
Measure of RQ3	• The interview protocol adequately measures IQ9.					
Measure of RQ4	• The interview protocol adequately measures IQ10.					

Appendix G: Theme: Religious Inclusive Organization

	Common codes reported by chaplains	Frequency
1	Support of chaplains in mission and vision	5
2	Religious diversity embraced	6
3	Religious diversity resourced	6
4	Religious diversity reflected in chaplain staffing	3
5	Chaplains provide education on religious diversity	4

Appendix H: Theme: Supportive Leadership

	Common codes reported by chaplains	Frequency
1	Support for chaplaincy	6
2	Provision of additional full-time chaplains	2
3	Provide chaplaincy department resources	2
4	Extend decision-making to chaplains	3
5	Chaplain's role recognized	4

Appendix I: Theme: Valued Team Member

	Common codes reported by chaplains	Frequency
1	Contact chaplains (e.g., referrals, calls etc.)	9
2	Recognition of unique religious & spiritual skills	7
3	Involved in interdisciplinary team meetings	7
4	Included in various committees (ethics, boards etc.)	6
5	Respect for chaplain input	7
6	Included in hospital workflow	4

Appendix J: Theme: Well Integrated

	Common codes reported by chaplains	Frequency
1	Feel positively about integration	7
2	Treated fairly	2
3	Respected	5
4	Trusted Colleague	5

Appendix K: Theme: Integration Positively Impacts Physical & Emotional Well-Being

	Common codes reported by chaplains	Frequency
1	Positive impact on physical & emotional well-being	6
2	Physical well-being tied to emotional well-being	6

Appendix L: Theme: Perceptions of Inclusion

	Common codes reported by chaplains	Frequency
1	Contacting Chaplains (e.g., referrals, calls etc.)	5
2	Inviting chaplains to interdisciplinary team meetings	5
3	Including chaplains on committees (ethics, boards etc.)	4
4	Treatment as a fellow colleague	3

Appendix M: Theme: Perceptions of Noninclusion

	Common codes reported by chaplains	Frequency
1	Poor Communication	5
2	Not valuing chaplain	5
3	Excluding from interdisciplinary team meetings	4
4	Not treated as a fellow colleague	3