Liberty University School of Divinity

Mental Health Chaplaincy: A Guide for Geriatric Psychiatric Chaplains

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by

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Abstract

The Veterans Administration (VA) and Department of Defense (DOD) evaluated the expanding roles of chaplains in mental health and identified the prevalent need for additional training among chaplains when integrating chaplaincy and mental health services. Literature revealed that chaplains were lacking in the skillsets and pastoral care practices needed to effectively care for elderly patients with mental health disorders. A gap remains in literature regarding the reported level of training and preparedness of chaplains who ministered to geriatric mental health patients within clinical settings, which this project sought to examine. Harter's competence motivation theory and the Holy Bible served as this project's theoretical and theological foundations, respectively. This quantitative study used a questionnaire instrument to survey 26 chaplains. The target population was professional chaplains working in a clinical setting within New York, New Jersey, and Connecticut, who had at least one or more pastoral visit(s) with patient(s) over 65-years diagnosed with a mental health disorder. The data variables of six areas of training, level of preparedness, and competency were analyzed via SurveyMonkey. The findings confirmed the need for additional training and preparedness among chaplains who ministered to geriatric mental health patients within clinical settings. The results and empirical literature informed the development of a practical guide that included ways to help improve this ministry challenge and assist geriatric psychiatric chaplains in providing comprehensive delivery of competent care to patients. Also, geriatric patients will tangibly benefit from receiving more competent and focused chaplaincy care, which in turn would be favorable for clinical practices as a whole.

   Keywords: chaplains, geriatric chaplains, mental health chaplains, psychiatric chaplains, self-care, competence, ethics

Dedication

I dedicate this thesis project to my Lord and Savior, Jesus Christ. He died for me, and I only want to live for Him. Words defy my expressions of gratitude for the Lord's provision through eight college degrees, three from Liberty University. Dr. Margaret GoPaul, you have inspired me literally to be my utmost for His highest. Your wisdom, mentoring, and Christian faith are unmatched by any other person or academic I have ever encountered in my life. Please do not ever doubt the impact upon me and the world that you continue to make for Christ. I hope the memory of doing this thesis project, as difficult as it was at times, conjures up a big red LU flag waving in victory high on a mountain top. We made it! To my mother, Lois Martinelli, I will never forget the story about how being denied good teeth and college education in your own life caused you to promise that your children would have better. All those times as a baby that you rocked me and promised aloud that, "You are going to college, you are going to college" was more prophetic than you might have ever imagined. With your support, love, and encouragement, I not only have great teeth, but a doctorate, as well.

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Finally, I would like to thank the healthcare, hospice, and VA chaplains that anonymously participated in the thesis project survey. As one of your compatriots, I understand the daunting nature of chaplain ministry and hope this thesis project will help advance the profession for good.

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Chapter 1: Introduction

Healthcare chaplaincy is one of many types of chaplaincy. Most chaplains in the

healthcare ministry work in clinical settings, usually a hospital or a hospice facility. It has been

shown that chaplains often work as members of interdisciplinary medical teams as part of the

holistic care of patients and families (Carey & Rumbold, 2015). In this chapter, the ministry

context of healthcare chaplains, the problem presented, the researcher's basic assumptions,

definitions, delimitations, and limitations of this study are discussed. Additionally, a well-

documented history of healthcare chaplaincy supported by literature is presented.

Ministry Context

The Joint Commission for the Accreditation of Hospitals made an industry-changing

decision in 1969 about the religious, spiritual needs, and rights of hospital patients. The

resolution required hospitals to grant patients accessibility to religious and spiritual care

(Adelson, Walker-Cornetta & Kalish, 2019). Spiritual assessments were developed to evaluate

patients dealing with emotional and behavioral disorders, substance abuse, and end of life issues.

Healthcare chaplains became the main spiritual source for patients, families, and hospital staff.

Thus, the number of chaplains in the U.S. healthcare system grew, and by the new millennium,

over half of hospitals added chaplains to their healthcare team (Adelson et al., 2019). Most

chaplains were employed at larger urban hospitals, medical school hospitals, and religious

hospitals, primarily Catholic hospitals (Adelson et al., 2019).

Chaplains have been shown to work on every floor and unit of hospitals and use a family-

centered care model, which included spiritual support to patients, families, visitors, and staff. It

was noted that although chaplains considered their own religious affiliations, denominations, and

beliefs as their spiritual grounding, they practiced a pluralistic view of religion when ministering to patients with varying and diverse faiths (Adelson et al., 2019).

VandeCreek and Burton (2001) defined 'spiritual care' as "a natural dimension of all persons and defines the nature of spiritual care…with the basic premise that attention to spirituality is intrinsic to healthcare" (p. 81). Spirituality was shown to help patients to preserve their health, to survive sickness, trauma, the death of loved ones, and the transitions associated with aging (VandeCreek & Burton, 2001). Chaplains addressed patients' concerns through their ability to reach into personal religious faith, practices, and rituals. Patients whose beliefs came from outside of conventional faith were encouraged to search for a comforting spiritual association and transcendence (VandeCreek & Burton, 2001). Kelly (2012) noted that the correlation between the terms, spiritual care, and religious care was complicated, and each had a plethora of definitions and nuances (Kelly, 2012). However, as chaplains continued to discover their place in healthcare, the lines between spiritual care, religious care, and patient care became clearer based on their clinical competence and effectiveness (Kelly, 2012).

History of the Association of Clinical Pastoral Education

Healthcare chaplaincy training required seminary/divinity school education in the form of a Master of Divinity (M.Div.) or, at times, a Master of Religion degree (Association of Clinical Pastoral Education, 2019). Chaplains were also expected to complete 1600 hours of Clinical Pastoral Education (CPE) in four units as separate internships or one-year residency at a hospital or an approved clinical setting. The Association of Clinical Pastoral Education has been the ruling organization over the development of continuing education for professional clinical chaplains for almost one hundred years (Association of Clinical Pastoral Education, 2019).

William A. Bryan MD, the Superintendent of the Worcester State Hospital, Worcester, MA, founded Clinical Pastoral Education in the mid-1920s (Association of Clinical Pastoral Education, 2019). Bryan hired Rev. Anton T. Boisen as a hospital chaplain. Boisen had personal experience with mental illness and was hospitalized in 1922 after experiencing psychotic breaks for two years. He believed schizophrenia was a sickness and that it was his ministry calling to unite religion and psychiatry. Boisen's inspiration aided in the development of a program at Worcester State Hospital, Worcester, MA in 1925 that used college students to work with patients on the wards. The students received instruction in theology during the evenings with Chaplain Boisen, and the program quickly garnered increased student interest, and the enrollment grew (Association of Clinical Pastoral Education, 2019).

That same year, Richard Cabot MD, who helped establish the field of medical social work, created a similar program called the 'Clinical Year for Theological Students' at Harvard University, Cambridge, MA (Association of Clinical Pastoral Education, 2019). In 1932, the Council of Clinical Training in New York, which incorporated the New England Clinical Pastoral Education group, was created. A fissure in the groups resulted in the creation of the Institute for Pastoral Care in 1944. Both the New York and Boston based associations of Clinical Pastoral Education existed until 1967 when the Association of Clinical Pastoral Education (ACPE) was founded. Over time, the Association of Clinical Pastoral Education added the Lutheran Advisory Council and the Southern Baptist Association of Clinical Pastoral Education under its advisement (Association of Clinical Pastoral Education, 2019).

Presently, the Association of Clinical Pastoral Education has three commissions: Standards, Accreditation of Centers, and Certification of Supervisors of Clinical Pastoral

Education (Association of Clinical Pastoral Education, 2019). Since 1969, the Association of

Clinical Pastoral Education has been on the U.S. Government's Department of Education's

Commissioners list of nationally recognized associations for Clinical Pastoral Education

(Association of Clinical Pastoral Education, 2019). The Association of Clinical Pastoral

Counseling has nine regions, and the association's national archives are in Pitts Theology

Library, Emory University in Atlanta, Georgia. Throughout the first 50 years of the creation of

Clinical Pastoral Education, most of the Clinical Pastoral Education Certified Supervisors were

male, white, and Protestant Christians (Association of Clinical Pastoral Education, 2019).

Currently, there has been a reported 670 active supervisors, of which over 140 are women

and represent the Protestant, Roman Catholic, Jewish, and Islamic faiths (Association of Clinical

Pastoral Education, 2019). Recruiting programs were established for African American and

Hispanic students and supervisors (Association of Clinical Pastoral Education, 2019). The

primary current goal of the Association of Clinical Pastoral Education is to make Clinical

Pastoral Education the model of chaplaincy training and theological education (Association of

Clinical Pastoral Education, 2019).

After the completion of Clinical Pastoral Education, healthcare chaplains are required to

work in a clinical setting for a year before seeking board certification from a certifying body

(Association of Professional Chaplains, 2019a). The main certifying organization of chaplains is

the Association of Professional Chaplains (APC) in Hoffman States, IL. Chaplains that pursued

board certification must participate in a lengthy vetting process that includes analysis, verbatims,

writing professional competencies, and a comprehensive interview with experienced chaplain

mentors and peers. The Association of Professional Chaplains also has a requirement for

chaplains to complete at least 50 hours of Continuing Education Units (CEUs) annually for the

maintenance of board certification. The Continuing Education Units have been shown to consist

of professional seminars, didactics, research and methodology, reading, and self-care, to name a

few (Association of Professional Chaplains, 2019a).

The challenge has been that healthcare chaplains ministered to patients on all hospital

units, including mental health units, pediatric mental health, adult mental health, eating

disorders, and geriatric psychiatric (Geri-psych) (Fletcher, 2019). The geriatric psychiatric floor

typically consisted of a unit specifically for the care of patients diagnosed with a psychological

disorder co-occurring with a physiological diagnosis, like dementia (Fletcher, 2019).

Historically, chaplain ministry on the mental health units, particularly geriatric psychiatric units,

has not been welcomed by psychiatrists and psychologists (Fletcher, 2019).

Some clinicians asserted that pastoral and spiritual care helped exacerbate the symptoms

of patients diagnosed with psychosis or personality disorders (Olson, 2007). Olson (2007)

posited that there was a marked, waning desire to allow spirituality and religion into the

psychiatric profession. Hence, chaplains' education, intellectual prowess, and relevance on

psychiatric units came into question. Olson (2007) advocated for chaplains' preparedness and

competency for working on the mental health floors when he noted that, "in spite of the

chaplains' strength in numbers, it now appears that the psychiatric chaplains- or at least this

chaplain-were primarily learning how to do therapy" (p. 12).

Although chaplains receive training in religious and spiritual traditions, namely,

sacraments and prayers, communion and blessings, universally accepted principles of

forgiveness, and faith, chaplains were often times deficient in the specific education and

knowledge needed to offer competent care to patients diagnosed with a psychiatric disorder(s) (Goh et al., 2012). According to Goh et al. (2012), spirituality has been proven to be an integral contributor to geriatric psychiatric patients' health and well-being. Spiritual expression aided elderly patients diagnosed with mental health diagnoses and neurodegenerative diseases with issues of morality, coping, and recovery (Goh et al., 2012).

Therefore, Goh et al. (2012) indicated that "there is a need for the development of effective training and operational policies in PC (pastoral care) in mental health services" (p. 129). Subsequently, the need for the development of ministry models that meet the diverse spiritual needs and practices of geriatric psychiatric patients has been found to be of importance in this ministry context. Thus, the acquisition of mental health knowledge and training that has been proven effective in the spiritual care of elderly patients with mental disorders was identified as essential for clinical chaplains (Goh et al., 2012).

U.S. Department of Veterans Affairs Chaplain Training

The U.S. Department of Veterans Affairs was the first agency that responded to the lack of chaplains' psychiatric training and preparedness (U.S. Department of Veteran Affairs, 2019). Many Vietnam veterans currently experiencing the results of military combat and aging have been shown to need spiritual assistance with co-occurring biological and mental health diagnoses. 'Mental Health and Chaplaincy' is a national initiative that was designed to create a coordinated administration of care for veterans, service members, and their families (U.S. Department of Veteran Affairs, 2019). The emotional, social, psychological, and spiritual needs were incorporated and integrated for ideal care. Along with inpatient and outpatient care, the

program included educational, research, clinical training, and community outreach activities (U.S

Department of Veteran Affairs, 2019).

The Mental Health Integration for Chaplain Services (MHICS) is a one-year training that

better equipped chaplains to provide ministry to veterans and armed forces members with mental

health diagnoses (U.S Department of Veteran Affairs, 2019). The MHICS required the

completion of three 12-week courses through distance learning and face-to-face training (U.S.

Department of Veteran Affairs, 2019). The faculty consisted of leading experts from the U.S.

Department of Veteran Affairs, the U.S. Department of Defense, and top universities in the U.S.,

who taught on topics that included PTSD, psychological health, sexual assault prevention, and

suicide prevention (U. S. Department of Veteran Affairs, 2019).

Despite the need for chaplain psychiatric training, few seminaries and divinity schools

have been found to offer courses in mental health or psychiatric care as part of their curriculum

for aspiring chaplains. Though, slowly, the trend has shown some signs of change (Liberty

University, 2019b). For instance, Liberty University is one of the very few divinity schools that

required students to enroll in Crisis Counseling, Pastoral Counseling, and Marriage and Family

Counseling in fulfillment of the Master of Divinity (M.Div.) degree (Liberty University, 2019b).

Some seminaries and divinity schools have started to offer dual degrees that are designed to

assuage the deficit in psychiatric training. Loyola Chicago is one of two divinity schools that

provided a Master of Divinity/Master of Arts in Pastoral Counseling (Loyola University-

Chicago, 2019). Some of the core classes included in the program are, Models of Pastoral

Counseling, Addictions and Modes of Therapy, Psychopathology, Testing, Measurement and

Assessment, and Research Methods (Loyola University-Chicago, 2019).

Further, Clinical Pastoral Education provided only practical training for chaplains assigned to mental health floors/units. Currently, chaplains with no formal mental health education or training have been called upon to minister to patients with psychiatric diagnoses (Fletcher, 2012). In response to the current ministry context's need for psychiatric training and preparedness for healthcare chaplains, particularly those ministering to geriatric psychiatric patients, this study surveyed chaplains' reported level of training and competency. The surveyed results were analyzed, and the data provided valuable information that was used in the development of a guide. The guide included ways to help improve this ministry challenges and augment chaplains' competency when ministering to mental health patients, particularly geriatric psychiatric patients.

Problem Presented

The problem this project addressed was the need for comprehensive chaplaincy training and preparation for competent ministry and care for mental health patients, specifically the geriatric population. Ministering to the geriatric population has been shown to require a combination of empathy, compassion, patience, specific training, and preparation (Lawrence et al., 2007). Lawrence et al. (2007) confirmed that ministry to the geriatric population was vital in confirming their faith, resolving moral and religious issues, dealing with misfortune or losses, and confronting sickness and disability. However, geriatric psychiatric patients have proven to be particularly intuitive about insincerity and incompetence, and they quickly developed protective walls to insincerity (Lawrence et al., 2007). Therefore, chaplains needed to be prepared to draw from their skillsets of well demonstrated and adaptive compassion, patience, empathy, and sensitive listening skills (MacKinlay, 2002).

Subsequently, when a chaplain is requested to minister to the geriatric population dealing with mental health challenges, their task can become even more delicate and challenging, especially for a trainee or inexperienced chaplain (Fletcher, 2019). This challenge had become further compounded by the fact that few seminaries and divinity schools have been found to offer courses in mental health or psychiatric care as part of their curriculum (Fletcher, 2019; Goh et al., 2014; Lawrence et al., 2007). Therefore, there remained an established need for chaplain psychiatric training and preparedness within the ministry context for healthcare chaplains (U. S. Department of Veteran Affairs, 2019). Hence, finding ways to improve this ministry challenge and increase chaplains' competency when ministering to mental health patients, particularly geriatric psychiatric patients, would have been valuable.

Purpose Statement

The purpose of this Doctor of Ministry study was to examine via survey, the level of training and preparedness of chaplains who ministered to geriatric mental health patients within clinical settings to address the need for comprehensive and competent care for mental health patients, specifically the geriatric population. The data collected from the chaplains served in the creation of a guide that included ways to help improve this ministry challenge and assist geriatric psychiatric chaplains in providing comprehensive delivery of competent care to patients.

Hence, this hands-on guide addressed fundamental aspects of mental health chaplaincy, such as specific geriatric psychiatric competencies, spiritual preparedness, mental preparedness, clinical preparation, ethical competence, using on-the-job tools, and self-care. Essentially, this action research served to advise chaplains not only about the clinical aspects of the job, but about daily management of work, the importance of debriefing, living a balanced personal and

professional lifestyle. Enhanced chaplains' self-awareness can benefit geriatric patients and

hospital staff psychologically and spiritually through the delivery of more competent, confident,

and focused pastoral care.

Specifically, the tangible benefits for chaplains would be the satisfaction received from

knowing that they have given their best and fulfilled God's desire to be workers of excellence.

Therefore, the Holy Bible stated that "they which believe in God may be careful to devote

themselves to good works. These things are excellent and profitable for people" (Titus 3: 8, King

James Version).

Additionally, having a practical guide that can be easily accessed in times of uncertainty

will relieve the stressor of feeling unprepared in certain unfamiliar situations. Hence, the

chaplains' daily management of work and the reminders of debriefing and self-care will promote

a balanced lifestyle. Furthermore, geriatric patients will tangibly benefit from receiving more

competent and focused chaplaincy care, which in turn would be favorable for clinical practices

as a whole.

Basic Assumptions

This study contained some assumptions. First, there was the assumption that chaplains

within the clinical field were willing to participate in the research and disclose information on

their level of training and preparedness. Second was the assumption that the respondents fully

understood the questions asked in the survey.

Third, there was the assumption that the information collected within the survey

questions included full disclosure and transparency from the sampled participants. Fourth, there

was the assumption that the respondents objectively based their answers and ratings on the

importance of training and preparation. Fifth, the study assumed that the specific sampled population provided valuable data to aid in the development of a practice guide for geriatric psychiatric mental health chaplains.

Definitions

Abuse: "Excessive or improper use of substance, e.g. alcohol or other drugs, which may result in damage to health or increased risk of damage, mistreat, harming or injuring another" (World Health Organization, 1994, p. 4).

Anxiety: "Apprehensive uneasiness or nervousness usually over an impending or anticipated ill: a state of being anxious" (Webster's College Dictionary, 1991, p. 63).

Aphasia: "Partial or total loss of the ability to articulate ideas or comprehend spoken or written language, resulting from damage to the brain from injury or disease" (Webster's College Dictionary, 1991, p. 64).

Bipolar disorder: "Any of several psychological disorders of mood characterized usually by alternating episodes of depression and mania" (Webster's College Dictionary, 1991, p. 138).

Catatonia: "A psychomotor disturbance that may involve muscle rigidity, stupor or mutism, purposeless movements, negativism, echolalia, and inappropriate or unusual posturing and is associated with various medical conditions such as schizophrenia and mood disorders" (Webster's College Dictionary, 1991, p. 214).

Co-occurring disorders: "Refers to the condition in which an individual has a co-existing mental illness and substance use disorder. While commonly used to refer to the combination of substance use and mental disorders, the term also refers to other combinations of disorders, such

a mental disorder and an intellectual disability" (The terms dual disorder and dual diagnosis were previously used to describe the same condition) (Psychology Today, 2019, p. 1).

Countertransference: "Transference on the part of the analyst of repressed feelings aroused by the patient" (Dictionary.com, 2019, para. 1).

CRISP: "An acronym that stands for cultural care, religious care, individual care, spiritual care, and pastoral care" (Fletcher, 2019, p. 56).

Debriefing: "To carefully review upon completion" (Webster's College Dictionary, 1991, p. 350).

Delirium: "An acute mental disturbance characterized by confused thinking and disrupted attention usually accompanied by disordered speech and hallucinations" (Webster's College Dictionary, 1991, p. 358).

Delusional: "Psychology: a persistent false psychotic belief regarding the self or persons or objects outside the self that is maintained despite indisputable evidence to the contrary" (Webster's College Dictionary, 1991, p. 359).

Dementia: "A usually progressive condition (such as Alzheimer's disease) marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior)" (Webster's College Dictionary, 1991, p. 359).

Depression: "A mood disorder marked especially by sadness, inactivity, difficulty in thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, and sometimes suicidal tendencies" (Webster's College Dictionary, 1991, p. 364).

Eating disorder: "Any of several psychological disorders (such as anorexia nervosa or bulimia) characterized by serious disturbances of eating behavior" (Webster's College Dictionary, 1991, p. 422).

Echolalia: "The often pathological repetition of what is said by other people as if echoing them" (Webster's College Dictionary, 1991, p. 423).

Geriatric: "A branch of medicine that deals with the problems and diseases of old age and the medical care and treatment of aging people" (Webster's College Dictionary, 1991, p. 559).

Hallucination: "A sensory perception, of any modality, occurring in the absence of the appropriate external stimulus. Hallucinations may be subdivided according to their intensity, complexity, clarity of perception, and the subjective degree of their projection into the external environment" (World Health Organization, 1994, p. 47).

Hearing-impaired: "Not able to hear well" (Webster's College Dictionary, 1991, p. 617).

Hypervigilance: "A state of excessive alertness, manifested by a constant scanning of the environment for indication of danger, Hypervigilance is seen most often in individuals with a paranoid personality structure, in post-traumatic stress disorders, and in some forms of psychoactive substance abuse" (World Health Organization, 1994, p. 54).

Insomnia, nonorganic: "Unsatisfactory quantity and/or quality of sleep which persists for a considerable period of time. It includes difficulty in falling asleep, difficulty in staying awake, or early final awakening" (World Health Organization, 1994, p. 56).

Mandated reporter: "Is a person who, because of his or her profession, is legally required to report any suspicion of child abuse or neglect to the relevant authorities. These laws are in

place to prevent children from being abused and to end any possible abuse or neglect at the

earliest possible stage" (Social Work Degree Guide, 2019, p. 1).

Ministry of presence: "Is a way of "being" rather than a way of "doing" or "telling." As

we prepare to be with those who suffer, we should not think about what to say or what to do"

(Pennel, 2012, p. 1).

Obsessive-compulsive disorder: "Relating to or characterized by recurring obsessions and

compulsions especially as symptoms of obsessive-compulsive disorder" (Webster's College

Dictionary, 1991, p. 934).

Post-traumatic stress disorder: "A psychological reaction occurring after experiencing a

highly stressing event (such as wartime combat, physical violence, or a natural disaster) that is

usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of

reminders of the event —abbreviation PTSD" (Webster's College Dictionary, 1991, p. 1055).

Psychiatric: "A branch of medicine that deals with mental, emotional, or behavioral

disorders" (Webster's College Dictionary, 1991, p. 1099).

Schizoaffective disorder: "An episodic disorder in which both affective and schizophrenic

symptoms are prominent so that the episode of illness does not justify a diagnosis of

schizophrenia or a depressive or manic episode. Manic, depressive, and mixed types can be

distinguished, depending on the preponderant of the affective ingredient" (World Health

Organization, 1994, p. 88).

Schizophrenia disorder: "A disorder characterized in general by fundamental and

characteristic distortions of thinking and perception, and the affects that are inappropriate or

blunted. Clear consciousness and intellectual capacity are usually maintained, although certain

cognitive deficits may evolve of time. The disturbance involves the most basic functions that gave the normal person a feeling of individuality, uniqueness, and self-direction. The most intimate thoughts, feelings and acts are often felt to be known or shared by others, and explanatory delusions may develop to the effect that natural or supernatural forces are at work to influence the afflicted individual's thoughts and actions in ways that re often bizarre. Although no pathognomonic symptoms can be identified, the most important psychopathological phenomena include thought echo, thought insertion or withdrawal, thought broadcasting, delusional perception and delusions of control, influence or passivity, hallucinatory voices commenting on or discussing the patient in the third person, disorders in the train of thought, catatonia, and negative symptoms. The course of schizophrenia can be continuous or episodic with progressive or stable deficit following the episodes or consist of one or more episodes with complete remissions" (World Health Organization, 1994, p. 88).

Schizotypal personality disorder: "A personality disorder characterized by peculiar or eccentric thoughts, behaviors, and patterns of speech, odd beliefs or fantasies, disturbances in the perception of events, difficulty in forming or maintaining close relationships, and a tendency to be suspicious or paranoid" (Webster's College Dictionary, 1991, p. 1200).

Social anxiety disorder: "A wariness of strangers and social apprehension or anxiety when encountering new, strange, or socially threatening situations. Such fears arise in early childhood but are severe enough to cause problems in social functioning" (World Health Organization, 1994, p. 94).

Suicidal ideation: "Refers to thinking about, considering, or planning suicide" (National Institute of Mental Health, 2020, para. 4).

Transference: "The redirection of feelings and desires and especially of those unconsciously retained from childhood toward a new object (such as a psychoanalyst conducting therapy)" (Webster's College Dictionary, 1991, p. 1416).

Limitations and Delimitations

There were some limitations to this study. First, the generalizability of this study's finding was decreased due to the sampling procedure, which was limited to chaplains within the scope of the Tristate area of New York, New Jersey, and Connecticut. Therefore, future studies that examined the response of chaplains state-wide and even internationally would add to this study's findings and generalizability and application.

Second, was the possible threat to validity as the main measurement instrument was created in the form of a survey, which limited the study from exploring questions in-depth and collecting more qualitative data (Gillham, 2008). Therefore, details such as the individual chaplain's daily experiences, strengths, and struggles were difficult to examine when using this instrument (Gillham, 2008).

There were also some delimitations to this study which examined the reported levels of training and preparedness of chaplains who specifically ministered to geriatric psychiatric patients within clinical settings. The rationale for the focus of the study was to collect quantitative data on a level of competency that aided the development of a practical guide designed specifically for geriatric psychiatric chaplains.

The specific practical guide intentionally served as an applicable guidepost for both trainee and experienced mental health chaplains in improving their delivery of competent and comprehensive care to geriatric psychiatric patients. Therefore, this study only surveyed

chaplains that had at least one or more pastoral visits with geriatric patients over 65-diagnosed with a mental health disorder. Also, the study focused on chaplains that worked within a defined clinical setting, such as a hospital, hospice, nursing home, skilled care nursing, or Veterans hospital.

Thesis Statement

Healthcare chaplains' competency and preparedness to minister to mental health patients, specifically on geriatric psychiatric units, can be adversely affected by insufficient mental health education, training, and preparedness. This study surveyed and examined the reported level of competency and preparedness of chaplains that minister to mental health patients, particularly geriatric patients with mental health disorders.

Specifically, the data collected were analyzed to determine the level of competency and preparedness of chaplains that minister to geriatric patients with mental health disorders, in terms of their geriatric psychiatric competencies, spiritual preparedness, mental preparedness, clinical preparation, ethical competence, use of on-the-job tools, and self-care.

In response to this need, the results of the study were used to suggest practical ways to develop a guide that filled the gap of training and preparation for healthcare chaplains. This hands-on guide included suggestions for training for chaplains at the academic level, which consisted of more counseling courses in graduate school and/or continuing education training. The next level of training could be on-the-job training, whereby employers provided legal/ethical guidelines, safely, and other training needed for the chaplains serving the mental health units or floors.

Another level of training would be focused on the spiritual, mental, and clinical preparedness of chaplains that served geriatric patients. This training would include valuable self-assessments, self-care, and the establishment of a safe and accessible support system. Having self-assessments of one's level of preparedness would assist chaplains in developing resilience to burnout, improve their quality of life (work and personal), and better prepare them to effectively serve their patients.

Summary

A transitory introduction of this thesis project's topic was outlined in this chapter with a well-documented history of healthcare chaplaincy supported by literature. The need for comprehensive chaplaincy training and preparation for competent ministry and care for mental health patients, specifically the geriatric population, was discussed in relation to the ministry context. The projects' purpose of examining the level of training and preparedness of chaplains who ministered to geriatric mental health patients within clinical settings was established along with the goal of developing a guide from the data collected.

In the ensuing chapter, an exhaustive literature review, including the history of healthcare chaplaincy, resistance to healthcare chaplains, mental health and mental illness, geriatric psychiatric ministry, theology of Christian chaplains, chaplains, and geriatric psychiatric education, and competencies of geriatric psychiatric chaplains are presented. Additionally, the theological and theoretical foundations that undergirded this research project are discussed.

Chapter 2: Conceptual Framework

In this chapter, a comprehensive review of precedent literature related to the history of healthcare chaplaincy, resistance to healthcare chaplains, mental health and mental illness, geriatric psychiatric ministry, theology of Christian chaplains, chaplains and geriatric psychiatric education, and competencies of geriatric psychiatric chaplain is presented. This literature review also discussed a review of current empirical publications related to the topic of mental preparedness, spiritual preparedness, prayer, worship, clinical training, ethics, and self-care of chaplains. Next, the theological and theoretical bases that undergirded this research project are described in detail.

Literature Review

Healthcare chaplaincy was one of many types of chaplaincy in which the chaplain ministered in a professional clinical setting; hospitals, hospices, nursing homes, skilled nursing homes or Veterans homes. Chaplains in these settings worked beside other medically trained personnel on interdisciplinary teams to enhance the holistic care of patients and families (Carey & Rumbold, 2015). The salient role and skill of a healthcare chaplain was the ability to be an exegete and a communication facilitator who served as a liaison between patient and clinical staff, clinical staff, hospital management, and the community and the church (Carey & Rumbold, 2015). The literature supported the well-documented development and history of healthcare chaplaincy.

History of Healthcare Chaplaincy

The Joint Commission for the Accreditation of Hospitals made a crucial decision in 1969 that affected the religious, spiritual needs, and rights of hospital patients (Adelson et al., 2019).

The resolution required hospitals to provide access to religious and spiritual services for all

patients (Adelson et al., 2019). Spiritual assessments were created and implemented for patients

with emotional and behavioral disorders, substance abuse, and end of life issues. Healthcare

chaplains became the primary spiritual providers for patients, families, and hospital staff. Thus,

the number of chaplains in the U.S. healthcare system increased. Between 1993 and 2003, 54%

to 64% of hospitals employed staff chaplains (Adelson et al., 2019). Most worked at larger

hospitals, hospitals associated with medical schools, and hospitals with religious affiliations

found mostly in urban areas (Adelson et al., 2019).

Healthcare chaplains ministered on every floor and unit of hospitals including, inpatient

and outpatient surgery, intensive care, the emergency department, and psychiatric units, to name

a few (Adelson et al., 2019). Chaplains used a family-centered care model that included patients,

families, visitors, and anyone associated with the patients as potential recipients of care. Though

healthcare chaplains followed the practices of their own faith and beliefs, they adopted a

pluralistic view when communicating about religion with their patients (Adelson et al., 2019).

Chaplains ministered under the assumption that the people in healthcare facilities and

communities, including staff, possessed a spiritual makeup (Adelson et al., 2019). Kelly (2012)

wrote, "people and communities are, therefore, spiritual not because they are religious but

because they are human or consist of human beings in relationship" (p. 469).

Chaplains were the imparters of "spiritual care" or "religious or pastoral care," the latter

connoted a more ministerial tone (VandeCreek & Burton, 2001, p. 81). VandeCreek and Burton

(2001) defined 'spiritual care' as "a natural dimension of all persons and defines the nature of

spiritual care…with the basic premise that attention to spirituality is intrinsic to healthcare" (p.

81). Spirituality defied the purely biologically notion of healthcare and helped patients to preserve health, to survive sickness, trauma, the death of loved ones, and the transitions involved with aging (VandeCreek & Burton, 2001). The correlation between the term spiritual care and religious care was complicated. Each had an abundance of definitions and interpretations (Kelly, 2012).

The Scottish Government in 2009 clearly described the universal terms, 'spiritual care' and 'religious (pastoral) care' (Kelly, 2012). Spiritual care made no presupposition about a person's conviction of life orientation and was established in one-to-one, person-centered relationships (Kelly, 2012). Religious care between the chaplain and the patient came with shared religious beliefs, liturgies, and assumption of a connection to a faith community (Kelly, 2012). Though spiritual care did not have to be religious, religious care was always spiritual. Kelly (2012) labeled spiritual care as the umbrella over religious care and posited that religious care intended to meet spiritual needs.

In the duties of spiritual care, chaplains handled spiritual distress when a patient, patient's family member or friend, or staff member struggled to discover meaning or purpose in their present situation, illness, death, disability, tragedy, or suffering (Kelly, 2012). This spiritual distress may have casted doubt on patients' and peoples' understanding and conception of the world and caused insecurity about their place in the world (Kelly, 2012). Christian chaplains were expected to embody the grace and love of Christ and affirm people in their feelings of powerlessness, vulnerability, hurt, and distress. Kelly (2012) found that through the process of normalizing distressed peoples' emotions, that sacred places and spiritual relevance were revealed to them through the exploration of the meaning and purpose of life-shaking experiences.

Subsequently, Kelly (2012) indicated that with all that was involved with ministry, chaplaincy training needed to be diverse and multifaceted. Hence, chaplains have been shown to engage in ministerial discourse and response, maintain a presence with people through challenging events, normalize negative events, establish trusting relationships, explore the difficult questions, preach hope, resilience and inner strength, mark meaningful moments with ritual, and facilitate a connection to the individual's spiritual or religious well-being (Kelly, 2012).

Chaplaincy training also included seminary/divinity school education in the form of a Master of Divinity (M.Div.) or a Master of Religion/Theology degree. Chaplains were taught about "Christian doctrine, ethics, ecclesiastical history, biblical studies, pastoral care, and apologetics" (Kelly, 2012, p. 472). In addition, chaplains were also required to complete 1600 hours of Clinical Pastoral Education (CPE) in four units as separate internships or one-year residency at a hospital or approved clinical setting before pursuing board certification (Kelly, 2012).

The formation of Clinical Pastoral Education (CPE) had a storied history (Association of Clinical Pastoral Education, 2019). William A. Bryan MD, the Superintendent of the Worcester State Hospital, Worcester, MA, founded Clinical Pastoral Education in the mid-1920s. Bryan hired Rev. Anton T. Boisen as a hospital chaplain. However, Boisen experienced psychotic breaks and was hospitalized from 1920 to 1922. Later, Boisen pursued a research interest in his personal mixture of denominational faith, Congregational and Presbyterian, and developed Clinical Pastoral Education (Association of Clinical Pastoral Education, 2019). Boisen felt that he was called to unite religion and medicine and believed that schizophrenia was a sickness of

the soul. Boisen's hypothesis that crisis was a religious quickening inspired a program to be

developed in 1925 that used theological students to serve as attendants on hospital wards. Bryan

was an ardent supporter of the program, and it flourished (Association of Clinical Pastoral

Education, 2019).

One of the first research assistants to aid Boisen in his scientific endeavors was Helen

Flanders Dunbar MD, a pioneer in psychosomatic research (Association of Clinical Pastoral

Education, 2019). Dunbar later became the Medical Director of the Council for Clinical Pastoral

Thinking of Theological Students in New York City (Association of Clinical Pastoral Education,

2019).

During the summer of 1925, Worcester State Hospital combined practical medical

experience and theological learning. Students cared for patients during the day and participated

in theological studies with Chaplain Boisen in the evenings. As the years passed, more

theological students enrolled in the program (Association of Clinical Pastoral Education, 2019).

That same year, Richard Cabot, a prominent figure in the founding of medical social

work, created a 'Clinical Year for Theological Students' at Harvard University, Cambridge, MA

(Association of Clinical Pastoral Education, 2019). Thus, Boisen publicly credited the founders

of the Clinical Pastoral Education movement; Cabot, Bryan, Charles F. Reed MD, and from the

Chicago Theological Seminary, Fred Eastman, and Professor Arthur Holt (Association of

Clinical Pastoral Education, 2019).

In January 1930, Cabot, Episcopal Bishop Henry Wise Hobson, Samuel Eliot of the

Arlington Street Unitarian Church of Boston, William A. Healy of the Judge Baker Foundation,

and Ashely Day Leavitt of the Harvard Congregational Church created the Council for Clinical

Training of Theological Students (Association of Clinical Pastoral Education, 2019). Dunbar was named Executive Director, Cabot, President; Hobson, Vice President; Boisen, Secretary, and Rev. Philip Guiles, field secretary (Association of Clinical Pastoral Education, 2019).

In 1932, Dunbar moved the Council for Clinical Training to New York (Association of Clinical Pastoral Education, 2019). A split occurred within the group, and Boisen and Dunbar remained in New York, while Cabot and Guiles from Boston formed the Institute for Pastoral Care in 1944. The two associations co-existed until they were joined in 1967 and renamed the Association of Clinical Pastoral Education, Inc. (Association of Clinical Pastoral Education, 2019). The Association of Clinical Pastoral Education also included the Lutheran Advisory Council and the Southern Baptist Association of Clinical Pastoral Education (Association of Clinical Pastoral Education, 2019).

The Association of Clinical Pastoral Education had three commissions: Standards, Accreditation of Centers, and Certification of Supervisors of Clinical Pastoral Education (Association of Clinical Pastoral Education, 2019). Since 1969, the Association of Clinical Pastoral Education had been on the U.S. Government's Department of Education Commissioners' List of nationally recognized associations for Clinical Pastoral Education (Association of Clinical Pastoral Education, 2019). There were nine regions represented in the Association of Clinical Pastoral Education. The national office is located in Decatur, GA, and the association's national archives are located in Pitts Theology Library, Emory University, Atlanta, Georgia (Association of Clinical Pastoral Education, 2019).

Throughout the first 50 years of the creation of Clinical Pastoral Education, most of the Clinical Pastoral Education Certified Supervisors were male, white, and Protestant Christians

(Association of Clinical Pastoral Education, 2019). Presently, of 670 active supervisors, over 140 were women and represented the Protestant, Roman Catholic, Jewish, and Islamic faiths. There were also recruiting programs established for African American and Hispanic students and supervisors (Association of Clinical Pastoral Education, 2019). Clinical Pastoral Education grew into an international movement of over 3,300 members and 350 Association of Clinical Pastoral Education Accredited Clinical Pastoral Education Centers worldwide. The focus of the Association of Clinical Pastoral Education was to develop and model theological education that would profoundly change the way that ministry was implemented in healthcare (Association of Clinical Pastoral Education, 2019).

After the completion of Clinical Pastoral Education, chaplains were expected to minister for a year in a clinical setting before qualification for board certification from several organizations (Association of Clinical Pastoral Education, 2019). The main certifying body has remained as the Association of Professional Chaplains in Hoffman States, IL. According to the Association of Clinical Pastoral Education (2019), chaplains that sought board certification experienced a comprehensive vetting process that included the written evaluation of 16 professional competencies, verbatims, and participation in extensive peer interviews.

Additionally, the Association of Professional Chaplains has stipulated that board-certified chaplains are required to complete at least 50 hours of Continuing Education Units (CEUs) per year to maintain certification (Association of Professional Chaplains, 2019a). The Continuing Education Units are expected to include professional seminars, webinars, didactics, conferences, research and methodology, reading, and self-care, to name a few (Association of Professional Chaplains, 2019b).

Resistance to Healthcare Chaplains

According to Fletcher (2009), chaplains have been shown to minister to patients on various floors and units, including mental health units, pediatric mental health, adult mental health, eating disorder, and geriatric psychiatric (geri-psych). The geriatric psychiatric unit has been defined as a unit comprised of patients diagnosed with a psychological disorder(s) co-occurring with a physiological diagnosis, for example, Alzheimer's disease (Fletcher, 2019).

Olson (2007) found that the chaplains' presence on the mental health units, particularly geriatric psychiatric units, had been met with some resistance from psychiatrists and psychologists. The assertion was that any discussion of religion and spirituality caused patients diagnosed with psychosis or other personality disorders to worsen (Olson, 2007). Further, Olson (2007) posited that the resistance was either a 'red herring' or a consistent demonstration of how little interest there was to allow spirituality and religion into the psychiatric profession. Olson (2007) wrote, "in spite of the chaplains' strength in numbers, it now appears that the psychiatric chaplains- or at least this chaplain-were primarily learning how to do therapy" (p. 12).

Goh et al. (2014) indicated that spirituality was a powerful contributor to geriatric psychiatric patients' health and well-being. Spiritual expression was shown to aid older patients that had mental health diagnoses and neurodegenerative diseases with morality, coping, and recovery (Goh et al., 2014). Though chaplaincy training included religious and spiritual traditions, sacraments and practices, communion and blessings, translations of the Holy Bible, universally accepted principles of forgiveness, faith, and love, chaplains lacked the education and knowledge of psychiatric diagnoses and assessment (Goh et al., 2014).

Further, additional research was recommended for the development of ministry models that met the multi-faith needs and concerns of geriatric psychiatric patients. Chaplains were deficient in the skillsets and pastoral care practices that were effective in the care of elderly patients with mental health disorders (Goh et al., 2014). There was a need for the establishment of effectual training, models, tools, and functional policies in pastoral care that were used in the care of geriatric psychiatric patients (Fletcher 2019, Goh et al., 2014; Lawrence et al., 2007).

Lucchetti, Braguetta, Vallada, and Vallada (2012) found that mental health chaplains held the position as trusted spiritual or religious experts and consultants to patients, patients' families, staff, and 60 % of hospitals had professional healthcare chaplaincy. However, the profession fell short of the psychiatric training required to understand the diagnostic intricacies of mental health patients, primarily geriatric psychiatric patients (Fletcher 2019, Goh et al., 2014; Lawrence et al., 2007; Lucchetti et al., 2012). Famed psychologist Carl Jung expressed his concern about the presence of clergy among the psychiatric (Fletcher, 2019). Jung wrote, "(clergy being) insufficiently equipped to cope with the urgent psychic needs of our age and that it is high time for the clergyman and the psychotherapist to join forces to meet this great spiritual task" (Fletcher, 2019, p. 55).

Studies have shown that psychiatric clinicians believed there were negative aspects of pastoral care for elderly adults with mental health needs (Fletcher, 2019; Lawrence et al., 2007). Specifically, Lawrence et al.'s (2007) qualitative analysis revealed five categories of the detrimental effects of pastoral care. These detrimental effects included: worsened psychiatric symptoms, caused intrusion and coercion, conflicted and interfered with psychiatric care, provided negative or terminal connotations, and had no therapeutic meaning or value. Further,

Fletcher (2019) posited that sometimes spirituality was 'unhealthy' (p. 34). Fletcher (2019) wrote, "to think that spirituality is universally good is rather like saying 'family' is good or 'personality' is good" (p. 34). Mental health services were full of people whose 'spirituality or spiritual community was distorted or damaged' (p. 34). Therefore Fletcher (2019) noted that it was the clinician's responsibility to respect the patient's spirituality or religion and discern healthy and unhealthy aspects of spirituality. Hence, clinicians were the ones that guided patients to separate their physical maladies from their spirituality, with help from chaplains (Fletcher, 2019).

Additionally, Carey and Rumbold (2015) postulated that criticism of chaplains and analysis of their performance was not a new practice. Personal letters recorded by soldiers in the U.S. Civil War (1860-1864) have shown that some chaplains failed to support soldiers, and sometimes even abandoned troops during difficult mental and spiritual times. There were also complaints about chaplains' demonstrations of bad judgment, intolerance, racial discrimination, and socio-religious dogma (Carey & Rumbold, 2015).

The literal adherence to and proselytization of Scripture by some chaplains during the Civil War and in modern times had caused mental health patients to self-injury (Lucchetti et al., 2012). Reportedly, some patients diagnosed with psychosis plucked their eye out after reading Matthew 5:29, that read "if your right eye causes you to stumble, pluck it out and throw it away from you" (Lucchetti et al., 2012, p. 316). Thus, attempts at spiritual healing by chaplains were sometimes connected to relapses in patients with schizophrenia (Lucchetti et al., 2012). Mental health contained a continuum of psychiatric functioning that ranged from depression and anxiety, to homeostasis, to thriving adaptive behaviors, and functioning (MacKinlay, 2002). Additionally,

mental health was a profession with intricate clinical, social, and ethical elements, which made

the chaplaincy even more difficult to negotiate (MacKinlay, 2002).

Though there were selected examples of negative associations with chaplains and

chaplaincy, Fletcher (2019) asserted that chaplains had a "role in the complex world of mental

health" (p. 19). The natural basis of mental health naturally helped to structure mental health

chaplaincy (Fletcher, 2019). For example, questions that came from mental health addressed

what does "well" and "mentally well" mean (Fletcher, 2019, p. 19)? Therefore, Fletcher (2019)

indicated that "there is no single answer, and it is amidst this ambiguity that mental health

chaplaincy has to find a place" (p. 19).

Mental Health and Mental Illness

Mental health was defined by the American Psychiatric Association (2018) as "the

foundation for thinking, communication, learning, resilience, and self-esteem…key to personal

well-being, relationships, and contributing to community or society" (p. 4). Mental illnesses were

health disorders, which included alteration of thinking, emotions, and behaviors (American

Psychiatric Association, 2018). One in five (19%) of U.S. adults encountered mental illness in a

year (American Psychiatric Association, 2018). One in 24 (4.1%) were diagnosed with severe

mental illness, and 1 in 12 (8.5%) had alcohol and drug abuse disorders (American Psychiatric

Association, 2018).

Common mental illnesses included anxiety disorders, depression, bipolar disorder,

schizophrenia, posttraumatic stress disorder (PTSD), addiction and substance abuse use

disorders, and suicidal ideation (American Psychiatric Association, 2018). Mental illness ranged

from mild to so severe that patients were hospitalized (American Psychiatric Association, 2018).

Mental illnesses have been shown to affect peoples' personality, thinking, perception, mood, behavior, and judgment (American Psychiatric Association, 2018). According to Guest Lowery (2018), "research strongly suggests that most mental disorders are caused by an interplay between heredity, brain biochemistry, and environmental factors. This is why mental illness is a brain disease" (p. 2).

Subsequently, Perez-Carter (2017) found that geriatric psychiatric units were occupied by mostly elderly patients that had mental health diagnoses that included major depressive disorders, bipolar disorder, and schizophrenia. Many of the patients also had a co-occurring disorder, which included dementia (Perez-Carter, 2017). Dementia was classified as a neurocognitive disorder and not simply a mental illness (Fletcher, 2019). According to the World Health Organization (2016), "dementia is an umbrella term that refers to 'a syndrome – usually of a chronic or progressive nature – in which there is deterioration in cognitive function beyond what might be expected from normal aging'" (p. 1).

The most prominent types of dementia were noted to be Alzheimer's, vascular dementia, dementia with Lewy bodies, Parkinson's dementia, and fronto-temporal dementias (Fletcher, 2019; World Health Organization, 2016). Fletcher (2019) noted that there were various subtypes of the disease, and the progression of dementia is non-specific (Fletcher, 2019). Typically, dementia presented with a slow decline in cognition and function. Thus, symptoms included marked changes in memory, recall, orientation, word formation, task completion, and judgment (American Psychiatric Association, 2018; Fletcher, 2019).

Further, Fletcher (2019) indicated that individuals diagnosed with dementia were also more likely to experience confusion and delirium from physiological maladies such as urinary or

respiratory infections, constipation, hormonal imbalances, dehydration, malnutrition, overmedication, and sedation. Mental and biological problems were found to exacerbate the inability of individuals diagnosed with dementia to communicate effectively, especially as the disease advanced (Fletcher, 2019). Unfortunately, it was shown that there was no pharmacological therapy available that significantly stemmed or cured the deleterious progression of dementia (Fletcher, 2019).

Mental Health Chaplaincy: Geriatric Psychiatric Ministry

The challenge for chaplains in ministry to patients on the geriatric psychiatric floors was found to be mostly in the area of mental illness or cognitive functions, primarily dementia, which was often misconceived, disregarded, or labeled as taboo (Fletcher, 2019). However, research has indicated that individuals in the general population that manifested psychiatric symptoms were more likely to approach their minister or clergy person before psychiatric professionals to discuss their mental health (Wang, Berlund, & Kessler, 2003). In fact, one-quarter of people that received assistance from clergy in any given year for their mental illness, possessed the most seriously impairing mental diagnoses (Wang et al., 2003). Therefore, it was shown that clergy played a pivotal role in the U.S. mental healthcare hierarchy and was listed as trusted members of communities, churches, and hospital staff. However, Wang et al. (2003) cautioned that "interventions appear to be needed to ensure that clergy member recognize that presence and severity of disorders, deliver therapies of sufficient intensity, and collaborate appropriately with health care professionals" (p. 647).

In the field of chaplaincy, there was found to be an interconnectedness between religion, spirituality, and pastoral care (Goncalves, Lucchetti, Menezes, & Vallada, 2015). Goncalves et

al. (2015) indicated that "defining complex and multifaceted concepts such as spirituality and religiosity is not easy as there is not universal definition accepted by researchers" (p. 293). Spirituality had been described as a force that linked individuals to the universe, and a way to discover meaning in life by connection to the sacred, distinguished from humanism (Goncalves et al., 2015). Hence, religion was considered as an amalgamation of evolving beliefs, practices, and rites that connected to the transcendent God (Goncalves et al., 2015). Likewise, pastoral care was portrayed as a meaningful recognition and support of spirituality and religion for other people (Fletcher, 2019). Therefore, Fletcher (2019) stated that when addressing pastoral care, "the truth of this and its relevance to our work emerges from the perception of the patient, not the chaplain, the job title or role description" (p. 23).

Few studies analyzed the clinical applicability between religion/spirituality and mental health (Koszycki, Raab, Aldosary, & Bradwejn, 2012). However, it was suggested that religious/spiritual intervention (RSI) was essential in the alteration of an individual's ability to accept illness, openly receive social support, and acquire an understanding of religion and faith that ultimately affected patient outcomes (Goh et al., 2012).

Regarding mental health, some studies had shown a direct correlation between religion/ spiritual interventions and psychological well-being, satisfaction, happiness, and moral values (Goh et al., 2012; Goncalves et al., 2015). In Goncalves et al.'s (2015) systematic review and meta-analysis of religious and spiritual interventions in mental health, the spiritual approaches used in mental health were focused on the subject's mental values, belief in a higher power, transcendence, meditation, and therapeutic models. The meta-analysis of seven studies revealed

that patients experienced a dramatic reduction in anxiety levels and depression when spiritual interventions were used (Goncalves et al., 2015).

Similarly, Puchalski (2001) indicated that among geriatric psychiatric patients, spirituality was found to significantly enhance the well-being of patients with dementia and other mental health maladies. Puchalski (2001) revealed that the three areas that were positively influenced by spirituality were morality, coping, and recovery. Subsequently, Goh et al. (2012) stated, "that clinical care of patients is optimized by developing a comprehensive understanding of their spiritual needs and providing more holistic services" (p. 128). Thus, specialized training and skill development were identified as an area of need for chaplains that ministered in mental health facilities (Goh et al., 2012).

Despite the training gap, pastoral care became recognized as a necessary element for the holistic care of geriatric psychiatric patients (Goh et al., 2012). Hence, a British study conducted by Lawrence et al. (2007) that examined clinicians' attitudes toward the addition of spirituality into geriatric psychiatry discovered that 92% acknowledged the significance of the spiritual dimension in older patients. However, an Australian study of over 200 clinicians found that only 34 % had ever referred patients to pastoral counseling (Payman, 2000).

In addition, Goh et al. (2012) indicated that chaplains who had ministered on geriatric psychiatric floors/units provided a sense of meaning and purpose to their patients' lives and helped them to cope with a lost sense of self. This positive outcome was reported since it was identified that older patients with psychiatric disorders often had difficulties with communication, cognitive function, and comorbid mental disorders, confusion, and distress with which trained chaplains could effectively intervene (Goh et al., 2012). Likewise, a study by

Koenig (1998) indicated that disability and depression in older adults were "adversely proportionate" to religious commitment (p. 221). Koenig (1998) stated that "religious coping was by far the dominant coping behavior used by medically ill, elderly patients" (p. 222). Also, Braam, Beckman, van Tillburg, Deeg, and van Tillburg (1997) found that religious salience was also strongly correlated with improvement in depression, which affirmed the benefits of religious and spiritual care to individuals diagnosed with a mental disorder.

Several researchers have validated the importance of pastoral care to patient well-being (Braam, 1997; Goh et al., 2012; Koenig, 1998; Lawrence, 2007). However, the integration of chaplains onto multidisciplinary teams in bio-psycho-social care of geriatric psychiatric patients was noted to be difficult, even though chaplaincy appeared to be the next 'logical extension' (Goh et al., 2012, p. 128). Subsequently, international researchers, Lawrence et al. (2007) continued to study the use, placement, and career pathways of chaplains and concluded that their assistance and ministry to individual patients in mental health was rare. Nevertheless, chaplains were shown to have limited roles in some hospitals' protocol and treatment plan for patient care management (Marche, 2006). Therefore, the question arose about chaplain competency in mental healthcare, whereby Lawrence et al. (2007) identified that "there is a need for the development of effective training and operational policies in pastoral care in mental health service" (p. 971).

Fletcher (2019) penned one of the only texts that exclusively addressed mental health chaplaincy, particularly on geriatric psychiatric units. Fletcher (2019) developed a spiritual assessment called "CRISP" (p. 26). CRISP is an acronym that stands for "cultural care, religious care, individual care, spiritual care, and pastoral care" (Fletcher, 2019, p. 26). According to Fletcher (2019), cultural care required an extensive awareness of and involvement with the

cultural elements of patient care. Fletcher (2019) asserted that though sometimes patients'

cultural affiliations were obvious, at other times, they may not be as noticeable. It was found that

some patients engaged in counter-cultural behavior; for example, a Jewish patient consumed

bacon or a Muslim patient that did not pray five times a day (Fletcher, 2019). Ideally, the

assessment of patients went beyond the knowledge of a surname and a patient's religious

affiliation on a hospital census (Fletcher, 2019). Hence, Fletcher (2019) stated that even

chaplains' in their continuous pursuit of significant facts about patients' faith and religion, failed

to assess patients holistically (Fletcher, 2019).

Subsequently, Fletcher (2019) stated that "religious care in mental health is full of

creativity, ambiguity, exploration, and re-imagining" and the religious care for geriatric

psychiatric patients was never that straightforward (p. 6). Thus, it would be prudent for chaplains

to evaluate the religious expression and faith language of patients and assess if interpretations

were altered by physical and/or mental health concerns (Fletcher, 2019). For example, it was

found that often, chaplains were translators of geriatric psychiatric patients' religious beliefs and

needs during the admission process. Also, it was often expected that when patients were

confused or lacked clarity, the chaplain would conduct a more-in-depth inquiry and evaluation of

spiritual nuances that may have been the antecedent (Fletcher, 2019). Thus, chaplains that

effectively functioned as translators for multidisciplinary teams were invaluable in forming the

connection of the spiritual to the psychiatric (Fletcher, 2019).

Individualized care has been recognized as the central dimension of healthcare and

chaplaincy work (Fletcher, 2019). For example, after a chaplain had ministered to a patient, the

patient was not labeled as the "dementia patient," but rather, "Jean in bed 2 who loved her

grandchildren and pictures of cats" (Fletcher, 2019, p. 27). Respect of the patient's individuality

was highlighted as the most crucial aspect of this patient's care (Fletcher, 2019). Thus, according

to Fletcher (2019), patients should be allowed to write their own script of care, and chaplains

should listen, ascertain, and respect the individual patient's unique and distinct spiritual needs

(Fletcher, 2019). Therefore, chaplains should have understood that patients' faiths did not exist

in a vacuum, and their life experiences, values, morals, and coping abilities reflected their

deepest held beliefs and personhood (Fletcher, 2019). Therefore, Fletcher (2019) suggested that

the complete person must be completely considered in all aspects of care by the chaplain

(Fletcher, 2019).

In addition, spirituality was defined as "the way someone does their belief, their thinking

about the deep stuff" (Fletcher, 2019, p. 28). It was shown that chaplains that ministered to

geriatric psychiatric patients were open to engage unusual, unique, and strange talk, emotions,

and expressions. Hence, the role of chaplain interventions during challenging engagements was a

matter of professional judgment (Fletcher, 2019). Therefore, Fletcher (2019) indicated that

"sometimes the pastoral work was at the centre, and the next moment we were exploring the

existential question of meaning" (p. 30).

Furthermore, Fletcher (2019) specified that pastoral care was the place where mental

health chaplaincy reportedly met with healthcare chaplaincy (Fletcher, 2019). Pastoral care

issues occurred regardless of a patient's mental health, especially when a family member died,

worry beset, and the support of friends dwindled (Fletcher, 2019). Therefore, it was found that it

was often the chaplains on the geriatric psychiatric floors that ministered to the patients that

experience locked down isolation and were allowed no visitors. Thus, the pastoral care element

of chaplaincy has been recognized as a resource to physically and emotionally assist patients

with their burdens, pain, and loss in many forms that occurred in their daily lives (Fletcher,

2019).

Research also supported the importance of religion on the general physical and mental

health of older people (Cox & Hammonds, 1988). It was established, that as individuals grew

older, they were more likely to express their belief in God, as they considered life and death

(Cox & Hammonds, 1988). Several studies that analyzed life satisfaction and religious

involvement found individuals that were involved with religion were better adjusted than those

that were not involved with religion (Cox & Hammonds, 1988; Krause & Van Tran, 1989;

Taylor & Chatters, 1986). Cox and Hammonds (1988) indicated that "one interpretation of these

positive associations is that church evolves into a focal point of social coherence and activity for

the elderly, supplying them with a feeling of community and well-being" (Cox & Hammonds,

1988, p. 8). Likewise, two other studies (Krause & Van Tran, 1989; Taylor & Chatters, 1986)

asserted that religious involvement bolstered patients' feelings of self-worth and capability.

Though studies have demonstrated the impact of religion in the lives of older people, few

empirical studies have evaluated the use of religious beliefs on the health of people with

cognitive impairment (Koenig et al., 1992). Koenig et al. (1992) postulated that since religious

coping declined in older people with cognitive impairment, like dementia, this neuro impairment

would make it difficult for professionals to access previously learned religious coping skills. It

was found that although individuals diagnosed with dementia experienced comfort from

participation in religious activities, as the disease progressed, they were unable to read religious

books, pray, listen to sermons or teachings (Koenig et al., 1992). However, Abramowitz (1993)

concluded that among even severely debilitated elderly patients, there was recognition of God

and attempts initiated toward contact with God. Therefore, MacKinlay (2002) stated that "it

would seem that within the depths of the person there remains a core of being, the spiritual

dimension, or the soul, that at times may be evident to others around" (p. 137).

Additionally, Koenig et al. (1992) asserted that knowledge of the stages of dementia that

a person may be experiencing and their personal religious history would be valuable to

caregivers, and professionals such as chaplains, in instituted care. It was noted that in the early

stages of dementia, a person may still recognize family and friends and possess knowledge about

traditions and activities (Hicks, 2018). Though less inhibited at this stage, people were able to

decipher what brought them hope and purpose, and what religious practices enhanced their well-

being (Hicks, 2018). Thus, it was found to be valuable when chaplains engaged patients and

explored the individual interplay between religion and equilibrium (Hicks, 2018).

During the middle stage of dementia, individuals were shown to recognize their loved

ones less and more often enjoyed reminiscing over old photographs or memories (Hicks, 2018).

This stage has been identified as an appropriate stage to appeal to the individual's senses through

objects and with less use of language or words. Further, it was found that individuals at this stage

tended to relish singing and reciting Scriptures from their long-term memory (Hicks, 2018).

Therefore, from a ministry perspective, Hicks (2018) indicated that chaplains could better assure

individuals diagnosed with dementia of God's presence and their churches' support.

During late-stage dementia, it was found that the best spiritual practice was to value the

individual through love and touch (Hicks, 2018). Therefore, Hicks (2018) postulated that

chaplains could connect with patients through demonstrated sensitivity to their mood and tone,

synched breathing, expressed gratitude to God for the patient, and short-spoken sentences that conveyed comfort and peace to the patient. Patients in the late stage of dementia were found to be consoled by familiar hymns, prayers, readings, and sacraments (Hicks, 2018). Additionally, Keck (1996) found that individuals diagnosed with dementia at this challenging stage tended to demonstrate comprehension but were unable to communicate in a way that their caregivers, family, and friends recognized.

Fortunately, MacKinlay (2002) introduced a model for the spiritual tasks of aging. The model was a template for chaplains, which questioned dementia patients about the ultimate meaning of life (MacKinlay, 2002). When using this template, chaplains were expected to explore and probe patients' "core of existence" and "where they found their deepest meaning" (MacKinlay, 2002, p. 138). Further, MacKinlay (2002) stated that patients' ultimate meaning may be displaced, and a low sense of worthiness may cause their inability to view themselves realistically. Hence, oftentimes, patients in the early stages of dementia have demonstrated difficulty in confronting the disease. Therefore, MacKinlay (2002) stated, "if life appears meaningless, then it seems there is nothing to respond to" (p. 139). Thus, the importance of marrying the spiritual tasks of discovering the meaning in life with hope was hailed as extremely valuable (MacKinlay, 2002).

As a result, through deliberate, individualized plans, patients were met at their point of needs once goals were established, and markers for growth were put into place (MacKinlay, 2002). Chaplains became "logotherapists" and hunters of meaning (MacKinlay, 2002, p. 140). Literature supported the hypothesis that a patient that believed in a personal and loving God found a sense of hope in life (Cox & Hammonds, 1988; Fletcher, 2019; Goh et al., 2012;

MacKinlay, 200). Thus, patients diagnosed with dementia were found to benefit from a connection to themselves, to others, to their lives, and to the life-giver (MacKinlay, 2002).

Further, MacKinlay (2002) reached into the Christian tradition and observed Jesus' words in John 14, which assured his followers that the Spirit reminded them of all things. Jesus stated, "the Spirit helps us in our weakness: for we do not know how to pray as we ought, but that very Spirit intercedes with sighs too deep for words" (Romans 8:26, English Standard Version). Thus, it was found that through loss/disabilities, intimacy with God/others was discovered or rekindled, which led to final meanings and ultimately hope in life (MacKinlay, 2002). Further, it was recognized that caregivers and spouses could benefit from using the spiritual practices of prayer, Bible reading, and forgiveness to cope and establish transcendent communication with patients with dementia (Stolley, 1997).

Another professional framework used by chaplains for the support of patients with dementia and their family members was based on the Progressively Lowered Stress Threshold (PLST) model (Stolley, Koenig & Buckwalter, 1999). The model was founded on the following assumptions: all humans needed some control over their personhood and environment, all behavior had purpose and is rooted in meaning, agitated clients were regarded as frightened, and patients existed on a 24-hour continuum (Stolley et al., 1999).

Effective religious and spiritual ministry to patients provided care which counteracted memory loss, accepted patients as they were, used patients' anxiety to establish limits on stimuli, taught other staff members to listen to the patients verbal and non-verbal cues, created a safe environment that supported cognitive inability, and offered support and care for other caregivers (Stolley et al., 1999). Therefore Stolley et al. (1999) concluded that "chaplains can incorporate

religious activities to be of the greatest benefit to the demented client…their religious lives can

continue, promoting a continued sense of satisfaction and solace" (p. 21).

In summation, it was recommended that the chaplain should function as not only a source

of comfort but also affirm the personhood of patients that exist in a culture that may not accept

their diminished capacity (Fletcher, 2019). Therefore, Fletcher (2019) noted that it was the

chaplains that involved caregivers and hospital staff in the "active, collaborative and meaning-

making" role of spiritual care, which was so valuable (Fletcher, 2019, p. 145). Consequently,

Fletcher (2019) aptly concluded that "the role of the chaplain in the face of dementia is to find

ways of celebrating the meaning and value of lives in which these 'pseudo-divinities' have lost

their power" (p. 143).

Theology of Christian Chaplains

According to Thomas (2012), Christian chaplains have been shown to live by Scriptures,

which instruct them to preach Jesus Christ and him crucified. Chaplains were forbidden to

proselytize and evangelize to patients about Jesus Christ. However, the Good News was still

disseminated. Therefore, Thomas (2012) stated that "a chaplain is a witness, not a missionary"

(p. 2). Chaplains were found to be ministers of the Gospel in fulfillment of the Apostle Paul's

instruction in Galatians 6:10 (NIV) to be good to everyone, especially those in the household of

faith (Thomas, 2012). Further, chaplains followed the mandates of Titus 2 and 3 (NIV), which

enabled them to live and exemplify the hope of eternal life through Jesus Christ (Thomas, 2012).

Further, Ryan (2017) revealed that the Christian presence and influence in mental health

have continued to increase. Hence, Fletcher (2019) stated that in terms of mental health care, "it

merely mirrors the reality that society more broadly has shown a significant increase in interest

in, and awareness of mental health and the need for additional services over recent years" (p. 45).

Fletcher (2019) suggested that there are two primary reasons why Christian identity in mental

health ministry mattered. The first reason was "authenticity," since chaplains and other clergy

members that worked in the mental health field confronted what was deemed the "the thick end

of the wedge" (Fletcher, 2019, p. 49). Chaplains were faced with patients that had severe mental

health diagnoses (Fletcher, 2019). Patients relied on chaplains and faith to provide them with

something beyond secular medicine (Fletcher, 2019). Aptly, Fletcher (2019) cautioned that

"there is always the danger…about spiritualizing, but there is nonetheless a demand for an

authentic Christian response that embraces mental health" (p. 50).

The second reason why Christian identity in mental health mattered was that the field of

mental health had been moving toward incorporating spiritual care and secularizing faith in

research and in practice (Fletcher, 2019). Several studies have shown a correlation between

religiosity and favorable mental health (Braam et al., 1997; Goh et al., 2012; Goncalves et al.,

2015; Koenig, 1998; Lawrence, 2007: Puchalski, 2001). Equally, collective religious activities

and church attendance have been shown to strengthen individuals' mental state and lessen

depression (Koenig et al., 1997; Spencer, Madden, Purtill, & Ewing, 2016).

Though the language about mental health and medical terminology had evolved

significantly over the years, the Holy Bible referenced incidences of what appeared to be mental

illness (Daniel 4, New International Version). In Daniel chapter four, King Nebuchadnezzar

reportedly experienced insanity. He lived away from people, acted like an animal, and ate grass

(Daniel 4, NIV). First Samuel described the influence of an evil spirit that caused King Saul to

despise David and repeatedly attempted to kill him several times (I Samuel 18:10, NIV). David

also spoke indirectly of depression as he described his feelings, emotions, and state of mind throughout the book of Psalms (Psalms, NIV). For example, David wrote, "you have put me in the lowest pit, in the darkest depths…I am confined and cannot escape; my eyes are dim with grief" (Psalms 88: 6-9, NIV).

Further, in Psalms 88, David referenced the loneliness and isolation that he had suffered since his youth (Psalms 88, NIV). For instance, David wrote, "…you have taken me from my friend and neighbor, darkness is my closest friend" (Psalm 88:19, NIV). Hence, human experiences with mental illness have always existed. People of every generation have struggled with their mental state, anxiety, depression, and isolation (Fletcher, 2019). Therefore Fletcher (2019) concluded that this understanding "may provide a stronger basis for building a biblical answer to the question of mental health…" (p. 51).

Additionally, Scripture asserted that the primary focus of Christianity is the soul, followed by the flesh (I Corinthians 6, NIV). The Apostle Paul instructed people not to sin against their own bodies because the Holy Spirit dwelt within them (I Corinthians 6:19, NIV). Also, the Old Testament described the heart (lebab) as the place where decisions were made (I Chronicles 12:14, NIV) and where wisdom and understanding were found (I Kings 3:12, NIV; Proverbs 16:23, NIV). Therefore, the spirit (ruah) and the soul (nepes) were considered to be the will and the place of innermost thoughts (Fletcher, 2019). The New Testament focused on the mind (nous), which included the physical function of the brain, understanding, decision making, and determination (Fletcher, 2012). Therefore, Fletcher (2019) posited that "just as Christians are called to make temples of their bodies, so, too, a greater emphasis needs to be placed on the need to care for and cultivate the mind" (Fletcher, 2019, p. 52).

Subsequently, the Christian ethics of responsibility, redemption, and reconciliation were essential parts of the chaplain's communication with patients (Fletcher, 2019). Whether in heart, mind, body, or soul, Scripture imparted that all people have transgressed and needed redemption as Apostle Paul stated, "all have sinned and fall short of the glory of God" (Romans 3:23, NIV). Scriptures indicated that the final judgment by Jesus Christ would separate the righteous from the unrighteous based solely on a belief in the crucifixion and resurrection of Jesus Christ (John 3: 36, NIV).

The pressing theological question from psychiatric professionals about the judgment of individuals that struggled with schizophrenia, psychosis, or dementia, was answered in Psalms chapter thirty-three (Psalms 33, NIV). The Holy Bible stated that God "made their hearts, so he understands everything they do" (Psalm 33:15, NIV). The focus on the actions of mankind, regardless of their mental state, was usurped by the truth of forgiveness obtained through the cross and Jesus Christ, the one mediator between God and man (I Timothy 2:5, NIV).

The Christian belief of repentance and redemption had been disputed by secular psychiatry when it included patients with mental illness and a lack of cognitive awareness (Fletcher, 2019). However, the Holy Bible asserted that God's grace was extended to all people through Christ's sacrifice (Hebrews 9:28, NIV). Jesus came to bridge the gap between each person and God, and God alone judged the heart (James 4:12, NIV). Subsequently, Thomas (2012) stated that, "the chaplain is called by God to bring His grace, common and saving, to those he serves in faithfulness to his truth and righteousness" (p. 24).

Therefore, through the death of Jesus Christ on the cross, the results of the Gospel were prayer and hope (Thomas, 2012). Christ was the substitute for mankind (II Corinthians 5:21,

NIV) and provided a new example of how to live (I Peter 2:21, NIV) as he secured absolute victory (I Corinthians 15:54, NIV). Christ offered to everyone the chance to become a new creation (II Corinthians 5:16, NIV). Psalm 103:3 (NIV) assured individuals that Jesus forgave all their sins and healed all their diseases. God cured every malady, and as Thomas (2012) posited, Christian ministers and chaplains had every right for their confidence in the Lord. Therefore, John 12:40 (NIV) stated that "I have not spoken on my own authority, but the Father who sent me has himself given me a commandment – what to say and what to speak."

Consequently, forgiveness and reconciliation were an integrated process in Christianity (Fletcher, 2019). God forgave mankind for the singular purpose of reconciliation (Frise & McMinn, 2010). Hence, Frise and McMinn (2010) indicated that "true forgiveness culminates in a healing of what has been broken" (p. 84). It was not a feel-good process without an end-result. Forgiveness was meant to be the catalyst for reconciliation that "deepens and enriches communities" (Frise & McMinn, 2010, p. 84). Therefore, Frise and McMinn's (2010) study has shown that genuine forgiveness required the release of negative feelings and the desire for revenge. Further, the positive feelings associated with forgiveness involved feelings of good will toward the offender, which was a pathway towards reconciliation (Frise & McMinn, 2010). Additionally, Frise and McMinn (2010) revealed that psychologists "responses indicated that reconciliation is not a necessary part of true forgiveness…the theologian's indication that forgiveness and reconciliation are related is consistent with the Christian theology literature" (p. 88).

Further, forgiveness became reconciliation through the cross as the Apostle Paul stated, "for if, while we were God's enemies, we were reconciled to him through the death of his Son,

how much more, having been reconciled, shall we be saved through his life" (Romans 5:10, NIV). God even demanded a demonstration of the state of reconciliation before an offering, with the caution "leave your gift in front of the altar. First go and be reconciled to them; then come and offer your gift" (Matthew 5:24, NIV). Hence, God gave mankind the message of reconciliation through Christ, in "that God was reconciling the world to himself in Christ, not counting people's sins against them…we are therefore Christ's ambassadors, as though God were making an appeal through us" (II Corinthians 5:18, 20, NIV).

Evidently, chaplains were the embodiment, the exhorters, and the example of Ephesians 4:32 (NIV), which instructed, "be kind and compassionate to one another, forgiving each other, just as in Christ God forgave you." There was a message of inclusivity in responsibility, redemption, and reconciliation (Ballard, 2007). Hence, all people were offered a collective and individual hope, no matter what mental health challenges they faced. It was the goal of Christian chaplaincy to direct the patients in the day-to-day walk of faith. Therefore Ballard (2007) concluded that "faithful living is indeed set in the context of the creative saving reality that is revealed in the Bible: but it is also having to seek to know what that means for today" (p. 40).

Chaplains and Geriatric Psychiatric Education

The literature supported that there was a lack of education in basic counseling skills, psychiatric diagnoses, and assessment in seminary/divinity school and Clinical Pastoral Education (CPE) curriculum (Fletcher, 2019; Goh et al., 2012; Lawrence et al., 2007). Four of the top divinity schools in the United States; Harvard University; Yale University; Princeton University, and Duke University, required no counseling classes or psychiatric assessment training in their Master of Divinity (M.Div.) programs (Duke University School of Divinity,

2019; Harvard University School of Divinity, 2019; Princeton University School of Divinity, 2019; Yale University School of Divinity, 2019).

Harvard University, Cambridge, MA offered a three year, 24 course Master of Divinity with the following requirements; six courses in histories, theologies and practices and any mix of religious traditions, a minimum of three courses with Scriptural interpretation, no more than nine courses total in the same religious tradition, three semesters of a traditional religious language, completion of three Arts of Ministry, and the completion of a Senior seminar, and paper (Harvard University School of Divinity, 2019).

Yale University School of Divinity offered a three-year, 72 credit Master of Divinity degree. The minimum requirements were twelve credits of Old or New Testament courses, twelve credits of Theology, including Systematic Theology, nine credits in historical studies, which included three hours of denominational courses, nine hours of additional theology courses, and eighteen credit hours of electives. Students were required to take a course each in non-Christian religion, gender/sexuality, race/ethnicity, disability and/or global/cultural diversity, and one course in Christian ethics. There was also a nine-hour workshop in 'Negotiating Boundaries in Ministerial Relationships," and a practicum (Yale University School of Divinity, 2019).

Princeton University, Princeton, NJ offered a three-year, 78-hour Master of Divinity. Students were required to take one Old Testament and one New Testament course, and three credits in each of the following: Early and Medieval History, Reformation History, Modern European and American History and Ecumenisms, and History of Religions or Sociology of Religion. Students were required to take a class in speech and oration, along with three credits in education and formation, pastoral care and specialized ministries, and distributive electives.

Further requirements included two field education units, courses on Christian Responsibility, Christian Responses to Race and Ethnicity, and a Capstone Project (Princeton University School of Divinity, 2019).

Duke University, Durham, North Carolina, offered a three-year, 72-credit Master of Divinity degree. The requirements included six credits of the Old Testament, three credits of Church History, Church Ministry/New Testament, Biblical Language, and six credits of Spiritual Formation. The second year of study included a field placement, three credits of Christian Theology, Christian Ethics, American Christianity, World Christianity, New Testament Exegesis, Preaching, and electives. The third year of study included a field education placement, Practicing Theology in Religion (Black Church), six electives, and a student portfolio (Duke University School of Divinity, 2019).

Vanderbilt University School of Divinity, another highly ranked university, also required no counseling classes or psychiatric training for ministers and chaplains in the Master of Divinity degree program (Vanderbilt University School of Divinity, 2019).

Loyola Chicago School of Divinity offered a course on Introduction to Pastoral Care and Counseling in its Master of Divinity program (Loyola University-Chicago, 2019). Loyola Chicago also had a combined Master of Divinity/Master of Arts in Pastoral Counseling which offered the following courses: Models of Pastoral Counseling, Family Therapy and Personal Transformation, Addictions and Models of Therapy, Psychopathology, Testing, Measurement and Assessment, Research Methods, Pastoral Psychodynamic Assessment and Intervention, Pastoral Counseling in a Intercultural Context, and Career Counseling for Pastoral Counselors (Loyola University-Chicago, 2019).

Gordon-Conwell Theological Seminary, Boston, MA, offered a combined 96 credit

Master of Divinity/Master of Arts in Counseling degree, which has been available since 1990

(Gordon-Conwell Theological Seminary, 2019). However, the dual program had been advertised

on the School of Divinity website over the last four years. Mandatory counseling classes were:

Introduction to Counseling, Clinical Counseling Skills, Lifespan Development, Theories of

Personality, Research Methods and Design, Psychopathology, Group Process, Multicultural

Diversity in Counseling, Career Counseling and Lifestyle Development, and Professional

Standards and Ethics. Electives in the dual program included counseling every age group,

counseling human sexuality, counseling addictive behaviors, and suicide prevention (Gordon-

Conwell Theological Seminary, 2019).

There are several seminaries and divinity schools in the United States that offered a

Master of Divinity – Chaplaincy and most recommended a minimal number of courses in

counseling. South Florida Bible College and Seminary 90 credit Master of Divinity-Chaplaincy

required one course in Pastoral Counseling (South Florida Bible College & Seminary, 2019).

Denver Seminary offered a 78 credit Master of Divinity-Chaplaincy and required: one

course in Brief Counseling, Brief Counseling practicum, and a choice between Crisis Counseling

or Counseling Responses in Crises & Disaster (Denver Seminary, 2019). The M.Div.-Pastoral

Care and Counseling offered Brief Counseling, Brief Counseling practicum, Pastoral Care and

Counseling Relationships, Crisis Counseling or Counseling Responses in Crisis and Disaster,

Community-Based Ministry Internship, and Marriage and Family Counseling (Denver Seminary,

2019).

The Wesley Biblical Seminary, Ridgeland, MS, offered a 78 credit Master of Divinity-Chaplaincy and required one course in Pastoral Counseling (Wesley Biblical Seminary, 2019).

Trinity Evangelical Divinity School, Deerfield, IL, offered a 72 credit Master of Arts in Chaplaincy and Ministry Care (Trinity Evangelical Divinity School, 2019). This Divinity School required 16 hours of counseling courses: Introduction to Counseling Ministries, Pastoral Counseling for Marriage and Family, Counseling Skills Training; Group Counseling, Multicultural Issues in Counseling, and Crisis Counseling (Trinity Evangelical Divinity School, 2019).

George Fox Seminary, Portland, OR offered a 78 credit Master of Divinity-Chaplaincy and required two courses in counseling: Pastoral Counseling and Ethics I, and Pastoral Counseling and Ethics II (George Fox Seminary, 2019).

BH Carroll Seminary, Irvine, TX, offered an 84 credit Master of Divinity-Chaplaincy that required two counseling courses: Basic Christian Counseling and Group Dynamics in Institutional Structures (BH Carroll Seminary, 2019).

Regent University offered a 72 credit Master of Divinity-Chaplaincy that required one course in counseling: Pastoral Care, Counseling, and Conflict (Regent University, 2019).

Grace Theological Seminary, Winona Lake, IN offered a 90 credit Master of Divinity-Chaplaincy and required three courses in counseling: Theological Foundations in Counseling, Pre-Marital & Marital Counseling, and Counseling Common Problems (Grace Theological Seminary, 2019).

Finally, Liberty University Rawlings School of Divinity, Lynchburg, VA offered a 75 credit Master of Divinity-Chaplaincy, 93 credit Master of Divinity-Community Chaplaincy, 93

credit Master of Divinity-Healthcare Chaplaincy, and 93 credit Master of Divinity-Military

Chaplaincy. All required the completion of at least two of three courses: Premarital and Marital

Counseling, Theories and Techniques in Counseling, and Chaplain Crisis Counseling (Liberty

University, 2019a).

The emphasis on mental health education in the chaplaincy was the result of chaplains'

responsibility in caring for veterans and military members with mental health issues and

diagnoses (Nieuwsma, Rhodes, Jackson, Cantrell, & Lane, 2013). The Second Constitutional

Congress voted in 1772 to compensate Army chaplains. President Lincoln also included

chaplains in his establishment of Homes for Disabled Volunteer Services (Nieuwsma et al.,

2013). Therefore, Nieuwsma et al. (2013) noted that "the enduring presence of chaplains in the

military over the centuries is a testament to the significance of a chaplain's presence in the midst

of some of life's most challenging moments for many military personnel" (p. 2).

Since September 11, 2001, and the ensuing military conflicts in the Middle East, the

Veterans Administration (VA) and Department of Defense (DOD) evaluated the expanding roles

of chaplains in mental health (Department of Defense & Veteran Administration, 2010). In Fall

2010, the VA/DOD Integrated Mental Health Strategy (IMHS) confronted the problems of

readjustment of military personnel to civilian life and the co-occurring psychiatric problems,

Post-Traumatic Stress Disorder (PTSD), mood disorders, and suicidality (Department of Defense

& Veterans Administration, 2010). The DOD Task Force Study released in 2010 on suicide

prevention in the Armed Forces reiterated the vital role chaplains had in ministry to the mental,

emotional, and spiritual needs of military members (Department of Defense & Veterans

Administration, 2010). Researchers concurred that chaplains play an important role in

ministering to the holistic needs of their patients, which included their spiritual, emotional, relational, and mental needs (Fravell, Nasser & Cornum, 2011; Hufford, Fritts, & Rhodes, 2010, Paragament & Sweeney, 2011).

Often, service members have shown trust for chaplains as spiritual advisors and confidantes (Nieuwsma et al., 2013). In the military, chaplains were granted complete chaplain-client confidentiality, and it lessened the fear of stigma or negative impact on service members' careers associated with professional psychiatric assistance (Nieuwsma et al., 2013). Therefore, Nieuwsma et al., (2013) stated that "chaplains often have established relationships with service members that facilitate service members seeking care from chaplains and enables chaplains to understand the broader context surrounding individual help" (p. 3).

Additionally, research verified that veterans that experienced PTSD harbored combat guilt and had difficulty with forgiveness (Henning & Freuh, 1997). Further studies confirmed that many veterans that had been treated for PTSD had rejected their religion, faith, and beliefs during war time and perceived that God had punished them (Drescher, 2010; Drescher & Foy, 1995). Subsequently, chaplains' involvement as part of the PTSD protocol has proven effective in helping veterans in their new acquisition and exploration of the meaning and purpose of life (Nieuwsma et al., 2013).

Therefore, veterans and military members needed a mental health system in place where chaplains better understood how patients' spiritual needs related to their psychiatric needs (Nieuwsma et al., 2013). As a result, Nieuwsma et al. (2013) stated that "this will entail more effectively integrating chaplaincy with mental health care services and an objective that is consistent with the mission of the VA" (p. 3). Thus, the conception and integration of the

Veterans Administration Mental Health and Chaplaincy Program, Strategic Action (SA) #23 of the VA/DOD's IMHS, consisted of two goals (Department of Defense & Veterans Administration, 2010; Nieuwsma et al., 2013).

In reaching the first goal, the current state of chaplaincy/mental health issues was analyzed, and suggestions for improved chaplaincy with mental health care engagement based on empirical research were provided (Nieuwsma et al., 2013). Second, the improvements identified by the task force for advanced chaplaincy collaboration and teamwork with mental health included: jointly trained chaplains and mental health care providers, enhanced communication of documentation between disciplines, organizational structures that aided teamwork, and implemented integrated solutions in a cohesive community of care (Nieuwsma et al., 2013). The barriers that impeded the joining of chaplains and mental health were as follows: lack of cross-training, professional roles blurred, unclear desired outcomes, discomfort with respective specialties, resources, chaplaincy subsumed by medical models, proselytizing, lack of relationships, cultural differences, lack of community collaboration, chaplaincy resistance to evidence-based research, and lack of common value system (Nieuwsma et al., 2013).

Potential solutions to the problem of non-collaboration were: cross-train chaplains and mental health professionals, embrace integrated roles, standardize processes across the entire system, change from bottom-up, prevent proselytizing and communication that was not the goal of chaplaincy, gain permission from patient to share information, involve other healthcare providers, and involve chaplains in the identification of expectations and measures (Nieuwsma et al., 2013). The major barriers between chaplains and mental health collaboration were issues of trust and confidence between the disciplines (Nieuwsma et al., 2013).

In terms of training, individual-level training was divided into three tiers (Nieuwsma et al., 2013). The first was Education and Relationship Building, which trained chaplains and mental healthcare providers through webinars, onsite training, and interdisciplinary relationship building (Nieuwsma et al., 2013). The second tier, Equipping Champions of Integration, co-educated chaplains and mental health providers in evidence-based training seminars that promoted advantageous partnership and practical integration (Nieuwsma et al., 2013). The third tier consisted of Mental Health Integration for Chaplain Services (MHICS) (Mental Health Integration for Chaplain Services (MHICS), 2019; Nieuwsma et al., 2013) and targeted chaplains that spent a significant portion of their professional engagement in mental health settings. The Mental Health Integration for Chaplain Services (MHICS) (2019) stated that "this program would provide interested chaplains an intensive, focused training experience aimed at better equipping them to participate as part of integrated mental health care teams" (p. 5).

The MHICS training is geared to be completed in three 12-week courses (Mental Health Integration for Chaplain Services (MHICS), 2019). Each course consisted of five online modules and one face-to-face module. The distance course included 50-60-minute videos, didactics, and 90-minute small group sessions using video conferencing. Topics of relevance were PTSD, sexual assault prevention, and suicidality (Mental Health Integration for Chaplain Services (MHICS), 2019). Therefore, Nieuwsma et al. (2013) indicated that "while there are gaps in the integration of chaplains and mental health services, the VA and DOD are taking proactive steps to ensure that chaplains and mental health care providers work together to provide the best possible care" (p. 14).

Competencies of Geriatric Psychiatric Chaplain

Christian chaplains that worked in mental health, particularly geriatric psychiatric units, did not choose to minister in that location by error (Warren, 2002). Hence, God had a purpose for the placement of chaplains amongst the population with which they worked, including the geriatric psychiatric population (Warren, 2002). Thus, the Apostle Paul stated, "it is God himself who has made us what we are and given us new lives from Jesus Christ; and long ages ago he planned that we should spend these lives in helping" (Ephesians 2:10, The Living Bible). Further, John 17:4 (The Message Bible) stated, "I glorified you on earth by completing down to the last detail what you assigned me to do," which included the role assigned as professionals.

Mental Preparedness

According to Warren (2002), the best mental preparation for Christian chaplains commenced with the acknowledgment that God saved them to serve him. The Lord redeemed individuals for his "Holy Work" through Jesus Christ's death on the cross (Warren, 2002, p. 228). Further, Warren (2002) noted that "through salvation our past has been forgiven, our present is given meaning, and our future is secured" (p. 228). Likewise, in light of these incredible benefits, the Apostle Paul concluded that "in view of God's mercy, to offer your bodies as a living sacrifice, holy and pleasing to God- this is your true and proper worship (Romans 12: 1, NIV).

Warren (2002) identified that through the process of self-evaluation, chaplains could recognize how much God was needed in the stress of servitude. Chaplains have been shown to experience the difficulties of transference and/or countertransference and the limited disclosure of their own stories in their ministry to geriatric psychiatric patients (Bowman, 2017). Thus,

Pargament (2007) postulated that spirituality was a legitimate dimension of the human

experience and to idealize spirituality, while tempting, should be avoided. Subsequently,

Pargament (2007) concluded that "spirituality can be part of the solution and part of the

problem" (p. xi).

Additionally, Warren (2002) suggested that chaplains should evaluate their professional

weaknesses during pastoral department debriefing sessions with other chaplains. It was noted

that there was a constant effort to limit weakness in performance, but weakness, was perceived

as a strength (Warren, 2002). Hence, Warren (2002) cautioned that "usually we deny our

weaknesses, defend them, excuse them, hide them, and resent them. This prevents God from

using them the way he desires" (p. 272). Therefore, according to Warren's (2002) assessment,

God has never been an advocate of self-sufficiency.

Subsequently, God's plan has been shown to shape the ministry of chaplains as they

delivered pastoral care (Association of Professional Chaplains, 2019b). This plan may involve

times when the chaplain responded to requests for pastoral care, participated in facilitating

worship, performed rituals and sacramental needs, were involved in team meeting and rounds,

served on institutional committees, promoted an interdisciplinary approach in pastoral care,

assisted in the coordination of community clergy, kept records of pastoral activities, and refined

and improved pastoral ministry (Association of Professional Chaplains, 2019b).

God formed the chaplains' ministry and mental processes through their acceptance of five

aspects: spiritual gifts, heart, abilities, personality, and experience (Warren, 2002). Thus, all the

chaplains' natural abilities were imparted by God, and they have been shown to be just as vital to

their ministries as their spiritual abilities (Warren, 2002). The Holy Bible also stated that God

provided individuals with everything they needed to fulfill his will (Warren, 2002). The Lord

used the different temperaments and varied experiences of chaplains in ministry to further his

purposes (Warren, 2002). Therefore, according to the Apostle Paul, "whatever you do, do it all

for the glory of God" (I Corinthians 10:31, NIV).

Ministry to mental health patients, geriatric psychiatric patients, in particular, required an

understanding of the literal and Biblically defined mind. The Holy Bible was clear about the

mind and instructed people 'to set their minds on things above' (Colossians 3:2, New

International Version). Romans 8:6 stated, "for to set the mind on the flesh is death, but to set the

mind on the Spirit is life and peace" (New International Version, 2011). Romans 12:2 (NIV)

stated, "do not be conformed to this world, but be transformed by the renewal of your mind, that

by testing you may discern what is the will of God, what is good and acceptable and perfect."

Also, I Corinthians 2:16 (NIV) asked, "for who has understood the mind of the Lord as to

instruct him?" Therefore, Chaplains have been shown to use scriptures to mentally prepare for

ministry (Warren, 2002). For example, Philippians 4:7 (NIV) assured that "the peace of God,

which surpasses all understanding, will guard your heart and your minds in Christ Jesus," which

is a powerful resource for chaplains' mental preparation.

Thus, the purposeful acceptance of God's calling in the minds and hearts of chaplains

was considered the beginning of their ministry (Warren, 2002). The acknowledgment of that

truth removed the elements of time pressure and frustration when God's agenda prevailed

(Warren, 2002). Hence, the objective of the chaplaincy was to be mindful of what God wanted to

bring into patients' lives and conditions. Therefore, Warren (2002) posited that "servants see

interruptions as divine appointments for ministry and are happy for the opportunity to practice service" (p. 259).

Spiritual Preparedness

There were various ways to prepare spiritually for ministry to mental health patients, particularly those of the geriatric psychiatric units (Borger, 2008). Spiritual preparedness ensured that chaplains had considered the state of their own soul and God's will before they ministered to mental health patients. Thus, Air Force Chaplain Robert Borger (2008) asserted that spirituality was a path that gives purpose and meaning to the human life. Spiritual preparedness for chaplains varied across denominational faiths and religions. Hence, Christian chaplains believed that their spiritual preparedness centered on the truth, knowledge, and Word of Jesus Christ, which included prayer and worship time (James 1:5, NIV; Proverbs 15:23, NIV; Warren, 2002). For followers of Christ, spirituality applied specifically to the indwelling of the Holy Spirit (Borger, 2008). Borger postulated that overall, spiritual readiness and preparedness reflected one's personal religious views and faith. Thus, Borger (2008) stated that spiritual preparedness "is being right with yourself and with your God" (p. 1).

Prayer. Prayer was identified as a vital part of the preparation for Christian chaplains (Jones, 2012). According to Jones (2012), the act of prayer involved deeply meaningful personal and shared experiences that promoted relationships both with God and others (Jones, 2012). Prayers and praying were identified as sacred events that reached across denominational lines and religious divides (Jones, 2012). Hence, Jones (2012) stated that "for many, prayer is a nominal part of their faith journey, while others rely on it as the most important part of their religious practice" (p. 106).

Christian chaplains believed what the Holy Bible stated about prayer and its purposes (Warren, 2002). The Lord instructed chaplains to pray and believe, "this is the confidence we have in approaching God; that if we ask anything according to his will, he hears us" (I John 5:14, NIV). Prayer has been shown to make the difference in the lives of chaplains as they sought after God for the task that was set before in ministry (Warren, 2002). Therefore, being prepared in prayer has proven to be a powerful and effective way for chaplains to approach their ministry (James 5:16, NIV; Warren, 2002). Subsequently, prayer gave chaplains the physical ability to minister, as they pursued the Lord and gained the strength and wisdom needed for the day (I Chronicles 16:11, NIV).

A chaplain's demeanor and life have been shown to be reflective of their prayer life whereby they can, "be joyful in hope, patient in affliction, faithful in prayer" (Romans 12:12, NIV; Warren, 2002). To quell stress and cope with the daily burdens of others' losses, grief, pains, and suffering, a chaplain's place of solace was found in prayer, where anxiety was replaced with thanksgiving before God (Philippians 4:6, NIV).

Subsequently, the Holy Bible instructed chaplains to pray continuously to promote their well-being and gain divine insights (I Thessalonians 5:17, NIV). Thus, in situations with geriatric psychiatric patients, when the wisdom of God was needed, chaplains have learned to draw on God's wellspring to receive a word in due season to share with sensitively, care, and compassion to their patients (James 1:5, NIV; Proverbs 15:23, NIV). Therefore, Christian chaplains have built their ministry on the Christ-centered power of prayer, which is a foundation of their ministry (Warren, 2002).

Worship. The heart of worship has been shown to go beyond singing songs and praising God to involving complete surrender to God's will (Warren, 2002). The Apostle Paul wrote, "therefore, I urge you, brothers and sisters, in view of God's mercy, to offer your bodies as a living sacrifice, holy and pleasing to God—this is your true and proper worship (Romans 12:1, NIV). Therefore, as Christian chaplains performed their ministry duties and fulfilled their calling, they were offering worship to God by their service (Warren, 2002).

Warren (2002) stated that "when we completely surrender ourselves to Jesus, we discover that he is not a tyrant, but a savior, not a boss, but a mother, not a dictator, but a friend (p. 79). However, surrender has been shown to require great trust, and the primary root of distrust was identified as fear (Warren, 2002). Thus, the Holy Bible reassured that love casted out fear, and chaplains have been shown to improve their well-being from times of surrender and worship to God (1 John 4:18, NIV, Warren, 2002). It was Christ that demonstrated the ultimate act of love on the cross that chaplains modeled (John 13:31-38; Warren, 2002). Therefore, the Holy Bible stated, "God proves his love for us in the while we still were sinners Christ died for us" (Romans 5:8, NIV). Hence, reliance upon God's will to lead their ministry required chaplains to surrender to God's will as an act that brought liberation, freedom, and a heavenly purpose to their work (Warren, 2002).

Warren (2002) postulated that surrender to God's control was not an act of self-denial, but of self-realization. God used the unique gifts he had bestowed upon people more mightily when they relinquished the control of them. Warren (2002) referenced C. S. Lewis, who confirmed that the more we let God have control, the more we can discover the true self, because God is our creator and he knows us intimately.

Consequently, Jesus was the perfect example that chaplains needed to follow (Warren, 2002). Though he was God, he surrendered and was obedient unto death, and likewise, the act of surrender may, at times, be challenging (Warren, 2002). Warren (2002) warned that "surrender is hard work. In our case, it is intense warfare against our self-centered nature" (p. 81).

Further, Warren (2002) posited that ministry worship was completed only through the act of surrender. Chaplains that ministered the Gospel of Jesus Christ to others have demonstrated a need for God's completed work in their own lives first (Warren, 2002). Often, change required the acknowledgment of past regrets, problems, fears, dreams, weaknesses, habits, wounds, and personal pitfalls (Warren, 2002). Therefore, chaplains have found that their personal tests have become testimonies through the daily death of their own fleshly practices and newfound self-sufficiency in Jesus Christ (Warren, 2002). This attitude was a true form of worship that prepared chaplains for ministry (Warren, 2002).

In conclusion, effective ministry was the result of chaplains that not only surrendered to God, but to his righteous purpose (Warren, 2002). Bill Bright, the founder of Campus Crusade for Christ, helped lead 150 million people to salvation through Jesus Christ (Warren, 2002). When asked about why God had used his life significantly, Bright responded, "…I made a contract with God. I literally wrote it out and signed my name at the bottom. It said, 'From this day forward, I am a slave of Jesus Christ'" (Warren, 2002, p. 84). The most vital act of worship for anyone in ministry was identified as surrender (Warren, 2002). Hence, Warren summarized that the greater the surrender, the greater the power of the Lord was in that person's life (Warren, 2002). Therefore, just as prayer, the act of worship has been demonstrated to serve as a foundational resource for the chaplains' ministry and their spiritual preparation (Warren, 2002).

Clinical Training

According to Guest Lowery (2012), behavioral health and mental health have been shown to address mental disorder and addictions and "it represents a movement from focusing on illness symptoms to behaviors that can promote stabilization and wellness" (p. 267). Chaplains that ministered to geriatric psychiatric patients have received proper training or acquired experience that enabled them to understand that mental illness may be hereditary, biochemical, or caused by environmental factors (Guest Lowery, 2012). Therefore, the Diagnostic and Statistical Manual of Mental Disorders has been relied upon as a comprehensive resource used by mental health professionals to identify diagnostic criteria and treatments for psychiatric disorders (American Psychiatric Association, 2013).

Chaplains that worked with the behavioral health population and received the appropriate clinical training were aware of the stigma that accompanied mental illness (Guest Lowery, 2012). Hence, Guest Lowery (2012) warned against the misconception that sent the message that individuals diagnosed with mental disorders were "violent, lazy and or unable to live productive lives" (p. 269). Therefore, the language chaplains used about mental illness either added to the stigma or encouraged understanding. For example, a patient with schizophrenia was not referred to as a "schizophrenic" but as "a person with schizophrenia" (Guest Lowery, 2012, p. 269). Hence, Guest Lowery (2012) called upon mental health chaplains to acquire the proper training and "remember people with mental disorders often over identify with their illness, and they struggle to see themselves in a fuller context" (p. 269).

As chaplains provided pastoral care to behavioral health patients, it was demonstrated that physical, emotional, and spiritual boundaries needed to be created (Guest Lowery, 2012).

For example, patients diagnosed with autism may be sensitive to various types of stimulation, and patients that had experienced abuse may prefer not to be touched (Guest Lowery, 2012). Hence, Guest Lowery (2012) suggested that "in behavioral health, expect that any and every "button' can be pushed – and welcome this as both gift and task" (p. 270).

Chaplain pastoral care assessments of behavioral health care patients often revealed religious and spiritual struggles (Guest Lowery, 2012). Due to theses diagnoses, patients have been shown to experience a religious/spiritual disconnection, which manifested in broken relationships with God (Guest Lowery, 2012). Also, patients that were diagnosed with depression have been reported to display an exaggerated amount of guilt over their shortcomings and mistakes. However, with the appropriate training, chaplains have been able to address the patient's need, be it their disconnection from God or guilt (Guest Lowery, 2012).

Equally, patients diagnosed with bipolar disorder have been shown to experience profound guilt about their impulsive behaviors that had adverse mental and physical effects (Guest Lowery, 2012). Guest Lowery posited that shame and a diminished sense of meaning plagued behavioral health patients. Many faced the loss of relationships, employment, housing, independence, and sometimes faith (Guest Lowery, 2012). Therefore, trained chaplains were shown to be prepared to assist patients with crises of identity and stood with them in their faith as they asked, "Why is this happening to me?", "Where is God in this illness?" and "What is my purpose in life now?" (Guest Lowery, 2012, p. 273).

Chaplains, primarily those on geriatric psychiatric floors, have been commonly assigned to facilitate pastoral care and spirituality groups (Guest Lowery, 2012). However, the patients on the geriatric psychiatry floors have been identified as needing delicate care, and in order to

effectively facilitate group sessions, proper training is required to ensure no harm comes to the patients. Hence Guest Lowery (2012) stated that "a well-facilitated group is a haven of healing, providing moments of connection, glimpses of the profound truth that we are not alone" (p. 273).

Additionally, amongst in-patient hospitals and facilities, spirituality groups were part of the patients' treatment plan (Guest Lowery, 2012). Therefore, as part of the chaplain's training, Guest Lowery (2012) suggested a specific order to be used to ensure a successful group. According to Guest Lowery (2012), this order included a brief review of the connection of life and religion, a review of general group guidelines, group introductions, a mindfulness exercise, a story or inspirational text, a discussion of reviewed topics like forgiveness, self-acceptance, and self-care or coping strategies.

Further, Guest Lowery (2012) suggested that other practical tools and training should be acquired when ministering to patients with differing mental health diagnoses. Many geriatric psychiatric patients have been diagnosed with dementia and other brain maladies concurrently with eating disorders, anxiety disorders, and mood disorders (American Psychiatric Association, 2013; Goh et al., 2012). Further, eating disorders, anxiety disorders, and mood disorders all have been identified as having their own symptomology (American Psychiatric Association, 2013). For example, patients diagnosed with eating disorders have been reported to struggle with self-destructive behaviors related to food (American Psychiatric Association, 2013; Yalom & Leszcz, 2005). Anorexia nervosa and bulimia (binge/purge) were two of the most common types of eating disorders (American Psychiatric Association, 2013).

Patients with eating disorders displayed symptoms of perfectionism, low self-esteem, rigidity, and emotional avoidance (Yalom & Leszcz, 2005). Hence, trained chaplains have been

more effective when focusing on the concept of grace versus works in patient relationships with God by using Scripture and positive religious materials. These patients needed help to find strength in their weaknesses, self-forgiveness, self-care, and reduced feelings of shame (Yalom & Leszcz, 2005). The Holy Bible stated, "but because of his great love for us, God, who is rich in mercy, made us alive with Christ even when we were dead in transgressions—it is by grace you have been saved" (Ephesians 2:4-5, NIV).

Patients with anxiety disorders, which include Obsessive-Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD) have been shown to experience excessive worry and psychologically and physiologically fear (American Psychiatric Association, 2013; Yalom & Leszcz, 2005). When dealing with patients diagnosed with an anxiety disorder, chaplains have been effective in reinforcing the "normalcy of religious uncertainty" and helping patients with the exploration of their faith as a life journey rather than just a belief (Yalom, & Leszcz, 2005, p. 276). Additionally, chaplains who were prepared and trained in using mindfulness were able to keep patients anchored in the present and strengthened their stress tolerance (Yalom, & Leszcz, 2005).

Further, chaplains that were equipped and trained in creating and implementing action steps were able to encourage patients in purposeful living and clarify and reframe their "cognitive distortions" about religion (Yalom & Leszcz, 2005, p. 276). Hence, the Holy Bible stated that "God has not given us a spirit of fear, but of power and of love and of a sound mind" (II Timothy 2:7, New King James Version).

Additionally, patients with mood disorders, such as major depression and bipolar disorder, have been found to experience problems with the regulation of their emotions, feelings,

and moods (American Psychiatric Association, 2013; Yalom & Leszcz, 2005). Further,

depression was identified as a primary indicator of suicidal ideation, and Yalom, and Leszcz

(2005) described bipolar disorder as "a roller coaster of emotions and impulsive behaviors"

(Yalom, & Leszcz, 2005, p. 277). When providing spiritual care to patients diagnosed with mood

disorders, chaplains have been shown to effectively use stories and experiences of hope for the

clarification of guilt, true belief, and the struggle of faith (Yalom & Leszcz, 2005). It was helpful

when chaplains were trained to assist patients in "safe expressions of feelings, self-forgiveness,

and aided them in the acceptance of God as a companion, not a fixer" (Yalom & Leszcz, 2005, p.

277).

In addition, when patients with mood disorders experienced mania, it was reported to be

beneficial when the chaplain was trained to remain calm, observant, maintain a safe but caring

distance, validate, and redirect disruptive behaviors (Yalom & Leszcz, 2005). Only when the

patient's stability was achieved should the chaplain introduce spiritual themes (Yalom & Leszcz,

2005). Thus, the Holy Bible stated, "but you, Lord, are a compassionate and gracious God, slow

to anger, abounding in love and faithfulness. (Psalm 86:15, NIV).

Next, patients with psychotic disorders have been shown to experience delusions,

hallucinations, and disorganized thoughts and behaviors (American Psychiatric Association,

2013; Yalom & Leszcz, 2005). Schizophrenia and psychosis have been identified as the most

common psychotic disorders (Yalom & Leszcz, 2005). Additionally, schizophrenia may be

accompanied with psychosis (American Psychiatric Association, 2013; Yalom & Leszcz, 2005).

Patients with schizophrenia and psychosis have been reported to engage with God and religion in

ways that were both rational and delusional (Yalom & Leszcz, 2005). Chaplains were instructed

not to confront the delusions or overtly speak about religion or religious books due to the

tendency of hyper-religiosity (Yalom & Leszcz, 2005). Rather, appropriately trained chaplains

have been effective in using reflective listening and exploring the patient psychotic experiences

"to find spiritual needs and sources of hope" (Yalom & Leszcz, 2005, p. 478). Additionally,

positive religious coping was then fortified through appropriate religious materials and

connection with the chaplain (Yalom & Leszcz, 2005). Therefore, the Holy Bible stated, "the

LORD is good to all: and his tender mercies are over all his works" (Psalm 145:9, NIV).

Ethical Training

Ethics were used in healthcare settings in three ways, namely, "the search for the good, as

rules to live by, and as critical analysis of morality" (Belinger, 2012, p. 178). In 1992, the Joint

Commission, which accredited hospital operation in the United States, directed that hospitals

implemented a mechanism for handling ethical issues (Belinger, 2012). Prior to 1992, a federal

Institutional Review Board (IRB) addressed ethical issues related to research only (Belinger,

2012).

The Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and

Students was approved in 2004 by six certifying associations in the United States and Canada

that were established to oversee chaplain organizations and training programs (Belinger, 2012).

The code of ethics concentrated on namely, relationships with clients, between supervisors and

students, faith communities, with other community professionals, with health care colleagues,

and in advertising and research (Belinger, 2012). Chaplains were expected to have knowledge

about the rules of their profession and about the rules by which other people and their colleagues

lived. Hence Belinger (2012) stated that "…chaplaincy organizations and health care institutions

that involve community clergy should aim to offer some ethics education for community clergy involved in patient care" (p. 182).

Chaplains have been mandated to hold a professional, social, and moral obligation to their patients and were the "truth tellers and justice seekers" (Belinger, 2012, p. 183). Thus, chaplains have been shown to play the role of critically reflecting on the harmful and unjust practices of health care systems. Subsequently, Belinger (2012) posited that though chaplains did not have much authority, "…the chaplain has an obligation not to be present to the suffering but also to question conditions that appear to promote or add to the suffering" (Belinger, 2012, p. 183).

According to Belinger (2012), although chaplain ministry occurred mostly at the bedside of patients, attention was given to ethics education, policy development, and healthcare structures that had productive, ethical consultations. When chaplains participated on interdisciplinary healthcare teams, they brought their uniquely honed abilities to reason in the realm of morality and religion to ethical situations (Belinger, 2012). Christian chaplains have been shown to live by a Biblical mandate of upholding ethics (Belinger, 2012). Hence, the Holy Bible stated, "he has shown you, O mortal, what is good. And what does the LORD require of you? To act justly and to love mercy and to walk humbly with your God" (Micah 6:8, NIV).

It has been established that all professionals in healthcare have a responsibility to the moral, psychological, and social issues that accompanied the care of patients (Belinger, 2012). No discipline of healthcare was expected to exist in a bubble or independently and that included the healthcare chaplaincy discipline. Thus, the bar for chaplain participation in ethical matters in healthcare was raised (Belinger, 2012). Subsequently, Belinger (2012) wrote, "…(chaplain

participation) will include the expectation that chaplains are well informed about the ethical

dimensions of the care of the sick, and are prepared to participate in ethical consultations, ethics

education, and the analysis and development of ethically sound policy" (p. 190).

Topics that healthcare chaplains have been involved with ethically in healthcare have

included: palliative care, collaborative decision making, advanced care planning, decisions about

food and feeding patients with eating disorders or near end of life, the care of terminal patients,

objections to a determination of death, religious objections to treatment decisions, and policy

supporting good practice (Belinger, 2012). Healthcare chaplains that held to ethical standards

were the preservers of justice. Hence the Holy Bible stated, "but let justice roll on like a river,

righteousness like a never-failing stream" (Amos 5:24, NIV).

Self-Care

Burns, Chapman, and Guthrie (2013) recommended chaplain self-care to be a major

theme in resilient ministry. Hence Burns et al. (2013) stated that "self-care…may include getting

to bed on time, saying no to work by setting aside time for Sabbath and sabbatical, getting

responsible exercise, and eating a proper diet" (p. 21).

Stuart (2012) posited that self-care was an integral part of professional ministry and that

the Council of Collaboration and the Association of Professional Chaplains required self-care

competency to be demonstrated by their members. Chaplains were trained in Clinical Pastoral

Education to identify stressors and to take scheduled breaks during the day, and retreat to the

chapel or outside for a change of scenery (Stuart, 2012).

Carter (2013) asserted that ministers in North America had experienced rising

percentages of stress and burnout. Thus, chaplains and clergy members were encouraged to take

intentional consideration of personal self-care plans (Carter, 2013). Burns et al. (2013) indicated

that "research has suggested pastors either hold unrealistic expectations of human productivity,

don't view self-care as an ethical imperative, or 'spiritualize away' their need for self-care" (p.

21).

Likewise, several Australian authors advocated for self-care as an ethical obligation (Tan,

2011; Wise, Hersh, & Gibson, 2012). The Australian Psychological Society's (2007) Code of

Ethics stated, "psychologists must ensure that their emotional, mental and physical state does not

impair their ability to provide a competent psychological service" (p. 19). Further, Barnett and

Cooper (2009) lobbied for the development of a "self-care ethos" that highlighted wellness at

every stage of mental health professionals' careers (p. 17).

For Christian chaplains, the Holy Bible was rife with knowledge about self-care (John 15:

5, NIV; Matthew 14:23, NIV; Matthew 26: 36 NIV). For example, in the middle of busy ministry

to countless people, Jesus took breaks and stepped away to pray to his Father in solitude

(Matthew 14:23, NIV; Matthew 26:36, NIV). Tan (2006) stated that this was a key life-altering

example to the power and effectiveness found in Jesus' ministry, and it has been shown to be the

key to individuals and their ministries. Hence, Tan (2006) suggested Biblical self-care that

involved shepherd-centeredness, and the perpetual presence in Christ as recommended in John

15:5 (NIV). This form of self-care included spirit-filled surrender to Jesus Christ solitude and

silence, simplicity, Sabbath-keeping, sleep, spiritual community, servanthood, and stress

management that promoted love and not competition (Tan, 2006). There was also the suggestion

of traditional spiritual actions of prayer, Bible study, meditation on the Lord, fasting, worship,

confession, fellowship, and service (Tan & Gregg, 1997). Further, Canning (2011) posited that

the Biblical equity of self-care went beyond the consideration of balance and stewardship to sanctified tribulation that destabilized the dependence on God's sovereign grace.

According to Tan and Castillo (2014), Christian chaplains called by God into ministry were not to be self-sufficient, independent, and full of self-confidence. Hence, Tan and Castillo (2014) stated that "as Christian human beings, we are aware that all we are, do and have, even out very breath and life, comes from God. Apart from God we can do nothing" (p. 5). Hence, Biblical ministry was done in communion with other good workers that helped to share the burden (Luke 10:1, NIV; Mark 6-7, NIV). Therefore, self-care evolved into 'we-care' or 'community-care' where ministry duties were distributed, which was found to be helpful (Tan & Castillo, 2014). Further, God-care was the piece of self-care that confirmed the relationship between a loving Father and his children. Thus, Tan and Castillo (2014) wrote, "as God works through us to heal, redeem, and refresh others, so God works through others to heal, redeem and refresh us" (p. 5).

In summation, self-care has been shown to be important for healthcare professionals, particularly chaplains that often encountered stressful environments that resulted in emotional and physical distress and secondhand traumatization (Barnett, Baker, Elman & Schoener, 2007). However, Baker (2003) had found that the absence of proper chaplains' self-care led to 'burnout,' which had been shown to impair function due to emotional or compassion fatigue, discontentment, and frustration with patients. Therefore, emphasis had been placed on chaplains' self-care to ensure that pastoral care was provided in an alert, effective, congruent, and compassionate manner for patients (Baker, 2003; Barnett et al., 2007; Tan & Castillio, 2014).

Theological Foundations

The theological basis that undergirded this research project came from the Holy Bible's strong endorsement and promotion of competent and excellent work ethics (2 Timothy 3:17 English Standard Version; Ecclesiastes 9:10 New Living Translation). Therefore, Scriptures laid the foundational standard and measure for this project to ask chaplains to evaluate that "whatever you do, do well" (Ecclesiastes 9:10, NLT). Also, the Biblical expectation "that the man of God may be competent, equipped for every good work" (2 Timothy 3:19 ESV) is the basis for this project's development of a practical guide to better equip geriatric psychiatric chaplain for ministry.

This research project strived to inspire chaplains who serve geriatric patients with mental health disorders to become living breathing examples of commitment to excellence as the "salt" and "light" to their patients and communities (Matthew 5:13-16 New International Version). This is the same commitment to excellence that Paul spoke of when he wrote "I urge you, then— I who am a prisoner because I serve the Lord: live a life that measures up to the standard God set when he called you" (Ephesians 4:1, Good News Translation).

The Holy Bible demonstrated that Jesus always prepared and knew his audience; the sick, the poor; the hapless, the harmless, the arrogant; the haters, the meek, the deceitful, men, women, and children (John 4, NIV; Luke 7:36-50, NIV; Luke 11:42, NIV; Matthew 18:1-5, NIV). Though he was God and recognized people at a cellular level, Jesus humbly engaged his followers with eyes privy to the despair in their hearts, and ears that longed to hear the meanderings of their free will (John 4, NIV; Luke 7:36-50, NIV; Matthew 9:10-17, NIV). Jesus was a perfect example of how to stand in others' shoes (sandals), which is a skillset that is vital

for the competency of every chaplain. Luke 9 (New International Version) revealed that before

Jesus preached to the 5000, he specifically instructed his disciples to first feed them. Jesus even

performed a miracle to ensure that every person ate until they were satisfied. His example to

chaplains was to be aware of the 'outer man's' hierarchy of needs before reaching for his soul.

Additionally, Jesus was the first mental health chaplain, as demonstrated when he

approached the Gerasene demoniac with a mission to set him free from the binds of possession

(Mark 5, NIV). When others were afraid to draw near to 'Legion,' who in modern times would

be diagnosed with multiple co-occurring mental health diagnoses, Jesus approached him with

compassion, awareness, and the competency to do minister (Mark 5, NIV).

Nouwen (1972) captured the foundational Biblical mandate of love that came without

limitation and pretense. Nouwen (1972) wrote, "For one man needs another to live, and the

deeper he is willing to enter into the painful condition which he and others know, the more likely

it is that he can be a leader, leading people out of the desert into the promised land" (p. 63). In

following the footsteps of Jesus, chaplains are called to preparedness with the awareness of not

walking ahead of the hurting but walking beside them with true empathy. Leadership did not

delegate the burden but instead bore the burden, as Christ so aptly proved on the cross (Matthew

27-32, NIV). Likewise, the role of a chaplain involves going into the trenches and being

equipped and prepared for any spiritual task.

Subsequently, self-care as part of preparation is an essential element in the life of a

healthcare chaplain who is often called to bear the burdens of their patients. Jesus taught the

value of self-care when he said to disciples, "let's go off by ourselves to a quiet place and rest

awhile. He said this because there were so many people coming and going that Jesus and his apostles didn't even have time to eat" (Mark 6: 31, New Living Translation).

Admittedly, to function in the role of a chaplain requires human cognizance but, more importantly, a willingness to be equipped and led by God. Hence, Jesus often does not call the qualified but qualifies the called as seen in the life of his disciple, Peter (Acts 2, NIV; Luke 22: 54-62, NIV). Similarly, God's grace will be sufficient for chaplains that minister on geriatric psychiatric floors.

Jesus emphasized the value of being prepared in the parable of the ten bridesmaids who "took their lamps and went out to meet the bridegroom" (Matthew 25: 1, NIV). Five of them were foolish, and five were wise. The foolish ones took their lamps but did not take any oil with them. The wise ones, however, took oil in jars along with their lamps (Matthew 25: 1-4, NIV). Hence, this research project gleans from this parable the lesson of preparedness and attempts to aid chaplains in keeping their 'lamps' prepared with 'oil' prior to visits with geriatric patients with mental health disorders. In summation, this research project focused on the need for spiritual, mental, physical, and clinical preparation of geriatric psychiatric chaplains which is undergirded by the theological teachings established in the Holy Bible (Ecclesiastes 9:10, NLT; Matthew 5:13-16, NIV; Matthew 25: 1-13 NIV; Ephesians 4:1, GNT; 2 Timothy 3:19 ESV).

Theoretical Foundations

The theoretical basis that undergirded the research project was founded on a few practices and models that provided justification for this research project. One such theory and conceptual framework is Harter's (1978) competence motivation theory. This theory of competence motivation was founded on a theory of achievement motivation, which is subject to

an individual's level of personal competence. The theory of competence motivation postulated

that an individual's degree of motivation heightens with each task that is mastered (Harter, 1978;

Weiss, & Ferrer Caja, 2002). Therefore, an individual's perceived competence directly

influences their selection, performance, and continuation of activities, task or occupational duties

(Weiss, & Ferrer Caja, 2002). As a ripple effect, it was found that when people mastered or felt

competent in a task or duty, it was more likely that they will develop confidence and feel

encouraged to engage in more duties within that area (Weiss, & Ferrer Caja, 2002).

Historically, the pioneer of competence motivation theory was identified as Robert White

with his classic publication addressing motivation reconsidered (White, 1959). It was White

(1959) who coined the term 'effectance,' meaning the ability of an individual to examine and

effect change to their environment. Hence, White (1959) advanced the hypothesis that when the

results of individuals' interaction with their environment (physically and socially) were

perceived as positive, they received intrinsic rewards (pleasure and a sense of efficacy). This

gain of intrinsic rewards, in turn, motivated the continuation of 'effectance' by those individuals

with their environment (White, 1959).

During the late 1950s, White's theory of competence motivation was considered original,

since it differed from the then popular psychoanalytic instinct theory and the human behavior

drive theories (Elliot, & Dweck, 2005). Later, in the 1970s, Susan Harter built on White's

effectance motivation theory and developed a broader theory that was later renamed competence

motivation theory (Harter, 1978). Harter's theory was similar to White's theory, with the

exception that Harter (1978) proposed the inclusion of negative effects or outcomes, unlike

White's theory. Harter (1978) suggested that anxiety and shame may be experienced when

individuals were unsuccessful at a task, which led to a decreased sense of competence and withdrawal from interaction in that domain.

Subsequently, Harter's (1978) theory related to this research project which sought to examine chaplains' level of competency. According to Harter's (1978) competence motivational theory, the chaplain's level of competence can affect their level of performance and commitment to service. Likewise, according to the competence motivational theory, chaplains that were equipped and prepared were more likely to feel encouraged to attempt new and advanced tasks related to geriatric psychiatric patient care (Harter, 1978; Weiss, & Ferrer Caja, 2002).

Thus, the development of this research's practical guide for geriatric psychiatric chaplains may help to better equip chaplains, and subsequently, lessen their challenging experiences or perceived failed visits when ministering to geriatric patients with mental health disorders. Subsequently, the chaplains will be less likely to experience a decreased sense of competence, which according to Harter (1978), can lead to anxiety, loss of intrinsic rewards, and withdrawal from duties or 'burnout.'

Summary

A comprehensive review of precedent literature related to this project was discussed at length in this chapter. Empirical research was incorporated to serve as the foundation for this projects' guide in the areas of mental preparedness, spiritual preparedness, prayer, worship, clinical training, ethics, and self-care. In the ensuing chapter, the methodology, including the intervention design that related to the ministry context problem and intervention implementation are discussed in detail.

Chapter 3: Methodology

In this chapter, the intervention design that addressed the ministry context problem and the alignment of the project's intervention with the project thesis and problem statement is presented. The intervention design's step-by-step tasks are presented in detail. Next, the sampled population, including the inclusion criteria, the rationale for the criteria, the sampling location, timeline, and duration of the sample, is discussed. The instrumentation and ethical procedures including, privacy, confidentiality and data security, informed consent, potential ethical issues, and bias/assumptions, are addressed. Finally, this chapter detailed the implementation of the intervention design, which included an explanation of how data triangulation was achieved, the specific type of data collection, the sequence for data collection, why the sequence was chosen, and how the data analysis plan related to this thesis project.

Intervention Design

The purpose of this Doctor of Ministry thesis project was to examine the level of training and preparedness of chaplains that ministered to geriatric mental health patients within clinical settings, in order to address the need for comprehensive and competent care for mental health patients, specifically the geriatric population. This intervention design directly addressed the ministry context problem, which was identified as the need for comprehensive chaplaincy training and preparation for competent ministry and care for mental health patients, specifically the geriatric population.

Intervention Design: Purpose and Objective

The purpose and objective of this project's intervention design were to access the level of training and preparedness of chaplains who ministered to geriatric mental health patients within

clinical settings. The project's objective was achieved by applying a quantitative approach using a general nonexperimental design to analyze data collected via a survey questionnaire to address the problem presented in this study. Specifically, a correlation design that allowed for the examination of the level of training and preparedness of chaplains and their reported sense of competence when ministering to mental health patients, specifically the geriatric population, was used.

The correlational design was chosen for this thesis project since it allowed for the examination of variables that would have been challenging to evaluate within a laboratory setting (Jackson, 2012). For example, this nonexperimental correlation design allowed this project to examine variables, such as chaplains reported levels of training, preparedness, and reported perception of competence, which cannot be controlled and manipulated. Thus, this project was able to examine and collect data regarding questions that would be non-accessible to experimental researchers (Kaplan, 2004).

Also, by using a quantitative approach that implemented a correlational design, the project benefited from the cost-effective data analysis provided by the use of applicable and efficient computing software (Jackson, 2012). Finally, the use of the correlation design, along with the use of a survey questionnaire, required less time compared to other study methods (Jackson, 2012).

This projects' intervention design surveyed and examined the reported level of competency and preparedness of chaplains that minister to mental health patients, particularly geriatric patients with mental health disorders. Specifically, the data collected were analyzed to determine the level of competency and preparedness of chaplains that minister to geriatric

patients with mental health disorders, in terms of their geriatric psychiatric competencies, spiritual preparedness, mental preparedness, clinical preparation, ethical competence, use of on-the-job tools, and self-care.

Therefore, the purpose and objectives of the project's intervention aligned with the problem presented in this project, whereby healthcare chaplains' competency and preparedness to minister to mental health patients can be adversely affected by insufficient mental health education, training, and preparedness.

The data collected from the chaplains served in the creation of a guide that included ways to help improve this ministry challenge and assist geriatric psychiatric chaplains in providing comprehensive delivery of competent care to patients. This hands-on guide addressed fundamental aspects of mental health chaplaincy, such as specific geriatric psychiatric competencies, spiritual preparedness, mental preparedness, clinical preparation, ethical competence, the use of on-the-job tools, and self-care. Thus, this guide not only advised chaplains about the clinical aspects of the job, but about daily management of work, the importance of debriefing, living a balanced personal, and professional lifestyle.

Intervention Design: Step-by-Step Tasks

The step-by-step tasks involved in this questionnaire each supported the purpose and objective of this thesis project. The purpose of this thesis project was to examine the level of training and preparedness of chaplains who ministered to geriatric mental health patients within clinical settings to address the need for comprehensive and competent care for mental health patients, specifically the geriatric population.

The objective of this project was to use the data collected from the chaplains to create a guide that included ways to help improve this ministry challenge and assist geriatric psychiatric chaplains in providing comprehensive delivery of competent care to patients. The first of this task was to gather demographic and background information about the participants' gender, age, state of residence, possession of an M.Div. degree, length of employment as a chaplain, clinical setting of employment, times per week ministered to geriatric psychiatric patients, and the amount of geriatric psychiatric patients ministered to in career. This task supported the purpose of this project by identifying the chaplains' background as it correlated to their level of training, preparedness, and reported competence. The data from this task will help to specifically craft the guide in accordance to chaplains' background.

The second task examined the adequacy of divinity school/seminary education and Clinical Pastoral Education training for ministry to geriatric psychiatric patients. Further questions inquired about the preparation for chaplains to minister to geriatric psychiatric patients with specific diagnoses in specific situations. This task supported the purpose of this project by identifying chaplains' geriatric mental health training as it correlated to their level of training, preparedness, and reported competence. The data from this task will help to precisely craft the guide in accordance with chaplains' geriatric mental health training needs.

The third task examined chaplains' spiritual, mental preparedness, and their specific methods of preparation prior to ministering to geriatric psychiatric patients. This task supported the purpose of this project by identifying chaplains' level of spiritual and mental preparedness as it correlated to their reported competence. The data from this task will help to specifically craft the guide in accordance with chaplains' spiritual and mental preparedness needs.

The fourth task examined chaplains' clinical preparation and patient interventions. This task supported the purpose of this project by identifying chaplains' level of clinical preparedness as it correlated to their reported competence. The data from this task will help to precisely craft the guide in accordance to chaplains' clinical preparedness needs.

The fifth task examined chaplains' knowledge and implementation of Mandated Reporting; Advance Care Planning and end of life decisions, staff collaboration with geriatric psychiatric patient cases, and patient advocacy. This task supported the purpose of this project by identifying chaplains' level of ethical competence as it correlated to their level of training, preparation, and reported competence. The data from this task will help to specifically craft the guide in accordance with chaplains' ethical competence needs.

The sixth task examined chaplains' training, self-protection and de-escalation techniques, access to counselors and social workers, debriefing, and suicidal prevention. This task supported the purpose of this project by identifying the chaplains' level of on-the-job tools as it correlated to their level of training, preparation, and reported competence. The data from this task will help to specifically craft the guide in accordance with chaplains' on-the-job tools needs.

The seventh task examined chaplains' intentional self-care, participation in debriefing for self-care, methods of self-care, time spent in prayer, meditation or devotional, and analysis of the level of self-care. This task supported the purpose of this project by identifying the chaplains' level of self-care as it correlated to their level of preparation and reported competence. The data from this task will help to precisely craft the guide in accordance with chaplains' self-care needs.

In summation, each of these tasks served to address this project's problem presented. Specifically, the problem this project addressed was the need for comprehensive chaplaincy

training and preparation for competent ministry and care for mental health patients, specifically the geriatric population.

This project identified that ministering to the geriatric population has been shown to require a combination of empathy, compassion, patience, specific training, and preparation (Lawrence et al., 2007). Further, ministry to the geriatric population was shown to be vital in confirming their faith, resolving moral and religious issues, dealing with misfortune or losses, and confronting sickness and disability (Lawrence et al., 2007). However, it was highlighted that geriatric psychiatric patients have been proven to be particularly intuitive about insincerity and incompetence, and they quickly developed protective walls to insincerity (Lawrence et al., 2007). Therefore, it was particularly crucial for chaplains to be prepared to draw from their skillsets of well demonstrated and adaptive compassion, patience, empathy, and sensitive listening skills (MacKinlay, 2002).

In response to this need, the data from each task were used to suggest practical ways to develop a guide to help to fill the gap of training and preparation for healthcare chaplains. This hands-on guide included suggestions for training for chaplains at the academic level, which may consist of more counseling courses in graduate school and/or continuing education training.

The next level of training could be on-the-job training. In this training, the guide focused on ways employers can provide legal/ethical guidelines, safely, and other training needed for the chaplains serving the mental health units or floors.

Another level of training focused on the spiritual, mental, and clinical preparedness of chaplains who serve geriatric patients. This training included valuable self-assessments, self-care, and establishing a safe and accessible support system. Having self-assessments of one's

level of preparedness would assist chaplains in developing resilience to burnout, improve their

quality of life (work and, personal), and better prepare them to effectively serve their patients.

Hence, each of these tasks helped to build this project's hands-on guide. The guide

addressed fundamental aspects of mental health chaplaincy, such as specific geriatric psychiatric

competencies, spiritual preparedness, mental preparedness, clinical preparation, ethical

competence, using on the job tools, and self-care.

Sampled Population

The target population was professional chaplains working in a clinical setting (hospitals,

hospices, nursing homes, skilled care nursing, or Veterans hospitals) within the Tristate region of

the United States (New York (NY), New Jersey (NJ), and Connecticut (CT). Also, the target

population included chaplains that had at least one or more pastoral visit(s) with patient(s) over

65-years diagnosed with a mental health disorder.

The power analysis used to calculate the sample size of this project involved a confidence

level of 95% with a confidence interval (margin of error) of +/-5 points. The G*Power 3.1

software program justified the power level, alpha level, and effect size (Faul, Erdfelder, Buchner,

& Lang, 2009). Based on a one tail with an alpha level of $\alpha = .05$ and a medium effect size (r

$=.30$), it was determined that the sample size required to obtain adequate power level (.70) was

25 participants. Therefore, the sample size of the target population for this project was estimated

as 25 participants.

Inclusion Criteria. The thesis project's sampling frame included chaplains that had a

likely chance of being selected for the project's sample (Gall, Borg, & Gall, 2003). Therefore,

the sampling frame specified inclusion criteria for potential participants that were based on the

chaplains' work location, work setting, and experience. Only professional chaplains who worked in the Tristate region of the United States (New York (NY), New Jersey (NJ), and Connecticut (CT) and within a clinical settings such as hospitals, hospices, nursing homes, skilled care nursing, and Veterans hospitals were included. Also, professional chaplains must have had at least one or more pastoral visit(s) with patient(s) over 65-years diagnosed with a mental health disorder to participate in the study.

Inclusion Criteria Rationale. This specific group of participants (professional chaplains) within the Tristate region (NY, NJ, and CT) of the United States was chosen based on the researcher's accessibility to a directory of professional chaplains within this region. Further, only chaplains that worked in a clinical setting (hospital, hospice, nursing home, skilled care nursing or Veterans hospital) and those who had experience with at least one or more pastoral visit(s) with patient(s) over 65-years diagnosed with a mental health disorder, were chosen. The rationale for these inclusion criteria correlated with the project's goal to obtain firsthand data from experienced chaplains in these settings which answered the research question related to their training, preparedness, and competency. Therefore, this selected group provided applicable data regarding the level of training and preparedness of chaplains who minister to geriatric mental health patients within clinical settings. By surveying this specific population sample of chaplains, the study was able to determine their level of education and training, as well as their reported sense of preparedness to minister to geriatric psychiatric patients. This information was valuable quantitative data regarding the areas of competency that can be used to improve competent care to geriatric patients with mental health disorders.

Sampling Location. The population sampling for this thesis project occurred in Hartford County, Connecticut. The location of the sampling was conducted online via SurveyMonkey, which facilitated access to professional chaplains within the Tristate region of the United States (New York (NY), New Jersey (NJ), and Connecticut (CT). These professional chaplains were sampled based on the criteria they worked in clinical settings such as hospital, hospice, nursing home, skilled care nursing or Veterans hospital.

Timeline and Duration of Sampling. The timeline for this sampling was two months. The stratified sampling strategy was selected as an appropriate sampling method based on this project's objective of increasing reliability and validity. This sampling strategy allowed for broad inferences to be made to the population (Frankfort-Nachmias & Nachmias, 2008). Therefore, this project used a stratified random sampling approach, and over a period of two months, the target population was separated by strata, and the samples were then randomly chosen from each stratum (Levy & Lemeshow, 2008).

Specifically, based on the researcher of this project's membership with the Association of Professional Chaplains (APC), permission was granted to access this organization's directory of professional chaplains. The steps taken first involved accessing the APC directory over a timeline of two months. Next, filters were used to limit the list to only professional chaplains that worked within a clinical setting such as hospital, hospice, nursing home, skilled care nursing or Veterans hospital. Also, a search criterion to filter and generate a list of only professional chaplains who worked in the Tristate region (New York, New Jersey, and Connecticut) was set up. After the lists were generated and exported to an excel document, the samples were randomly selected, and the group list, consisting of emails of the target sample, was constructed.

Next, the instrument tool, SurveyMonkey, was accessed, and a researcher account was created. SurveyMonkey is an online survey development service that operates via a cloud-based software (SurveyMonkey, 2016). This resource tool, SurveyMonkey, efficiently facilitated the researcher to upload the project's approved informed consent and 39-question questionnaire, which was done within the two-month timeline.

The target sample was then sent via email, the recruitment letter and a link to SurveyMonkey with access to the informed consent on the first page, followed by the 39-question questionnaire. The 39-question questionnaire approved by the Liberty University Internal Review Board (IRB) was placed on Survey Monkey for a period of one month.

Instrumentation

Quantitative data was collected using the instrument in the form of a questionnaire. The design of the 39-question multiple-choice questionnaire implemented a combination of survey question approaches. The types of survey question approach included the use of some demographic questions, five-point Likert scale questions, which allowed participants to express how much they agree or disagree with a presented statement (Likert, 1932), dichotomous (YES/NO) questions, and checkbox questions.

The questionnaire was comprehensive to ensure inquiry about several important aspects of mental health ministry, including questions about chaplains' training and preparedness. The survey sought to examine whether chaplains received enough training from their formal seminary/divinity school education and Clinical Pastoral Education, to effectively minister to mental health patients, particularly those on geriatric psychiatric floors.

The questionnaire began with three screening questions which served as an inclusion filter that included only chaplains from the Tristate region (NY, NJ, and CT), those who worked in a clinical setting (i.e., hospital, hospice, nursing home, skilled care nursing or Veterans hospital) and had at least one or more pastoral visit(s) with a patient over 65-years of age who was diagnosed with a mental disorder. The remaining 36 questions contained seven categories, which were integral to chaplains' ministry. These categories consisted namely of questions related to demographics/background information, specific mental health training and patient engagement, spiritual and mental preparation, clinical preparation, ethical competencies, on-the-job tools, and self-care.

The instrument, a 39-question questionnaire was titled "Survey of Training and Preparation Levels of Geriatric Mental Health Chaplains" (See Appendix C). The first section, titled "Screening Questions," contained three questions. These questions examined whether the participants met requirements to participate per the project's inclusion criteria. The questions asked if the participants worked in the Tristate region (NY, NJ, and CT), whether they worked in a clinical setting (i.e., hospital, hospice, nursing home, skilled care nursing or Veterans hospital), and had at least one or more pastoral visit(s) with a patient over 65-years of age who was diagnosed with a mental disorder.

The second section, titled "A: Demographics and Background" contained eight questions related to gender; age; location (State) of employment; education level such as a Master of Divinity degree, length of employment as a chaplain, type of clinical setting of employment; the amount of times per week spent ministering to geriatric psychiatric patients, and the amount of geriatric mental health patients ministered to in career.

The second section, titled "B: Specific Geriatric Mental Health Training. Demographics and Background," contained eight questions related to the adequacy of divinity school/seminary education and Clinical Pastoral Education training for ministry to geriatric mental health patients. This section further asked whether internship and/or residency in Clinical Pastoral Education provided training for ministering specifically to geriatric mental health patients. If the participant answered yes, they were further prompted to select the type of training received to minister to geriatric mental health patients from the list of options provided. The list included didactics on ministering to geriatric mental health patients, reviewed psychiatric assessments and diagnoses, shadowed geriatric psychiatric chaplain, assigned as an intern/resident chaplain on the geriatric psychiatric unit/floor or other.

Next, this section B further asked if additional training in psychology, mental health, or counseling was received. If the participant answered yes, they were further prompted to select the type of additional training they have received in psychology, mental health or counseling from the list of options provided. The list included: additional classes or courses in psychology, mental health, or counseling; didactics on counseling geriatric mental health patients, continuing Educating (CEUs) on geriatric mental health patients, reading scholarly books/articles on counseling geriatric mental health patients, attending training/seminars/webinars on counseling geriatric mental health patients or other.

Section B continued by asking participants to indicate how adequately prepared they felt to develop and implement a plan of care to promote well-being and continuity of care for geriatric mental health patients. The participants provided their responses using a 5-point Likert scale to rate their responses from strongly agree, agree, neutral, disagree, or strongly disagree.

Participants also indicated how adequately prepared they felt to gather and evaluate relevant data pertinent to the geriatric mental health patients' situation and bio/psycho-social-spiritual/religious health. Again, they provided their responses using a 5-point Likert scale to rate their response from strongly agree, agree, neutral, disagree, or strongly disagree.

Next, section B asked participants which diagnoses or situations they felt competently trained to handle while ministering to geriatric mental health patients. The diagnoses or situations listed were as follows: depression, anxiety, obsessive-compulsive disorder, post-traumatic stress, bipolar disorder, borderline personality disorder, eating disorder, brief psychotic disorder, schizophrenia, schizoaffective disorder, schizotypal personality disorder, delusional disorder, substance-induced psychosis, cognitive impairments, and co-occurring disorders. The list also included: catatonia, echolalia, aphasia, hearing impairment/decline, suicidal ideation, transference, countertransference, trauma response, agitation, physical and verbal aggression, none of the above or all of the above.

The third section, titled "C. Spiritual and Mental Preparation," contained four questions. Participants were asked if prior to visiting geriatric mental health patients, they would regularly have adequate time to spiritually prepare. If they responded yes, participants were asked if they engaged in one or more of the following preparation actions: pray, meditate, read the Bible or a religious book, meet with other chaplains, personal or group devotional, other or they had the choice to select 'not applicable.' Next, participants were asked if prior to visiting geriatric mental health patients, they felt they regularly had adequate time to mentally prepare. If they answered yes concerning mental preparedness, participants were asked if they engaged in one or more of the following, namely, self-evaluation of current mental status, practice positive thinking, deep

breathing, imagery, listen to music, self-talk, other or they have the choice to select 'not applicable.'

The fourth section, titled "D. Clinical Preparation," contained two questions. Participants were asked if prior to visiting geriatric mental health patients, they would regularly have time to clinically prepare. If they responded yes, participants were asked if they engaged in one or more of the following clinical preparation actions: refresh knowledge about patient's diagnosis, religious status and preferences, contemplate different interventions based on diagnosis, consult with the staff about the patient, review the patient's chart, self-evaluation of clinical competence, 'other' or 'no time to prepare.'

The fifth section, titled "E. Ethical Competence," contained six questions. Participants were asked if they received any training from their employer on Mandated Reporting. If they responded yes, they were asked how much they agreed or disagreed with the following statement: "I feel knowledgeable and competent to handle ethical issues related to Mandated Reporting cases." The participants provided their responses using a 5-point Likert scale to rate their responses from strongly agree, agree, neutral, disagree or strongly disagree, and they had the option to select 'not applicable.'

This section E continued by asking participants were asked if they were trained in Advanced Care Planning and end of life decisions. If they responded yes, they were asked how much they agreed or disagreed with the following statement: "I feel competent in assisting with end of life decisions related to geriatric mental health patients." The participants provided their responses using a 5-point Likert scale to rate their responses from strongly agree, agree, neutral, disagree, or strongly disagree, and they had the option to select 'not applicable.'

Finally, participants were asked if they received training from their employer about collaborating with staff for the advocacy of geriatric mental health patients and families or participated in regular interdisciplinary team meetings. If they responded yes, they were asked how much they agreed or disagreed with the following statement: "I feel competent advocating for geriatric mental health patients and their families." The participants provided their responses using a 5-point Likert scale to rate their responses from strongly agree, agree, neutral, disagree, or strongly disagree.

The sixth section, titled "F. On-The-Job Tools," contained three questions. The first questions asked whether participants received on-the-job training about self-protection and de-escalation of patients. The second question asked whether participants had access to counselors and social worker for crisis event debriefing. The third question asked if participants were trained to handle suicidal prevention according to their workplace protocol.

The seventh section, titled "G. Self-Care," contained five questions. Participants were asked if they intentionally practiced self-care. If they answered yes, participants were asked if they would regularly participate in any of the following debriefing session after ministering to geriatric mental health patients: debriefing with patient's doctor, patient's nurse, patient's social worker, patient's counselor, patient's aide, another chaplain/minister or no time to brief.

Next, participants were asked to choose which of the following hobbies or other interests they engaged in as part of their self-care: praying, meditating, seeking solitude time, spending quality time with family and or friends, reading novels/poetry, gardening, drawing, writing, journaling. The list also included: hunting, fishing, camping, walks on the beach/swimming, bird watching, outdoor sporting activities, sightseeing, motorcycle riding, traveling on vacation,

watching movies, singing; listening to music, camping, going to the beach, bird watching, indoor sporting activities or other. The participants also had the option to select 'not applicable."

Section G continued by asking participants how many minutes/hour per week they spent in prayer, meditation, and/or personal devotional. They had a choice to choose from a time range of: 0 to 15 minutes, 16 to 30 minutes, 31 minutes to less than 1 hour, 1 to 2 hours, 3 to 4 hours, 5 to 6 hours, 7 to 9 hours or 10 hours or more. Lastly, participants were asked to indicate how much they agreed or disagreed with the statement: "my level of self-care as described above significantly contributes to my level of resiliency and effectiveness as a chaplain to geriatric mental health patients." The participants provided their responses using a 5-point Likert scale to rate their responses from strongly agree, agree, neutral, disagree, or strongly disagree.

Administration of Instrument. The instrument, a 39-question questionnaire was posted to SurveyMonkey's website for one month. A list of emails of selected chaplains from the APC's directory was created and saved as an excel file. Next, the recruitment letter was sent via the individual emails of the selected population sample that included chaplains that were primarily employed in hospitals, hospices, nursing homes, skilled nursing homes, and Veterans hospitals in the Tristate region (NY, NJ or CT).

Chaplains that chose to participate and advance research in the field of chaplaincy were asked to proceed by clicking on the SurveyMonkey link provided. At this stage, the informed consent was the first page seen by the participant. Since this project was anonymous, no consent form was required to be signed and returned to the researcher. Hence, participants provided their informed consent by simply clicking 'next' at the end of the consent page, which took them to the questionnaire section and indicated their willingness to take part in the questionnaire.

At this stage, the instrument administration launched, and the participants were then presented with the 39-question questionnaire. The first three questions served as a screener, and if participants met these criteria, they were provided with the next 36 questions which were related to their level of training, preparation (spiritual, mental, and clinical), ethical competence, on-the-job tools, and self-care used during pastoral visits with geriatric patients with mental health disorders. The questionnaire required the commitment of approximately 10-15 minutes to complete. After completion of the questionnaire, the participants were prompted to click the "submit" button to indicate the completion of their participation and upload their answers to SurveyMonkey.

Additionally, the participants were informed that the questionnaire was completely anonymous, and no personal identifying information was collected. Also, participants were informed that they might withdraw from the study at any time by simply clicking the "cancel" button or closing the survey link.

Ethical Procedures

The researcher of this project holds membership with the Association of Professional Chaplains (APC), which automatically granted access to this organization's directory of professional chaplains. The APC membership number for the researcher is 60106 (See Appendix D). Nevertheless, permission to obtain access to the directory of professional chaplains was verified and approved by the organization (See Appendix E). The researcher agreed that the questionnaire would not be promoted as an APC sponsored or directed survey, and the survey will be sent to less than 100 members. Also, the researcher agreed at the APC's request that if feedback was received from a member that asked not to have emails sent to them, that request

would be respected, and they will be informed that they can opt-out of being listed in the directory by contacting the APC's office (See Appendix E).

This study did involve interaction with human subjects in the form of an online questionnaire. The institutional permission, which included an Institutional Review Board (IRB) application, was acquired to safeguard that the ethical principles of beneficence, justice, and respect for persons were met in this thesis project. The IRB approval number for this project is IRB Exemption 4193.013120 (See Appendix F).

Privacy. During the data collection, emails were sent to participants with the recruitment letter and a link to the SurveyMonkey questionnaire. The questionnaire was posted on SurveyMonkey, and participants simply clicked the link to anonymously participate. Therefore, the privacy of the participants was safeguarded. The researcher had no way of knowing which participants gave which response, and additionally, the questionnaire contained no identifying data such as name, specific age, date of birth or address. Also, to ensure the anonymity of participants, the consent form was not signed and returned to the researcher. The participants had the option to simply click 'next' at the end of the consent form, which brought them to the start of the questionnaire and provided their consent to take part in the questionnaire. Finally, SurveyMonkey will allow the researcher to securely analyze the data collected. Therefore, the privacy of the participants was safeguarded.

Confidentiality and Data Security. The dataset is at low to no risk of confidentiality risk since the questionnaire was conducted anonymously. Therefore, the researcher had no way of knowing which participants gave which response, and additionally, the questionnaire contained no identifying data such as name, specific age, date of birth or address.

Nevertheless, the records of this project will be kept private. Research records will be stored securely, and only the researcher and mentor have access to the initial records. Specifically, hard copies of data received from SurveyMonkey are securely locked in a locked filing cabinet, and the researcher is the only person with access to that secure cabinet. The raw electronic data is stored on an administrator password-protected computer, which is equipped with Norton antivirus software, Malwarebytes anti-malware, and anti-spyware protection. Antivirus protection, along with Malwarebytes anti-malware and anti-spyware protection, is scanned daily, and current updates are applied to preserve the security of the data set.

In compliance with the Office for Human Research Protection (45 CFR 46), the data will be kept for at least three years (Office for Human Research Protections, 2019). After the three-years, the hard copy dataset will be securely shredded and disposed of, and the stored electronic copies will be professionally deleted from hard drives.

Informed Consent. The participants were provided with an institution approved IRB informed consent form (See Appendix B). The potential participants were provided with a brief background of this project, which sought to develop a guide for geriatric psychiatric chaplains that identified specific areas of training, preparation (spiritual, mental, and clinical), ethical competence, on-the-job tools, and self-care needed when providing care for this population. Further, the potential participants were informed that they were selected because they were professional chaplain that worked in clinical settings (i.e., hospital, hospice, nursing home, skilled care nursing or Veterans hospital) within the Tristate region (NY, NJ or CT), with at least one or more pastoral visit(s) with patient(s) over 65-years diagnosed with a mental health disorder.

Before agreeing to participate, potential participants were encouraged to ask any questions by contacting the researcher at the contact information provided. Additionally, if the potential participant wanted to speak to someone other than the researcher, they were encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu.

Next, the steps needed to participate were described in detail, along with the estimated completion time. The first steps included going to the SurveyMonkey link provided. This step was estimated to take less than one minute to complete. The second step included completing a 39-question questionnaire, which included three screening questions. If the chaplain met criteria they were directed to, the other 36 questions, which were related to their level of training, preparation (spiritual, mental, and clinical), ethical competence, on-the-job tools, and self-care used during pastoral visits with geriatric patients with mental health disorders. This questionnaire was estimated to take approximately 10-15 minutes. The third step included, click the prompt to submit the questionnaire. This procedure was estimated to take less than one minute to complete.

Additionally, the risks involved in this project were disclosed to be minimal, which means they were equal to the risks encountered in everyday life. Participants were informed that they should not expect to receive a direct benefit from taking part in this project, and it was disclosed that no compensated for participating in this project would be provided.

The confidentiality and data security were disclosed as aforementioned. Also, potential participants were informed that participation in this project was voluntary. They were assured that their decision whether to participate or not to participate would not affect their current or future relations with Liberty University or the APC.

Additionally, potential participants were assured that if they decided to participate, they were free not to answer any question (s) or withdraw at any time prior to submitting the survey without affecting the aforementioned relationships. Finally, instruction on how to withdraw from the project was provided. The instructions stated that if the choice was made to withdraw from the project, they may simply exit the survey and close their internet browser, and responses were not recorded or included in the project.

Potential Ethical Issues and Bias/Assumptions. No ethical issues arose during this thesis project. The researcher did not have any personal relationship with the participants. Also, professional chaplains from the researcher's place of employment were not included in this project, which eliminated the ethical risk of conducting the study at the researcher's place of employment, power differentials, and the use of incentives. Lastly, there were no conflicts of interest within the study.

The researcher brought some assumptions to this project. First, was the assumption that chaplains within the clinical field were willing to participate in the research and disclose information on their level of training and preparedness. Second, the researcher assumed that the respondents fully understood the questions asked in the survey.

Third, there was the assumption that the information collected within the survey questions included full disclosure and transparency from the sampled participants. Fourth, the researcher assumed that the respondents objectively based their answers and ratings on the importance of training and preparation. Fifth, was the assumption that the specific sampled population provided valuable data to aid in the development of a practice guide for geriatric psychiatric mental health chaplains.

Intervention Design Implementation

This research project used more than one method to collect data and theoretical constructs related to this project's topic by means of data triangulation. An extensive literature review provided a variety of data sources related to the history of chaplaincy, the resistance to healthcare chaplains, mental health and mental illness, geriatric psychiatric ministry, the theology of Christian chaplains, chaplains, and geriatric psychiatric education. Data sources on empirical literature were provided for topics related to competencies of geriatric psychiatric chaplains; metal preparedness, spiritual preparedness, chaplain training, ethics, self-care, theological foundations, and theoretical foundations.

Additionally, the thesis project used multiple perspectives/theories to interpret the project set of data. Therefore, this project used the theory of competence motivation, which postulated that an individual's degree of motivation heightens with each task that is mastered (Harter, 1978; Weiss, & Ferrer Caja, 2002). Thus, an individual's perceived competence directly influences their selection, performance, and continuation of activities, task, or occupational duties (Weiss, & Ferrer Caja, 2002). As a ripple effect, it was found that when an individual mastered or felt competent in a task or duty, it was more likely that they will develop confidence and feel encouraged to engage in more duties within that area (Weiss, & Ferrer Caja, 2002).

Further, the Holy Bible was used as a theological foundation upon which the project's data set was interpreted. One of the key theological bases that undergirded this research project came from the Holy Bible's strong endorsement and promotion of competent and excellent work ethics (2 Timothy 3:17 English Standard Version; Ecclesiastes 9:10 New Living Translation).

Finally, quantitative data were collected using the instrument in the form of a questionnaire. The design of the 39-question multiple-choice questionnaire implemented a combination of the survey question approach. The types of survey question approach included the use of some demographic questions, and 5- point Likert scale questions, which allowed participants to express how much they agreed or disagreed with a presented statement (Likert, 1932), dichotomous (YES/NO) questions, and checkbox questions. In summation, this overall method of data triangulation was one way to ensure the validity of this research (Frankfort-Nachmias & Nachmias, 2008).

Data Collection

Quantitative data was collected using the instrument in the form of a questionnaire. The design of the 39-question multiple-choice questionnaire implemented a combination of survey question approaches. The types of survey question approach included the use of some demographic questions, 5-point Likert scale questions, which allowed participants to express how much they agree or disagree with a presented statement (Likert, 1932), dichotomous (YES/NO) questions, and checkbox questions.

Data Sequence

The purpose of this study was to develop a guide for geriatric psychiatric chaplains that will aid chaplains in ministering more effectively to geriatric mental health patients. Therefore, the instrument tool in the form of a questionnaire was designed to collect data on chaplains' specific areas of training, preparation (spiritual, mental, and clinical), ethical competence, on-the-job tools, and self-care of chaplains.

The specific sequence for data collection focused on seven categories referencing aspects of chaplains' ministry. This sequence of data collected retrieved data in order of the chaplain's demographics/background information, specific mental health training and patient engagement, spiritual and mental preparation, clinical preparation, ethical competencies, on-the-job tools, and self-care. Each category represented a part of chaplaincy training that was necessary for clinical ministry.

The first sequence collected data on demographics and background. This stage involved eight questions about gender, age, state of residence, possession of a M.Div. degree, length of employment as a chaplain, clinical setting of employment, times per week ministered to geriatric psychiatric patients, and the amount of geriatric psychiatric patients ministered to in career. The second sequence contained eight questions about the adequacy of divinity school/seminary education and Clinical Pastoral Education training for ministry to geriatric psychiatric patients. Further questions inquired about the preparation for chaplains to minister to geriatric psychiatric patients with specific diagnoses in specific situations.

The third sequence of data collection contained four questions about chaplains' spiritual, mental, and specific methods of preparation prior to ministering to geriatric psychiatric patients. The fourth sequence contained two questions about clinical preparation and patient interventions. The fifth sequence of the data collection contained six questions about the knowledge and implementation of Mandated Reporting, Advance Care Planning and end of life decisions, staff collaboration with geriatric psychiatric patient cases, and patient advocacy.

The sixth sequence contained three questions about training, self-protection and de-escalation techniques, access to counselors and social workers, debriefing, and suicidal

prevention. The seventh and last sequence contained four questions about intentional self-care, participation in debriefing for self-care, methods of self-care, time spent in prayer, meditation or devotional, and analysis of level of self-care.

The aforementioned sequence of data collection was chosen to specifically retrieve data that could then be used in the creation of a guide that included ways to help improve this ministry challenge and assist geriatric psychiatric chaplains in providing comprehensive delivery of competent care to patients. This hands-on guide addressed fundamental aspects of mental health chaplaincy, such as specific geriatric psychiatric competencies, spiritual preparedness, mental preparedness, clinical preparation, ethical competence, using on-the-job tools, and self-care.

Data Analysis

SurveyMonkey development service that operated via a cloud-based software was used to conduct the data analysis (SurveyMonkey, 2016). Before conducting the statistical analyses, SurveyMonkey efficiently ensured that the data was cleaned. This process involved screening to safeguard that the data were valid and reliable for the purpose of this thesis project. Some of the screening included looking for missing data, which helped to ensure that they were sufficient data points to run the analyses and prevent any potential bias in the results. Additionally, the data were screened to check for outliers. This screening was important since outliers can potentially influence the mean from the median and disproportionately affect the results of this thesis project (Green & Salkind, 2014).

Specifically, after this thesis project's data collection process was completed, Sensing's (2011) recommended three analytical frames of reference for analyzing data was used. Sensing

(2011) suggested examining the results of the data using the multi-method approach that allowed for triangulation, which was namely "themes, slippages, and silences in the data" (pp. 197-200).

This project's data analysis considered the convergence and divergence in the dataset (Sensing, 2011). The common responses provided by participants were categorized as "themes" (Sensing, 2011, p. 197). Next, the data were analyzed for any disparate responses among participants, and this was categorized as "slippages" (Sensing, 2011, p. 197). Further, the areas in which the participants neglected to provide a response were categorized and analyzed as a "silence" (Sensing, 2002, p. 197). Finally, the approach used for analyzing the data was the "questions" approach, whereby the responses provided by participants were organized question by question. This approach was applicable for this thesis project as a standardized questionnaire format was used to collect the data set (Sensing, 2011).

In conclusion, this chapter discussed the intervention designed and showed how it directly addressed the ministry context problem, which was identified as the need for comprehensive chaplaincy training and preparation for competent ministry and care for mental health patients, specifically the geriatric population. Also, the step-by-step tasks involved in this project's instrument (questionnaire) were shown to support the purpose and objective of this thesis project.

Next, the sampled population including, the inclusion criteria, sampling location, timeline, and duration, was discussed at length. Further, the instrumentation demonstrated that quantitative data was collected using the instrument in the form of a questionnaire. The design of the 39-question multiple-choice questionnaire implemented a combination of survey question approaches, such as demographic questions, five-point Likert scale questions (Likert, 1932),

dichotomous (YES/NO) questions, and checkbox questions. This discussion was followed by the presentation of how the instrument was administered and the ethical procedures exercised in this project.

The final section addressed the intervention design implementation and highlighted that this research project used more than one method to collect data and theoretical constructs related to this project's topic through the use of data triangulation. Next, the data collection, data sequence was discussed. Lastly, the data analysis using SurveyMonkey development service, which operated via a cloud-based software and Sensing's (2011) recommended three analytical frames of reference, was discussed at length.

<p style="text-align:center">Summary</p>

The intervention design and implementation that addressed the ministry context problem, and the alignment of the project's intervention with the project thesis and problem statement were discussed in this chapter. This chapter also included: step-by-step tasks, sampled population, inclusion criteria, ethical procedures, researcher's bias/assumptions, data collection, and data analysis.

In the ensuing chapter, the results of addressing the study's problem presented in chapter one are presented. By using the analysis tools outlined in chapter three, the responses provided by participants were organized question by question, along with an analysis of the findings. Illustrative tables, graphs, and charts are presented to easily identify results and correlations between responses.

Chapter 4: Results

This chapter provides answers related to the results of addressing the study's problem presented in chapter one. The problem this project addressed was the need for comprehensive chaplaincy training and preparation for competent ministry and care for mental health patients, specifically the geriatric population. Illustrative tables, graphs, and charts are presented to easily identify results and correlations between responses. By using the analysis tools outlined in chapter three, the responses provided by participants were organized question by question, along with an analysis of the findings. Specifically, the analysis discussion considers the convergence and divergence in the results by identifying common responses (themes), disparate responses (slippages), and neglected responses (silence) in the data (Sensing, 2011).

Sample's Descriptive and Demographic Characteristic

The sample totaled 26 participants with 24 completions consisted of males 12 (50%), females 12 (50%) and "other" 0 (0%). Of the sample, (N = 26), 1 (4.1%) were between the age of 18-30, 3 (12.5%) were between the age of 31-45, 6 (25%) were between the age of 46-60, and 14 (58.3%) were 61 and over.

Of the sample (N = 26), and 24 completions, 9 (37.5%) worked in New York, 3 (12.5%) worked in New Jersey, and 12 (50%) worked in Connecticut. Based on total sample size of 26 participants, and 24 completions, 19 (79.2%) earned a Master's in Divinity (M.Div.), and 3 (13.0%) were chaplains for 0-5 years, 5 (21.7%) were chaplains for 6-11 years, 3 (13.0%) were chaplains for 12-17 years, and 12 (52.2%) were chaplains for over 18 years.

Of the sample (N = 26), and 24 completions, 18 (75%) worked in a hospital setting, 1 (4.1%) worked in a hospice setting, 0 (0%) worked a nursing home setting, 0 (0%), worked a

skilled care nursing setting, and 5 (20.8%) worked in a Veterans hospital setting. Based on the

sample size of 26, and 24 completions, the reported times per week spent ministering to geriatric

mental health patients were reported as 15 (62.5%) by referral only, 5 (20.8%) 1-3 times, 2

(8.3%) daily, 2 (8.3%) full-time mental health chaplain. Of the sample size of 26, and 24

completions, the numbers of geriatric mental health patients ministered to within the chaplains'

careers were reported as 2 (8.3%) 1-50 patients, 4 (16.7%) 51-100 patients, 2 (8.3%) 101-150

patients, and 16 (66.7%) 151 patients and over.

Results of Addressing This Problem

Category B examined "Specific Geriatric Mental Health Training," which contained eight

questions. This category began with question 12, as illustrated in Figure 1.

Q12 Please indicate how much you agree or disagree with the following statement:My training in Seminary and/or Divinity School alone DID NOT provide adequate training for ministering specifically to Geriatric mental health patients.
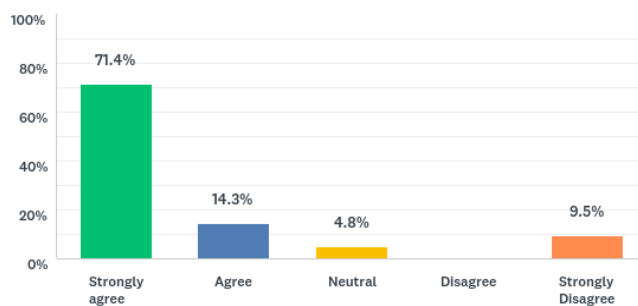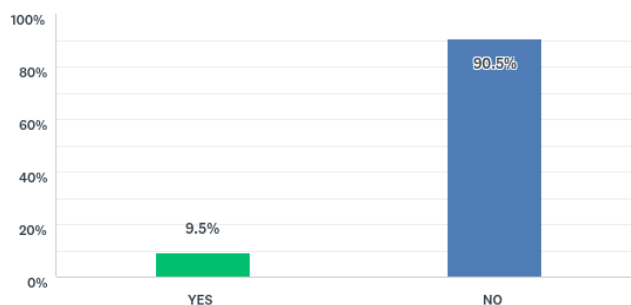
Figure 1. Question 12 of "Specific Geriatric Mental Health Training"

Of total sample (*N = 26*), and 21 completions, 15 (71.4%) strongly agreed, 3 (14.3%)

agreed, 1(4.8%) was neutral, 0 (0%) disagreed, and 2 (9.5%) strongly disagreed with this

statement.

When taking into account the convergence and divergence of question 12's results, a robust common response (theme) emerged indicating that a significant majority of 18 (85.7%) chaplains strongly agreed that their seminary and/or divinity school alone did not provide adequate training for ministering specifically to geriatric mental health patients. Disparate responses (slippages) were only reported from two chaplains. One chaplain was neutral, and no neglected responses (silence) were identified in the data.

The next question in category B, "Specific Geriatric Mental Health Training," was question 13, which is illustrated in Figure 2.

Q13 Did your Internship and/or Residency in Clinical Pastoral Education provide training for ministering specifically to Geriatric mental health patients?

Figure 2. Question 13 of "Specific Geriatric Mental Health Training"

Of total sample ($N = 26$), and 21 completions, 2 (9.5%) selected "yes," and 19 (90.5%) selected "no" to this statement.

When taking into account the convergence and divergence of question 13's results, a robust common response (theme) emerged indicating that a significant majority of 19 (90.5%) chaplains conveyed that their internship and/or residency in Clinical Pastoral Education did not provide training for ministering specifically to geriatric mental health patients. Disparate responses were only reported from two chaplains and no neglected responses were identified.

The next question in category B was question 14, which is illustrated in Table 1.

Table 1

Question 14 of "Specific Geriatric Mental Health Training"

<div style="border:1px solid black; padding:10px">

If you answered YES to the previous question.

What type of training did you receive to minister to Geriatric mental health patients?

☐ Didactics on ministering to Geriatric mental health patients

☐ Reviewed psychiatric assessments and diagnoses

☐ Shadowed Geriatric Psychiatric Chaplain

☐ Assigned as an Intern/Resident Chaplain on the Geriatric Psychiatric unit/floor

☐ Other

</div>

Of total sample ($N = 26$), only two participants qualified to answer this question, but three participated. Results reported, 0 (0%) selected "didactics on ministering to geriatric mental health patients," 1 (33.3%) selected "reviewed psychiatric assessments and diagnoses," 1 (33.3%) selected "shadowed geriatric psychiatric chaplain," 0 (0%) selected "assigned as an intern/resident Chaplain on the geriatric Psychiatric unit/floor," and 1 (33%) selected "other."

When taking into account the convergence and divergence of question 14's results, a common response (theme) emerged, indicating that chaplains mainly reviewed psychiatric assessments and diagnoses (33.3%), shadowed geriatric psychiatric chaplain (33.3%) and used "other" means to obtain training to minister to geriatric mental health patients. There were no disparate responses (slippages) or neglected responses (silence) identified in the data.

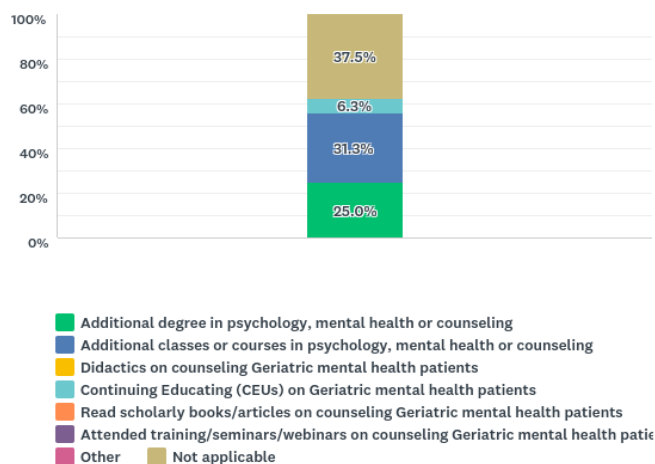The next question in category B was question 15, which is illustrated in Table 2.

Table 2

Question 15 of "Specific Geriatric Mental Health Training"

Do you have additional training in psychology, mental health, or counseling?
□ **YES** □ **NO**

Of total sample (*N = 26*), and 22 completions, 10 (45.5%) selected "yes," and 12 (55.5%) selected "no" to this statement. When taking into account the convergence and divergence of question 15's results, a common response (theme) emerged, indicating that a majority (54.5%) of chaplains conveyed that they did not have additional training in psychology, mental health or counseling. Disparate responses (slippages) were also significantly reported, with 45% of chaplains indicating having some form of training. No neglected responses were identified in the data.

The next question in category B was question 16, which is illustrated in Figure 3.

Q16 If yes, what additional training in psychology, mental health or counseling have you completed?

Legend:
- Additional degree in psychology, mental health or counseling
- Additional classes or courses in psychology, mental health or counseling
- Didactics on counseling Geriatric mental health patients
- Continuing Educating (CEUs) on Geriatric mental health patients
- Read scholarly books/articles on counseling Geriatric mental health patients
- Attended training/seminars/webinars on counseling Geriatric mental health patie
- Other   Not applicable

Figure 3. Question 16 of "Specific Geriatric Mental Health Training"

Of total sample (*N = 26*), and 16 completions, 4 (25%) selected "additional degree in psychology, mental health or counseling," 5 (31.3%) selected "additional classes or courses in psychology, mental health or counseling," 0 (0%) selected "didactics on counseling geriatric mental health patients," 1 (6.3%) selected "Continuing Educating (CEUs) on geriatric mental health patients," 0 (0%) selected "read scholarly books/articles on counseling geriatric mental health patients," 0 (0%) selected "attended training/seminars/webinars on counseling geriatric mental health patients," 0 (0%) selected "other," and 6 (37.5%) selected "not applicable."

When taking into account the convergence and divergence of question 16's results, a common response (theme) emerged, indicating that chaplains mainly found this question 'not applicable' (37.5%) since a majority (54.5%) did not have additional training. When training was attained, it was reported mainly as an additional degree in psychology (25%) and additional classes or courses (31.3%) in psychology, mental health or counseling. There were no disparate responses (slippages) or neglected responses (silence) identified in the data.

The next question in category B was question 17, which is illustrated in Figure 4.

Q17 Please indicate how much you agree or disagree with the following delivery of care statements:I feel adequately prepared to develop and implement a plan of care to promote the well-being and continuity of care for Geriatric mental health patients.
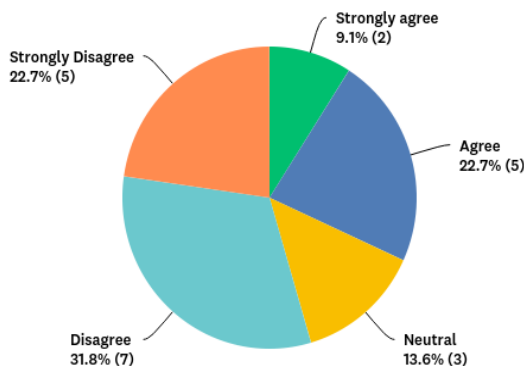

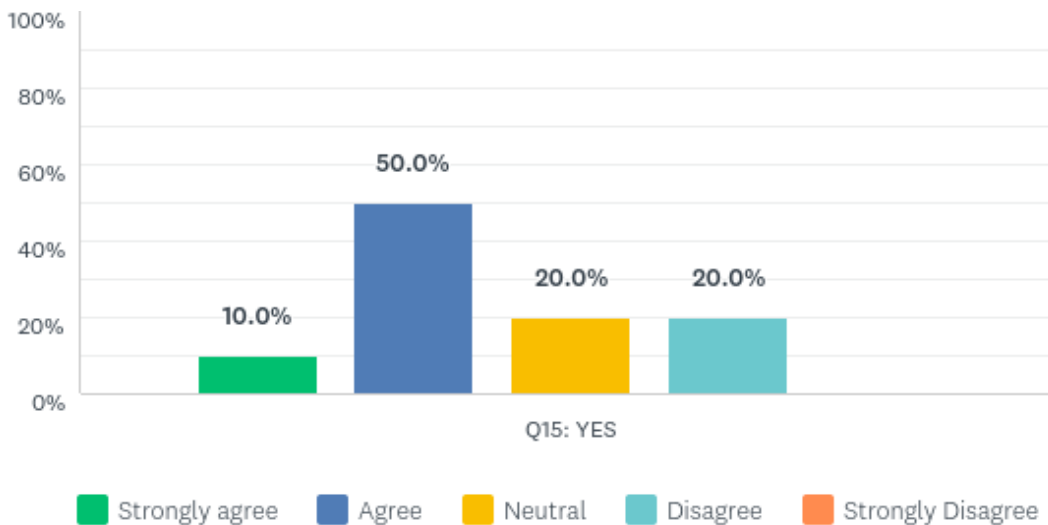*Figure* 4. Question 17 of "Specific Geriatric Mental Health Training"

Of total sample ($N = 26$), and 22 completions, 2 (9.1%) strongly agreed, 5 (22.7%) agreed, 3 (13.6%) were neutral, 7 (31.8%) disagreed and 5 (22.7%) strongly disagreed with this statement.

When taking into account the convergence and divergence of question 17's results, a common response (theme) emerged, demonstrating that a majority 12 (54.5%) of chaplains conveyed that they did not feel adequately prepared to develop and implement a plan of care to promote the well-being and continuity of care for geriatric mental health patients.

Disparate responses (slippages) were reported with 7 (31.8%) chaplains agreeing that they felt adequately prepared to develop and implement a plan of care to promote the well-being and continuity of care for geriatric mental health patients. There were four skipped or neglected responses (silence) identified in the data, which were partially reflective of incompletions.

A correlational analysis of questions 15 and 17 was conducted to examine the effects of additional training on chaplains' reported level of adequate preparedness to develop and implement a plan of care to promote the well-being and continuity of care for geriatric mental health patients. The results indicated that a strong correlation between additional training (degree, or courses) and chaplains' increased reported level of preparedness and competence in this area.

Of the 10 chaplains that reported additional training, a majority of 6 (60%) reported feeling adequately prepared to develop and implement a plan of care to promote the well-being and continuity of care for geriatric mental health patients, 2 (20%) was neutral and 2 (20%) still reported some level of inadequacy. See illustration in Figure 5.

Figure 5. Analysis of Questions 15 and 17 of "Specific Geriatric Mental Health Training"

The next question in category B was question 18, which is illustrated in Figure 6.

Q18 Please indicate how much you agree or disagree with the following delivery of care statements:I feel adequately prepared to gather and evaluate relevant data pertinent to the Geriatric mental health patients' situation and bio/psycho-social-spiritual/religious health.
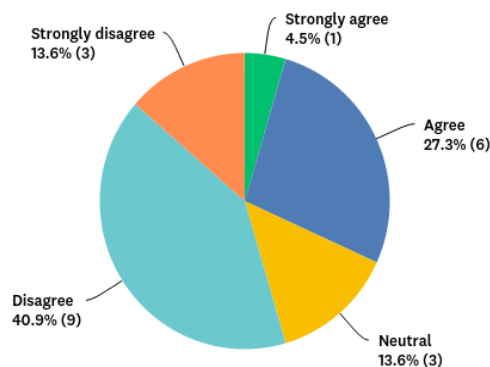

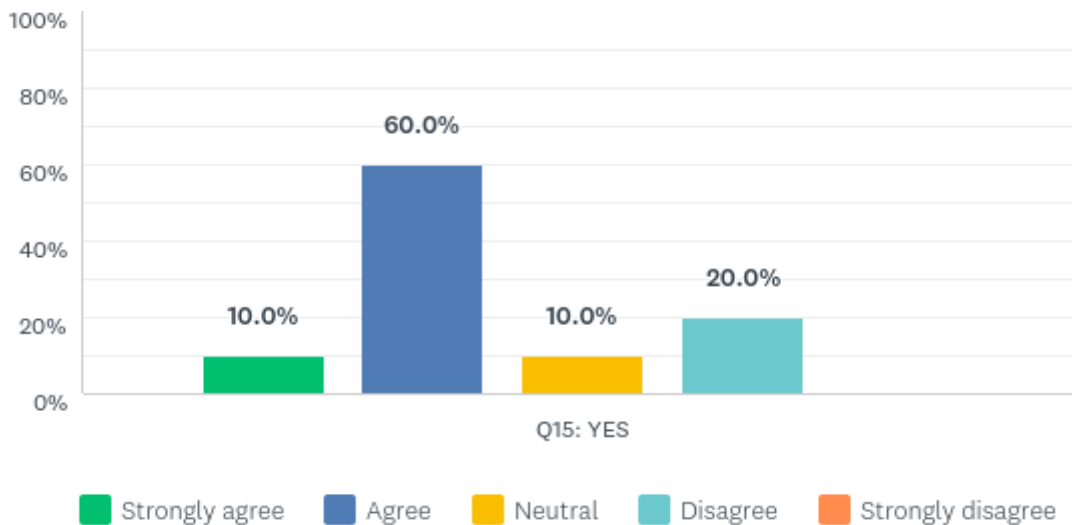*Figure* 6. Question 18 of "Specific Geriatric Mental Health Training"

Of total sample (*N = 26*), and 22 completions, 1 (4.5%) strongly agreed, 6 (27.3%) agreed, 3 (13.6%) were neutral, 9 (40.9%) disagreed, and 3 (13.6%) strongly disagreed with this statement.

When taking into account the convergence and divergence of question 18's results, a common response (theme) emerged, demonstrating that a majority of 12 (54.5%) chaplains conveyed that they did not feel adequately prepared to gather and evaluate relevant data pertinent to the geriatric mental health patients' situation and bio/psycho-social-spiritual/religious health.

Disparate responses (slippages) were reported with 7 (31.8%) chaplains agreeing that they felt adequately prepared to develop and implement a plan of care to promote the well-being and continuity of care for geriatric mental health patients. There were four skipped or neglected responses (silence) identified in the data, which were partially reflective of incompletions.

A correlational analysis of questions 15 and 18 was conducted to examine the effects of additional training on chaplains' reported level of adequate preparedness to gather and evaluate relevant data pertinent to the geriatric mental health patients' situation and bio/psycho-social-spiritual/religious health. The results revealed a strong correlation between chaplains who obtained additional training (degree or courses) and an increased reported level of preparedness and competence in this area.

Of the 10 chaplains that reported additional training, a majority of 7 (70%) reported feeling adequately prepared to gather and evaluate relevant data pertinent to the geriatric mental health patients' situation and bio/psycho-social-spiritual/religious health, 1(10%) was neutral and 2 (20%) still reported some level of inadequacy. See illustration in Figure 7.

Figure 7. Analysis of Questions 15 and 18 of "Specific Geriatric Mental Health Training"

The next question in category B was question 19, illustrated in Figures 8 and 9.

Q19 Which of the following diagnoses or situations do you feel competently trained to handle when ministering to Geriatric mental health patients? (Choose all that apply).
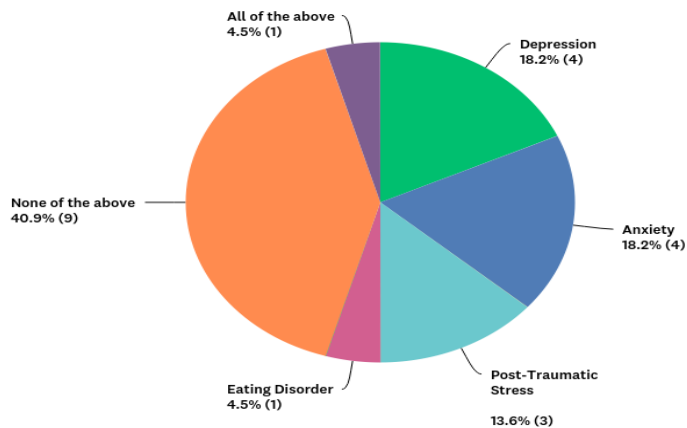

Figure 8. Question 19 of "Specific Geriatric Mental Health Training"

ANSWER CHOICES	RESPONSES	
Depression	18.2%	4
Anxiety	18.2%	4
Obsessive Compulsive Disorder	0.0%	0
Post-Traumatic Stress	13.6%	3
Bipolar Disorder	0.0%	0
Borderline Personality Disorder	0.0%	0
Eating Disorder	4.5%	1
Brief Psychotic Disorder	0.0%	0
Schizophrenia	0.0%	0
Schizoaffective Disorder	0.0%	0
Schizotypal Personality Disorder	0.0%	0
Delusional Disorder	0.0%	0
Substance-Induced Psychosis	0.0%	0
Cognitive-impairments (Dementia, delirium)	0.0%	0
Co-occurring Disorders	0.0%	0
Catatonia	0.0%	0
Echolalia	0.0%	0
Aphasia (speech impairment)	0.0%	0
Hearing impairment/decline	0.0%	0
Suicidal Ideation	0.0%	0
Transference	0.0%	0
Counter-transference	0.0%	0
Trauma Response	0.0%	0
Agitations, Physical and Verbal Aggression	0.0%	0
None of the above	40.9%	9
All of the above	4.5%	1
TOTAL		22

Figure 9. Question 19 of "Specific Geriatric Mental Health Training"

When taking into account the convergence and divergence of these results from a total sample ($N = 26$), with 22 completions for question 19, there was a common response (theme) with 9 (40.9%) chaplains indicating not feeling competently trained when ministering to geriatric mental health patients. Also, there was a significant level of neglected responses (silence) identified in the data, with no selection shown for 20 of the 24 diagnoses listed. This silence may be interrupted as a lack of competent training when dealing with these diagnoses among geriatric mental health patients.

Disparate responses (slippages) reflected chaplains' competence with four diagnoses, namely, 4 (18.2%) selected depression, 4 (18.2%) selected anxiety, 3 (13.6%) selected post-traumatic stress, and 1 (4.5%) selected eating disorder. Additionally, 1 (4.5%) selected "all of the above."

Category C examined "Spiritual and Mental Preparation," which contained four questions. This category began with question 20 as illustrated in Figure 10.

Q20 Prior to visiting Geriatric mental health patients, do you regularly have adequate time to spiritually prepare?
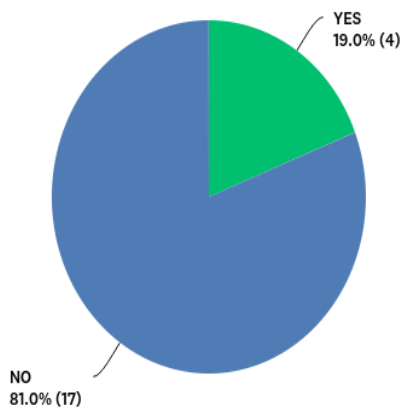

Figure 10. Question 20 of "Spiritual and Mental Preparation"

Of total sample ($N = 26$), and 21 completions, 4 (19.0%) selected "yes," and 17 (81.0%) selected "no" to this statement.

When taking into account the convergence and divergence of question 20's results, a common response (theme) emerged, indicating that a majority of 17 (81.0%) chaplains conveyed that they did not regularly have adequate time to spiritually prepare. Disparate responses (slippages) were minimally reported with 4 (19.0%) of chaplains, indicating that they regularly have adequate time to spiritually prepare. There were no neglected responses (silence) identified in the data.

The next question in category C was question 21, which is illustrated in Figures 11 and 12.
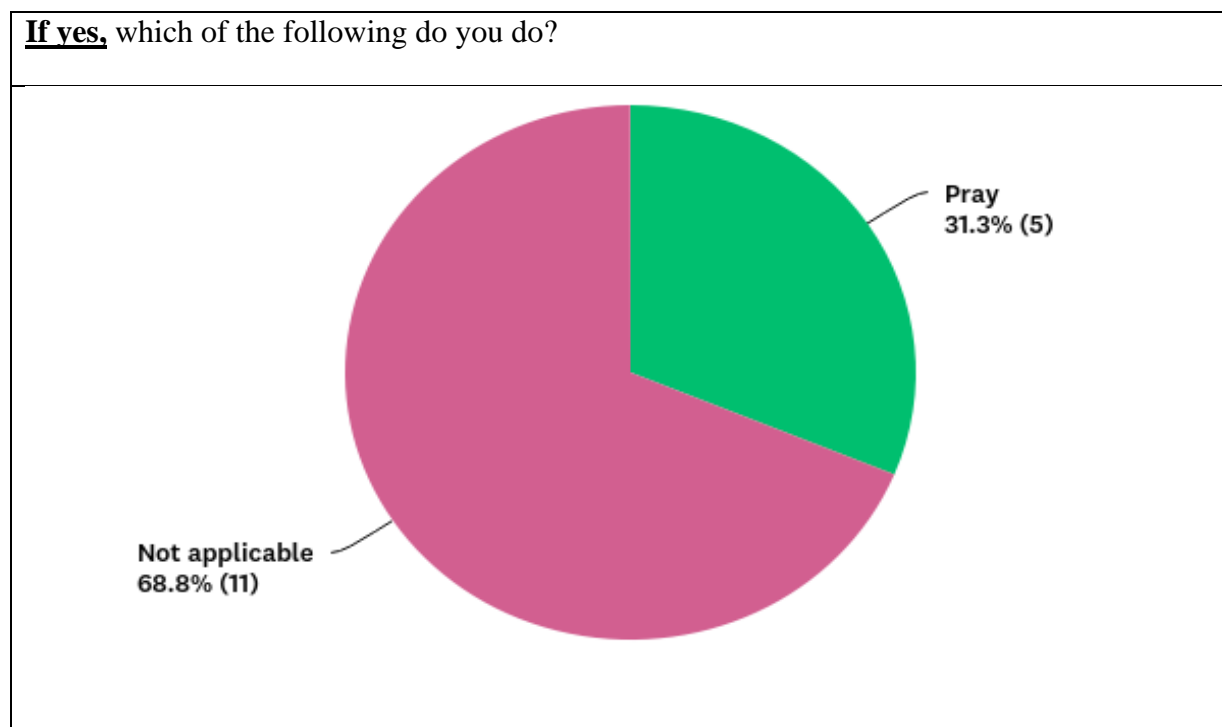

Figure 11. Question 21 of "Spiritual and Mental Preparation"

ANSWER CHOICES	RESPONSES	
Pray	31.3%	5
Meditate	0.0%	0
Read the Bible or Religious Book	0.0%	0
Meet with other Chaplains	0.0%	0
Personal or group devotional	0.0%	0
Other	0.0%	0
Not applicable	68.8%	11
TOTAL		16

Figure 12. Question 21 of "Spiritual and Mental Preparation"

When taking into account the convergence and divergence of these results from a total sample ($N = 26$), with 21 completions for question 21, there was a robust common response (theme) with 11 (68.8%) chaplains indicating that prior to visiting geriatric mental health patients, the spiritual preparation options were not applicable. Disparate responses (slippages) reflected that 5 (31.3%) chaplains selected prayer as their choice of spiritual preparation. Also, there was a significant level of neglected responses (silence) identified in the data, with no selection shown for five of the six choices listed. This silence may be interrupted as a lack of adequate time to spiritually prepare.

The next question in category C was question 22, which is illustrated in Table 3.

Table 3

Question 22 of "Spiritual and Mental Preparation"

Prior to visiting Geriatric mental health patients, do you <u>regularly have adequate time</u> to **mentally** prepare?
☐ **YES**   ☐ **NO**

Of total sample (*N = 26*), and 22 completion, 5 (22.7%) selected "yes," and 17 (77.3%)

selected "no" to this statement.

When taking into account the convergence and divergence of question 22's results, a

common response (theme) emerged, indicating that a majority of 17 (77.3%) chaplains conveyed

that they did not regularly have adequate time to mentally prepare. Disparate responses

(slippages) were minimally reported with 5 (22.7%) chaplains indicating that they regularly had

adequate time to mentally prepare. There were no neglected responses (silence) identified in the

data. See illustration in Figure 13.
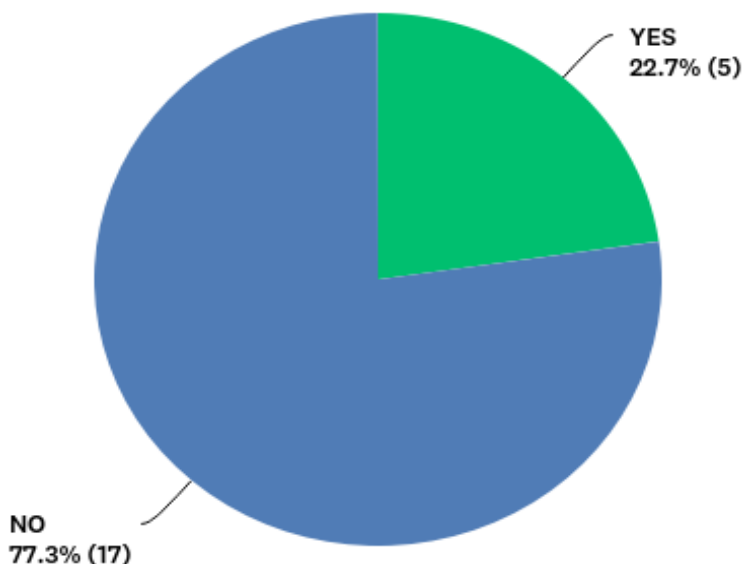
Figure 13. Question 22 of "Spiritual and Mental Preparation"

The next question in category C was question 23, which is illustrated in Figure 14.

Q23 If yes, which of the following do you do?
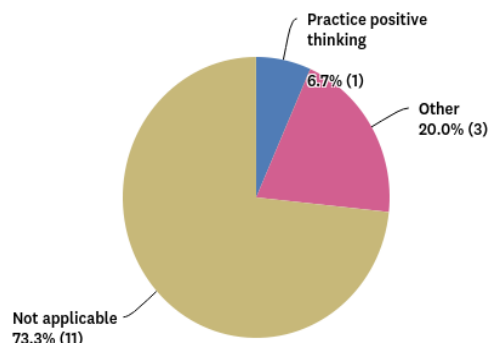
ANSWER CHOICES	RESPONSES	
Self-evaluation of current mental status	0.0%	0
Practice positive thinking	6.7%	1
Deep breathing	0.0%	0
Imagery	0.0%	0
Listen to music	0.0%	0
Self-talk	0.0%	0
Other	20.0%	3
Not applicable	73.3%	11
TOTAL		15

Figure 14. Question 23 of "Spiritual and Mental Preparation"

When taking into account the convergence and divergence of these results from a total sample ($N = 26$), with 15 completions for question 23, there was a strong common response (theme) with 11 (73.3%) chaplains indicated that prior to visiting geriatric mental health patients, the mental preparation options were not applicable. Disparate responses (slippages) reflected that 1 (6.7%) chaplains selected 'positive thinking,' and 3 (30%) selected 'other' as their choices of mental preparation. Also, there was a significant level of neglected responses (silence) identified

in the data, with no selection shown for five of the seven choices listed. This silence may be interrupted as a lack of adequate time to mentally prepare.

Category D examined "Clinical Preparation," which contained two questions. This category began with question 24 as illustrated in Table 4.

Table 4

Question 24 of "Clinical Preparation"

Prior to visiting Geriatric mental health patients, do you <u>regularly have adequate time</u> to **clinically** prepare?
□ **YES**   □ **NO**

Of total sample (*N = 26*), and 22 completions, 10 (45.4%) selected "yes," and 12 (54.6%) selected "no" to this statement. When taking into account the convergence and divergence of question 24's results, a common response (theme) emerged, indicating that a majority of 12 (54.6%) chaplains conveyed that they did not regularly have adequate time to clinically prepare. Disparate responses (slippages) were also reported with 10 (45.4%) chaplains indicating that they regularly had adequate time to clinically prepare. There were no neglected responses (silence) identified in the data.

The next question in category D was question 25, which asked "if yes, which of the following do you do? See illustration in Figure 15.

ANSWER CHOICES	RESPONSES	
Refresh knowledge about patient's diagnosis, religious status and preferences	23.81%	5
Contemplate different interventions based on diagnosis	4.76%	1
Consult with the staff about the patient (MD, nurse, LPC, Social Worker)	4.76%	1
Review the patient's chart	9.52%	2
Self-evaluation of clinical competence	4.76%	1
Other	0.00%	0
No time to prepare	52.38%	11
TOTAL		21

Figure 15. Question 25 of "Clinical Preparation"

When taking into account the convergence and divergence of these results from a total

sample ($N = 26$), with 21 completions for question 25, there was a common response (theme)

with 11 (52.4%) chaplains indicated that prior to visiting geriatric mental health patients, they

did not have adequate time to clinically prepare. Some disparate responses (slippages) were

reflected as shown in Figure 14, but no neglected responses (silence) were identified in the data.

Category E examined "Ethical Competence," which contained six questions. This

category began with question 26, as illustrated in Table 5.

Table 5

Question 26 of "Ethical Competence"

Did you receive any training from your employer on Mandated Reporting?
□ **YES**   □ **NO**

Of total sample ($N = 26$), and 22 completions, 6 (27.3%) selected "yes," and 16 (72.7%) selected "no" to this statement. When taking into account the convergence and divergence of question 26's results, a common response (theme) emerged, indicating that a significant majority of 16 (72.7%) chaplains conveyed that they did not receive any training from their employer on Mandated Reporting. Disparate responses (slippages) were reported with 6 (27.3%) of chaplains, indicating they did receive Mandated Reporting training. There were no neglected responses (silence) identified in the data. See illustration in Figure 16.
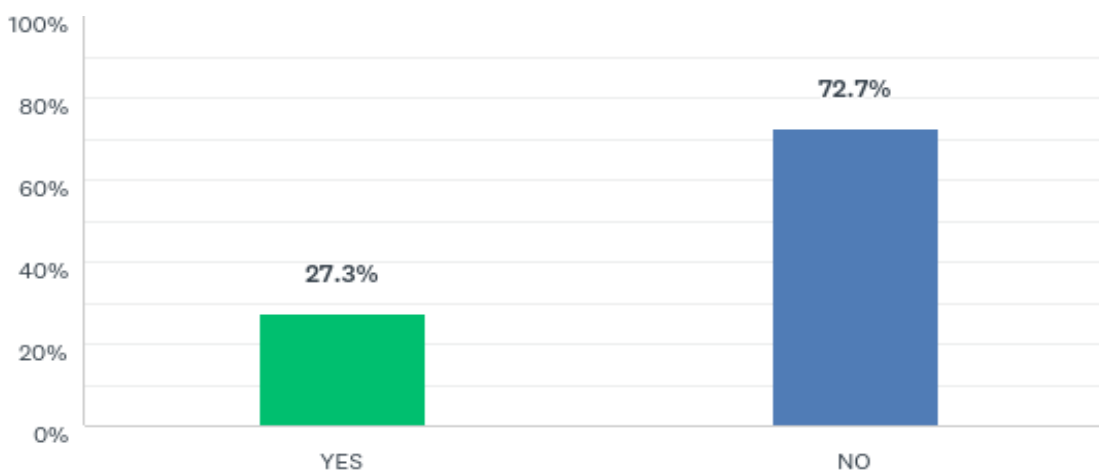

Figure 16. Question 26 of "Ethical Competence"

The next question in category E was question 27, which is illustrated in Table 6.

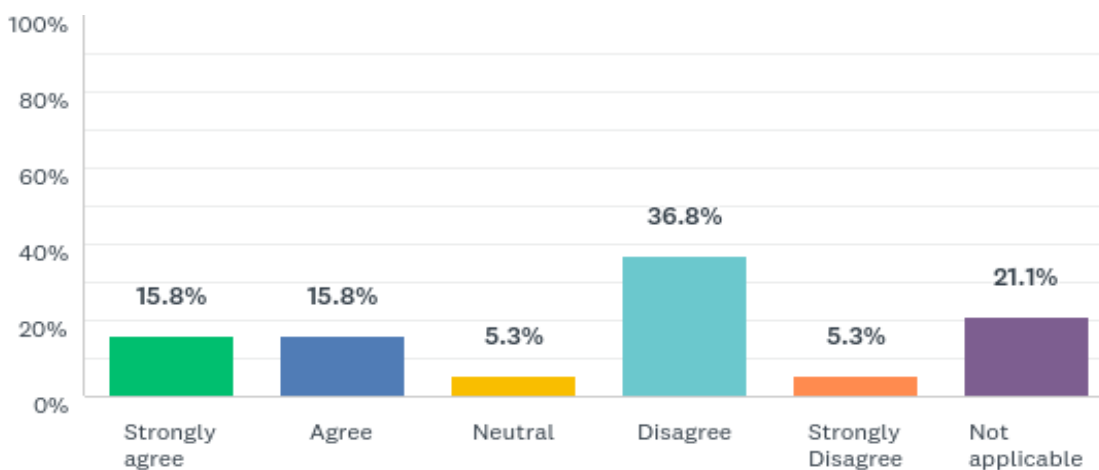Table 6

Question 27 of "Ethical Competence"

If **YES**, please indicate how much you agree or disagree with the following statement:
I feel knowledgeable and competent to handle ethical issues related to Mandated Reporting cases.

Of total sample (*N = 26*), and 19 completions, 3 (15.8%) strongly agreed, 3 (15.8%) agreed, 1 (5.3%) was neutral, 7 (36.8%) disagreed, 1 (5.3%) strongly disagreed with this statement, and 4 (21.1%) selected 'not applicable.'

When taking into account the convergence and divergence of question 27's results, a common response (theme) emerged, demonstrating that a majority 8 (42.1%) of chaplains conveyed that they did not feel knowledgeable and competent to handle ethical issues related to Mandated Reporting cases. Disparate responses (slippages) were reported with 6 (31.6%) chaplains agreeing that they felt knowledgeable and competent to handle ethical issues related to Mandated Reporting cases. There were no neglected responses (silence) identified in the data, and 4 (21.1%) reported a selection of 'not applicable.' See illustration in Figure 17.

Figure 17. Question 27 of "Ethical Competence"

The next question in category E was question 28, which is illustrated in Table 7.

Table 7

Question 28 of "Ethical Competence"

Are you trained in Advanced Care Planning and end of life decisions?
□ **YES** □ **NO**

Of total sample (*N = 26*), and 22 completions, 19 (86.4%) selected "yes," and 3 (13.6%) selected "no" to this statement.

When taking into account the convergence and divergence of question 28's results, a common response (theme) emerged, indicating that a significant majority of 19 (86.4%) chaplains conveyed that they were trained in Advanced Care Planning and end of life decisions. Disparate responses (slippages) were reported with 3 (13.6%) chaplains indicating they were not trained in this area. There were no neglected responses (silence) identified in the data.

The next question in category E was question 29, which is illustrated in Table 8.

Table 8

Question 29 of "Ethical Competence"

If **YES**, please indicate how much you agree or disagree with the following statement:
I feel competent in assisting with end of life decisions related to Geriatric mental health patients.
1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree Not applicable

Of total sample (*N = 26*), and 19 completions, 1 (5.3%) strongly agreed, 9 (47.4%) agreed, 0 (0%) was neutral, 9 (47.3%) disagreed, 0 (0%) strongly disagreed with this statement, and 0 (0%) selected 'not applicable.'

When taking into account the convergence and divergence of question 29's results, a common response (theme) emerged, demonstrating that a majority of 10 (52.6%) chaplains conveyed that they did feel competent in assisting with end of life decisions related to geriatric mental health patients. However, disparate responses (slippages) were significantly reported with 9 (47.4%) chaplains reporting they did not feel competent in assisting with end of life decisions related to geriatric mental health patients. There were no neglected responses (silence) identified in the data, and 0 (0%) selected 'not applicable.' See illustration in Figure 18.

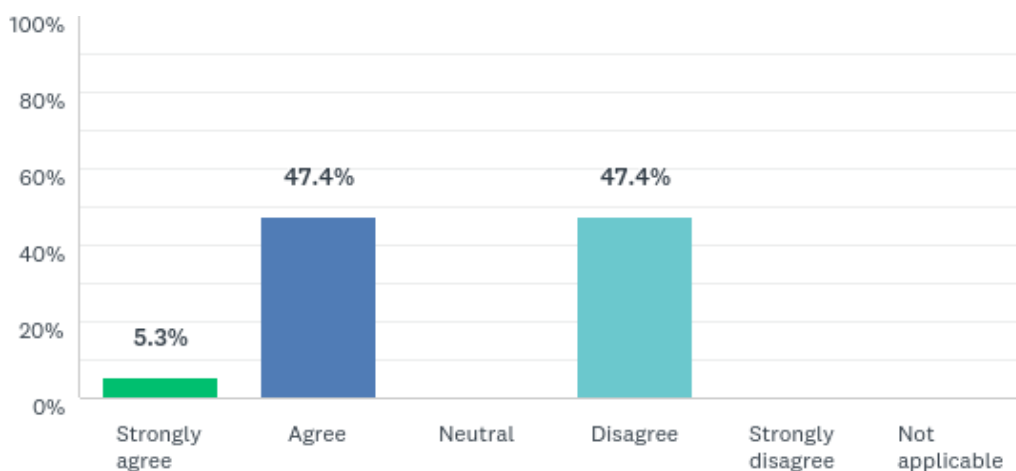*Figure* 18. Question 29 of "Ethical Competence"

The next question in category E was question 30, which is illustrated in Table 9.

Table 9

Question 30 of "Ethical Competence"

Did you receive training from your employer about collaborating with staff about the advocacy of Geriatric mental health patients and families or participate in regular interdisciplinary team meetings?
□ **YES**   □ **NO**

Of total sample (*N = 26*), and 21 completions, 5 (23.8%) selected "yes," and 16 (76.2%) selected "no" to this statement.

When taking into account the convergence and divergence of question 30's results, a common response (theme) emerged, indicating that a significant majority of 16 (76.2%) chaplains conveyed that they did not receive training from their employer about collaborating with staff about the advocacy of geriatric mental health patients and families or participating on regular interdisciplinary team meetings. Minor disparate responses (slippages) were reported with 5 (23.8%) chaplains indicating that they received training in this area. There were no neglected responses (silence) identified in the data.

The next question in category E was question 31, which is illustrated in Figure 19.

Q31 If YES, please indicate how much you agree or disagree with the following statement:I feel competent advocating for Geriatric mental health patients and their families.
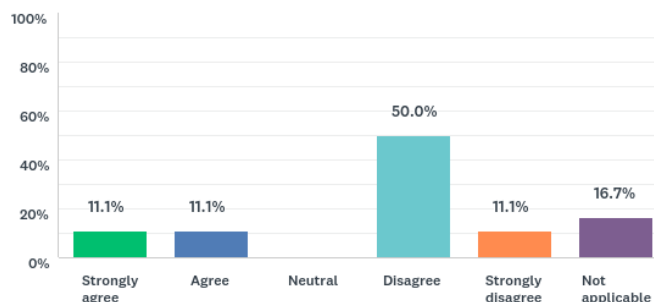
Figure 19. Question 31 of "Ethical Competence"

Of total sample (*N = 26*), and 18 completions, 2 (11.1%) strongly agreed, 2 (11.1%) agreed, 0 (0%) was neutral, 9 (50.0%) disagreed, 2 (11.1%) strongly disagreed with this statement, and 3 (16.7%) selected 'not applicable.'

When taking into account the convergence and divergence of question 31's results, a common response (theme) emerged, demonstrating that a significant majority of 11 (61.1%)

chaplains conveyed that they did not feel competent advocating for geriatric mental health

patients and their families. Disparate responses (slippages) were minimally reported with, 4

(22.2%) chaplains reporting feeling competent advocating for geriatric mental health patients and

their families. There were no neglected responses (silence) identified in the data, and 3 (16.7%)

selected 'not applicable.'

Category F examined "On-The –Job-Tools," which contained three questions. This

category begun with question 32, as illustrated in Figure 20.

Q32 Did you receive on the job training about self- protection, and de-escalation of patients?

Figure 20. Question 32 of "On-The-Job Tools"

Of total sample (*N = 26*), and 22 completions, 6 (27.3%) selected "yes," and 16 (72.7%)

selected "no" to this statement. When taking into account the convergence and divergence of

question 30's results, a common response (theme) emerged, indicating that a significant majority

of 16 (72.7%) chaplains conveyed that they did not receive on-the-job training about self-

protection, and de-escalation of patients. Minor disparate responses (slippages) were reported

with 6 (27.3%) chaplains indicating that they received training in this area. There were no

neglected responses (silence) identified in the data.

The next question in category F was question 33, which is illustrated in Table 21.

Q33 Do you have access to Counselors or Social workers for crisis event debriefing?
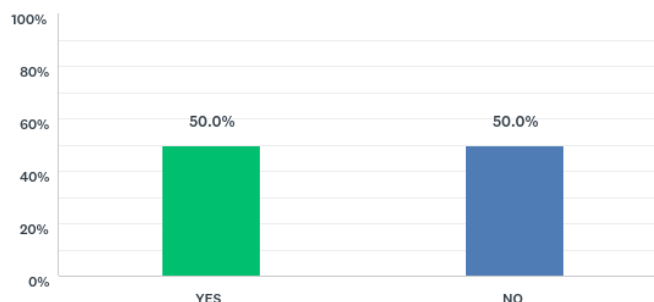
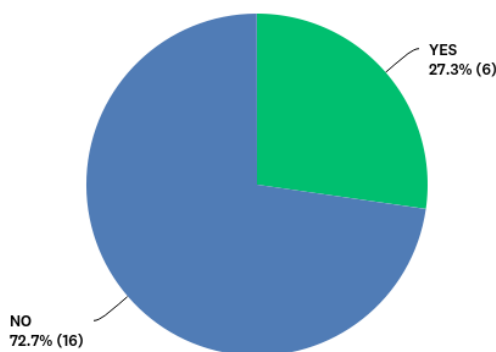*Figure* 21. Question 33 of "On-The-Job Tools"

Of total sample (*N = 26*), and 22 completions, 11 (50%) selected "yes," and 11 (50%) selected "no" to this statement. When taking into account the convergence and divergence of question 30's results, a common response (theme) equally emerged for both responses with 11 (50%) chaplains reporting that they did have access to counselors and social workers for crisis event debriefing, while another 11 (50%) reported they did not. There were no disparate responses (slippages), or neglected responses (silence) identified in the data.

The next question in category F was question 34, which is illustrated in Figure 22.

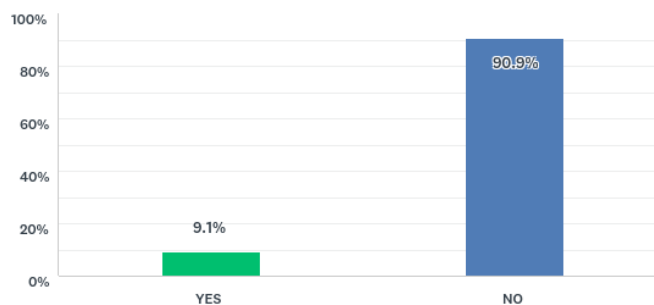Q34 Were you trained to handle suicidal prevention according to your employer's protocol?

Figure 22. Question 34 of "On-The-Job Tools"

Of total sample (*N = 26*), and 22 completions, 2 (9.1%) selected "yes," and 20 (90.9%)

selected "no" to this statement. When taking into account the convergence and divergence of

question 34's results, a common response (theme) emerged, indicating that a significant majority

of 20 (90.9%) chaplains reported they were not trained to handle suicidal prevention according to

their employer's protocol. Minor disparate responses (slippages) were reported with only two

(9.1%) chaplains indicating they received training in this area. There were no neglected

responses (silence) identified in the data.

Category G examined "Self-Care," which contained five questions. This category begun

with question 35, as illustrated in Figure 23.

Q35 Do you practice intentional self-care?

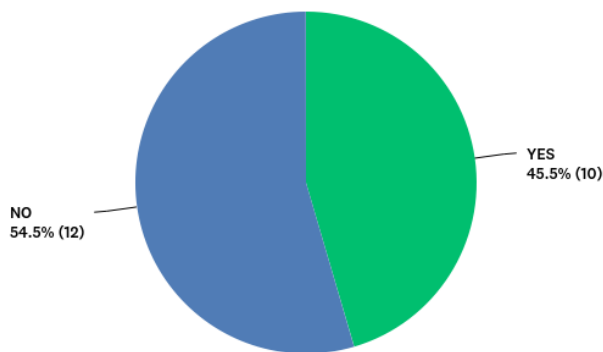*Figure* 23. Question 35 of "Self-Care"

Of total sample (*N = 26*), and 22 completions, 10 (45.5%) selected "yes," and 12 (54.5%)

selected "no" to this statement. When taking into account the convergence and divergence of

question 35's results, a common response (theme) emerged, indicating that a majority of 12

(54.5%) chaplains reported they did not practice intentional self-care. Disparate responses

(slippages) were reported with 10 (45.5%) chaplains indicating they did practice intentional self-

care. There were no neglected responses (silence) identified in the data

   The next question in category G was question 36, which is illustrated in Figure 24.

If **yes**, after ministering to Geriatric mental health patients, do you regularly participate in any of the following debriefing sessions?		
ANSWER CHOICES	**RESPONSES**	
With patient's Doctor	4.8%	1
With patient's Nurse	4.8%	1
With patient's Social Worker	0.0%	0
With patient's LPC/Counselor	0.0%	0
With patient's Aide	0.0%	0
With another Chaplain/Minister	23.8%	5
No time to debrief	9.5%	2
Not applicable	57.1%	12
TOTAL		21

Figure 24. Question 36 of "Self-Care"

   When taking into account the convergence and divergence of these results from a total

sample ($N = 26$), with 21completions for question 36, there was a common response (theme)

with 12 (57.1%) chaplains indicating that after ministering to geriatric mental health patients,

regular participation in debriefing sessions was not applicable, and 2 (9.5%) reported no time to

debrief. Disparate responses (slippages) reflected 5 (23.8%) chaplains indicated that they

debriefed with another chaplain/minister, 1(4.8%) debriefed with patient's doctor, and 1(4.8%)

debriefed with patient's nurse. No neglected responses (silence) were identified in the data.

The next question in category G was question 37, which is illustrated in Figure 25.

If **YES**, which of the following hobbies or other interests do you engage as part of your self-care? (Choose all that apply).

ANSWER CHOICES	RESPONSES	
Praying	4.8%	1
Meditating	4.8%	1
Seeking solitude time	4.8%	1
Spending quality time with family and/or friends	0.0%	0
Reading novels/poetry	0.0%	0
Gardening	4.8%	1
Drawing	0.0%	0
Writing	4.8%	1
Journaling	0.0%	0
Hunting	0.0%	0
Fishing	0.0%	0
Camping	0.0%	0
Walks on the beach/swimming	0.0%	0
Bird watching	0.0%	0
Outdoor sporting activities	4.8%	1
Sightseeing	0.0%	0
Motorcycle riding	0.0%	0
Traveling on vacation	0.0%	0
Watching movies	0.0%	0
Singing	4.8%	1
Listening to music	4.8%	1
Camping	0.0%	0
Going to the beach	0.0%	0
Indoor sporting activities	0.0%	0
Other	9.5%	2
Not applicable	52.4%	11
TOTAL		21

Figure 25. Question 37 of "Self-Care"

The next question in category G was question 38, which is illustrated in Figure 26.

How many <u>minutes/hours per week</u> do you spend in prayer, meditation and/or personal

devotional?

ANSWER CHOICES	RESPONSES	
0 to 15 minutes	33.3%	4
16 to 30 minutes	16.7%	2
31 minutes to under 1 hour	8.3%	1
1 to 2 hours	16.7%	2
3 to 4 hours	8.3%	1
5 to 6 hours	8.3%	1
7 to 9 hours	8.3%	1
10 hours or more	0.0%	0
TOTAL		12

Figure 26. Question 38 of "Self-Care"

The next question in category G was question 39, which is illustrated in Figure 27.

Q39 Please indicate how much you agree or disagree with the following statement: My level of self-care as described above significantly contributes to my level of resiliency and effectiveness as a chaplain to Geriatric mental health patients.
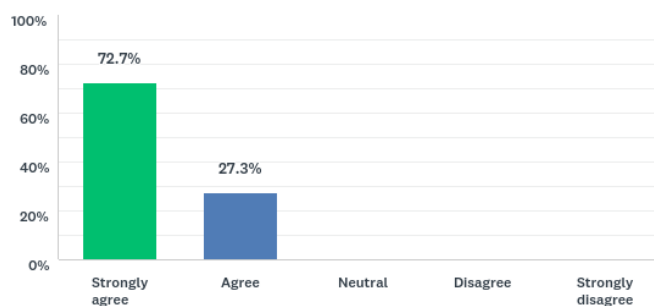

Figure 27. Question 39 of "Self-Care"

Of total sample (*N = 26*), and 22 completions, 16 (72.7%) strongly agreed, 6 (27.3%) agreed, 0 (0%) was neutral, 0 (0%) disagreed, 0 (0%) strongly disagreed with this statement. When taking into account the convergence and divergence of question 39's results, a strong common response (theme) emerged, demonstrating that a full majority of 22 (100%) chaplains agreed that their level of self-care as described above, significantly contributed to their level of resiliency and effectiveness as a chaplain to geriatric mental health patients. There were no neglected responses (silence) identified in the data.

A correlational analysis of questions 17 and 39 was conducted to examine the effects of chaplains' reported level of competence and intentional self-care. The results indicated that a strong correlation between chaplains who felt competent and their increased practice of intentional self-care. Of the five chaplains that reported feeling adequately prepared to develop and implement a plan of care to promote the well-being and continuity of care for geriatric mental health patients, a significant majority of 4 (80%) reported practicing intentional self-care. See illustration in Figure 28.

	YES	NO	TOTAL
Q17: Agree	80.0% 4	20.0% 1	100.0% 5
Total Respondents	4	1	5

Figure 28. Analysis of Questions 17 and 39 of "Self-Care"

In summation, the results and analysis of this project are presented in this chapter. The ensuing chapter discusses how the results compared to the literature review, the theoretical framework, and the theological framework. Next, a guide addressing the areas of training and preparation is presented, along with implications, recommendations, and future research.

Chapter 5: Conclusion

This chapter recaps the purpose of this thesis project and a brief overview. A detailed discussion on how the results of the research project compared to the information gleaned from the literature review, the theoretical framework, and the theological framework is presented. Following a comparison of the results with literature, practical steps to address each area are presented in the form of an instructional guide. Next, the implications of the research related to what was learned by the research and how the results might apply in other settings were discussed. Lastly, recommendations, future research, and a summation of this research project are presented.

Purpose of the Study and Brief Overview

The purpose of this Doctor of Ministry study was to examine via survey, the level of training and preparedness of chaplains that ministered to geriatric mental health patients within clinical settings, to address the need for comprehensive and competent care for mental health patients, specifically the geriatric population. The data collected from the chaplains served in the creation of a guide that included ways to help improve this ministry challenge and assist geriatric psychiatric chaplains in providing comprehensive delivery of competent care to patients.

This hands-on guide addressed fundamental aspects of mental health chaplaincy, such as specific geriatric psychiatric competencies, spiritual preparedness, mental preparedness, clinical preparation, ethical competence, using on-the-job tools, and self-care. Primarily, this action research served to advise chaplains, not only about the clinical aspects of the job, but about daily management of work, the importance of debriefing, living a balanced personal, and professional lifestyle. Enhanced chaplains' self-awareness can benefit geriatric patients and hospital staff

psychologically and spiritually through the delivery of more competent, confident, and focused pastoral care.

The tangible benefits for chaplains would be the satisfaction received from knowing that they have given their best and fulfilled God's desire to be workers of excellence. Additionally, having a practical guide that can be easily accessed in times of uncertainty can relieve the stressor of feeling unprepared in certain unfamiliar situations. Hence, the chaplains' daily management of work and the reminders of debriefing and self-care will promote a balanced lifestyle. Furthermore, geriatric patients will tangibly benefit from receiving more competent and focused chaplaincy care, which in turn would be favorable for clinical practices as a whole.

Results' Correlations to Literature Review and Presentation of Guide

This section addressed the results of each of the six areas examined within the questionnaire, namely, 'specific geriatric mental health training,' 'spiritual and mental preparation,' clinical preparation,' ethical competence,' on-the-job tools,' and 'self-care' in relational to the empirical findings of the literature. Following the comparison of results and the literature review, steps that may be helpful in each area are presented as an instructional guide for chaplains.

Specific Geriatric Mental Health Training

Literature reported a lack of education in basic counseling skills, psychiatric diagnoses, and assessment in seminary/divinity school and Clinical Pastoral Education (CPE) curriculum (Fletcher, 2019; Goh et al., 2012; Lawrence et al., 2007). Additionally, four of the top divinity schools in the United States; Harvard University, Yale University, Princeton University, and Duke University, required no counseling classes or psychiatric assessment training in their

Master of Divinity (M.Div.) programs (Duke University School of Divinity, 2019; Harvard University School of Divinity, 2019; Princeton University School of Divinity, 2019; Yale University School of Divinity, 2019). The results of this questionnaire confirmed literatures reported lack of education in basic counseling skills, psychiatric diagnoses, and assessment in seminary/divinity schools. Of a total sample ($N = 26$), and 21 completions, 18 (85.7%) chaplains reported that their training in seminary and/or divinity school alone did not provide adequate training for ministering specifically to geriatric mental health patients.

Also, of the total sample ($N = 26$), and 21 completions, 19 (90.5%) chaplains reported that their internship and/or residency in clinical pastoral education did not provide training for ministering specifically to geriatric mental health patients. This result corroborated with researchers Fletcher (2019), Goh et al. (2012), and Lawrence et al.'s (2007) identified a lack of education in basic counseling skills, psychiatric diagnoses, and assessment within the Clinical Pastoral Education (CPE) curriculum. Further, 9 (40.9%) chaplains reported not feeling competently trained to handle specific mental health diagnoses when ministering to geriatric mental health patients, and there was a significant level of neglected responses with no selection shown for 20 of the 24 diagnoses listed. This silence may be interrupted as a lack of competent training when dealing with these diagnoses among geriatric mental health patients.

Further, a majority of 12 (54.5%) of the 22 surveyed chaplains reported feeling inadequately prepared to develop and implement a plan of care to promote the well-being and continuity of care for geriatric mental health patients. Also, 12 (54.5%) of 22 chaplains conveyed that they did not feel adequately prepared to gather and evaluate relevant data pertinent to the geriatric mental health patients' situation and bio/psycho-social-spiritual/religious health.

Practical Guide for Geriatric Mental Health Training. The first step to address the lack of education in basic counseling skills, psychiatric diagnoses and assessment in seminary/divinity school would include the dissemination of empirical evidence as reported in this project's findings and literature review to seminary/divinity schools. Promoting awareness of the need for training in basic counseling skills, psychiatric diagnoses, and assessment, would be the first step in appealing to seminary/divinity schools when reviewing their curriculums. There are some exemplary schools that might serve as prototypes for the inclusion of mental health training. Schools, such as Liberty University Rawlings School of Divinity and BH Carroll Seminary, require two to three counseling courses (BH Carroll Seminary, 2019; Liberty University, 2019a). Also, Grace Theological Seminary requires three courses in counseling (Grace Theological Seminary, 2019).

The second step to address the lack of education in basic counseling skills, psychiatric diagnoses and assessment in seminary/divinity school would include the recommendation to model the approach of the Veterans Administration and Department of Defense in addressing the expanding roles of chaplains in mental health (Department of Defense & Veteran Administration, 2010). Nieuwsma et al. (2013) stated that "this will entail more effectively integrating chaplaincy with mental health care services" (p. 3). Potential solutions to the problem included cross-training chaplains and mental health professionals. This cross-training method included embracing integrated roles, standardizing processes across the entire system, changing from the bottom up, and preventing proselytizing, and communication outside the boundaries of chaplaincy. It also included gaining patients' permission to share information, involving other

healthcare providers and including chaplains in the identification of expectations and measures (Nieuwsma et al., 2013).

In terms of training, individual-level training was divided into three tiers (Nieuwsma et al., 2013). The first was Education and Relationship Building, which trained chaplains and mental healthcare providers through webinars, onsite training, and interdisciplinary relationship building (Nieuwsma et al., 2013). The second tier, Equipping Champions of Integration, co-educated chaplains and mental health providers in evidence-based training seminars that promoted beneficial partnership and practical integration (Nieuwsma et al., 2013). The third tier consisted of Mental Health Integration for Chaplain Services (MHICS) (Mental Health Integration for Chaplain Services (MHICS), 2019; Nieuwsma et al., 2013), and targeted chaplains that spent a significant portion of their professional engagement in mental health settings. The Mental Health Integration for Chaplain Services (MHICS) (2019) stated, "this program would provide interested chaplains an intensive, focused training experience aimed at better equipping them to participate as part of integrated mental health care teams" (p. 5).

In summation, simple steps for augmenting the lack of education in basic counseling skills, psychiatric diagnoses, and assessment in seminary/divinity schools' curriculums would include pursuing didactics on ministering to geriatric mental health patients, reviewing psychiatric assessments and diagnoses, and shadowing geriatric psychiatric chaplains. Also, chaplains may seek to be assigned as an intern/resident chaplain on the geriatric psychiatric unit/floor to gain hands-on training.

Spiritual Preparation

According to literature, spiritual preparedness ensured that chaplains had considered the

state of their own soul and God's will before they ministered to mental health patients.

Therefore, Air Force Chaplain Robert Borger (2008) asserted that spirituality is a path that gives

purpose and meaning to human life. The results of this project indicated that of the total sample

($N = 26$), and 21 completions, 17 (81.0%) chaplains reported they did not regularly have

adequate time to spiritually prepare prior to visiting geriatric mental health patients.

Practical Guide for Spiritual Preparation. Spiritual preparedness for chaplains varied

across denominational faiths and religions (Borger, 2008). Steps to improve spiritual

preparedness include setting aside a specific time to engage in spiritual preparation. Christian

chaplains believe that their spiritual preparedness centered on the truth, knowledge, and Word of

Jesus Christ, and this may include prayer and worship time (James 1:5, NIV; Proverbs 15:23,

NIV; Warren, 2002). Specific steps may consist of prayer, meditation, reading the Bible or

religious book, meeting with other chaplains, and personal or group devotionals.

Additionally, preparing a heart of worship before ministering to mental health patients

would be a valuable preparation step (Warren, 2002). The heart of worship has been shown to go

beyond singing songs and praising God, to involving complete surrender to God's will (Warren,

2002). The Apostle Paul wrote, "therefore, I urge you, brothers and sisters, in view of God's

mercy, to offer your bodies as a living sacrifice, holy and pleasing to God—this is your true and

proper worship" (Romans 12:1, NIV). Therefore, as Christian chaplains perform their ministry

duties, they can remain in a state of offering worship to God through their service (Warren,

2002). Hence, just like prayer, the act of worship has been demonstrated to serve as a

foundational resource for the chaplains' ministry and their spiritual preparation (Warren, 2002).

Mental Preparation

The literature identified that through the process of mental self-evaluation, chaplains

could recognize how much God was needed in the stress of servitude (Bowman, 2017; Warren,

2002). Chaplains have been shown to experience the difficulties of transference and/or

countertransference and the limited disclosure of their own stories in their ministry to geriatric

psychiatric patients (Bowman, 2017). Further, Pargament (2007) postulated that spirituality was

a legitimate dimension of the human experience and to idealize spirituality, while tempting,

should be avoided. Therefore, the literature suggested that chaplains should evaluate their

professional weaknesses during pastoral department debriefing sessions with other chaplains

(Warren, 2002). It was noted that there was a constant effort to limit weakness in performance,

but weakness was perceived as a strength (Warren, 2002). Hence, Warren (2002) cautioned that

"usually we deny our weaknesses, defend them, excuse them, hide them, and resent them. The

results of this project correlated with literature in that 17 (77.3%) of the 22 chaplains surveyed

reported that they did not regularly have adequate time to mentally prepare prior to visiting

geriatric mental health patients.

Practical Guide for Mental Preparation. Suggestions to improve mental preparedness

might include setting aside a specific time to engage in mental preparation. Next, for Christian

chaplains, understanding that ministry to mental health patients, geriatric psychiatric patients, in

particular, requires an understanding of the literal and Biblically defined mind. The Holy Bible

was clear about the mind and stated "do not be conformed to this world, but be transformed by

the renewal of your mind, that by testing you may discern what is the will of God, what is good

and acceptable and perfect" (Romans 12:2, NIV). Also, I Corinthians 2:16 (NIV) asked, "for

who has understood the mind of the Lord as to instruct him?" Therefore, Chaplains can engage

the use of Scriptures to mentally prepare for ministry (Warren, 2002). For example, Philippians

4:7 (NIV) assured that "the peace of God, which surpasses all understanding, will guard your

heart and your minds in Christ Jesus," which is a powerful resource for chaplains' mental

preparation.

Next, the purposeful acceptance of God's calling in the minds and hearts of chaplains

was considered the beginning of their ministry (Warren, 2002). Hence, the acknowledgment of

that truth removes the elements of time pressure and frustration when God's agenda prevailed

(Warren, 2002). Specifically, chaplains could mentally prepare by being mindful of what 'God

wanted to bring into patients' lives and conditions. Therefore, Warren (2002) posited that

"servants see interruptions as divine appointments for ministry and are happy for the opportunity

to practice service" (p. 259).

Additionally, chaplains can engage in specifically planned mental preparation activities

before visiting geriatric mental health patients. These activities might include self-evaluation of

their current mental status, practicing positive thinking, deep breathing, imagery, listening to

music, and self-talk.

Clinical Preparation

According to literature, behavioral health and mental health have been shown to address

mental disorders and addictions, and "it represents a movement from focusing on illness

symptoms to behaviors that can promote stabilization and wellness" (Guest Lowery, 2012, p.

267). Chaplains that had ministered to geriatric psychiatric patients were expected to have received proper training on various diagnoses, and have acquired experience that enabled them to understand that mental illness may be hereditary, biochemical, or caused by environmental factors (Guest Lowery, 2012). The results of this project indicated that of the total sample ($N =$ 25), and 22 completions, a majority of 12 (54.6%) chaplains reported that they did not have adequate time to clinically prepare prior to visiting geriatric mental health patients. Further, when chaplains were asked what diagnoses or situations they felt competently trained to handle when ministering to geriatric mental health patients, 9 (40.9%) chaplains indicated not feeling competently trained, and there was no selection shown for 20 of the 24 diagnoses listed. This silence may be interrupted as a lack of competence in training when confronted with these diagnoses. Chaplains' competence was reported among four diagnoses, namely, 4 (18.2%) selected depression, 4 (18.2%) selected anxiety, 3 (13.6%) selected post-traumatic stress, and 1 (4.5%) selected eating disorder. Additionally, 1(4.5%) selected "all of the above."

Practical Guide for Clinical Preparation. Steps to improve clinical preparedness include setting aside time to refresh knowledge about patient's diagnosis, religious status, and preferences, contemplate different interventions based on diagnosis, consult with the staff about the patients, review the patient's chart, and self-evaluation of clinical competence.

First, when conducting self-evaluation of clinical competence using the Diagnostic and Statistical Manual of Mental Disorders as a resource, has been shown to be a good starting point (American Psychiatric Association, 2013). Second, chaplains that work with the behavioral health population should be aware of the stigma that accompanied mental illness (Guest Lowery, 2012). Hence, Guest Lowery (2012) warned against the misconception that sends the message

that individuals diagnosed with mental disorders are "violent, lazy and or unable to live productive lives" (p. 269). Thus, chaplains must be mindful that the language used about mental illness will either add to the stigma or encourage understanding. For example, a patient with schizophrenia should not be referred to as a "schizophrenic" but as "a person with schizophrenia" (Guest Lowery, 2012, p. 269). Therefore, Guest Lowery (2012) called upon mental health chaplains to acquire the proper training and "remember people with mental disorders often over identify with their illness, and they struggle to see themselves in a fuller context" (p. 269). Chaplains should remain cognizant of this thought pattern when dealing with individuals with mental health disorders.

Third, it is valuable to learn about the presentation of different mental diagnoses and appropriate physical, emotional, and spiritual boundaries needed (Guest Lowery, 2012). For example, patients diagnosed with autism may be sensitive to various types of stimulation, and patients that had experienced abuse may prefer not to be touched (Guest Lowery, 2012). Next, patients diagnosed with bipolar disorder have been shown to experience profound guilt about their impulsive behaviors that have adverse mental and physical effects (Guest Lowery, 2012). Guest Lowery posited that shame and a diminished sense of meaning plagued behavioral health patients. Many faced the loss of relationships, employment, housing, independence, and sometimes faith (Guest Lowery, 2012). Therefore, trained chaplains should be prepared to assist patients with crises of identity and stand with them in their faith as they ask, "Why is this happening to me?", "Where is God in this illness?" and "What is my purpose in life now?" (Guest Lowery, 2012, p. 273).

Fourth, chaplains, primarily those on geriatric psychiatric floors, have been commonly assigned to facilitate pastoral care and spirituality groups (Guest Lowery, 2012). However, the patients on the geriatric psychiatry floors have been identified as needing delicate care. So, in order to effectively facilitate group sessions, proper training is required to ensure no harm comes to the patients. Therefore, Guest Lowery (2012) stated that "a well-facilitated group is a haven of healing, providing moments of connection, glimpses of the profound truth that we are not alone" (p. 273). Also, amongst in-patient hospitals and facilities, spirituality groups are typically part of the patients' treatment plan (Guest Lowery, 2012). Therefore, as part of the chaplain's training, Guest Lowery (2012) suggested a specific order to be used to ensure a successful group. This order included a brief review of the connection of life and religion, a review of general group guidelines, group introductions, a mindfulness exercise, a story or inspirational text, a discussion of reviewed topics like forgiveness, self-acceptance, and self-care or coping strategies (Guest Lowery, 2012).

Further, Guest Lowery (2012) suggested that other practical tools and training should be acquired when ministering to patients with differing mental health diagnoses. Many geriatric psychiatric patients have been diagnosed with dementia and other brain maladies concurrently with eating disorders, anxiety disorders, and mood disorders (American Psychiatric Association, 2013; Goh et al., 2012). Further, eating disorders, anxiety disorders, and mood disorders have been identified as having their own symptomology (American Psychiatric Association, 2013). For example, it is helpful to be aware that patients diagnosed with eating disorders have been reported to struggle with self-destructive behaviors related to food (American Psychiatric

Association, 2013; Yalom & Leszcz, 2005). Anorexia nervosa and bulimia (binge/purge) were two of the most common types of eating disorders (American Psychiatric Association, 2013).

Patients with eating disorders displayed symptoms of perfectionism, low self-esteem, rigidity, and emotional avoidance (Yalom & Leszcz, 2005). Hence, trained chaplains have been more effective when focusing on the concept of grace versus works in patient relationships with God by using Scripture and positive religious materials. These patients need help to find strength in their weaknesses, self-forgiveness, self-care, and reduced feelings of shame (Yalom & Leszcz, 2005).

Next, patients with anxiety disorders, which include Obsessive-Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD) have been shown to experience excessive worry and psychologically and physiologically fear (American Psychiatric Association, 2013; Yalom & Leszcz, 2005). When dealing with patients diagnosed with an anxiety disorder, chaplains have been effective in reinforcing the "normalcy of religious uncertainty" and helping patients with the exploration of their faith as a life journey rather than just a belief (Yalom, and Leszcz, 2005, p. 276). Additionally, chaplains who were prepared and trained in using mindfulness were able to keep patients anchored in the present and bolstered their stress tolerance (Yalom, & Leszcz, 2005). Further, chaplains who were equipped and trained in creating and implementing action steps were able to encourage patients in purposeful living and clarify and reframe their "cognitive distortions" about religion (Yalom & Leszcz, 2005, p. 276).

Additionally, patients with mood disorders, such as major depression and bipolar disorder, have been found to experience problems with the regulation of their emotions, feelings, and moods (American Psychiatric Association, 2013; Yalom & Leszcz, 2005). Further,

depression was identified as a primary indicator of suicidal ideation, and Yalom and Leszcz

(2005) described bipolar disorder as "a roller coaster of emotions and impulsive behaviors" (p.

277). When providing spiritual care to patients diagnosed with mood disorders, using stories and

experiences of hope for the clarification of guilt, true belief, and the struggle of faith have been

shown to be most effective (Yalom & Leszcz, 2005). It was helpful when chaplains were trained

to assist patients in "safe expressions of feelings, self-forgiveness, and aided them in the

acceptance of God as a companion, not a fixer" (Yalom & Leszcz, 2005, p. 277).

In addition, when patients with mood disorders experienced mania, it was reported to be

beneficial when the chaplain was trained to remain calm, observant, maintain a safe but caring

distance, validate, and redirect disruptive behaviors (Yalom & Leszcz, 2005). Only when the

patient's stability was achieved should the chaplain introduce spiritual themes (Yalom & Leszcz,

2005).

Next, patients with psychotic disorders have been shown to experience delusions,

hallucinations, and disorganized thoughts and behaviors (American Psychiatric Association,

2013; Yalom & Leszcz, 2005). Schizophrenia and psychosis have been identified as the most

common psychotic disorders (Yalom & Leszcz, 2005). Additionally, schizophrenia may be

accompanied by psychosis (American Psychiatric Association, 2013; Yalom & Leszcz, 2005).

Patients with schizophrenia and psychosis have been reported to engage with God and religion in

ways that were both rational and delusional (Yalom & Leszcz, 2005). Chaplains were instructed

not to confront the delusions or overtly speak about religion or religious books due to the

tendency of hyper-religiosity (Yalom & Leszcz, 2005). Rather, appropriately trained chaplains

have been effective in using reflective listening and exploring the patient psychotic experiences

"to find spiritual needs and sources of hope" (Yalom & Leszcz, 2005, p. 478). Additionally, positive religious coping was then fortified through appropriate religious materials and connection with the chaplain (Yalom & Leszcz, 2005). In summation, Guest Lowery (2012) suggested that "in behavioral health, expect that any and every "button' can be pushed – and welcome this as both gift and task" (p. 270).

Ethical Competence

According to literature, the Common Code of Ethics for chaplains, pastoral counselors, pastoral educators, and students was established to oversee chaplain organizations and training programs (Belinger, 2012). The code of ethics concentrated on namely, relationships with clients; between supervisors and students, faith communities, with other community professionals, with health care colleagues, and in advertising and research (Belinger, 2012). Chaplains were expected to have knowledge about the rules of their profession, as well as the rules of their colleagues and others. Hence Belinger (2012) stated that "…chaplaincy organizations and health care institutions that involve community clergy should aim to offer some ethics education for community clergy involved in patient care" (p. 182).

The results of this project indicated that of the total sample ($N = 26$), and 22 completions, 16 (72.7%) of chaplains reported that they did not receive training from their employers on Mandated Reporting and only 8 (41.1%) reporting not feeling competent, while 4 (21.1%) was silent and selected 'not applicable.' However, when asked about training in the Advanced Care Planning and end of life decisions, of the total sample ($N = 26$), and 22 completions, 19 (86.4%) chaplains indicated they were trained in this area. Next, when asked if they received training from their employers about collaborating with staff about the advocacy of geriatric mental health

patients and families or participate in regular interdisciplinary team meetings, 16 (76.2%) of chaplains conveyed they did not receive training in this area.

      Practical Guide for Ethical Competence. Chaplains have been mandated to hold a professional, social, and moral obligation to their patients and be the "truth tellers and justice seekers" (Belinger, 2012, p. 183). Thus, chaplains have been shown to play the role of critically reflecting on the harmful and unjust practices of health care systems. Subsequently, Belinger (2012) suggested that the chaplain should not only be "present to the suffering but also to question conditions that appear to promote or add to the suffering" (Belinger, 2012, p. 183).

      Next, although chaplain ministry occurred mostly at the bedside of patients, attention should be given to ethics education, policy development, and healthcare structures that had productive, ethical consultations (Belinger, 2012). When chaplains participated in interdisciplinary healthcare teams, they should bring their uniquely honed abilities to reason in the realm of morality and religion to ethical situations (Belinger, 2012). Christian chaplains have been shown to live by a Biblical mandate about upholding ethics (Belinger, 2012). Hence, the Holy Bible stated, "he has shown you, O mortal, what is good. And what does the LORD require of you? To act justly and to love mercy and to walk humbly with your God" (Micah 6:8, NIV).

      It has been established that all professionals in healthcare have a responsibility to the moral, psychological, and social issues that may accompany the care of patients (Belinger, 2012). No discipline of healthcare was expected to exist in a bubble, or independently and that included the healthcare chaplaincy discipline. Thus, the bar for chaplain participation in ethical matters in healthcare was raised (Belinger, 2012).

Hence, chaplains should seek additional experience and training on ethical topics in healthcare. These topics include; palliative care, collaborative decision making, advanced care planning, decisions about food and feeding patients with eating disorders or near end of life, the care of terminal patients, objections to a determination of death, religious objections to treatment decisions, and policy supporting good practice (Belinger, 2012). Those that held to ethical standards were the preservers of justice. Hence the Holy Bible stated, "let justice roll on like a river, righteousness like a never-failing stream" (Amos 5:24, NIV).

On-The-Job Tools

The literature identified that chaplains were lacking in the skillsets and pastoral care practices needed to effectively care for elderly patients with mental disorders (Goh et al., 2014; Lawrence et al., 2007). There was a reported need for adequate training, models, tools, and functional policies in pastoral care related to geriatric psychiatric patients (Fletcher 2019, Goh et al., 2014; Lawrence et al., 2007). Additionally, literature reported that the chaplaincy profession fell short of the psychiatric training required to understand the diagnostic intricacies of mental health patients, primarily geriatric psych patients (Fletcher 2019, Goh et al., 2014; Lawrence et al., 2007; Lucchetti et al., 2012). The results of this project confirmed this need for additional training, specifically, access to on-the-job tools and resources. The results indicated that 16 (72.7%) of the 22 surveyed chaplains received no on the job training about self-protection and de-escalation of patients, and 11 (50.0%) reported no access to counselors and social workers for crisis event debriefing. Additionally, a majority of 20 (90.9%) of chaplains reported no on-the-job training on how to handle suicide prevention according to your employer's protocol.

Practical Guide for On-The-Job-Tools. It is important for chaplains to receive specific training related to their population since studies have identified negative aspects of pastoral care for elderly adults with mental health needs, when executed inappropriately (Fletcher, 2019; Lawrence et al., 2007). Specifically, Lawrence et al.'s (2007) revealed five categories of the detrimental effects of pastoral care. These detrimental effects of pastoral care can lead to worsened psychiatric symptoms, intrusion and coercion, create conflict, and interfere with psychiatric care, provide negative or terminal connotations, and even have no therapeutic meaning or value.

Therefore, Fletcher (2019) wrote, "to think that spirituality is universally good is rather like saying 'family' is good or 'personality' is good" (p. 34). Mental health services were full of people whose "spirituality or spiritual community was distorted or damaged" (p. 34). Hence, chaplains should strive to respect patient's spirituality or religion and discern healthy and unhealthy aspects of spirituality (Fletcher, 2019). Also, chaplains should be prepared to help clinicians in guiding patients to separate their physical maladies from their spirituality (Fletcher, 2019).

Additionally, the Veterans Administration Mental Health and Chaplaincy Program, Strategic Action (SA) #23 (Department of Defense & Veterans Administration, 2010), is an ideal model on how to integrate and train chaplains to better function in the mental health system.

Practical steps to advance chaplaincy collaboration and teamwork with mental health included jointly training chaplains and mental health care providers, enhanced communication of documentation between disciplines, organizational structures that aided teamwork, and implementing integrated solutions in a cohesive community of care (Nieuwsma et al., 2013).

There were some identified barriers that impeded the joining of chaplains and mental health, which can be pitfalls to be aware of in this process. These pitfalls are lack of cross-training, professional roles blurred, unclear desired outcomes, discomfort with respective specialties, resources, chaplaincy subsumed by medical models, proselytizing, lack of relationships, cultural differences, lack of community collaboration, chaplaincy resistance to evidence-based research, and lack of common value system (Nieuwsma et al., 2013).

Self-care

According to literature, chaplain self-care should be a major theme in resilient ministry (Burns et al., 2013; Carter, 2013; Stuart, 2012). Additionally, Stuart (2012) posited that self-care was an integral part of professional ministry, and the Council of Collaboration and the Association of Professional Chaplains required their members to demonstrate self-care competency. Literature found that ministers in North America had experienced rising percentages of stress and burnout. Thus, chaplains and clergy members were encouraged to take intentional consideration of personal self-care plans (Carter, 2013). Burns et al. (2013) indicated that "research has suggested pastors either hold unrealistic expectations of human productivity, don't view self-care as an ethical imperative, or 'spiritualize away' their need for self-care" (p. 21). The results of this project concurred with literature. The survey found that while 22 (100%) of the 22 surveyed chaplains agreed that their level of self-care significantly contributed to their resiliency and effectiveness as a chaplain, more than half, 12 (54.5%) reported not being able to intentionally practice self-care.

Practical Guide Self-care. Some every day and practical suggestions to intentional self-care will first start with purposefully carving out time for 'self.' This time may include planning

a healthy bedtime and setting an alarm as a reminder, setting aside time for personal prayer or relaxation, establishing an attainable exercise routine, and eating a proper diet (Burns et al., 2013). Additionally, chaplains can draw from their CPE training, which taught them to identify stressors, take scheduled breaks during the day, and retreat to the chapel or outside for a change of scenery (Stuart, 2012).

There was also the suggestion of traditional spiritual actions of prayer, Bible study, meditation on the Lord, fasting, worship, confession, fellowship, and service (Tan & Gregg, 1997). Therefore, the following can be engaged as part of self-care, namely, praying, meditating, seeking solitude, spending quality time with family and/or friends, reading novels/poetry, gardening, drawing, writing, journaling, hunting, fishing, camping, and walks on the beach/swimming. Other activities may include, but not limited to, bird watching, outdoor sporting activities, sightseeing, motorcycle riding, traveling on vacation, watching movies, singing, listening to music, dancing, camping, going to the beach, and indoor sporting activities.

How Results Related to the Theoretical Framework

The theoretical basis that undergirded the research project was founded on Harter's (1978) conceptual framework known as the competence motivation theory. Essentially, the theory of competence motivation was founded on a theory of achievement motivation, which is subject to an individual's level of personal competence.

First, the theory of competence motivation broadly postulated that an individual's degree of motivation heightened with each task that was mastered (Harter, 1978; Weiss, & Ferrer Caja, 2002). Therefore, an individual's perceived competence directly influenced their selection, performance, and continuation of activities, task, or occupational duties (Weiss, & Ferrer Caja,

2002). As a serendipitous a ripple effect, it was discovered that when an individual mastered or felt competent in a task or duty, it was more likely that they will develop confidence, and feel encouraged to engage in more duties within that area (Weiss, & Ferrer Caja, 2002).

Likewise, when reviewing the results of this project in relation to the theory of competence motivation, the results concurred with Harter's theory. For instance, the more experienced or trained chaplains reported a greater sense of competence. For instance, of the 10 chaplains that reported additional training, a majority of 7 (70%) reported feeling adequately prepared and competent. Also, the results indicated a strong correlation between chaplains who felt competent and their increased practice of intentional self-care. Of the five chaplains that reported feeling adequately prepared, a significant majority of 4(80%) reported practicing intentional self-care. Subsequently, according to the competence motivational theory, chaplains who were equipped and prepared were more likely to feel encouraged to tackle new and advanced tasks related to geriatric psychiatric patient care (Harter, 1978; Weiss, & Ferrer Caja, 2002).

Additionally, Harter (1978) found that a decreased sense of competence can lead to anxiety, loss of intrinsic rewards, and withdrawal from duties or 'burnout.' Thus, this research's practical guide for geriatric psychiatric chaplains may help to better equip chaplains in this area. Potentially, this guide could prepare chaplains to effectively deal with challenges experienced or perceived unsuccessful visits, thus, lessening the likelihood of them experiencing a decreased sense of competence and the ripple effect of burnout.

How Results Related to the Theological Framework

The theological basis that undergirded this research project was founded on the Holy

Bible's strong endorsement and promotion of competent and excellent work ethics (2 Timothy

3:17 ESV; Ecclesiastes 9:10 NLT). Therefore, Scriptures laid the foundational standard and

measure for this project to ask chaplains to evaluate that "whatever you do, do well"

(Ecclesiastes 9:10, NLT).

The Holy Bible demonstrated that Jesus always prepared and knew his audience; the sick,

the poor; the hapless, the harmless, the arrogant; the haters, the meek, the deceitful, men, women,

and children (John 4, NIV; Luke 7:36-50, NIV; Luke 11:42, NIV; Matthew 18:1-5, NIV). The

results of this project demonstrated a need for chaplains to be more knowledgeable about their

patients, as demonstrated in question 19, which examined what diagnoses chaplains felt

competently trained to handle when ministering to geriatric mental health patients. A total

sample ($N = 26$), with 22 completions, indicated that 9 (40.9%) of chaplains did not feel

competently trained, and there were no selections shown for 20 of the 24 diagnoses listed. This

silence may be interrupted as a lack of competence in training when dealing with these

diagnoses.

Further, Jesus emphasized the value of being prepared in the parable of the ten

bridesmaids who "took their lamps and went out to meet the bridegroom" (Matthew 25: 1, NIV).

Five of them were foolish, and five were wise. The foolish ones took their lamps but did not take

any oil. The wise ones, however, took oil in jars along with their lamps (Matthew 25: 1-4, NIV).

The results of this project reported a majority, 17 (81.0%) of the 21 surveyed chaplains reported

that they did not regularly have adequate time to spiritually prepare. Also, 17 (77.3%) of

chaplains reported that they did not regularly have adequate time to mentally prepare, and a majority of 12 (54.6%) did not regularly have adequate time to clinically prepare. Hence, this research project gleaned from this parable the lesson of preparedness and attempted to aid chaplains in keeping their 'lamps' prepared with 'oil' prior to visits with geriatric patients with mental health disorders.

Also, Jesus taught the value of self-care when he said to disciples, "let's go off by ourselves to a quiet place and rest awhile. He said this because there were so many people coming and going that Jesus and his apostles didn't even have time to eat" (Mark 6: 31, New Living Translation). Likewise, self-care should be an essential element in the life of a healthcare chaplain who is often called to bear the burdens of their patients. However, the results of this project indicated a lack in this area. The results of this project indicated that a majority, 12 (54.5%) of the 22 surveyed chaplains reported they did not practice intentional self-care.

In summation, the Biblical expectation "that the man of God may be competent, equipped for every good work" (2 Timothy 3:19 ESV) and the results that indicated a need in this area, was the basis for the development of this guide to better equip geriatric psychiatric chaplain for ministry. Hence, the guide focused on the need for spiritual, mental, physical, and clinical preparation of geriatric psychiatric chaplain, which is undergirded by the theological teachings established in the Holy Bible.

Implications

What the Researcher Learned

The researcher discovered that a significant majority of chaplains were not trained to handle suicidal prevention according to their employer's protocol. Chaplains that reported

additional training felt more adequately prepared to minister to geriatric mental health patients.

There was a strong correlation between chaplains who felt competent and their increased practice

of intentional self-care. Although all 22 (100%) of chaplains agreed that their level of self-care

significantly contributed to their level of resiliency and effectiveness as a chaplain to geriatric

mental health patients, 12 (54.5%) of the chaplains reported they did not practice intentional self-

care.

How Results Might Apply in Other Settings

Specific training, spiritual, mental, and clinical preparation, ethical competence, on-the-

job tools, and self-care are all transferable data and steps that can be applied to other clinical

settings. These settings include hospice care, palliative care, and pediatric mental health units.

Additionally, the results of this thesis project might apply to research that is geared towards

spirituality and mental healthcare. It will be a valuable resource to advance research.

Also, these results may be applied in academic settings such as Clinical Pastoral

Education (CPE) programs. CPE program developers may use the data and practical guide from

this project to inform and create steps in their curriculum to help fill the gaps in training. The

guide may also be used to promote early preparation for chaplaincy and self-care.

Recommendations and Future Research

One limitation of this project was its generalizability, which was decreased due to the

sampling procedure. The sampling procedure was limited to chaplains within the scope of the

Tristate area of New York, New Jersey, and Connecticut. Therefore, future studies examining the

response of chaplains in other states and even internationally, would increase generalizability

and provide more empirical applicable data for professional chaplains in healthcare settings.

This project also identified possible a threat to the validity of the results since the main measurement instrument was created in the form of a survey questionnaire. Using only a questionnaire limited the study from exploring questions in-depth, open-ended questions, and collecting more qualitative data. Therefore, details, such as the individual chaplain's daily experiences, strengths, and struggles were difficult to examine when using this instrument (survey questionnaire). Hence, it would be beneficial to have further studies that implement a mix-methods approach. Qualitative data could be used in combination with the questionnaire data to build on this project's findings. Lastly, further studies that included a sample size greater than 26 ($n > 26$) would increase this project's findings by adding more statistical power to the existing consistent and statistically significant results.

Summary

This thesis project identified the need for comprehensive chaplaincy training and preparation for competent ministry and care for mental health patients, specifically the geriatric population. The literature revealed that chaplains were lacking in the skillsets and pastoral care practices needed to effectively care for elderly patients with mental health disorders. However, a gap remained in literature regarding the reported level of training and preparedness of chaplains that ministered to geriatric mental health patients within clinical settings, which this project sought to examine.

The data collected indicated a significant majority of chaplains strongly agreed that their seminary and/or divinity school or Clinical Pastoral Education did not provide them with adequate training for ministering specifically to geriatric mental health patients. The majority of chaplains reported they did not regularly have adequate time to spiritually, mentally, and

clinically prepare. Chaplains reported a lack of on-the-job tools and training, such as suicide prevention and reporting, training about self- protection and de-escalation of patients. There was a strong correlation between chaplains who felt competent and their increased practice of intentional self-care. Although all 22 (100%) of chaplains agreed that their level of self-care significantly contributed to their level of resiliency and effectiveness as a chaplain to geriatric mental health patients, 12 (54.5%) of the chaplains reported they did not practice intentional self-care.

The data collected from the chaplains served in the creation of a guide that included ways to help improve this identified ministry challenge and assist geriatric psychiatric chaplains in providing comprehensive delivery of competent care to patients. This hands-on guide addressed fundamental aspects of mental health chaplaincy, such as specific geriatric psychiatric competencies, spiritual, mental, and clinical preparation, ethical competence, using on-the-job tools, and self-care. Ultimately, the project endeavors to better equip chaplains and subsequently lessen their decreased sense of competence, which can lead to anxiety, loss of intrinsic rewards, and withdrawal from duties or 'burnout.' Furthermore, geriatric patients will tangibly benefit from receiving more competent and focused chaplaincy care, which in turn would be favorable for clinical practices as a whole.

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Appendix A: Recruitment Letter

Dear Chaplain,

As a graduate student in the Rawlings School of Divinity at Liberty University, I am conducting research in fulfillment of a Doctor of Ministry degree with a cognate in Pastoral Counseling. The title of my research project is "Mental Health Chaplaincy: A Guide for Geriatric Psychiatric Chaplains." The purpose of my research study is to develop a guide for geriatric psychiatric chaplains that will aid chaplains in ministering to geriatric mental health patients, and I am writing to invite you to participate in my study.

If you meet the criteria listed below and are willing to participate, you will be asked to complete a questionnaire via SurveyMonkey. Criteria to participate are:

1. Must be a professional chaplain who works within a clinical setting such as hospital, hospice, nursing home, skilled care nursing, or Veterans hospital.
2. Must work within the Tristate region (New York, New Jersey or Connecticut).
3. Must have at least one or more pastoral visit(s) with patient(s) over 65-years (geriatric) diagnosed with a mental health disorder.

The questionnaire would involve basic background information and your level of training, preparation (spiritual, mental and clinical), ethical competence, tools and self-care used during pastoral visits with geriatric patients with mental health disorders. The questionnaire will take approximately 10-15 minutes to complete.

Participation will be completely anonymous and no personal identifying information will be collected. Your participation is voluntary and you may withdraw from the study at any time.

To participate, click on the following link provided to complete the questionnaire: https://www.surveymonkey.com/r/KP9M7P2

A consent document is the first page you will see after you click on the survey link. The consent document contains additional information about my research but you do not need to sign it. Please click "next" at the end of the consent information to indicate that you have read the consent information and would like to take part in the questionnaire.

Your participation in this research study will be valuable in providing quantitative data regarding what areas of competency can be improved to provide competent care to geriatric patients with mental health disorders. With your kind and gracious feedback, I endeavor to formulate a practical guide that can be used to equip both trainee and experienced chaplains. I hope that this guide will ultimately become an added tool to help patients, chaplains, hospitals, nursing homes, and training sites.

Sincerely,

Rev. Deena Martinelli, D.MIN. Candidate, M.Div., BCC.
Hospital Chaplain
Eastern Connecticut Hospital Network (ECHN)
Cell:
Email:

Appendix B: Informed Consent

CONSENT FORM

Mental Health Chaplaincy: A Guide for Geriatric Psychiatric Chaplains
Rev. Deena Martinelli, D.MIN. Candidate, M.Div., BCC
Liberty University
Rawlings School of Divinity

You are invited to be in a research study that seeks to develop a guide for Geriatric Psychiatric Chaplains that would identify specific areas of training, preparation (spiritual, mental and clinical), ethical competence, tools and self-care needed when providing care for this population. You were selected as a possible participant because you are 18 years of age or older and a professional chaplain that works in a clinical setting (i.e. hospital, hospice, nursing home, skilled care nursing, or Veterans hospital) within the Tristate region (New York (NY), New Jersey (NJ) or Connecticut (CT) with at least one or more pastoral visit(s) with patient(s) over 65-years of age who are diagnosed with a mental health disorder. Please read this form and ask any questions you may have before agreeing to be in the study.

Deena Martinelli, a doctoral candidate in the Rawlings School of Divinity at Liberty University, is conducting this study.

Background Information: The purpose of this study is to develop a guide for geriatric psychiatric chaplains that will aid chaplains in ministering to geriatric mental health patients. The study will examine specific areas of training, preparation (spiritual, mental and clinical), ethical competence, tools and self-care of chaplains.

Procedure(s): If you agree to be in this study, I would ask you to do the following:

1. Complete an anonymous questionnaire related to your background information, level of training, preparation (spiritual, mental and clinical), ethical competence, tools, and self-care used during pastoral visits with geriatric patients with mental health disorders. This questionnaire will take approximately 10-15 minutes to complete.

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Benefits: Participants should not expect to receive a direct benefit from taking part in this study.

Compensation: Participants will not be compensated for participating in this study.

Confidentiality: The records of this study will be kept private. Research records will be stored securely, and only the researcher and the researcher's faculty chair will have access to the records.

- Data will be stored on a password-locked computer and a locked filing cabinet and may be used in future presentations. After three years, all electronic records will be deleted and hard copy records will be shredded.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time, prior to submitting the survey, without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Contacts and Questions: The researcher conducting this study is Rev. Deena Martinelli. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at ~~deena.martinelli@~~. You may also contact the researcher's faculty chair, Dr. Margaret Gopaul, at ~~███████████~~

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. By clicking on the next page, you are providing your consent to take part in the study and this questionnaire.

Appendix C: Study Instrument Questionnaire

Survey of Training and Preparation Levels of Geriatric Mental Health Chaplains

Screening Questions

1. Are you a professional chaplain working within the Tristate region (NY, NJ, and CT)?
   ☐ YES   ☐ NO

2. Do you work within a clinical setting (i.e. hospital, hospice, nursing home, skilled care nursing, or Veterans hospital?
   ☐ YES   ☐ NO

3. Do you have at least one or more pastoral visit(s) with a patient over 65-years of age who is diagnosed with a mental disorder?
   ☐ YES   ☐ NO

A. Demographics and Background

1. Which gender do you identify with?
   ☐ Male   ☐ Female   ☐ Other_____

2. Which category below includes your age?
   ☐ 18-30   ☐ 31-45   ☐ 46-60   ☐ 61 and over

3. In which Tristate do you currently work?
   ☐ New York   ☐ New Jersey ☐ Connecticut

4. Did you earn a Master's in Divinity (M.Div.) degree?
   ☐ YES   ☐ NO

5. How long have you been a Chaplain?
   ☐ 0-5years   ☐ 6-11 years   ☐ 12-17 years   ☐ 18 years and over

6. In what clinical setting do you currently work?
   ☐ Hospital ☐ Hospice, ☐ Nursing home, ☐ Skilled care nursing, ☐ Veterans hospital

7. How many times <u>per week</u> do you minister to Geriatric mental health patients?
   ☐ By referral only   ☐1-3 times   ☐ Daily   ☐ Full-time Mental Health Chaplain

8. How many Geriatric mental health patients have you ministered to in your career?
   ☐ 1-50 patients   ☐ 51-100 patients   ☐ 101-150 patients   ☐ 151 patients and over

B. Specific Geriatric Mental Health Training

9. Please indicate how much you agree or disagree with the following statement:
My training in Seminary and/or Divinity School alone <u>DID NOT</u> provide <u>adequate</u> training for ministering specifically to Geriatric mental health patients.

   1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

10. Did your Internship and/or Residency in Clinical Pastoral Education provide training for ministering specifically to Geriatric mental health patients?
    ☐ **YES**   ☐ **NO**

11. <u>If you answered YES to the previous question.</u>
What type of training did you receive to minister to Geriatric mental health patients?
☐ Didactics on ministering to Geriatric mental health patients
☐ Reviewed psychiatric assessments and diagnoses
☐ Shadowed Geriatric Psychiatric Chaplain
☐ Assigned as an Intern/Resident Chaplain on the Geriatric Psychiatric unit/floor
☐ Other_____

12. Do you have additional training in psychology, mental health, or counseling?
    ☐ **YES**   ☐ **NO**

13. **<u>If yes</u>**, what additional training in psychology, mental health or counseling have you completed?
☐ Additional degree in psychology, mental health or counseling
☐ Additional classes or courses in psychology, mental health or counseling
☐ Didactics on counseling Geriatric mental health patients
☐ Continuing Educating (CEUs) on Geriatric mental health patients
☐ Read scholarly books/articles on counseling Geriatric mental health patients
☐ Attended training/seminars/webinars on counseling Geriatric mental health patients
☐ Other _____
☐ Not applicable

14. Please indicate how much you agree or disagree with the following delivery of care statements:
I feel <u>adequately prepared</u> to develop and implement a plan of care to promote the well-being and continuity of care for Geriatric mental health patients.

   1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

15. I feel <u>adequately prepared</u> to gather and evaluate relevant data pertinent to the Geriatric mental health patients' situation and bio/psycho-social-spiritual/religious health.

   1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

16. Which of the following <u>diagnoses or situations</u> do you feel competently trained to handle when ministering to Geriatric mental health patients? (Choose all that apply).

☐ Depression	☐ Cognitive impairments (Dementia, delirium)
☐ Anxiety	☐ Co-occurring disorders
☐ Obsessive-Compulsive Disorder	☐ Catatonia
☐ Post-Traumatic Stress Disorder	☐ Echolalia
☐ Bipolar Disorder	☐ Aphasia (speech problems)
☐ Borderline Personality Disorder	☐ Hearing impairment/decline
☐ Eating Disorder	☐ Suicidal Ideation
☐ Brief Psychotic Disorder	☐ Transference
☐ Schizophrenia	☐ Counter-transference
☐ Schizoaffective Disorder	☐ Trauma Response
☐ Schizotypal personality disorder	☐ Agitations, Physical and Verbal Aggression
☐ Delusional Disorder	☐ None of the above
☐ Substance-induced Psychosis	☐ All of the above

C. **Spiritual and Mental Preparation**

17. Prior to visiting Geriatric mental health patients, do you <u>regularly have adequate time</u> to **spiritually** prepare?
   ☐ **YES**   ☐ **NO**

18. **<u>If yes,</u>** which of the following do you do?
   ☐ Pray
   ☐ Meditate
   ☐ Read the Bible or Religious Book
   ☐ Meet with other Chaplains
   ☐ Personal or group devotional
   ☐ Other_____
   ☐ Not applicable

19. Prior to visiting Geriatric mental health patients, do you <u>regularly have adequate time</u> to **mentally** prepare?

□ **YES**   □ **NO**

20. **If yes,** which of the following do you do?
   □ Self-evaluation of current mental status
   □ Practice positive thinking
   □ Deep breathing
   □ Imagery
   □ Listen to music
   □ Self-talk
   □ Other_____
   □ Not applicable

D. **Clinical Preparation**

21. Prior visiting to Geriatric mental health patients, do you regularly have time to **clinically** prepare?
   □ **YES**   □ **NO**

22. **If yes,** which of the following do you do?
   □ Refresh knowledge about patient's diagnosis, religious status and preferences
   □ Contemplate different interventions based on diagnosis
   □ Consult with the staff about the patient (MD, nurse, LPC, Social Worker)
   □ Review the patient's chart
   □ Self-evaluation of clinical competence
   □ Other_____
   □ No time to prepare

E. **Ethical Competence**

23. Did you receive any training from your employer on Mandated Reporting?
   □ **YES**   □ **NO**

24. If **YES**, please indicate how much you agree or disagree with the following statement:

   I feel knowledgeable and competent to handle ethical issues related to Mandated Reporting cases.
   1.   Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

   □ Not applicable

25. Are you trained in Advanced Care Planning and end of life decisions?
   □ **YES**   □ **NO**

26. If **YES**, please indicate how much you agree or disagree with the following statement:

   I feel competent in assisting with end of life decisions related to Geriatric mental health patients.
   1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

   □ Not applicable

27. Did you receive training from your employer about collaborating with staff about the advocacy of Geriatric mental health patients and families or participate in regular interdisciplinary team meetings?
   □ **YES**   □ **NO**

28. If **YES**, please indicate how much you agree or disagree with the following statement:
   I feel competent advocating for Geriatric mental health patients and their families.
   1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

   □ Not applicable

F. **On The Job Tools**

29. Did you receive on the job training about self- protection and de-escalation of patients?
   □ **YES**   □ **NO**

30. Do you have access to Counselors or Social workers for crisis event debriefing?
   □ **YES**   □ **NO**

31. Were you trained to handle suicidal prevention according to your employer's protocol?
   □ **YES**   □ **NO**

G. **Self-care**

32. Do you practice intentional self-care?
   □ **YES**   □ **NO**

33. If **yes,** after ministering to Geriatric mental health patients, do you <u>regularly</u> participate in any of the following debriefing sessions?
   □ With patient's Doctor
   □ With patient's Nurse
   □ With patient's Social Worker
   □ With patient's LPC/Counselor
   □ With patient's Aide

☐ With another Chaplain/Minister
☐ No time to debrief
☐ Not applicable

34. If **yes**, which of the following hobbies or other interests do you engage as part of your self-care? (Choose all that apply).

☐ Praying	☐ Bird watching.
☐ Meditating	☐ Outdoor sporting activities.
☐ Seeking solitude time	☐ Sightseeing
☐ Spending quality time with family and/or friends.	☐ Motorcycle riding
☐ Reading novels/poetry	☐ Traveling on vacation
☐ Gardening	☐ Watching movies
☐ Drawing	☐ Singing
☐ Writing	☐ Listening to music
☐ Journaling	☐ Camping
☐ Hunting	☐ Going to the beach
☐ Fishing	☐ Indoor sporting activities
☐ Camping	☐ Other
☐ Walks on the beach/swimming	
☐ Not applicable	

35. How many <u>minutes/hours per week</u> do you spend in prayer, meditation and/or personal devotional?
☐ 0 to 15 minutes
☐ 16 to 30 minutes
☐ 31 minutes to under 1 hour
☐ 1 to 2 hours
☐ 3 to 4 hours
☐ 5 to 6 hours
☐ 7 to 9 hours
☐ 10 hours or more

36. Please indicate how much you agree or disagree with the following statement:

My level of self-care as described above, significantly contributes to my level of resiliency and effectiveness as a chaplain to Geriatric mental health patients.

1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree

Appendix D: Proof of APC Membership

ASSOCIATION OF PROFESSIONAL
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Healing through Spiritual Care

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Home > My Profile

Print Page | Facebook

My Profile

Personal Profile Information

Welcome Deena!
Your Membership Expires: 10/31/2020

Points of Contact

Please review the information in your profile and update as needed.

Under "Profile Contact Information," please enter the address at which you would like APC to send communications.

- Using the Address Type pull-down menu, indicate whether the address is Work or Home
- Use postal abbreviations (e.g. Ave. St.)
- Include a daytime phone number.

The "Additional Location Information" section at the bottom of the page has fields for your home or alternate contact information. Please complete these fields so that we can reach you even if your primary contact address and phone change.

Please click on the "My Organization" menu option on the right to update your work information.

If you would like a receipt for an invoice or payment, go to the "My Invoices" menu option on the right. Once your payment has been processed, your invoice will be marked "paid."

Be sure to click "Save Changes" at the bottom of the page.

Prefix:	Rev. ▾
First Name:*	Deena
Middle Name:	Anne
Last Name:*	Martinelli
Suffix:	
Member Type:	Board Certified Chaplain
Member ID	60106
Affilation Date:	5/6/2015
Expiration Date:	10/31/2020

My Profile

My Organization

Bookmarks

Members Only Pages

My Groups

Register for Events

Online Directory

My Continuing Education

My Job Listings

Discussion Forum

Home Page

Account Details

My Directory Options

My Invoices

My BCCI Certification

Logout

ASSOCIATION OF PROFESSIONAL

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Home > My BCCI Certification

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My BCCI Certification

Maintenance of Certification Status

Deena Martinelli

BCCI Certification Expiration Date:	10/31/2020
Certification Type:	Board Certified Chaplain
Specialty Certification Type:	

Most Recent Continuing Education Report	2019
Quinquennial Maintenance of Certification Years	2021 and 2026
Quinquennial Maintenance of Certification Complete Date	
Quinquennial Maintenance of Certification Peer Review	

Board of Chaplaincy Certification Inc.

Welcome Deena!
Your Membership Expires: 10/31/2020

Points of Contact

My Profile

My Organization

Bookmarks

Members Only Pages

My Groups

Register for Events

Online Directory

My Continuing Education

My Job Listings

Discussion Forum

Home Page

Account Details

My Invoices

My BCCI Certification

Logout

LAKE

Appendix E: APC Directory Permission

M Gmail   Deena Martinelli ◄▬▬▬▬▬▬▬►

Permission to Access Member Directories

3 messages

Deena Martinelli ▬▬▬▬▬▬▬▬▬   Fri, Jan 31, 2020 at 3:41 PM
To: ▬▬▬▬▬▬▬▬▬▬▬

Dear Kyle,

This is Rev. Deena Martinelli (Member # 60106). Thank you kindly for speaking with me today (1/31/20). As we discussed, I'm writing about the permission granted via our phone conversation to use the APC directory to access my fellow chaplains with a research questionnaire. Thank you again for your permission to do so and the clarification that the members listed have given permission for purposes like this.

Thank you for taking the time to clarify this and your approval.

Sincerely,

Rev. Deena Martinelli, M.Div, M.A. BCC
▬▬▬▬▬▬▬▬▬

Member # 60106

--
Rev. Deena Martinelli, M.A., M.Div., BCC.

Kyle Christiansen ◄▬▬▬▬▬▬▬▬▬►   Fri, Jan 31, 2020 at 3:50 PM
To: Deena Martinelli ◄▬▬▬▬▬▬▬►

Hello Deena,

Thank you for your question. First let me ask that you do not promote your questionnaire as an APC Sponsored or directed survey.

Secondly please do not send your survey to all of the membership, but instead like you mentioned over the phone a small group of members (lets say less than 100).

The member directory is an Opt-in option for members. Members that are in the directory have given their permission to be listed, therefore it is appropriate to use this tool to connect with other APC members and share your work with them. If you receive feedback from a member that asks not to have emails sent to them we ask that you respect that and let them know that they can opt out of being listed in the directory by contact the APC office.

Thank you for your inquiry.

Regards,

Kyle

Kyle Christiansen, MA

Membership and Marketing Manager

Association of Professional Chaplains®

████████████████████

████████████████

Tel: ██████████   Direct: ████████

Fax: ████████
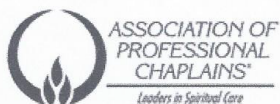
████████████████████

████████████████

Save the Date!

20/20 Vision:
The Future of Spiritual Care

May 11-14, 2020

Cleveland, Ohio

Registration opens early January 2020

ASSOCIATION OF
PROFESSIONAL
CHAPLAINS®
Leaders in Spiritual Care

[Quoted text hidden]

Deena Martinelli <██████████████████   Fri, Jan 31, 2020 at 4:00 PM
To: Kyle Christiansen <████████████████████

Hello Kyle,

Thank you for your prompt reply, approval and further clarification.
1. Yes, the survey will NOT be promoted as an APC Sponsored or directed survey.
2. I will NOT be sending the survey to ALL the members. It will definitely be less than 50 selected individuals.
3. Yes, if I receive feedback from a member that asks not to have emails sent to them, I will do as you stated and respect that and let them know that they can opt out of being listed in the directory by contacting the APC office.

Sincerely,

Rev. Deena Martinelli, M.Div, M.A. BCC

Member # 60106

[Quoted text hidden]
[Quoted text hidden]

Appendix F: IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

January 31, 2020

Deena A. Martinelli
IRB Exemption 4193.013120: Mental Health Chaplaincy: A Guide for Geriatric Psychiatric
Chaplains

Dear Deena A. Martinelli,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under exemption category 46.101(b)(2), which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:101(b):

> (2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
>
> > (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

Please note that this exemption only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued exemption status. You may report these changes by submitting a change in protocol form or a new application to the IRB and referencing the above IRB Exemption number.

If you have any questions about this exemption or need assistance in determining whether possible changes to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

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UNIVERSITY.
Liberty University | Training Champions for Christ since 1971