Multifaith Hospital Chaplains and Prayer at the Patient's Bedside: Exploration of a Multifaith Prayer Resource for Chaplain Support

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Statement of Need

How can a multifaith prayer resource best support a multifaith hospital chaplain in caring for/being with the other (patient, family, client, colleague)?

To become a board-certified chaplain (BCC), the chaplain is required to have a current endorsement in accordance with the applicant's spiritual/faith tradition. Coming from a faith community allows a chaplain to immerse and become familiar with ritual, prayer, and scripture of that particular faith and house of worship. However, working in a clinical setting, a chaplain is introduced to and supports patients, families, and staff of diverse faiths, cultures, beliefs, and backgrounds.

Spontaneous prayer has long been the standard for clinical chaplains to offer inclusive, personal prayer to our population, allowing chaplains to be present with and meet the patient and or family where they are. For a multifaith chaplain, there are times when they are called to visit with and/or perform a prayer and or ritual with a patient and or family that is not in their faith tradition.

For staff chaplains and chaplain residents/interns in clinical settings (hospitals, hospices, clinics, nursing homes) prayer is frequently the culmination of, and often the very reason for, spiritual care visits with patients, families, and staff, emotionally touching the heart of what needs healing most. Chaplain staff are also often requested to provide a faith-based ritual at bedside with patient, family, friends, and clinical staff present. Chaplain staff are less likely to pray with nonconcordant patients than those of their own faith, according to Silton et.al. (2012).

When pastoral support is requested for bedside ritual for patients about to be extubated, imminently dying, postdeath, preoperative, asking for confession, etc., a lack of understanding of the patient's religion can pose a challenge to chaplains in presenting an effective or appropriate faith-focused intervention that can better support patient and or family.

The topic of this study has been with me a decade. As a hospital volunteer in 2010, before starting my Clinical Pastoral Education (CPE) in 2013, I wondered why there wasn't a multifaith prayer and ritual book to support multifaith chaplains in caring for their multifaith patient and family population. I was raised in a secular Jewish family. In my 40's I became a Tibetan Buddhist practitioner. Hence, when I began my hospital chaplaincy training, I was initially challenged because of my lack of familiarity with rituals and prayers when dealing with Christians. When a Christian family requested to pray The Lord's Prayer at bedside, I felt unsure because of my lack of familiarity. While the patient and family appeared to have warmly received me and were grateful for spontaneous prayer, often they requested the Lord's Prayer. I was left with the impression that the Lord's Prayer had been most meaningful for them in connecting with a Higher Power, God. I soon memorized the Lord's Prayer to better support patients and their family.

In the past year, two cases emerged on the Palliative Care Unit (PCU) of my major New York City hospital. The dying patients' families requested end-of-life (EOL) ritual and had no access to their clergy person: one patient and family were Episcopal; the other patient and family, Zen Buddhist. An Episcopalian chaplain was located within the Spiritual Care Department of the hospital and performed an EOL ritual for the grateful patient and family. The request from the Buddhist family's EOL forgiveness ritual fell to a chaplain on the PCU who was not Buddhist. The chaplain, not familiar with Buddhism, discussed this request with her

supervisor, who had familiarity with its various traditions. After hearing from this family that they were Zen Buddhists, an appropriate EOL ritual was organized. The family acknowledged the importance of it being specifically Zen and how it supported their grieving process. The chaplain involved felt less stressed and confident once she knew the EOL ritual was appropriate.

Another chaplain, from the Jewish faith, said she only offers spontaneous prayer. In a joint visit with a Catholic patient, after spontaneous prayer was facilitated, the Lord's Prayer was offered. The patient was able to join in the prayer and instantly became tearful. After asking the patient what her tears were about, perhaps feeling safer and more connected, she expressed her fear of dying, giving us an opportunity to explore her beliefs further. At the end of this visit, the other chaplain wondered out loud if she "should learn the Lord's Prayer," because she too felt a deepened relationship with the patient (and maybe God).

In the beginning of my research for this paper the Director of the Spiritual Care and Education Department informed me of the website chaplainonhand.org that contains a multifaith prayer page with translations, but no religious rituals. I acknowledged that that this was the first time I had ever heard of it and wondered if many experienced chaplains are unfamiliar with it because it's not a designated website just for prayer and just for chaplains.

In this paper, I plan to study the multifaith hospital chaplain's relationship to prayer at the bedside of their multifaith (concordant and discordant) population (patient and their families), a portion who are non-English speaking, and if they determine a multifaith prayer resource (designated app, website, book) would be supportive.

Literary Review

Although chaplains historically ministered to people from their own religion (Cadge, 2013), today they increasingly work in interfaith settings with patients and families from diverse religious and spiritual backgrounds. Some navigate between their own religious backgrounds and those of the individuals with whom they work easily. Others are challenged as their status as a person of faith comes into conflict with their status as an interfaith chaplain (Cadge & Sigalow, 2013).

The need to pray is a patient's most significant spiritual need. "Many patients said that even if they could not do anything else, they could pray" (Hermann, 2007, p. 17). Others believed they couldn't cope with their illness if they couldn't pray. Patients reported praying for relief from pain, forgiveness of sins, courage, a peaceful death, and the well-being of loved ones (Hermann, 2007).

According to a 2008 study, prayer was the most commonly used intervention by hospital chaplains with all patient groups. Prayers and blessings were the most frequent interventions with patients who were dying or at the end stage of a disease. The facilitation of religious rites and rituals were very rare, except during visitations with dying patients (Handzo et al., 2008).

This literature did not distinguish spontaneous from fixed prayer. For many multifaith chaplains and the faith traditions from which they minister, spontaneous versus fixed prayer are two very separate activities. From my experience, some ministers and chaplains will only do one or the other, or at least will emphasize one over the other.

With spontaneous, or customized prayer, ideally words pour openly from the heart in response to our life's events and or crises. These prayers, whether spoken or quiet, are an authentic expression of the pain or joy felt in a particular moment, and their strength lies within it

being shared in that moment (Green, 2003).

> The second sort of prayer is liturgical or fixed prayer . . . assigned words to be spoken regularly at certain times in the day, week, or year. These prayers evoke powerful responses in us precisely because of their familiarity. To recite them regularly is to develop an attachment to their poetic phrases, their melodies, and the various meanings we link with them. Each time we recite them, all of our memories of the many other times we said them, along with the recall of prior generations who spoke these same prayers are with us. This well of memory creates a deep echo-chamber, lending a richness and a profundity to the words of prayer. (Green, 2003, pp. 153–154)

In their 2010 study, Galek et al. reported that chaplains displayed a statistically meaningful higher rate of prayer with patients from their own religion than they did with patients of other religions. Protestant chaplains prayed with Protestant patients 50% more than with patients of other religions; Catholic chaplains prayed with Catholic patients 20% more. Jewish chaplains were also prone to pray with Jewish patients than with other patients. This study, however, does not focus on the use of fixed and or spontaneous prayer in chaplain visits.

Abu-Ras and Laird's 2011 study stated chaplaincy is typically practiced through traditional Jewish and Christian lenses, with little response paid to the impact of the Islamic view of nursing and caring. Therefore, many Muslim patients might not receive proper religious and spiritual care, especially as they relate to daily religious devotionals, medical ethics, and end-of-life goals.

Their study supports the argument that there is a lack of attention to the spiritual needs of Muslims compared with those of Christians and Jewish patients. Emerging from their data is an implicit bias and discrimination toward Muslim patients. "Christian chaplains were more likely

than their Jewish counterparts to report praying with or for a Muslim patient" (Abu-Ras & Laird, 2011, p. 9).

Social identity theory asserts that individuals have multiple social identities derived from perceived group memberships (Stets & Burke, 2000). The self-categorization of chaplains and patients as members of the same faith group may influence their in-group ties and preferences. The especially elevated proportion of prayer of Episcopal, Lutheran, and Presbyterian chaplains with patients of their own religion shows that these chaplains and patients have a significant social identity with their own faith groups (Galek et al., 2010).

Similarly, Evenson et al. (1993) recognized prayer as an essential part of a chaplain's visit since it reestablishes or intensifies ties to faith traditions. "Religious practices can help to relax, distract, and counteract the effects of loneliness and isolation that is so prevalent among patients" (Kalkhoran & Karimollahi, 2007, p. 6).

Kohut's Self Psychology helps us understand some of the chaplain's intrapersonal contributions to developing secondary traumatic stress (STS) symptoms in response to therapeutic work. Overfunctioning is a common trait of chaplains, who often repeat their childhood patterns in an unconscious pursuit to regulate their own sense of self. Unfortunately, this pattern can leave the chaplain vulnerable to occupational stress syndromes such as burnout and STS. Moreover, Self Psychology illuminates how one's sense of self is stabilized though feeling a sense of worth by helping others (Galek et al., 2011). This paper questions if a chaplain may feel deficient or may add to STS when presented with praying with a patient and/or family not of the chaplain's own faith, and thereby not offer prayer intervention.

Poloma and Gallup (1991) identified four major American prayer styles: ritual prayer, conversational prayer, petitionary prayer, and contemplative or meditative prayer. As per their

article, ritual prayer is the reciting of prayers contained in fixed liturgy. In conversational prayer, patients and/or family use their own words to speak with God, asking for forgiveness and seeking direction. With petitionary prayer, patients ask for something specific, for example, healing or recovery. Finally, in contemplative or meditative prayer, the patient is still, in quiet, experiencing the sacred.

The focus of this research will be on the multifaith hospital chaplain's relationship to fixed prayer and spontaneous prayer with patient and family. Multifaith hospital chaplains' lack of fluency in another faith that might lead to feelings of discomfort and inauthenticity. How do we best care for patients and families who do not adhere to the same religion as ours (Schipani & Bueckert, 2009)? "Or to those who adhere to more than one tradition? Or to those who have no formal affiliation but live their own idiosyncratic configuration of religious beliefs, experiences, and behaviors?" (Ganzevoort et al., 2014, p. 179).

Clinical Review

The forthcoming material elucidates Bion, Winnicott, and Jung's expression of their experience of ultimate reality, wholeness, and perhaps God, from their psychological, secular lens. In doing so, along with Bowlby's and Ainsworth's studies on Attachment and Schore's Right Brain Affect Regulation, we can explore how these concepts interface with chaplaincy, patient, and prayer. How might the findings from each of the theorists presented in this Clinical Review relate to the prayer experience?

Psycho-Spiritual

Viewed from within the depth psychological perspective, each person has their individual experience of God. The psychotherapist interested in practicing with a religious receptivity is primarily interested in the God of direct experience. "The divine is indistinguishable from Mind or Consciousness itself" (Corbett, 1996, p. 2). Processing emotional distress is no longer an exclusively secular affair; an experience of the divine may be located *within* one's psychopathology (Corbett, 1996).

Each religion has a different view of divinity.

> There is no single, agreed-upon God, only different experiences and concepts of God or of ultimate reality. . . . The psyche itself is universal. . . . The divine as Mind structures the world as we know it, and spirit is actually synonymous with transpersonal 23 levels of the psyche—we use the word 'psychological' rather than 'spiritual' when we think we understand what is happening. (Corbett, 1996, p. 3)

Bion: Faith in O

Bion utilizes the sign, O, to denote ultimate reality (the absolute truth, the godhead, the infinite, wholeness—the thing-in-itself).

> O stands for the absolute truth in and of any object; it is assumed that this cannot be known by any human being; it can be known about, its presence can be recognized and felt, but it cannot be known. It is possible to be at one with it. That it exists is an essential postulate of science but it cannot be scientifically discovered. No psycho-analytic discovery is possible without recognition of its existence, at-one-ment with it and evolution. (Eigen, 1993, pp. 123–125)

Bion further asserts that for the psychologist, the O (ultimate reality) of psychoanalytical experience is what might be expressed as the emotional truth of a session. This can also be reflected in the chaplain's visit. When a chaplain supports a patient, crucial to their care is to create a sacred space for the godhead, for the infinite, for wholeness to emerge, so we can discover the ultimate truth, essence, O, and allow for healing.

> O does not fall in the domain of knowledge or learning save incidentally; it can "become," but it cannot be "known." It is darkness and formlessness but it enters the domain K (knowledge) when it has evolved to a point where it can be known, through knowledge gained by experience, and formulated in terms derived from sensuous experience; its existence is conjectured phenomenologically. (Bion, 1977, p. 66)

This can happen organically with chaplain and patient through spiritual witnessing and/or processing. Very often it emerges with prayer that is liturgical or fixed, or customized. As prayer somehow creates a bridge from knowing to being.

Bion views faith not only as a condition that makes psychoanalysis possible but as the latter's chief organizing core. As in chaplaincy, he systematically distinguishes between faith and knowledge, and between being and knowing. For us, the being of knowing and knowing of being are inextricably intertwined. Yet, we are not in the same qualitative space when we focus on

knowing rather than focus on who we really are by *being* (Eigen, 1993).

According to Bion, we live with the faith that emotional truth is possible, even necessary, as a source of healing. As chaplains, we understand that nothing can be more important than learning to attend to the emotional and spiritual truth of patients by *meeting them where they are* in their illness, emotional, and life trajectories. When we reach out toward the unknowable, our faith that something important happens clears a safe and sacred space for truth. Our intention to be in relationship with the emotional reality that is present makes a difference in how both patient and chaplain come to feel about themselves. For better or worse, those who open to being in connection cannot be the same, in the long run, as those who do not (Eigen, 1993).

Our goal in faith is to connect with what is beyond our portrayals and images. In prayer, we can use those representations to illuminate the mystery of who we are. We live our lives in such a way that being and knowing can coexist. Prayer can help us develop a critical trust in possible points of intersection, if intersection is possible. Communion with O is a journey of the heart and mind, not something that can be taught and taken for granted (Eigen, 1993).

Even when the caregiver is a good container (Bion, 1962), their vision can be unclear (Bion, 1977). For example, thoughts or feelings that a baby cannot process are emptied into its mother, who contains and detoxifies them by her own mental functions (memory and reverie) and feeds the baby usable responses. More generally, the mind as container is more concerned with regulating the balance of pleasure and pain than with emotional truth. Ideally, the individual grows in their ability to contain and successfully embody their painful states along with their wish to feel good (Eigen, 1993). This, of course, relates to the chaplain's awareness of self and other, and their ability to process and understand the difference between being and knowing. Through presence and active listening, the chaplain can support patients and others in containing

their anxiety and being with their experience.

For Bion, the subject's expression of emotional truth is not limited to language. "Its evolving quality spreads out in all temporal directions. We open ourselves to meet it" (Eigen, 1993, p. 131). As mentioned earlier, prayer, fixed or not, can be a source or a bridge depending on the patient's and the chaplain's relationship with it and each other. Prayer can be a support and/or an expression of faith that allows for the transcendence of knowing toward being O.

In a case study: Patient A, a fifty-five-year-old male with end stage multiple myeloma, asked for this chaplain's presence at bedside. He and this chaplain gently held hands as a Buddhist purification mantra was chanted and we both simply relaxed our bodies and mental gripping and released into just being. Patient A knew he was dying and had no words for his experience, only deep gratitude. It was his practice, through prayer, to simply be led to be with his dying.

If we are to develop as whole persons, the actual truth of our emotional realities must evolve. This state of affairs may be expressed by one of Bion's pithiest instructions: "One cannot know O, one must be it" (Bion, 1977, p. 27).

Winnicott: Faith in the True Self

Winnicott's True Self, similar to Bion's O, was meant as a lived experience, but it also functions as a core principle of personal development (Eigen, 1993). Winnicott believes that the True Self is in some sense absolutely private. Perhaps not only is it unreachable, it may also be ungraspable, as well. This ungraspable completeness may not be foreign to chaplains and patients who have an awareness of being vulnerable, open, and transparent. And through their faith practice and prayer, they open themselves, allowing True Self to emerge.

For Winnicott, the True Self feeling is fundamentally defenseless; it is most basically

unprotected and described by the feeling of genuine wholeness. Both he and Bion connect genuine wholling processes with trueness. They are asking us to give up everything (we have or know) for ultimate freedom. Perhaps by not having an agenda or a fixation, the chaplain can trust enough, have faith enough, and provide a good enough holding environment for the emergence of True Self.

Winnicott compares a basic True Self with a False Self, the latter being a self-protective personality distortion or construct. The True Self feeling involves a sense of all-out personal aliveness, more than simple animal aliveness, because it includes an awareness of being or feeling real (Eigen, 1993). Similar to Bion's O, it thus requires a lived acknowledgement of being the self one is, and this felt presence is one's true being.

For Winnicott, life requires violence or disturbance (hatching processes). However, he believes that in human life, most desirably, this occurs within a predominance of love. In his account of the use of the object, we see that "an *I love you* spontaneously arises in the wake of the *I destroy you*, and this *I love you* makes destructiveness creative" (Eigen, 1993, p.128). This experience can be present as patients awaken to their truth after a distressing diagnosis of illness or a heartbreaking prognosis that time is short. As chaplains create a sacred and safe space, a good-enough holding environment, embracing a field of love-destruction, fixed and/or customized prayer, depending on their and the patient's histories, can support personal growth and truths for both having faith in Winnicott's True Self.

Jung: Faith in Self

For Jung, the idea of God is all-pervading (Jung, 1966a, p.110). Confirmation that there is an "extrapsychic" presence or cosmic sanctity is a given. 'God' is a psychological fact and the psyche is real (Jung, 1938, para. 751). This attitude is an echo of William James's (1902/1958)

remark that God is real since he produces real effects. The Self "might equally be called the 'God within us.' The beginnings of our whole psychic life seem to be inextricably be rooted in this point, and all our highest and ultimate purposes seem to be striving towards it" (Jung, 1934a, para. 399).

> There is another, whom we do not know. He speaks to us in dreams and tells us how differently he sees us from the way we see ourselves. When, therefore, we find ourselves in a difficult situation to which there is no solution, he can sometimes kindle, a light that radically alters our attitude. (Jung 1933a, p. 153)

Jung called "the total personality which, though present, cannot be fully known, the Self" (1959a, p.5). His "idea is that there exists an *a priori* intrapsychic image of God, which he calls the Self, reflects an old intuition that something transcendent and eternal, an essence which is distinct from the everyday personality, exists at the core of the person" (Corbett, 1996, p.39).

Jung brings the Self into the field of applied psychology, establishing its varying impacts in both normal development and psychopathology. "The Self is also thought of as the unknowable totality of consciousness itself, which at times represents aspects of itself as one of an infinite number of possible images, none of which is the Self itself" (Corbett, 1996, p. 40). "Wholeness [the Self] is thus an objective factor that confronts the subject independently of him . . . so wholeness lays claim to a position and a value superior to those of the syzygy" (Jung, 1959a, p. 31).

With this understanding, the Self serves as a prototype for the evolution or development of the subjective experience of being, or acquiring, a personal self (Corbett,1996). The personal self relatively exists in time and is a function of remembering and education, incorporated within a body representing its physical properties. "The self-concept is based on a series of affectively

important experiences and events which are felt to be joined together into the sense of 'I'" (Corbett, 1996, p. 40). Seemingly, occurrences happen to the developing self by design. It is as though the self's life's external experiences correspond to an internal proclivity decided by the Self. "Or, simply stated, the Self is the archetypal underpinning of the self. Jung refers to the Self as the 'principle by which man is shaped'" (Corbett, 1996, p. 40).

> Jung's model of the psyche allows it to have a sacred understanding to coexist and be in relationship with nature, in which the divine or ultimate reality is intrinsically experienced as by virtue of the Self. When we experience the spiritual, what is beyond words, the numinous, we're not 'projecting' outside our selves onto nature; we are experiencing the reality of the continuity of the Self across the barrier of the skin. The structure of the self, which includes both our psychology and physiology, is determined by the same archetypal or spiritual dynamics as those which obtain in nature at large. (Corbett, 1996, p. 106)

The Self is expressed in dreams, fairy tales, and myths as someone who is superior: a hero, a prophet, a savior, royalty. As symbol of the totality, of wholeness, it appears as a circle, a square, a cross, a quadrangle of the circle or mandala. It is the One (God) within us. Perhaps, prayer can serve as a sacred bridge from self to Self, from knowing to being.

O, True Self, Self

Similar to Bion's O and Winnicott's True Self, Jung's Self is an expression of wholeness and totality. The realization of the Self, O, True Self is the ultimate goal of the individuation or the wholling process.

The writings of three psychotherapists generate meaning which reflects or brings the subject into unity with the truth about themselves. This hunger for emotional truth is often in

conflict with the ego. The wholling process expressed here is not primarily based on mastery or control, although alertness is key. It evolves fundamentally through faith in a spontaneous play of experiencing and meaning which aims to express and unfold what is most real for the subject, their emotional truth, or the subject's authenticity (Eigen, 1993). The sacred space established between chaplain and patient allows for liminality and a surrendering of the self. This spontaneous play is an aspect of prayer and our taking the risk of exposing ourselves to ultimate change (Ulanov & Ulanov, 1988).

Being in Relationship

"The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed" (Jung, 1933b, p. 49). Being in relationship is at the essence of prayer. It's also the foundation of the chaplain and patient cocreation of a sacred and safe space, holding environment. In both situations, there is an intention to dyad, between human and a divine source and/or between human and human. Each human embodies their individual psychosocial-spiritual history. Therefore, it would be beneficial to explore, through the lenses of Jung, Winnicott, Bowlby, and Ainsworth, both patient's and chaplain's relationship to prayer, themselves, and each other.

Jungian Archetypes

> The concept of the archetype . . . is derived from the repeated observation that, for instance, the myths and fairytales of world literature contain definite motifs which crop up everywhere. We meet these same motifs in the fantasies, dreams, deliria, and delusions of individuals living today. These typical images and associations are what I call archetypal ideas. The more vivid they are, the more they will be coloured by particularly strong feeling-tones. . . . They impress, influence, and fascinate us. They

> have their origin in the archetype, which in itself is an irrepresentable, unconscious, pre-existent form that seems to be part of the inherited structure of the psyche and can therefore manifest itself spontaneously anywhere, at any time. Because of its instinctual nature, the archetype underlies the feeling-toned complexes [*q.v.*] and shares their autonomy. (Jung, 1961, para. 847)

Jung professed that archetypes exist in the collective unconscious. Archetypes organize our experience. He proposed that these representations are ubiquitous, innate, and recurring.

> Primordial images . . . which are inborn in him from the earliest times, eternally living, outlasting all generations, still make up the groundwork of the human psyche. It is only possible to live the fullest life when we are in harmony with these symbols; wisdom is a return to them. (Jung, 1933a, para. 794)

Depending on the self-awareness of the chaplain, they may be cognizant that their personality and identity can be expressed by its embodied archetype. Jung felt that most people's personalities were governed by one particular archetype. An archetype is expressed through an individual's cultural influences and unique personal experiences. We explore the Wounded Healer, the Persona, and the Shadow archetypes in the following paragraphs.

The Wounded Healer

Each archetype has a spectrum of attributes that includes their light and shadow parts. The Wounded Healer may archetypically symbolize the chaplain. One of Jung's closest colleagues, Marie Louise von Franz is believed to have said, the wounded healer is one of the archetypes of the Self [our wholeness, the God within] with risks of aggrandizement and splitting.

The Wounded Healer comes from the Greek myth of Chiron, a demigod, who was wounded by Heracles with an arrow tipped with venom. Though he was immortal, he now would

suffer from an incurable wound for all eternity. This wound propelled Chiron to help wounded others. But he suffered from a deeper wound. He was rejected by his mother for being half horse and was raised and taught by Apollo, the God of Healing and Light. After a lifetime of healing those who are suffering, Chiron eventually heals and frees himself by exchanging his immortality for death by becoming human.

"The process of individuation," as per von Franz, "generally begins with a wounding of the personality and the suffering that accompanies it. This initial shock amounts to a sort of 'call,' although it is not often recognized as such" (1964, p.166).

> As Jung wrote, Freud himself accepted my suggestion that every doctor should submit to a training analysis before interesting himself in the unconscious of his patients for therapeutic purposes. . . . We could say, without too much exaggeration, that a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient. This, and nothing else, is the meaning of the Greek myth of the wounded physician. (Jung, 1946/1966b, pp. 115–116)

The same can be said of chaplains who are at the bedside of patients. The wounded *chaplain* needs to examine their wounds to provide the depth of care necessary for a healing or therapeutic relationship with patient, family member, or hospital staff. Understanding that "failures . . . are priceless experiences in that they not only open up the way to a deeper truth" (Jung, 1933b, p. 59), allowing us to shift our perspectives and force the chaplain to change his views, process, and approach (Jung, 1933b).

> This "use of the self" is not a matter of self-preoccupation but, on the contrary, a healthy utilization of one's own responses to enhance the quality of pastoral care. Appreciation of

> the complex, affect-laden nature of the intersubjective relationship between helper and helpee can deepen understanding, strengthen empathy, and increase the mutuality of respect, even as it enhances the creation of a safe space with healthy boundaries. (Cooper-White, 2004, p. 128)

The Persona

> The persona . . . is the individual's system of adaptation to, or the manner he assumes in dealing the world. Every calling or profession, for example, has its own characteristic persona. . . . One could say, with a little exaggeration, that the persona is that which in reality one is not, but which oneself as well as others think one is. (Jung, 1948/1968c, p. 221)

Reflecting on Jung, a chaplain's persona is formed by and defines how we want to be seen in our lives and the world. It's not essentially who he or she truly is, but who and how they want to appear to others and to themselves (Schoen, 2009). Schopenhauer makes us acutely aware that we all wear our masks and play our roles (1851/2009). It may not be surprising that a chaplain's persona acts to defend the ego from undesirable images.

When a chaplain identifies too closely with an archetype, they can become out of touch with their authentic self. A chaplain who is not self-aware may have implicit bias that protects their fragile ego from the perhaps frightening, unknown other (e.g., patient, emotion, experience). An anxious chaplain may avoid stepping into a room because of their insecurity supporting an angry family stricken with heartbreaking grief. Or a patient may pretend to be at ease when their illness trajectory rattles them to their core. Each of them not in touch with their truer self to be present enough for deeper healing.

The Shadow

The shadow is the unseen part of the personality that the ego doesn't recognize or know (Neumann, 1990). It "personifies everything that the subject refuses to acknowledge about himself and yet is always thrusting itself upon him directly or indirectly—for instance, inferior traits of character and other incompatible tendencies" (Jung, 1954/1968b, para. 513).

"Everyone carries a shadow, and the less it is embodied in the individual's conscious life, the blacker and denser it is. At all counts, it forms an unconscious snag, thwarting our most well-meant intentions" (Jung, 1948/1958a, pp. 181–182).

> The Shadow is a living part of the personality and therefore wants to live with it in some form. It cannot be argued out of existence or rationalized into harmlessness. This problem is exceedingly difficult, because it not only challenges the whole man but reminds him at the same time of his helplessness and ineffectuality. (Jung, 1954/1968a, pp. 20–21)

"Closer examination of the dark characteristics—that is, the inferiorities constituting the shadow—reveals that they have an emotional nature, a kind of autonomy, and accordingly an obsessive or, better, possessive quality" (Jung, 1968d, para.15). The individual's shadow strengthens, emboldens, and becomes reliant upon the person's addictive behavior for expression, to have any life in the light outside of where it's hidden. The more unaware and unconscious we are of our personal shadows, the more vulnerable we are to having those shadows break out and be set free for a time by addictive behaviors (Schoen, 2009). "The psychological rule says that when an inner situation is not made conscious, it happens outside, as fate" (Jung, 1959, p. 71).

> This integration [of the shadow] cannot take place and be put to a useful purpose unless one can admit the tendencies bound up with the shadow and allow them some measure of

> realization—tempered, of course, with the necessary criticism. This leads to disobedience and self-disgust, but also to self-reliance, without which individuation is unthinkable. . . . Knowing your own darkness is the best method for dealing with the darkness's of other people. One does not become enlightened by imagining figures of light, but by making the darkness conscious. The most terrifying thing is to accept oneself completely. Your visions will become clear only when you can look into your own heart. Who looks outside, dreams; who looks inside, awakes. (Jung, 1973, p. 335)

"The self, as a symbol of wholeness, is a *coincidentia oppositorium* [coming together of opposites], and therefore contains light and dark simultaneously. (Jung, 1912/1952, para. 576).

> Man's task is . . . to become conscious of the contents that press upward from the unconscious. Neither should he persist in his unconsciousness nor remain identical with the unconscious elements of his being, thus evading his destiny, which is to create more and more consciousness. As far as we can discern, the sole purpose of human existence is to kindle a light in the darkness of mere being. (Jung, 1961, p. 326)

Sometimes this is expressed as patients, with their family, face their mortality. Jung expounded:

> I have known those people who most feared life when they were young to suffer later just as much from fear of death. . . . We are so convinced that death is simply the end of the process that it does not ordinarily occur to us to conceive of death as a goal and a fulfillment, as we do without hesitation the aims and purposes of youthful life in its ascendance. (1999, p.12)

In this case study: Patient B, a twenty-nine-year-old South American male with a rare lymphoma came to New York City with his mother to find a cure and then was in remission for

two years. He was recently hospitalized because his cancer reoccurred in a far more aggressive form and he and his medical team planned to start chemo treatment inpatient, then outpatient.

In our visits, though he often appeared anxious and frightened, he presented himself as proud, contained, and protective, as he spoke of his vision of the future: having a "normal life," seeing his eleven-year-old daughter (who because of her denied visa, was never allowed U.S. entry), being intimate with his girlfriend, going back to work, and trusting that God was going to cure him.

After a syncopal episode and being rushed to the Medical ICU, he and his family were given the news that an inoperable tumor was about to infringe on his heart that would soon cause it to burst and him to die. The prognosis shocked him and his family, who were told that he had minutes to a few days to live.

Patient B, frozen, trembling, asked for us to be alone, and his parents left his room in tears and disbelief. After we worked together to thaw, soften, breathe, and somehow reestablish some sort of grounding (if at all possible), he sobbed and he grasped my hand. After expressing his traumatic experience, his fear and heartbreak, he became vulnerable, open, dropped his protective guard, and then said that he had "accomplished everything [he] needed to in this life. [He had] a loving family, a beautiful daughter. [He] traveled the world, . . . was professional, . . . and was blessed. . . . [He was] OK." In prayer, he thanked God for his life and asked God to watch over his loved ones. It was the end of my work week and we understood that we probably would never see each other again after our good bye. He died three days later.

A week passed and his mother returned to the hospital with her sister for some closure. I joined them and their social worker. As she was unable to stop her tears, she said she couldn't bring herself to have a final conversation with him and felt unresolved after years of caring for

him. I shared what her son, Patient B, told me. When she heard his last words spoken to me, she shared that because she never asked, she didn't know if he felt complete; now somehow she felt more at peace. His words were written on paper, which she now keeps as a bookmark and reflects upon daily.

In this case, Patient B may have found his way to integrate aspects of his shadow and bring them to light, maybe allowing him to face his imminent "death as a goal and a fulfillment" (Jung, 1999, p.12), perhaps beyond his understanding.

Winnicott: Object Relations

> The good-enough 'mother' (not necessarily the infant's own mother) is one who makes active adaptation to the infant's needs, an active adaptation that gradually lessens, according to the infant's growing ability to account for failure of adaptation, and to tolerate the results of frustration. (Winnicott, 1953, p. 10)

According to Winnicott, this caregiver continually encounters and understands the invincibility of the infant. True Self begins to emerge through the nurturing given to the infant's frail ego by the mother's recognition of the infant's all-powerful (omnipotent) expressions. (Winnicott, 1953).

Winnicott's "good-enough mother" (1971/1989, p.10) found expression in numerous ways regarding patient, chaplain, and prayer. Each of our unique images of God emerges from remembering real experiences of needing our parents and how they reacted and held us. They come from how we imagined our parents' responses, for better or for worse (Ulanov & Ulanov, 1982).

Similar to our good-enough mother as infants, as adults we need someone larger than life who understands us and our fears. We want a God who will guarantee that life will be fair

> in the end, that the wicked will be punished and he good rewarded. Above all, we need an intermediary with the unknown. Our various pictures of God make this possible. (Ulanov & Ulanov, 1982, p. 27)

This is reflected in the internal/external worlds of both patient and chaplain. Based on their religious beliefs, their understanding and relationship with God or God's image, and if their God is punishing, loving, or both, God (or no-God) impacts their ability to adapt, be resilient, and cope. Just as True Self can emerge due to good-enough mothering, a False Self develops due to the lack of such. A loving God or punishing God, perhaps, can function similarly.

There is an organic human inclination to protect our genuine nature (True Self) from being examined by the external world. To avoid rejection and being emotionally wounded, we defend our True Selves. The problem is, by not being open and vulnerable, we can miss opportunities to be in genuine relationship with others. "The organized False Self is associated with a rigidity of defenses which prevents growth during the student period" (Winnicott, 1960, p. 144). In analyzing the False Self we are investigating the initial stage of object relations, when the infant is most of the time unintegrated; synthesis of the various sensory-motor elements belong to the fact that the mother holds the infant, sometime bodily, all the time symbolically (Winnicott, 1960).

Chaplains who do not feel emotionally and or spiritually held may not be attuned to their authenticity and need to defend their undeveloped ego or inner world from the nonstop scrutiny of their relational environment. They may relate to both themselves and patients through primarily a false self-lens. Over time this may feel natural. Adding a layer of pretense with others may result in somatically feeling exhausted, empty, or emotionless. Behaviors may feel strained, withdrawn, unseen, or disconnected.

This was echoed by Galek et al. (2011), who reported that interfacing between self and system can promote burnout and, perhaps, be associated with other conditions. While chaplains try to validate their self-worth through others, the development that leads them to do so may make them more prone to burnout or STS since, in Weiner's words, "The person who felt unrewarded and unappreciated for who he or she was in childhood is much more vulnerable to uncaring responses in the environment" (Weiner, 1989, p. 97). Active listening, which is key to chaplaincy and other clinical practices, can often feel unfulfilling and decrease self-esteem. The ongoing desire for external validation of self-worth may be particularly problematic in business-oriented organizations, such as hospitals, which request the highest quality functioning with little reward or support (Weiner, 1989).

The idealistic expectations that clergy have about helping others (Grosch & Olsen, 2000) are likely to intensify anxiety among hospital chaplains because short patient hospitalizations and intense workloads put a constraint on the time chaplains have with individual patients, lessening their feelings of effectiveness. Research indicates that clinical staff gain meaning from their work related to caring for patients over lengthy periods of time (Overvold et al., 2005).

Winnicott found that occasionally, the infant's movement expresses an unprompted impulse; the basis of the action is the True Self, "and the gesture indicates the existence of a potential True Self" (1960, p. 145). This expression can take various forms in a chaplain-patient visit through spontaneous emotional (sorrow, anger) and or somatic (tears, heaving) expression.

Prayer as Transitional Object and/or Transitional Phenomena

"The transitional object is a symbol of the union of the baby and the mother (or part of the mother). . . . The use of the object symbolizes the union of two now separate things, the baby and mother" (Guntrip, 1969, p.420).

> There may emerge some thing or some phenomenon, perhaps a bundle of wool or the corner of the blanket . . . or a word or a tune, or a mannerism that becomes vitally important to going to sleep, and is a defense against anxiety, especially anxiety of the depressive type. (Winnicott, 1975, p. 232)

Prayer may emerge as a transitional object "or some phenomena . . . that becomes vitally important . . . and is a defense against anxiety" (Eigen, 1993, p. 135). It too can symbolize "the union of two separate things," heaven and earth, God and human.

Reflecting an individual's pattern and evolvement with prayer, an infant's patterns may continue into childhood, so that the initial soft object continues to be essential "at bedtime or at a time when loneliness or when a depressed mood threatens" (Winnicott, 1953, p. 5). This comforting article or repetitive behavior that began in early stages of development can emerge in future years when deprivation threatens (Winnicott, 1953). Art and religion for Winnicott function as adult versions of the transitional object (Ulanov, 2001). Over time the transitional object broadens out into creative inspiration and gratitude, and of religious feeling (Winnicott, 1953).

> The impact of Winnicott's theory, is to relocate religion neither far outside ourselves (God's transcendence) nor completely inside ourselves (God's immanence) but in the illusory space in between, in the interplay of subjectivity and objectivity. We create God-images out of our bodily need and desire, which give rise to some kind of imagining about the transcendent, which is met by intimations of a real God that, like the teddy bear we both find and create. (Ulanov, 2001, p. 96)

We creatively give prayer an important mission of religion that involves providing specific dogma, forms, history, devotion, prayer (Ulanov, 2001). "Without them, we have no

'objects,' no transitional toys to play with, to arrive at our connection without reality to which religious symbols point" (Ulanov, 2001, p. 97).

Bowlby's and Ainsworth's Attachment Behavior

In Bowlby's and Ainsworth's view, attachment styles that children model based on their early interactions with caregivers form a range of emotion management. Secure attachment falls midpoint between overly organized strategies for controlling and minimizing emotions and the uncontrolled, disorganized, and ineffectively governing emotions. The goal of the behaviors is closeness to the mother who provides a refuge that protects the infant from predators. Most apparent in early childhood, it can be observed throughout the life span (Bowlby, 1988). Children with a safe bond to both parents were most self-assured and capable; least so were children who didn't have a safe connection to either; and those with a safe bond to only one parent fell in the middle (Bowlby, 1988).

> Attachment behaviour is any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiving. At other times the behaviour is less in evidence. Nevertheless, for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security, and so encourages him to value and continue the relationship. Whilst attachment behavior is at its most obvious in early childhood, it can be observed throughout the life cycle, especially in emergencies. (Bowlby, 1988, Lecture 2, para.9)

When how we are organized by attachment is triggered by loss—of health, identity, or dignity—patients, families, and friends seek refuge in God to reestablish their lost experience of

security. For Christians, Romans 8:38–39 teaches that "neither death nor life, nor angels nor rulers, nor things present nor things to come, nor powers, nor height nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord." This non-separation is also expressed in numerous religions as Oneness, or The One. For others, perhaps the very ground of being provides a sense of safety and connection.

Bowlby's research stated there is significant proof that whether attachment behavior becomes organized depends on the kinds of experience one has in his "family of origin, or, if he is unlucky, out of it" (Bowlby, 1988, Lecture 1, para.9). Attachment's parenting behavior has strong genetic origins, which accounts for the powerful feelings connected with it; but the nuances of the "behavior depends on our experiences—experiences during childhood especially, experiences during adolescence, experiences before and during marriage, and experiences with each individual child" (Bowlby, 1988, Lecture 1, para.14).

Ainsworth illuminated:

> The behavioral system includes not only its outward manifestations, but also an inner organization, presumably rooted in neurophysiological processes. This inner organization is subject to developmental change, not only because it is under genetic guidance but also because it is sensitive to environmental influences. As the inner organization changes in the course of development, so do the outwardly observable behavioral manifestations and the situations in which they are evoked. (1989, p.709–710)

In the 1970s Mary Ainsworth developed "The Strange Situation" which studied infant-parent separation, in which infants are periodically separated from and reunited with one parent. She examined "the way in which a baby's behavior is patterned when the attachment system is activated at varying levels of intensity through simple manipulations of his environment in a

laboratory situation" (Ainsworth et al., 1978/2015). Children's attachment can develop as *secure, anxious-avoidant, anxious-ambivalent*, and disorganized depending their separation experience.

Similar to the children who were temporarily separated from their parents in Ainsworth's studies, patient and families feeling forsaken by God in times of crises can experience a plethora of distressing feelings. When prayers go unanswered, there is often feelings of fear, anxiety, anger, and abandonment. Often doubt leads to variations of negative interpretations of why God is not present or isn't answering prayers in the way that is wanted. Self-blame, self-shame, self-guilt, and harmful feelings of being punished are often felt by patients and families.

Psychopathology occurs because disturbances in attachment behaviors have taken place. Such disruption can result from caregivers' intimidations to end the bond to the child, actual physical or emotional intrusions of the bond, or circumstances that impede efforts at reunion. Since "behavior depends on our experiences" (Bowlby, 1988, Lecture 1, para.14), if a patient's attachment behavior is insecure because of childhood trauma and distrust, they may have a distrustful and/or negative or non-relationship with prayer. Prayer can become a triggering dynamic as patients transfer this mistrust onto the chaplain, activating the chaplain's counter-transference. That is why it is paramount not only for chaplains to provide a safe, sacred place for patients struggling with severe illness, dying, death, and or God, but also for themselves in recognition of their own attachment behaviors.

Similar to parenting, the essence of chaplaincy is creating a safe space where prayer has opportunity to be present, being accessible and ready to respond when called upon to inspire and support, and to intervene only when needed. Echoing Bion's O, "we seek always to teach by example, not precept, by discussion, not instruction" (Bowlby, 1988, Lecture 1, para.57).

Chaplain Anxiety

Anxiety and stress can be confused for the same experience. Stress is our reaction to events that upset our physical and mental balance. Anxiety can be defined as a reaction to stress. According to the *DSM-5*, anxiety is "anticipation of future threat" (2013, p. 189). Once anxiety emerges as a response to stress, emotional and physical symptoms including worry and fear and behaviors like being avoidant or hypervigilant can take over.

Like other clergy, chaplains typically help patients and family members deal with the emotional distress of grief and bereavement (Flannelly et al., 2003; Fogg et al., 2004). Chaplains also address a range of other emotional reactions of patients and families, including anxiety, depression, loneliness, and end of life. Because of the nature of their work, chaplains deal with these and other emotional issues on a much more regular basis than clergy (Fogg et al., 2004; Flannelly et al., 2003; Moran et al., 2005).

Chaplains may experience anxiety and confusion in deciding how to cultivate and navigate spiritual and therapeutic connections that best serve their patient population (Herlihy, 2015). Secondary Trauma Syndrome (STS) can develop in those working with trauma victims (Figley, 1995; McCann & Pearlman, 1990; Thomas & Wilson, 2004). STS and burnout can impair a chaplain's capacity to effectively work with patients and families (Dutton & Rubinstein, 1995; Farber & Heifetz, 1982). Both have been found to be associated with, and may contribute to, depression and anxiety disorders (Ahola et al., 2005; Davidson & Fairbank, 1993; Willcock et al., 2004).

When chaplains counsel in the areas of spiritual crises and end of life, the way they handle their own personal existential anxiety will influence their effectiveness far more than their intellectual understanding of their theology. Chaplains have a trust that supports coping with

their existential anxiety; this coping is derived from their true faith from which they find the strength to be with their feelings. The core of this trust will be frequently tested (Clinebell, 1966/2016). Clinebell has shared that "Karen Horney saw neurotic anxiety as an attempt to defend oneself against fear of death by lessening the threat, by keeping oneself feeling already half dead" (1966/2016, p. 218). Her statement relates to many human beings, not just chaplains.

Leon Wurmser (1995) classified the first of three types of shame as *shame anxiety*. "This is anticipatory anxiety about the imminent threat of being exposed, humiliated, belittled or rejected. It signals the danger of contemptuous rejection and corresponds roughly to discretion shame" (Pattison 2000, p. 85). This may emerge when chaplains struggle with inauthenticity, and/or are challenged by feelings of discomfort praying with a patient of another religion. This may also appear if the chaplain has feelings of inadequacy dealing with the patient and family of another social sphere or when the chaplain is implicitly fearful ministering to a patient whose gender identity feels foreign. The unknown can be a scary place to inhabit.

> In Winnicott's (1965, 1971) work . . . primal catastrophe is the failure of the infant's continuity of being to be supported or established. It may take the form of unthinkable anxieties or primitive agonies such as going to pieces, falling forever, lack of relationship to body, and loss of orientation. In structural terms, discontinuity gains its meaning from continuity. The infant maintains its continuity in the face of or through disruptions up to a point. But a breaking point can be reached and the sense of continuity lost. In normal circumstances the mother nurses the baby back into existence to the point where discontinuity can once more be tolerated and used for growth purposes. Over and over the baby dies out and is reborn. Faith is nourished by this repeated resurrection. It has roots in an underlying sense of continuity which is reestablished in new ways. Our first

> symbolizing activity expresses our sense of ongoing being. (Eigen, 1993, p. 223)

Schore's Right Brain Theory and Its Relevance to Attachment Behavior

This repeated resurrection is also explored in Allen Schore's extension of Bowlby's work on Attachment. His writings emphasized that "rupture and repair, both in the developmental and psychotherapeutic contexts, involve important opportunities for interactive regulation of dysregulated affective states" (2019, p. 266). Schore is

> interested in the mechanisms of change, especially in the early development of the right brain self-system. . . . [He's] exploring how the object relations sequences between mother and the infant shape emerging psychic structure. . . . These are investigations of interpersonal neurobiology. An interpersonal neurobiology of human development enables us to understand that the structure and function of the mind and the brain are shaped by experiences, especially those involving emotional relationships, and to understand how brains align their neural activities in social interactions. (2019, p.266–267)

Schore states that similar right brain-to-right-brain social and emotional processes experienced between mother and infant later get played out in therapy. "Rupture and repair are potential contexts for emotional growth" (2019, p. 267).

> Enactments represent communications of previous ruptures that triggered negative affects so intense and so painful that they were banished from consciousness. As the therapy progresses and the attachment bond in the therapeutic alliance strengthens, there is enough safety for the patient to dissemble the dissociative defenses and let the affects come online more frequently. (Schore, 2019, p. 267)

In a secure attachment, intimate context in characterized by mutual love in the

relationship between the mother and infant. That love is also the mother's capacity to receive communications that not only bring pleasure but also are stressful, and is able to hold those feelings in herself and then regulate them and communicate that back to her newborn. Emotional contact between human beings originates with mother and infant, eventually becoming the way we communicate with each other (Schore, 2019). As chaplains slow down, they offer a more contemplative connection and presence, which provides a source of regulation and an opportunity for the patient to fall into healing relationship.

"These deeper communications and miscommunications . . . have more to do with right brain abilities to read the spontaneous facial expression, tone of voice, and gestures of other humans" (Schore, 2019, p. 269).

"It is here in the higher right hemisphere, which processes not only emotional states and higher cognitive functions but also spiritual and moral experiences. It is here in the right where the self is transcended, where the self becomes larger and expanded" (Schore, 2019, p. 271). A patient's dissociative anxiety can prevent them from being in connection, in relationship, with themselves, with others, with prayer. "Regulation is the key to the quiet mind" (Schore, 2019, p.274).

Pargament & Raiya (2007) wrote that "religion has been linked to psychological goals, such as anxiety reduction, personal control, peace of mind, self-development and the search for meaning" (p. 744).

Chaplains' awareness of right-brain-to-right-brain communications supports understanding their profound experience of *being with* the patient. This experience recalls what was expressed earlier in this paper: *being with* the patient allows for Jung's Self, Bion's O, and Winnicott's True Self to emerge. By being with the patient, chaplains allow for the tenderness

and the sacred space that can repair rupture. Similarly, prayer can serve as a bridge toward wholeness, toward healing, toward "he who has no name," toward God.

Theological Review

Seek My Face

Psalm 27:7-8 NKJV
7 Hear, O Lord, *when* I cry with my voice!
Have mercy also upon me, and answer me.
8 *When You said,* "Seek My face,"
My heart said to You, "Your face, Lord, I will seek."

The ancient Vedas of India told us that "The One Existence the wise call by many names" (Bose, 1988). Every religion offers its name for the Divine: Brahmin, Krishna, Tao, Buddha, Tara, Allah, Adonai, Tagashala, Wankan Tanka, Oshun, Isis, and Christ, to name a few.

The ancient scriptures of Hinduism known as the Bhagavad Gita tell us that God "appeared with an infinite number of faces" (Bose, 1988, p. 195). Meister Eckhart said: "Love is nothing other than God. . . . In the same love in which God loves the Godself, God loves all things" (Fox, 2018, p.76). Rabbi Abraham Joshua Heschel declared: "There is only one synonym for God: One" (Merkle, 1985, p.80).

The face of mystery is beyond words; as Thich Nhat Hanh noted, "we know the Holy Spirit as energy and not as notions and words" (1999, p. 101). Aquinas called God "A source without a source" (Fox, 2018, p.64). Hart called God "the unconditioned source of all things" (2013, p. 134). Other names for God as found within every creature are the Cosmic Christ, True Nature (or Buddha Nature), and YHWH. All guide us to the Sacred in all things, the "light within all things" (Fox, 2018). The Trappist monk Thomas Merton said "the Blinding One speaks to us gently in ten thousand things. . . . He shines not on them but from within them" (1974, p. 508). Martin Buber reveals, "God is the 'wholly Other,' but He is also the wholly Same, the wholly Present" (1958, p. 80).

In accordance with Kabbalah, God is known as *Ein Sof* or "the Infinite"—not

comprehendible by humans. God cannot be contained by any thought or concept. Since no one can contain God, it is called Nothingness, Ayin (Fox, 2018).

God being called Nothingness is further illuminated by Deepak Chopra, who explained: "God is uncreated. The universe cannot reveal God, since everything that exists is created" (2014, p.253). He wrote: "Let's assume that God is infinite. Our minds are not equipped to perceive the infinite. We perceive what we are prepared to see and know" (2012, p. 2). We are left in awe without language, with the unperceivable because it's uncreated, Nothingness.

Green (2003) imparted: "It is *we* who determine that God has a face. It is by the act of saying 'Thou' to a faceless cosmos that we give it a face and turn it from subject into object, creating a projected God with whom we can enter into dialogue and have a conversation" (p. 30). "We are frightened of our mortality and ultimate powerlessness. We cannot live without a faceless God . . . we need a God to whom we can cry, with whom we can argue, with whom we can trust and even love" (p.31). Heschel wrote in his 1945 article Prayer: "The thirst for companionship . . . indicates the intense loneliness from which we suffer." He continued, "In the hour of greatest agony we are alone. It is such a sense of solitude which prompts the heart to seek the companionship of God." Prayer can help us surrender to the unperceivable nature of God that allows us to be with our great loneliness, our being's awareness of its non-being, our suffering.

Suffering and "The Threat of Non-Being"

The Buddha's first teaching, The Four Noble Truths, states that *life is suffering*. The early teachings of the Theravadan Buddhists designate three levels or types of suffering: *undeniable suffering*, the *suffering of impermanence*, and the *suffering of selfish conditioning* (Buddhaghosa, 1964; Harvey, 1990). *Undeniable suffering* includes all emotional and somatic forms of anguish usually equated with the word "suffering": the miseries of old age and dying, of physical injury

and disease, of heartache, and of psychological distress (Makransky, 2012).

The *suffering of impermanence* is the useless attempt to get and to grasp onto agreeable possessions imagining they're a constant source of safety and well-being. In Buddhism, *impermanence* is an inescapable fact of human existence. As Buddhists, we are taught that life is precious, as everything changes moment by moment. As we live our lives and progress toward death, our minds cling to these possessions, creating the painful suffering of loss (Makransky, 2012).

> The *suffering of selfish conditioning*
>
> underlies the prior two. This form of suffering is inherent in the mind's subconscious attempt to create from the impermanent flow of its experience the impression of a substantial, unchanging, and separate sense of self surrounded by a stable world. The mind's ongoing attempt to fabricate such a reified, unchanging impression of self and world, in turn, conditions numerous anxious patterns of thought and reaction: clinging to whatever seems to affirm a fixed, unchanging self and its world, fearing or hating whatever seems to threaten it. (Makransky, 2012, p.62)

"Any physical world is an impermanent one. The reality of decay and death is built into our world, since a cosmos composed of material, of 'stuff,' by its very nature cannot be perfect. . . . The existence of spirit does not change the reality that the world through which it moves is physical and therefore perishable" (Wolpe, 2008, p. 132).

This expression of suffering, impermanence, is also expressed by Paul Tillich's summarization of his understanding the impact of existential anxiety. He defines "anxiety as the awareness of finitude" (1951, p. 191). "Finitude is experienced on the human level; nonbeing as a threat to being. The end is anticipated" (1951, p. 190).

Tillich pointed out that the existential anxiety generated by the "threat of nonbeing" (1952/2000, p. 39) has three distressing expressions: "the fear of fate and death, emptiness and loss of meaning, and feelings of guilt and condemnation. This anxiety permeates our whole being" (Clinebell, 1986/2011, p.220).

People struggle emotionally and become ill, not only because of pressing frustrations but also because they are distressed about their fate, purpose, and meaning (Hiltner, 1949). Viktor Frankl (1963) expounded: "If there is meaning in life at all, then there must be meaning in suffering. Suffering is an ineradicable part of life, even as fate and death. Without suffering and death human life cannot be complete" *(*p. 67). He illuminated, "I called to the Lord from my narrow prison and He answered me in the freedom of space. How much suffering there is to get through" (p.89).

Suffering has no particular religion. Nor does hope, fear, or love. But some human beings do adhere to a specific religion. Religion can offer text, language, community, tradition, and structure that can support understanding, transcending, and making meaning of our struggle. Religion can create a vessel to hold and shepherd us through our fears, our helplessness, our aloneness. It offers refuge, redemption, forgiveness, guidance, values. Its prayers can guide towards unveiling our truth and lead us toward wholeness, resurrecting the love within. Ulanov & Ulanov (1982) writes, "In prayer we say in fact who we are—not who we should be or who we wish we were, but who we are. All prayer starts with confession."

Prayer and Its Origin

Heschel (1945) taught, "In prayer, we establish a living contact with God, between our concern and His will, between despair and promise, want and abundance. We affirm our adherence by invoking His love." "The goal of prayer is not to translate a word, but to translate

the self; not to render an ancient vocabulary in modern terminology, but to transform our thoughts into thoughts of prayer" (Heschel, 1954, p. 17).

Praying has been documented as early as 5,000 years ago (Glassé, 2003). Today, most major religions involve prayer in one way or another: some ritualize the act, requiring a strict sequence of actions or placing a restriction on who is permitted to pray, while others teach that prayer may be practiced spontaneously by anyone at any time.

According to numerous sources, including the *Merriam-Webster Dictionary*, the word *pray* is first found in Middle English, meaning "ask earnestly." It comes from the Old French *preier*, which is derived from the Latin word *precari*, which simply means "entreat or ask." The origin of prayer in both Jewish and Christian traditions is found in the Biblical Psalms[1]. In Buddhism, it is found in the Pali Canon, which contains the words of the historical Buddha.

Each of us who prays has our own individual character, abilities, and temperament. Each of us who prays come from our own social, economic, and family history and systems. And each of these will impact what is expected from prayer, as well as how much understanding, awareness, or passion each will commit and devote to the ritual about to occur (Hoffman, 1999).

"To pray is to change. This is a great grace. How good of God to provide an oath whereby our lives can be taken over by love and joy and peace and patience and kindness and goodness and faithfulness and gentleness and self-control" (Foster, 1992, p. 6).

"Prayer is not simply a conversation with God, one in which you, the prayer, are on one side of a conversation and doing the speaking, while God is 'somewhere else,' and is either doing the listening or not" (Green, 2003, p. 154). "Rabbi Pinkhas said, 'People think that they pray *to* God, but that is not the case. Rather prayer itself is of the essence of divinity'" (Green,

[1] As stated by Rabbi Seth Bernstein, January 2020, in his advising of this theology section.

2003, p. 155).

The practice of prayer is a sacred one, taking place internally and externally. It is about sincerely listening, not just its verbal expression.

> In prayer, we give voice to the deepest self that lies within us, the spark of divinity that lies within our soul. That innermost spark, like the highest, primordial Torah, dwells in a realm beyond words. We give it the gift of language, allowing it to come forth and be present to the world of our conscious lives. (Green, 2003, pp. 155–156)

"We do not pray alone. God prays through us" (Green, 2003, p. 156).

Prayer may take the form of a hymn, incantation, formal creedal statement, or a spontaneous utterance in the praying person. It may be done privately and individually, or it may be done corporately in the presence of fellow believers. Prayer can be incorporated into a daily "thought life," in which one is in constant communication with a god. Some people pray throughout all that is happening during the day and seek guidance as the day progresses. This is actually regarded as a requirement in several Christian denominations (Wynne, 1911).

> Anthropologically, the concept of prayer is closely related to that of surrender and supplication. The traditional posture of prayer in medieval Europe is kneeling or supine with clasped hands; in antiquity, more typically with raised hands. The early Christian prayer attitude was standing, looking up to heaven, with outspread arms and bare head. (Russell & Russell, 1989)

> At its heart, most theology, like most fiction, is essentially autobiography. . . . That is to say, [we] cannot talk about God or sin or grace, for example, without at the same time talking about those parts of [our] own experience where these ideas became compelling and real. (Buechner, 1970, p. 3)

Buechner might inquire, for the patient and/or family member, how does their autobiography (i.e., history) impact their relationship with who they are now, God, One-ness, universe, faith, religion, health or illness, family/friends, work, and prayer? How does their autobiography impact their understanding of, or desire to understand, their self and/or their inner world, who they truly are, and what they feel is missing? How does it allow for connection and disconnection? Does their autobiography include a positive or negative connection with God, religion, church, liturgy, religion, life events, trauma, family? And as a result, how are connections intrinsically woven and perhaps inexplicably woven into their human and spiritual fabric?

The same can be said for hospital chaplains. How does their autobiography impact their relationship with God, religion, illness, gender, sexuality, age, and themselves? Part of their CPE training is to explore the seen and unseen parts of the chaplain's personhood, their countertransference, and to understand what stops them from being open, alive, and in connection with One-ness. It offers the possibility for them to explore their shadow parts and to be able to further access their light, wholeness, and truth, so they can fully be in relationship with patients, family, staff, others, themselves, the unknown, God, and the universe.

Prayer replaces the sacrifice offered by our ancestors. In authentic prayer, the only gift we have to offer is ourselves. We do so by revealing our innermost hearts, by recognizing there's a higher power in our lives, by connecting with others, and by being generous to those less fortunate (Green, 2003).

Prayer enters a zone beyond space and time: "that part of our life that knows no boundaries and partakes of the timelessness of God's eternity. There, each moment exists in a permanent 'now,' standing out from other moments as all there is" (Ulanov & Ulanov, 1982,

p.90).

> Not only do we discover the hungry parts of ourselves that we need to feed when we pray for the hungry persons of the world, but we discover the neglected parts of the world through praying into being the neglected parts of ourselves. (Ulanov & Ulanov, 1982, p. 92)

Prayer exposes and then transforms us. Its purpose is to reveal everything that's inside us, including the desire to open and surrender to the unavoidable changes that are forthcoming (Ulanov & Ulanov, 1982). "We are not called out of fleshly existence. But what was hidden is now shown to us; what was far below us in shrouded darkness is now right before us in the light" (Ulanov & Ulanov, 1982, p. 117). This way of prayer has such distinct grace, as a gift from God and as an extraordinary and naturally complete understanding, that it can feel transcendent (Ulanov & Ulanov, 1982).

Rabbi Anne Brener (2005) stated,

> Prayer . . . uncovers the authentic inner conversation of the self and places it in dialogue with the timeless, universal conversation of the infinite. This connection can promote healing whether physical cure or the resolution of a painful situation is possible or not. (p.125)

Prayer Types: Fixed and Spontaneous

Prayer is often allocated into two classifications. First is spontaneous, or customized prayer: words that pour openly from the heart in response to our immediate life's events and or crises. These prayers, whether spoken or quiet, are an authentic expression of the pain or joy felt in a particular moment, and their strength lies within their being shared in that moment (Green, 2003).

The second classification of prayer is liturgical or fixed prayer:

> Assigned words to be spoken regularly at certain times in the day, week, or year. These prayers evoke powerful responses in us precisely because of their familiarity. To recite them regularly is to develop an attachment to their poetic phrases, their melodies, and the various meanings we link with them. Each time we recite them, all of our memories of the many other times we said them, along with the recall of prior generations who spoke these same prayers are with us. This well of memory creates a deep echo-chamber, lending a richness and a profundity to the words of prayer. (Green, 2003, pp. 153–154)

Chaplains can use prayer to get to the heart of the matter and address the worries of patients, families, and/or staff. Whether utilizing traditional liturgy, through organic expression of emotion, or in silence, prayer can be used to express pained voices, to confirm beliefs, to gain clarity, and to support healing relationship with the sacred.

Citing Rabbi Abraham Joshua Heschel's assertion that Shabbat creates a cathedral of time, Brener (2005) expanded upon that, stating, "Prayer creates a cathedral in soul. No matter what mode is chosen for prayer, it can build word by word, and breath by breath the Place of connection between those who suffer and the Source of Healing" (p. 126).

Fixed/Liturgy

Heschel (1945) taught:

> The ability to express what is hidden in the heart is a rare gift, and cannot be counted upon by all men. What, then, makes it possible for us to pray is our ability to affiliate our own minds with the pattern of fixed texts, to unlock our hearts to the words, and to surrender to their meanings. For words are not dead tools, but living entities full of spiritual power.

This spiritual power can carry and hold us through our most emotional and physical pain, our darkest times. "The deep and various longings of our souls need deep and various ways to express themselves. Sometimes, we find this expression through reading familiar words in our prayer books, what the rabbis call *keva* (fixed) prayer" (Taylor, 2005, p. 150). Individuals deeply supported by their faith, prayer, and spiritual relationship can draw upon their foundational experiences that have been formed. They can find refuge and relief in traditional liturgy and are likely to be open to healing services and to respond to recognized prayers, text, and blessings (Brener, 2005).

> Literary texts . . . were written by someone, at some time, and are intended to be read by someone else at some other time. All texts are messages. They may be telegrams, diaries, newspaper editorials, or even prayers, but whatever form they take, the meaning they provide goes beyond their literal content. (Hoffman, 1999, loc. 2211)

> The chief character in the liturgical story that we repeat whenever we meet for worship is the entire Christian church or the entire Jewish People—not just now, but forever. To their role as performatives (establishing a present), then, we can now add a second function of liturgical language: establishing a past. (Hoffman, 1999, loc. 2394)

Psalms

For many hospital patients, a psalm explored with a chaplain can create a sacred space, an opportunity for meaningful contemplation, self-care and devotion, long past the chaplain's visit (Weintraub, 2001).

"The 150 psalms that constitute this important component of the 'Writings' section of our (Hebrew) Bible reflect a wide range of experience and expression—anger and acceptance, blunder and bravado, complaint and comfort, despair and delight, exhaustion and exhilaration,

frustration and faith, and so on" (Weintraub, 2001, p. 162). Kenneth Pargament (2007) wrote that we "find expressions of deep longing for God that go hand in hand with pleas for wisdom, comfort, safety, and forgiveness. Through their association with the sacred, very human goals become elevated to greater meaning" (p. 69).

Psalms serve as a source of structured expression, to mark certain moments and give a container for feelings, ideas, and values, either in an established, traditional, communal context, or in one's own personal, innovative time and place. The psalms, especially those of lamentation, can offer the suffering patient, family member, *and chaplain*[2] deep coping and solace (Capps, 1981). People dealing with illness, suffering, and loss often turn, quite naturally, to the resources of the world around them for spiritual healing . . . to bridge the worlds of the senses with that of the spirit in a conscious manner" (Weintraub, 2001, p. 173).

The power of Psalms lies in what meaning we find in their words and the devotion we bestow them. They're a vessel for our hopes, as well as our distress, anxiety, fears, and worries. Psalms inspire us to let go and also offer up our deepest desires, understandings, and prayers. In a chaplain's spiritually caring for patient and family, much is related to timing and relationship, so it's paramount to remember that *any text must come out of the context* and not be a obstacle to, but rather an aid for, human connection and relatedness (Weintraub, 2001).

"A Patient and Psalms: A Short Vignette:" Patient C is a Black 76-year-old Christian female now at the end of her life due to renal failure after years of hemodialysis. When she was awake and alert, she always expressed her faith with chaplains by reading her favorite psalms. Now in hospice and appearing nonresponsive, the palliative care clinical team compassionately manage her symptoms. But when her chaplain experienced Ms. C not responding to tactile or

[2] Italics added by writer.

vocal stimulation, she remembered that Ms. C always requested devoutly exploring the psalms when they previously visited. Psalm 91 was her favorite. Her chaplain understood that sometimes a person's hearing remains to the very end of life, sat at her bedside, and read it to her. As the chaplain was about to finish Psalm 91, she looked up and saw Ms. C's eyes now wide open, looking radiantly alive, as if the power of psalm pierced through her stillness and connected with her heart, and perhaps provided a bridge for her to be in deepest relationship with it, her spirit, her God.

Psalm 91[3]

1 He that dwelleth in the secret place of the most High shall abide under the shadow of the Almighty.

2 I will say of the Lord, He is my refuge and my fortress: my God; in him will I trust.

3 Surely he shall deliver thee from the snare of the fowler, and from the noisome pestilence.

4 He shall cover thee with his feathers, and under his wings shalt thou trust: his truth shall be thy shield and buckler.

5 Thou shalt not be afraid for the terror by night; nor for the arrow that flieth by day;

6 Nor for the pestilence that walketh in darkness; nor for the destruction that wasteth at noonday.

7 A thousand shall fall at thy side, and ten thousand at thy right hand; but it shall not come nigh thee.

8 Only with thine eyes shalt thou behold and see the reward of the wicked.

9 Because thou hast made the Lord, which is my refuge, even the most High, thy

[3] https://www.bible.com/bible/1/PSA.91.KJV

habitation;

10 There shall no evil befall thee, neither shall any plague come nigh thy dwelling.

11 For he shall give his angels charge over thee, to keep thee in all thy ways.

12 They shall bear thee up in their hands, lest thou dash thy foot against a stone.

13 Thou shalt tread upon the lion and adder: the young lion and the dragon shalt thou trample under feet.

14 Because he hath set his love upon me, therefore will I deliver him: I will set him on high, because he hath known my name.

15 He shall call upon me, and I will answer him: I will be with him in trouble; I will deliver him, and honour him.

16 With long life will I satisfy him, and shew him my salvation.

Merton wrote: **"**Used as private prayer, the Psalms unite us to the praying Church though in a less formal and official manner, because the Psalms are always the Church's prayer." Perhaps for Ms. C's visit with her chaplain the Psalms, especially Psalm 91, "are in the most perfect sense the "prayer of Christ" (1955, p. 17). Additionally, Jews publish Psalms in all kinds of sizes and bindings in both Hebrew and English. The small ones are for individual and private prayer and meditation. Christians have a book known as a Psalter. In many denominations, the Hebrew Bible/Old Testament is not as readily available as the Psalter. Hence, for many Christians, the New Testament is accompanied by the Psalter and no other book from the Hebrew Bible/Old Testament.[4]

[4] As stated by Rabbi Seth Bernstein, January 2020, in his advising of this theology section.

Custom-Made or Spontaneous Prayers

Taylor (2005) wrote:

> Yet, we know from experience that these words may not always match what we feel. Our human soul yearns to express what is most profoundly true for us at a given time. This is especially true in those moments when we are faced with the mystery of living and dying, of knowing and not knowing. . . . Custom-made prayer infused with *kavannah* (spontaneous, heartfelt intention) encourages our spirits to speak their truths in the moment. Jewish tradition teaches that sincere prayer enables us to experience an immediate connection to the Divine Presence, however we conceive of God. (p.150)

Custom-made intercessory prayer asks God to intercede in our lives. In offering it, we lay our hopes, sorrows, pains, illness, and wishes before the Eternal. Through spontaneous prayer, chaplains have the opportunity to facilitate a healing connection with God for those who are in a fragile state (Taylor, 2005).

How do you talk to God? What do you say? Prayer provides a bridge between individuals and God. The Hebrew word for praying, *lehitpalel*, signifies an inquiry into the state of one's soul as a prelude to making it ready for communication with God (Taylor, 2005, p.151).

To lay a foundation for offering a custom-made prayer on behalf of patients and their families, a chaplain needs to provide a safe space for them to tell their story, to empower them to express their innermost feelings: fear, despair, loneliness, anger, hope. This way it reflects their struggle (Taylor, 2005).

Prayer is as useful for those who seek to help as for those who need help. Each pastoral encounter can be considered as an act of prayer. There can be many different answers to prayer, just as there are many ways to interpret an answer to a question, if there in fact is an answer

(Wynne, 1911).

A multifaith prayer resource opens opportunities for both chaplain and patient to create a sacred place for connection. It offers words that can touch and heal the heart when, perhaps, we cannot find our own.

Prayer as Healing

> Prayer heals the one who prays, restoring wholeness or a balance that can be lost when we are beset by concern and worry. . . . And since the One who lies within us, to whom we give the words of prayer, lies as well within the heart of the one in which we pray, we would indeed be setting false and unnecessary limits to say that the energy of our love, expressed in prayer, *cannot* reach the other. (Green, 2003, pp. 156–157)

Finding healing words in religious scripture can penetrate the souls of those seeking spiritual comfort. Echoing what was previously stated by Green, it has been proved that through repeated sound and movement, prayer can reduce anxiety and support inner peace and quiet. Prayers can also be used as affirmations that strengthen and promote aspects a person needs to cultivate and to incorporate as part of their healing process. These nurturing words can be read and repeated out loud, written, and/or chanted. Repeatedly hearing liturgical language can mend the brokenhearted, restoring meaning and direction to their lives (Brener, 2005).

> To seek healing through the use of prayer is to aim toward the unimaginable. One must suspend the intellect and call out that holy phrase, "I don't know." By helping those who suffer to reach beyond the limits of their understanding, the [chaplain] helps to reframe the definition of what healing might look like. (Brener, 2005, pp. 130–131)

As we widen our "heart-lens," the suffering patient and family can open up to a more expansive view of reality (Brener, 2005).

If, as Brener and others stated, prayer is a conversation with God, then that conversation can include words of traditional and fixed prayers, the spontaneous words of prayer, or a combination of both. As a chaplain gains comfort offering both types of prayer, individually or together, the patient and family can feel more fully witnessed. Fixed and spontaneous prayer together can support both the multifaith chaplain and patient in connecting with wholeness, One-ness. It's an opportunity to be present with what's *here now*, while drawing on ancestors through words of prayer.

Supporting the patient in finding their spiritual voice is a way of renewing faith. When they are placed in the context of community and ancestors, patients are likely to feel less isolated or singled out in their suffering. Shifting a patient's focus to a communal context from an individual one gives them a broader perspective of the healing process by recognizing that others are also in pain (Brener, 2005).

Challenges of Prayer

Prayer is taking the risk of exposing ourselves to an ultimate change of this dimension. . . . But for us, anything approaching such a change would be momentous, even if our experiences of it were so gradual that it was all but imperceptible except when looked back upon from the viewpoint of eternity (Ulanov & Ulanov, 1982, p.116–117).

Chaplains may find obstacles to offering custom-made prayer. They may need to delve into their own faith tradition and beliefs to find comfort in connecting with patient and God. Both patient and chaplain may feel participation too vulnerable, too tender, and inauthentic, at times (Taylor, 2005).

"The two great obstacles to using prayer to construct a Holy Place in which God can dwell are none other than God and prayer" (Brener, 2005, p. 126). When one is confused and is

suffering, God's accessibility and prayer's effectiveness seem hidden. When we are in emotional, spiritual, or physical pain, many become distressed with any reference to God or prayer (Brener, 2005).

Patients can be uncomfortable with the word "God," which can arouse in them childhood concepts that may not have matured or healed. They may feel a connection to a power or something larger than or beyond themselves that is supportive, but they are still ill at ease saying that it's God. This might lead to a suppressed desire or need for prayer.

Hoffman declared "If only we moderns could believe in God with the fervor of those who came before us, goes the argument, we would have no difficulty with our worship" (1999, p. 115).

> Whether our faith stops at faith in the patterns of the universe or goes on to become faith in God as well depends largely on what we mean by "God," what evidence of God we expect to find, and whether we would recognize God sufficiently to "let God in." If God is seen by us as we imagined in our childhood, we may not find in our prayers clear and ample demonstration of God's reality. (Hoffman, 1999, p. 141)

Prayer can also be threatening to the chaplain. The chaplain may feel self-conscious about motivating a person to travel into the depth of their pain and struggle, to expose themselves, and their truth to the universe. Or they can feel inauthentic and uncomfortable ministering to and praying with a patient and family not of their religion; or when a chaplain feels anxious needing a translator to meaningfully support a patient who does not speak their language.

The anxious chaplain, when faced with hopelessness and despair, may struggle with what to pray for. This "struggle can hinder or even prevent the chaplain from praying or creating an

atmosphere of prayer that very well might be the desire of the patient at a given moment in time.[5]"

> Many people perceive clergy as religious authority figures and as religious figures who "stand in" for God. Such perceptions trigger a variety of early life memories and feelings, positive and negative; for example, about God, parents, good and evil, heaven and hell, sex, Sunday school, funerals, religious fears, and magical beliefs. Pastoral counselors who are aware of these unfinished psychological and spiritual issues from people's past may respond to opportunities to help them correct old distortions and thus develop more constructive attitudes toward all things religious. (Clinebell, 1996/2011, p. 214)

> The problem . . . is that scientifically speaking, most prayers are neither true nor false. They cannot be judged by their truth value alone. They are not meant to be a simple verbal picture of reality. They link us to our past, establish institutional facts for our present, or help us to dream, to hope, and to aspire. (Hoffman, 1999, loc. 2571).

Prayer Book

As stated earlier, Heschel (1945) reflected on the human fear and pain of being alone. "It is such a sense of solitude which prompts the heart to seek the companionship of God. He alone can know the motives of our actions; He alone can be truly trusted. Prayer is confidence, unbosoming oneself to God."

> For prayer to be ours, to be a vehicle for the soul or the Divine within to communicate with us, it has to be in our language. Not because God needs words, but because we do. . . . As the innermost self, really the Self of God within us, makes itself manifest to us, it must reach and "travel" through all of our most vulnerable and wounded

[5] As stated by Rabbi Seth Bernstein, December 2019, in his advising of this theology section.

> places. To do so, it needs a language that can reach us where we hurt and where we feel true joy. (Green, 2003, p. 156)

In support of the multifaith chaplain, who at the bedside may hesitate or be uncomfortable for reasons known and unknown, and for the patient whose distress and suffering prevents them from articulating their pain and or sorrow, there can be an offering in support of words. "The power of words often surpasses the power of our minds. The word is often the giver, and man the recipient. Thus man submits to the words. They inspire his mind and awaken his heart" (Heschel, 1945).

"There is a book which everyone talks about . . . a book which has the distinction of being one of the least known books in our literature. It is the prayer book. . . . Almost any word, any passage, has untold resources of meaning, paradoxical beauty and depth" (Heschel, 1954 (p. 81). The same might be said of a multifaith prayer resource (mobile app, website) or book for chaplains. Though it might not be a book or app "which everyone talks about," or even book that every chaplain talks about. There is no way of knowing how many chaplains—and people—might use it in the most desperate moments when no other resource seems readily available or accessible.[6] It can further lift chaplains, patients, families, and all beings toward opening to deepest part of themselves and to the One that allows for healing, relationship, peace, freedom, and unconditional love.

[6] As stated by Rabbi Seth Bernstein, December 2020, in his advising of this theology section.

Method

Hypotheses

This is a quantitative pilot study exploring four hypotheses:

1. Multifaith chaplains will affirm overall comfort facilitating prayer.
2. Multifaith chaplains will prefer facilitating spontaneous prayer over fixed prayer.
3. Multifaith chaplains will affirm comfort facilitating prayer with those of disparate faiths.
4. Multifaith chaplains will affirm the benefit of a multifaith prayer resource in their provision of care.

"Quantitative approaches to research center on achieving objectivity, control, and precise measurement" (Leavy, 2017, p. 87). This voluntary survey, comprising 32 questions, was conducted with a group of multifaith hospital chaplains of varied religions and experience, working within a major hospital network at five sites within the boroughs of Manhattan and Queens that serve the New York tri-state area.

Exclusion Criteria and Refusals

Sixteen out of 37 department chaplains who were emailed participated in the survey and handed back completed surveys. One participant did not identify gender. Thirteen of the chaplains were from the Department of Spiritual Care and Education. Three chaplain volunteers were with the Palliative Care Department.

Of those responding to the email sent announcing the study, 9 participants RSVP'd yes, 1 participant RSVP'd no. Two of the chaplains who RSVP'd yes did not participate: one apologized ahead of time because he had an "emergency crisis with a staff member." One chaplain arrived too late to participate.

It should be noted that the 2 directors from the Department of Spiritual Care and

Education, who approved and scheduled the study, did not participate. There was one chaplain, who arrived a few minutes late, returned her consent form and asked for a few minutes extra to complete the survey. Since this researcher needed to leave the auditorium because of Grands Rounds beginning, the participant emailed a scanned copy of the survey.

Participants

The sample of participants worked within a major hospital network at five sites within the boroughs of Manhattan and Queens that serve the New York tri-state area in NYC. This researcher had an in-person meeting with the Director of the Spiritual Care and Education Department of a major medical institution in New York City to present the survey to the department's multifaith chaplain population to discuss gaining permission to present the survey that explores multifaith chaplains' relationship to fixed, spontaneous, secular prayer with patients.

Solicitation Protocol/Recruitment

On November 1, 2019, the Director of Spiritual Care and Education emailed an evite to introduce the survey to the department's 37 chaplains (see Appendix A). In addition, the email was forwarded to five volunteer palliative care department chaplains by this researcher. This writer sent a follow-up email to all 37 chaplains and volunteer chaplains on November 13, 2019 (see Appendix B).

Data Analysis

A database of the tabulation of demographic information and questionnaire scores was organized in order to identify themes, sub-themes using Microsoft Excel (2017). Subsequently, this researcher performed descriptive statistical analysis and correlations focusing on the relationships between demographics, statement of experience, and prayer (fixed, secular,

spontaneous). The purpose of the survey was to correlate the chaplains' relationships with prayer (spontaneous versus fixed) and with the patient, measuring the benefit of a designated mobile prayer app. Measures of frequency, central tendencies, and position were obtained to explore the hypotheses.

Correlation computations were done to explore possible relationships among the metric variables. Some of the most interesting correlations were that of age with some of the pastoral care variables. These correlations suggest that an app, which could help chaplains to better interact with a diverse spectrum of patients, especially those not from their own faith or who speak another language, would be beneficial.

K-Means Cluster analysis was used to see if there were certain individuals who grouped together statistically. The result was that was one main group consisting of all but one individual. That one individual, subject #9, presented as an outlier along multiple attributes of patient engagement. This may be attributed to the persons express discomfort with prayer outside of their faith tradition.

A hierarchical regression analysis was run to try to predict what contributed to question #9, "Do you feel inauthentic praying with patients and or family at the bedside?" While results would need to be investigated further, it brought forth that chaplains may avoid praying with patients because a language barrier contributes to their feeling inauthentic. The K-Means Cluster analysis and the hierarchical regression analysis findings reinforce some of the findings from the correlation analysis discussed earlier.

Procedure

The survey was administered to sixteen multifaith chaplains on November 15, 2019 at 10:40 a.m. at an auditorium at the hospital before Department of Spiritual Care Department

Grand Rounds. Five minutes was allotted for participants to read and sign Consent Form. Fifteen minutes was allotted for chaplains to read and complete the survey questionnaire.

The chaplains completed the survey in under the 15 minutes allotted, most participants completed the survey within ten minutes. All were supportive and enthusiastically engaged. Six asked this researcher to share the results of the study when completed. A five-dollar Starbucks gift card was given to each participant, as well as the directors of the Department of Spiritual Care and Education as a thank-you for completing the survey. The gesture was appreciated by all—some saying, "You should have mentioned this in your email," as if it would have energized a larger response or perhaps solidified their attendance. Thank-you emails were sent to all the participants that this researcher had email addresses for.

The instruction letter (see Appendix C) stated that the survey is confidential. Prior to taking the survey, participants signed, dated, and returned a consent form (see Appendix D) (page 2 of instructions) to this researcher. To support confidentiality, each participant was assigned a unique participant number on the consent form, and each survey included only that participant number to identify the participant. The participant's name does not appear on the survey.

Page 3 of the instruction letter contained three definitions of prayer as it pertains to this research project (see Appendix E). Definitions were to be read before and, if needed, during the answering of survey questions.

The survey of 32 questions was printed and fastened together. Participants were asked to keep the survey intact and to use a pen to complete it. The time allotted for this survey was 15 of the 20 minutes. Participants were asked to be as honest as possible and asked to answer every question on the survey. When the participants finished the survey, they were asked to put down

their writing instrument. Surveys were collected and participants were thanked after completed surveys were collected.

The survey (see Appendix F) is composed of Likert scales, which is a continuum of graded answer choices of always to never (Likert, 1932); yes/no, multiple-choice, and open-ended questions; as well as a demographic chaplain profile.

Survey questions explored chaplains' feelings and experiences facilitating prayer (spontaneous, fixed, secular), including chaplains' comfort, anxiety, and hesitation while praying with patients. The questions also solicited participants in naming of five other faith traditions whose prayer and ritual would be most beneficial to their clinical ministry. Participants were asked to identify their current religion's most utilized prayers. The demographics in the survey included religion, years of experience and education, and cultural background.

Survey questions that addressed the four hypotheses regarding multifaith chaplain relationship to prayer (question numbers correspond to survey numbering) are as follows:

1) ***Multifaith chaplains will affirm overall comfort facilitating prayer.***

- Likert Scale questions:
    - Q1. Is prayer a part of your patient visit?
    - Q2. Do you use materials for prayer or ritual?
    - Q3. Do you pray in another's faith tradition (not your own)?
    - Q4. Do you hesitate praying with a patient?
    - Q5. Do you hesitate offering a prayer for a patient of another faith?
    - Q6. Do you hesitate to pray with a patient because he/she is non-English speaking?
- Yes/No questions:

    - Q13. Did you ever not pray because the patient/family member is not of your religion/faith tradition?
    - Q14. Did you ever not pray spontaneously on your part because the patient was not in your religion/faith tradition?
    - Q19. Are you ever uncomfortable performing a prayer that is not concordant with your religion?
    - Q20. Do you ever utilize secular prayer?
    - Q21. Do you feel comfortable utilizing other religion's sources for prayer?
    - Q22. Do you feel comfortable utilizing other religion's sources for ritual?
    - Q23. Do think it would be useful to have a source for multifaith prayers for chaplains?
    - Q24. Have you ever not prayed with a patient because they were non-English speaking?
    - Q25. Do you prefer secular prayer to fixed religious prayer?
- Open-ended questions:
    - Q26. What 3 to 5 written materials do use for prayer to support patients at the bedside?
    - Q27. What 3 to 5 objects do use for prayer or ritual to support patients at the bedside?
    - Q28. What are the 3 to 5 prayers/psalms that you use most from your religion?

2) Multifaith chaplains will prefer facilitating spontaneous prayer over fixed prayer.

- Likert Scale questions:
    - Q2. Do you use materials for prayer or ritual?

- Q11. Do you prefer facilitating spontaneous prayer at the bedside, rather than fixed prayer?
- Q12. Do you hesitate to utilize both fixed prayer and spontaneous prayer with patient and or family?

- Yes/No questions:
  - Q19. Are you ever uncomfortable performing a fixed prayer that is not concordant with your religion?
  - Q25. Do you prefer secular prayer to fixed religious prayer?

3) Multifaith chaplains will affirm comfort facilitating prayer with those of disparate faiths.

Likert Scale questions:

- Q3. Do you pray in another's faith tradition (not your own)?
- Q5. Do you hesitate offering a prayer for a patient of another faith?
- Q10. Do you feel inauthentic praying with a patient not concordant with your religion?

- Yes/No questions:
  - Q13. Did you ever not pray because the patient/family member is not of your religion/faith tradition?
  - Q14. Did you ever not pray spontaneously on your part because the patient was not in your religion/faith tradition?
  - Q15. Did you ever not pray, even though you were asked, because the patient was not in your religion/faith tradition?
  - Q19. Are you ever uncomfortable performing a prayer that is not concordant with your religion?

- Q21. Do you feel comfortable utilizing other religion's sources for prayer?

4) ***Multifaith chaplains will affirm the benefit of a multifaith prayer resource in their provision of care.***

- Likert Scale questions:
  - Q2. Do you use materials for prayer or ritual?
- Yes/No questions:
  - Q21. Do you feel comfortable utilizing other religion's sources for prayer?
  - Q22. Do you feel comfortable utilizing other religion's sources for ritual?
  - Q23. Do think it would be useful to have a source for multifaith prayers for chaplains?
  - Q24. Have you ever not prayed with a patient because he/she was non-English speaking?
  - Q25. Do you prefer secular prayer to fixed religious prayer?
- Open-ended questions:
  - Q26. What 3 to 5 written materials do use for prayer to support patients at the bedside?
  - Q27. What 3 to 5 objects do use for prayer or ritual to support patients at the bedside?
  - Q28. What are the 3 to 5 prayers/psalms that you use most from your religion?
  - Q29. What 5 religions most represent your patient population?
- Multiple choice questions:
  - Q30. Who are you most comfortable reciting or facilitating prayer?
  - Q31. What would your preferred multifaith prayer source for chaplains be?

    - Q32. If a multifaith prayer app were to be created, what features would you like it to include (check all that apply)?

Survey questions that addressed multifaith chaplains' anxiety (discomfort, inauthenticity) facilitating prayer and with chaplaincy that provide data supporting the fourth hypothesis and the need for multifaith prayer source:

- Likert Scale questions:
    - Q4. Do you hesitate praying with a patient?
    - Q5. Do you hesitate offering a prayer for a patient of another faith?
    - Q6. Do you hesitate to pray with a patient because they are non-English speaking?
    - Q7. Do you hesitate to interact with a patient because they are non-English speaking?
    - Q8. Do you feel inauthentic as a chaplain?
    - Q9. Do you feel inauthentic praying with patients and or family at the bedside?
    - Q10. Do you feel inauthentic praying with a patient not concordant with your religion?
    - Q11. Do you prefer facilitating spontaneous prayer at the bedside, rather than fixed prayer?
- Yes/No questions:
    - Q13. Did you ever not pray because the patient/family member is not of your religion/faith tradition?
    - Q14. Did you ever not pray spontaneously on your part because the patient was not in your religion/faith tradition?
    - Q15. Did you ever not pray, even though you were asked, because the patient was

not in your religion/faith tradition?

- Q16. Did you ever perform a ritual for a patient/family not in your faith tradition?
- Q17. Did you ever abstain from performing a ritual when asked because of patient being discordant with your religion?
- Q18. Would you feel comfortable performing a ritual of another religion (confession, forgiveness, at death, post death) if you had an appropriate source/guide?
- Q19. Are you ever uncomfortable performing a prayer that is not concordant with your religion?

There following questions in the survey serve the future development of a multifaith prayer resource, but are not relevant to this project's hypotheses. They focus on ritual and secular prayer and will not be included in the Results section:

- Yes/No questions:
  - Q16. Did you ever perform a ritual for a patient/family not in your faith tradition?
  - Q17. Did you ever perform a ritual when asked because of a patient being discordant with your religion?
  - Q18. Would you feel comfortable performing a ritual of another religion (forgiveness, confession, at death, post death) if you had an appropriate resource guide?
  - Q20. Do you ever utilize secular prayer?
  - Q22. Do you feel comfortable utilizing another religion's sources for prayer?
  - Q25. Do you prefer secular prayer to fixed religious prayer?

Demographic Data Collection

Of the 16 chaplains who participated in the survey, the gender breakdown is as follows: 9 identified as female, 4 as male, one as "trans," and one was left blank. Their current religion status is as follows: 2 identified as Buddhist, 10 as Christian, 4 as Jewish. Chaplains employed are as follows: 9 staff chaplains, 4 chaplain residents, 2 chaplain intern volunteers, and 1 director. It was further broken down between 12 full-time chaplain employees, 1 part-time staff, and 3 volunteers.

Table 1

Demographics Chart

Characteristic	Chaplain Intern		Chaplain Resident		Staff Chaplain		Director/Manager		Full Sample	
	n	%	n	%	n	%	n	%	n	%
Gender										
Female	2	100	1	25	6	67	1	100	10	63
Male	0	0	2	50	3	33	0	0	5	31
Trans	0	0	1	25	0	0	0	0	1	6
Age Group										
20-29	0	0	0	0	2	22	0	0	2	13
30-39	0	0	2	50	3	33	0	0	5	31
40-49	0	0	2	50	0	0	0	0	2	13
50-59	1	50	0	0	1	11	0	0	2	13
60-69	1	50	0	0	3	33	1	100	5	31
Highest Education										
Bachelor	1	50	0	0	0	0		0	1	6
Doctor	0	0	0	0	1	11	1	100	2	13
Master	1	50	4	100	5	56	0	0	10	63
Post Doctor	0	0	0	0	2	22	0	0	2	13
Rabbinical	0	0	0	0	1	11	0	0	1	6
Board Certified										
No	2	100	4	100	7	78	1	100	14	88
Yes	0	0	0	0	2	22	0	0	2	13
CPE Units Completed										

1	0	0	0	0	0	0	0	0	0	0
2	1	50	1	25	0	0	0	0	2	13
3	0	0	3	75	0	0	0	0	3	19
4	1	50	0	0	5	56	0	0	6	38
5	0	0	0	0	1	11	0	0	1	6
>5	0	0	0	0	3	33	1	100	4	25
Work Location										
[redacted]	1	50	0	0	0	0	0	0	1	6
[redacted]	0	0	1	25	1	11	0	0	2	13
[redacted]	0	0	3	75	5	56	1	100	9	56
[redacted]	0	0	0	0	1	11	0	0	1	6
[redacted]	0	0	0	0	1	11	0	0	1	6
[redacted]	1	50	0	0	1	11	0	0	2	13
Employment Status										
Full Time	0	0	3	75	8	89	1	100	12	75
Part Time	0	0	1	25	0	0	0	0	1	6
Part Time Volunteer	0	0	0	0	1	11	0	0	1	6
Volunteer	2	100	0	0	0	0	0	0	2	13
Original Religion										
Buddhist	0	0	0	0	0	0	0	0	0	0
Christian	2	100	3	75	4	44	1	100	10	63
Jewish	0	0	0	0	5	56	0	0	5	31
None	0	0	1	25	0	0	0	0	1	6
Current Religion										
Buddhist	2	100	0	0	0	0	0	0	2	13
Christian	0	0	3	75	6	67	1	100	10	63
Jewish	0	0	1	25	3	33	0	0	4	25
Clergy Title										
Pastor	0	0	1	25	0	0	0	0	1	6
Minister	0	0	0	0	1	11	0	0	1	6
Rabbi	0	0	1	25	2	22	0	0	3	19
Reverend	0	0	0	0	1	11	0	0	1	6
Reverend Dr	0	0	0	0	0		1	100	1	6
None	2	100	2	50	5	56	0	0	9	56

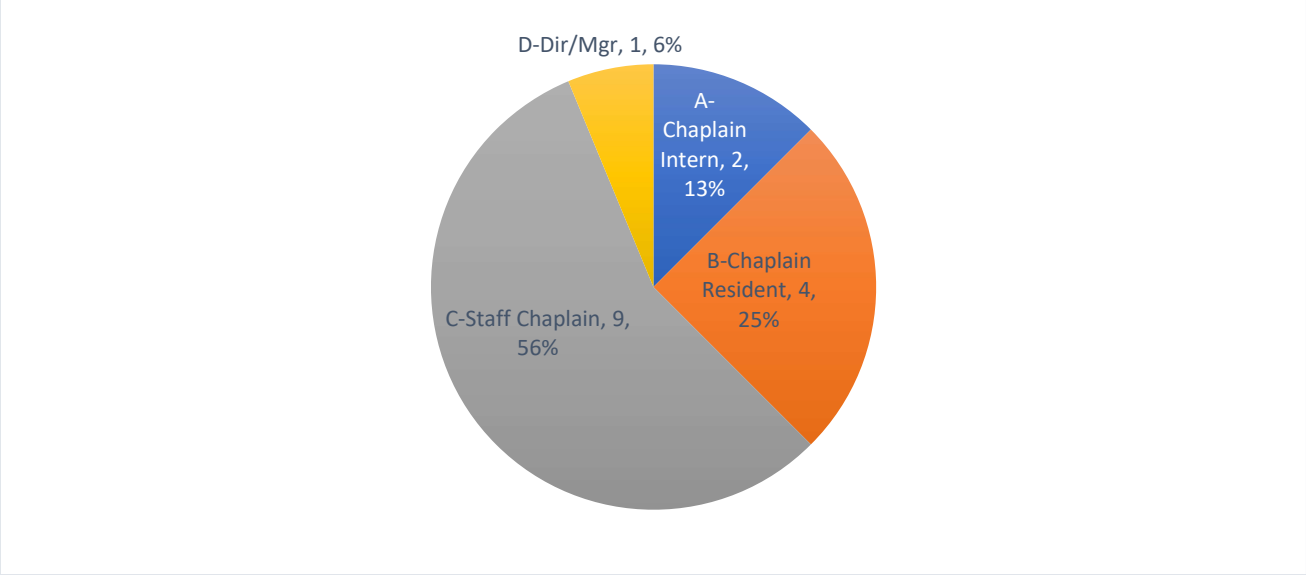
Results

Analysis of Demographic Data

Demographic data is shown in Figures 1 through 6c. Slightly more than half (56%) of the participants were staff chaplains. Five participants (25%) were chaplain residents. One (6%) manager participated. The 2 chaplain interns (13%) who participated were from a palliative care department (See Figure 1).

Figure 1

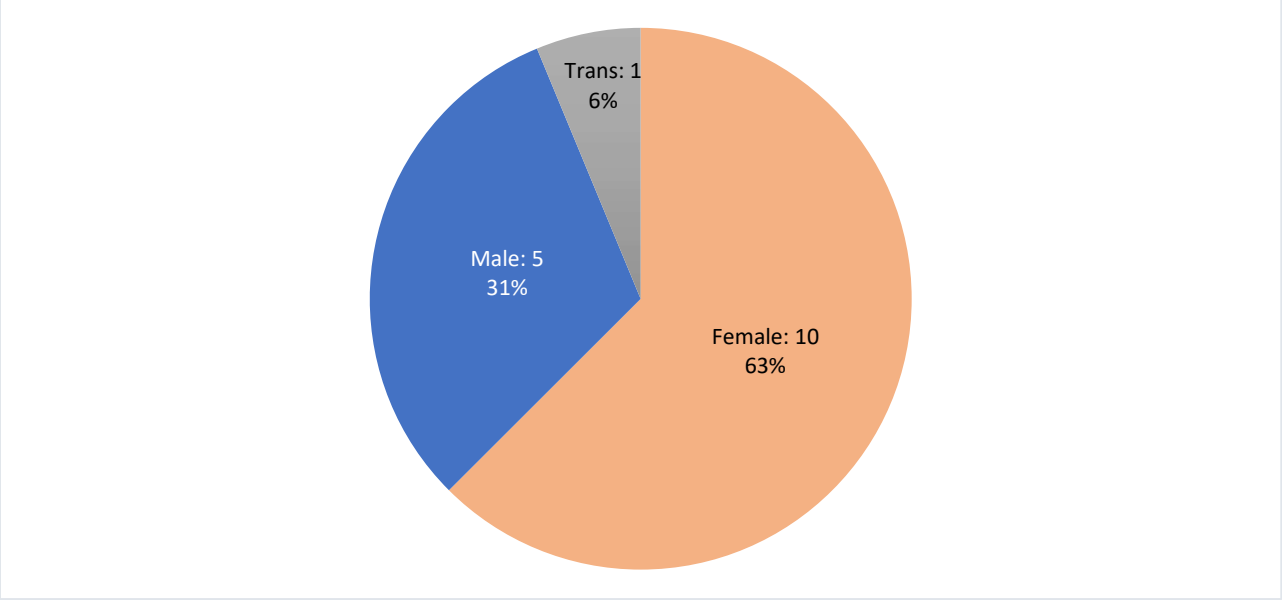
Participants by Job Title



Almost two thirds of the participants were female. One chaplain (6%) identifies as trans. (See Figure 2.)

Figure 2

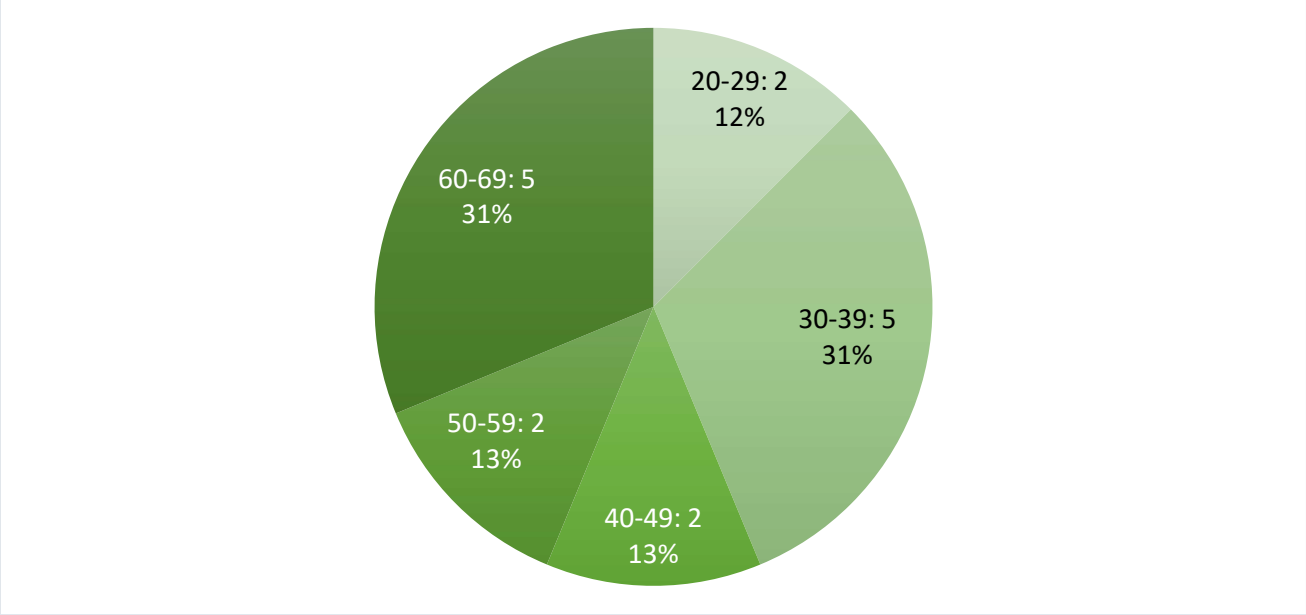
Participants by Gender



The majority of chaplain participants were either in their 30s (31%; 5 persons) or in their 60s (31%, 5persons). No one was over 70 years old. Ages 20–29, 40–49, 50–59 each represented 13% (2 persons). See Figure 3a.

Figure 3a

Participants by Age Group



In Figure 3b chaplains were evenly distributed among age groups. Both chaplain interns are over fifty years old, as is the chaplain manager, and 44% of the participants.

Figure 3b

Participants by Job Title Within Age Group

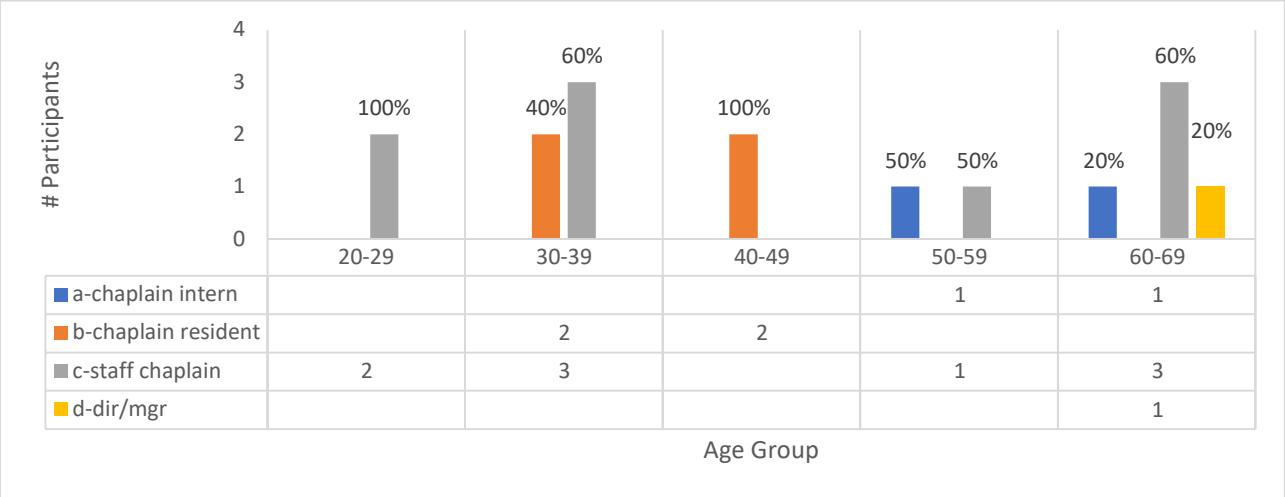
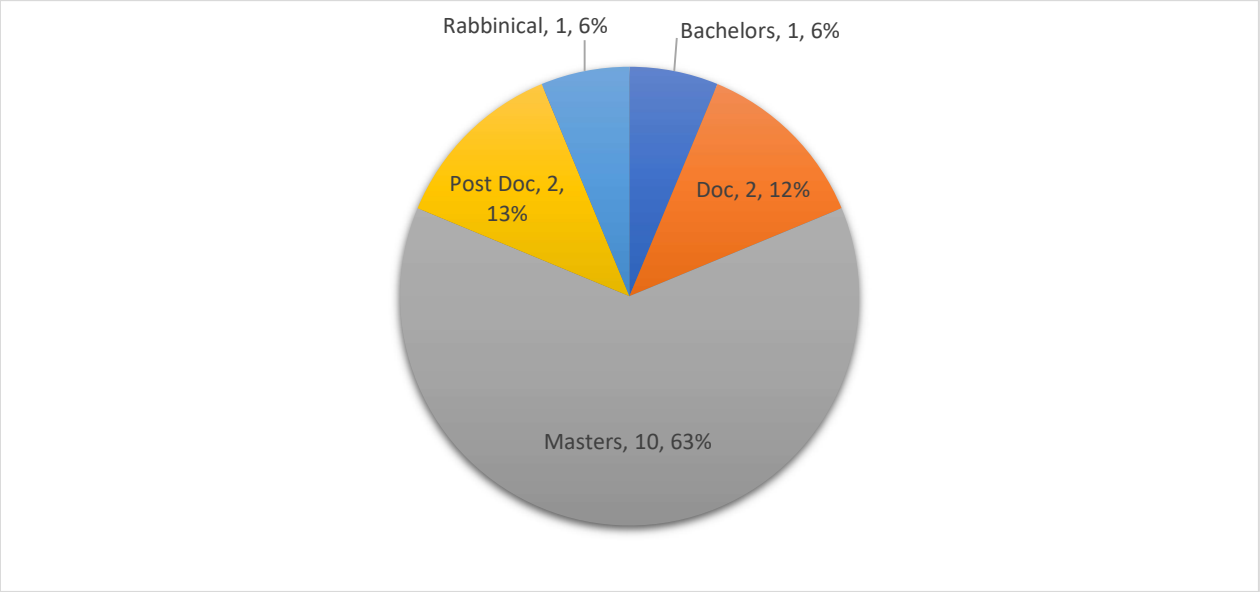


Figure 4 presents that 63% (10) chaplain participants' education level is at a master's level and that 25% of participants were at doctorate or post doctorate level. One chaplain participant's highest education level is a bachelor's degree.

Figure 4

Participants by Education Level



For a comparison, the percentage of certified chaplain participants in the survey was compared to the percentage within the entire Department of Spiritual Care and Education (see Figures 5a and 5b). We see that the percentage of certification is nearly the same.

Figure 5a

Participants by Board Certification

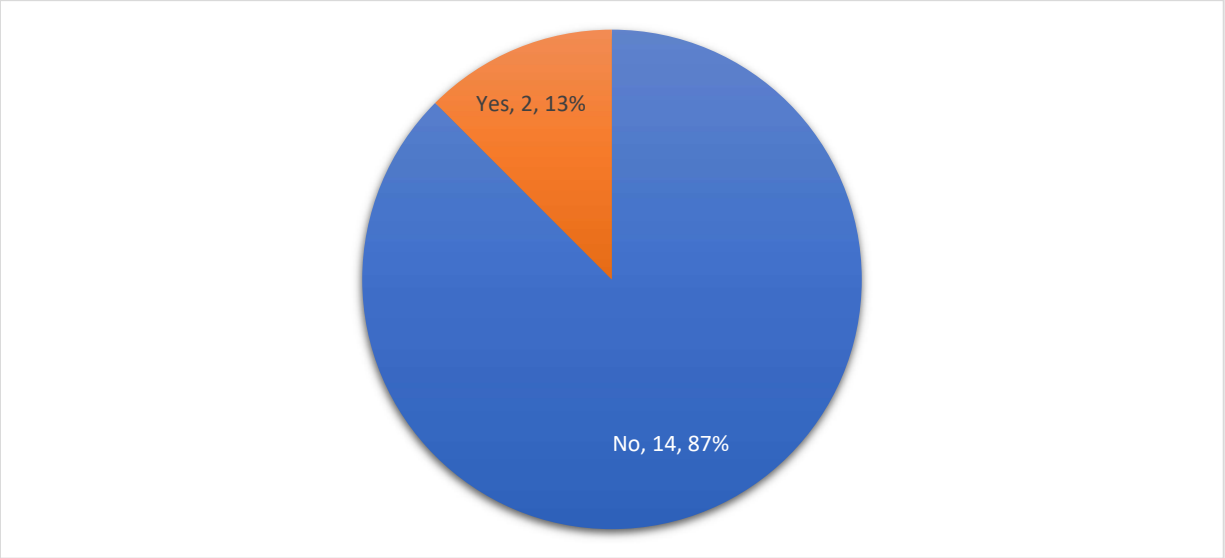
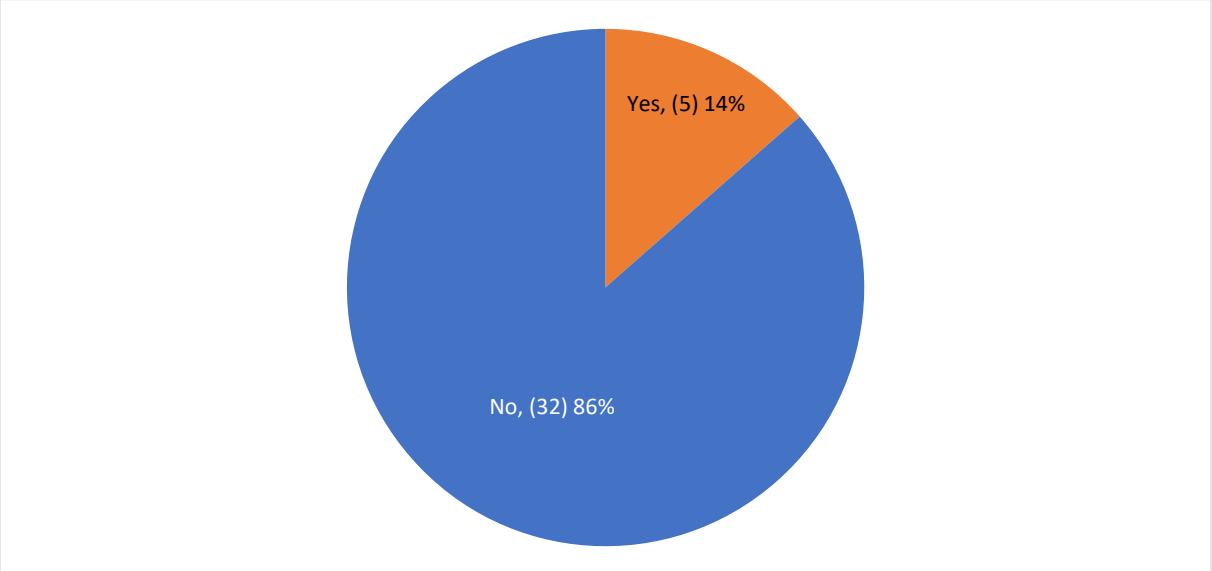


Figure 5b

Spiritual Care Department by Board Certification



Four CPE units are required for board certification. Sixty-nine percent (11) of participants satisfied the CPE unit requirement for board certification, and of those 11 participants, five (31% of all participants) had 5 or more units (see Figure 6a). The chaplain director and four staff chaplains completed more than 4 units; those with fewer than the 4-unit requirement consisted only of interns and resident chaplains (see Figure 6b & Figure 6c).

Figure 6a

Participants by CPE Units

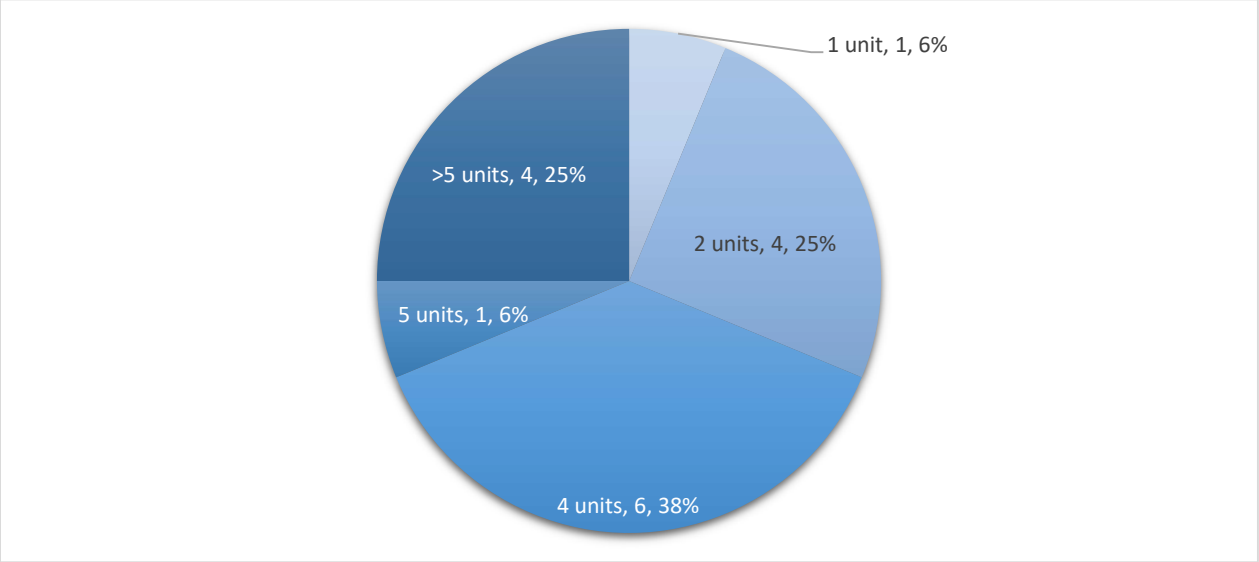


Figure 6b

Participants by Job Title Within CPE Units

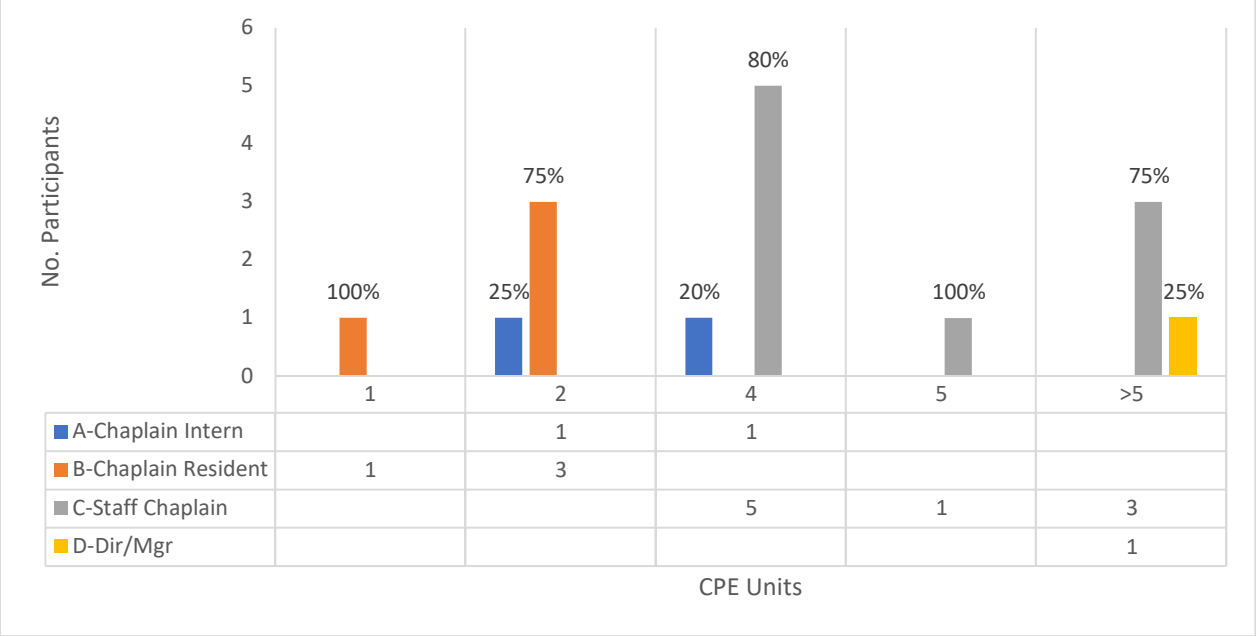
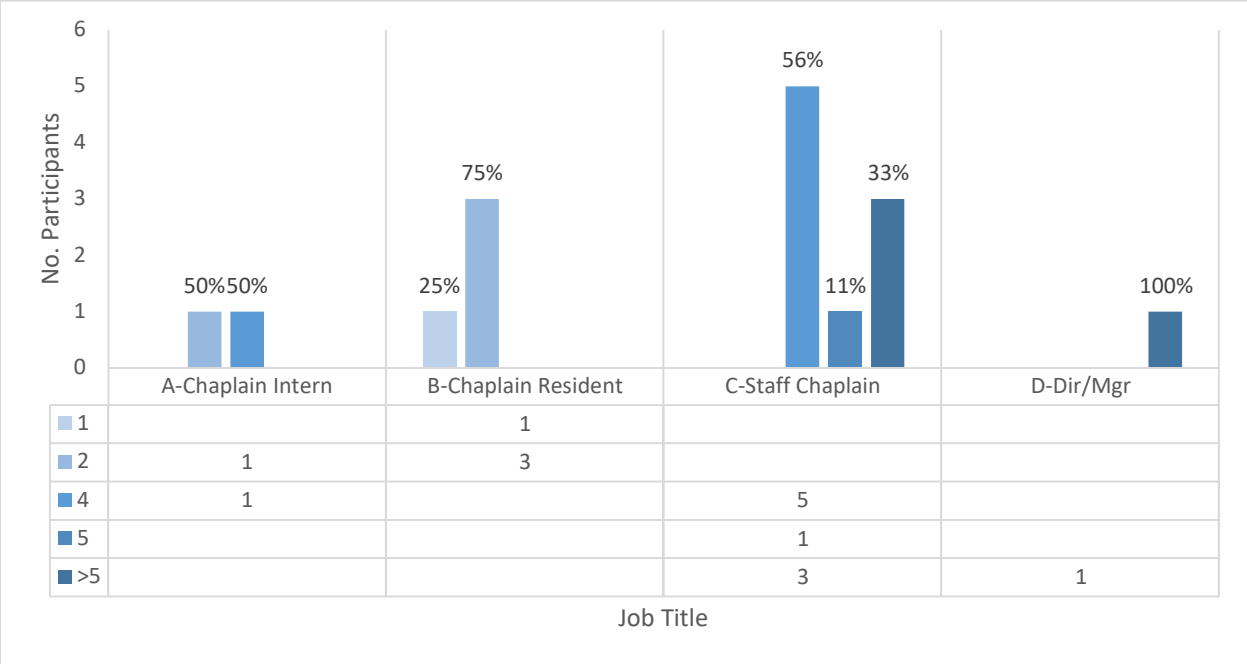


Figure 6c

Participants by CPE Units Within Job Title



Analysis for Survey Questions

Figures 7a through 36b correspond to the survey questions.

Figures 7a and 7b illustrate Question 1. Prayer is often facilitated by chaplain participants in visits; 63% of our participants pray often, 37% pray sometimes. All chaplain participants according to this survey utilize prayer.

Figure 7a

Frequency Of Prayer As Part of Patient Visit

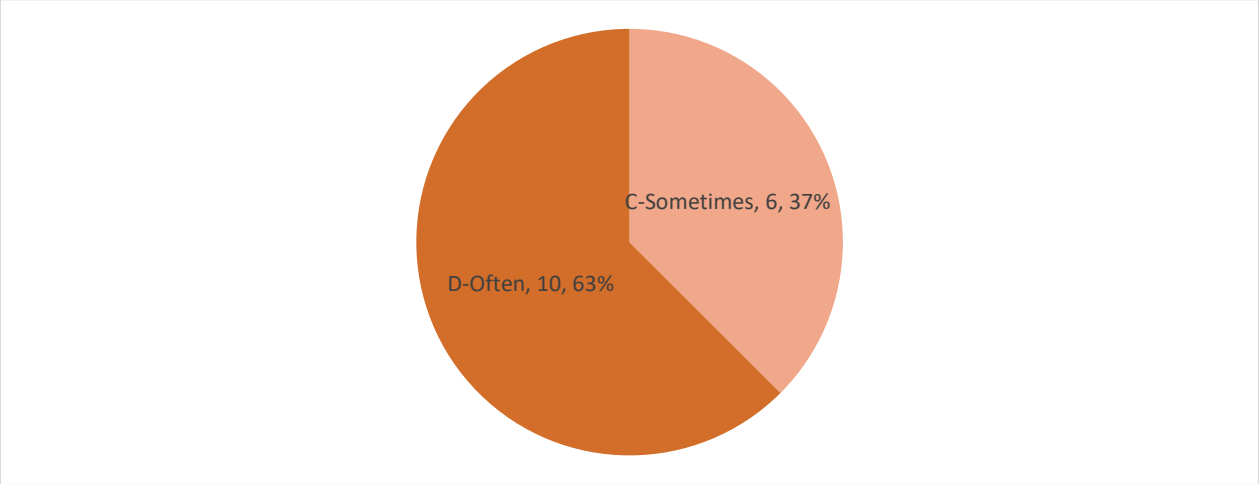
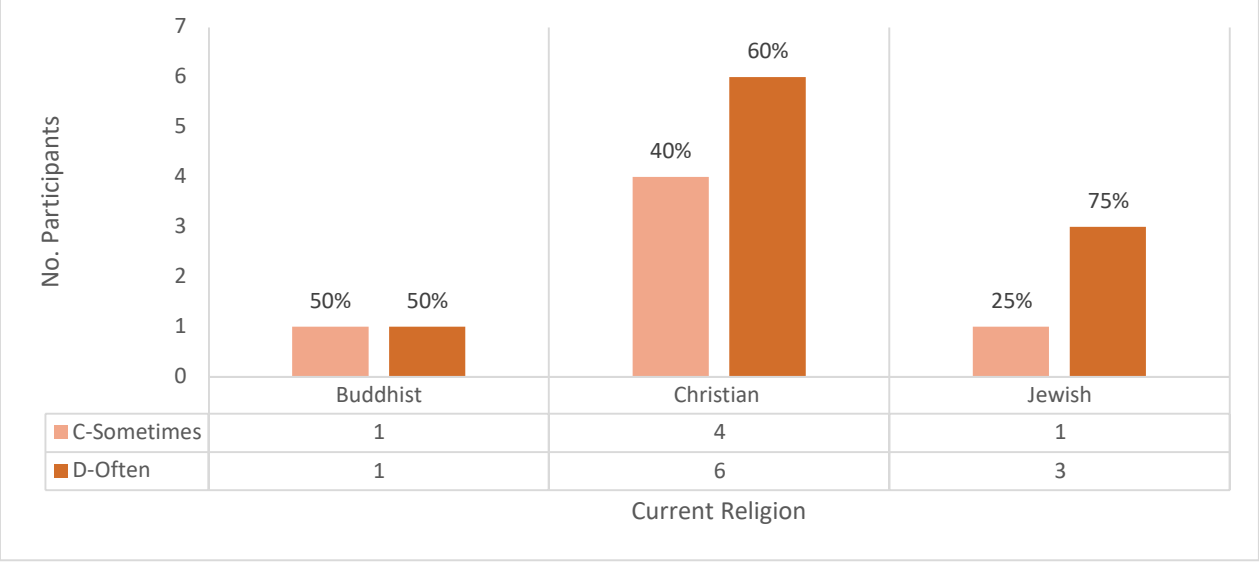


Figure 7b

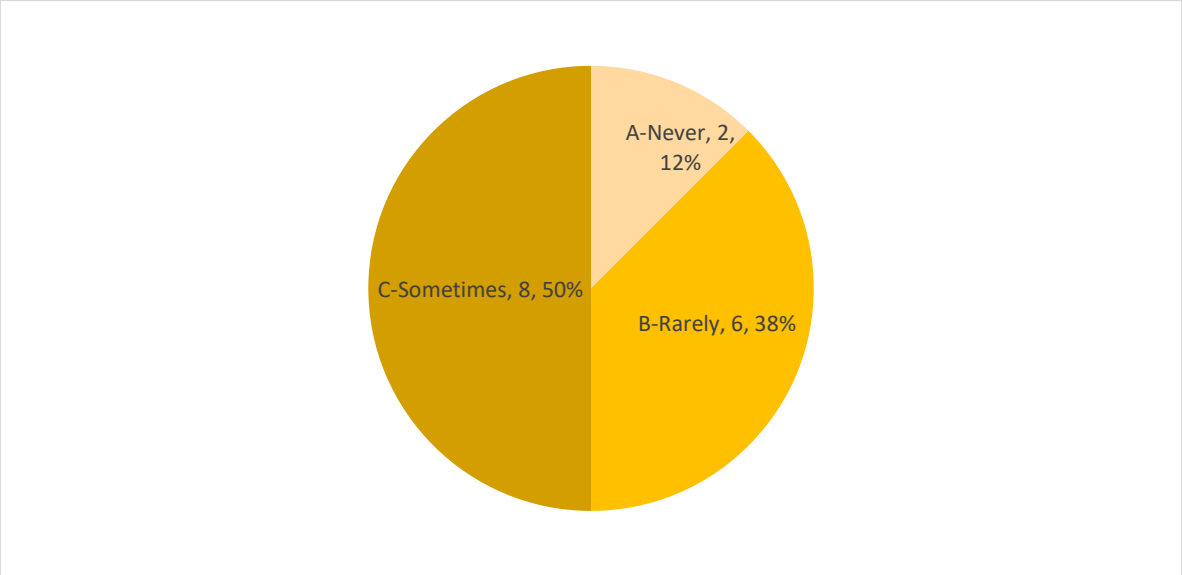
Frequency of Prayer As Part of Patient Visi t- By Chaplain's Religion



In Figure 8 (refers to Question 2) we see 50% of participants sometimes use materials for prayer; while 50% rarely or never use materials.

Figure 8

Frequency of Use of Materials for Prayer or Ritual



In Figure 9a (refers to Question 3), we see that 88% of chaplain participants pray in another's faith tradition (not their own). In Figure 9b, we examine this broken down by job title: 63% of the chaplains often or always pray in another's faith tradition. Twenty-five percent pray sometimes, 12% rarely or never pray with patients of another faith tradition. One (25%) of the Jewish chaplains never prays in another faith. The Buddhist chaplains or 12% of the population often/always pray with patients of another faith.

Figure 9a

Frequency of Prayer in Another's Faith Tradition

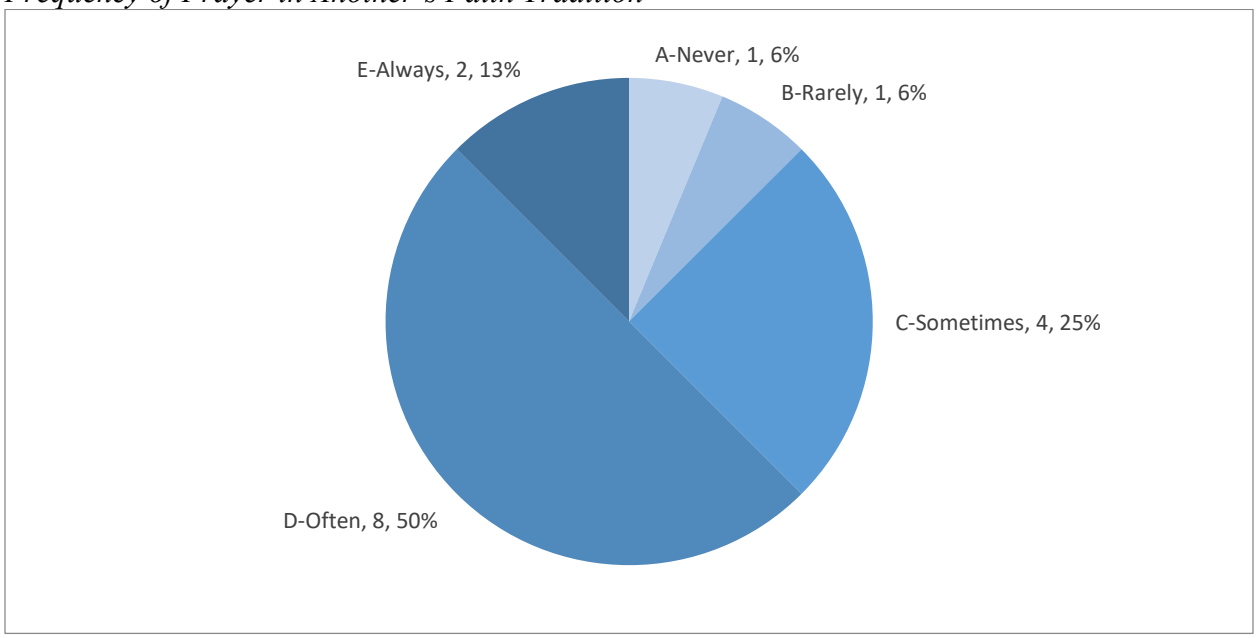
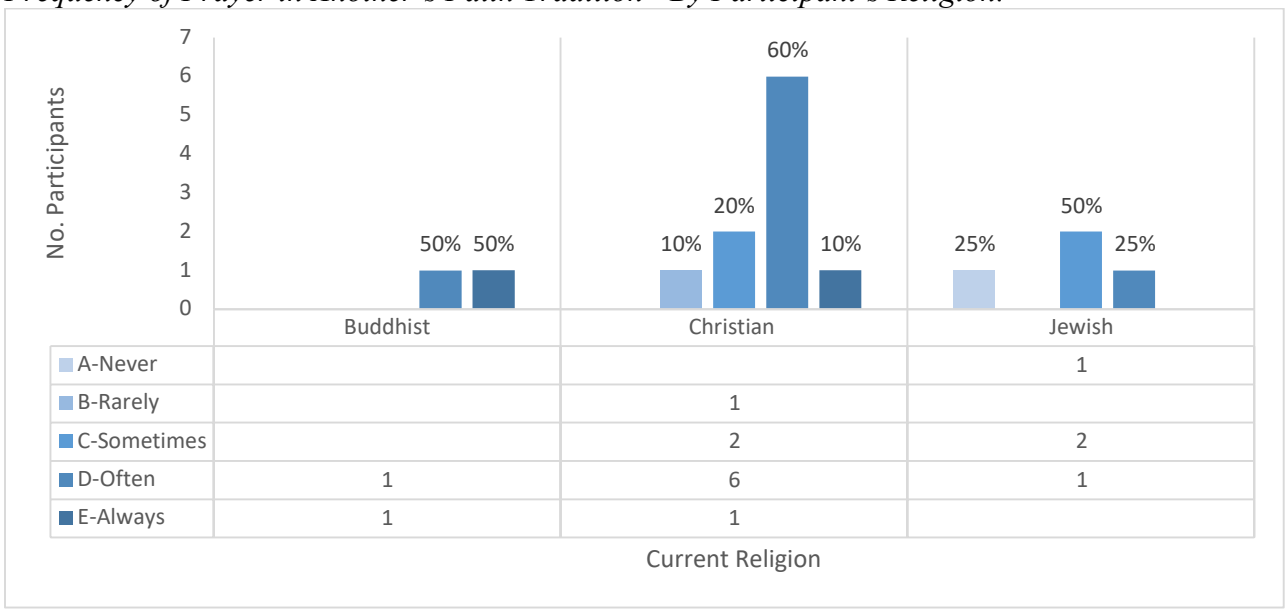


Figure 9b

Frequency of Prayer in Another's Faith Tradition - By Participant's Religion.



As shown in Figure 10a (Question 4), 19% of chaplains never hesitate praying for a patient of another faith, 38% rarely hesitate. But 44% sometimes and often do hesitate. Figure 10b further details this by the participant's religion.

Figure 10a

Frequency of Hesitation Praying With a Patient

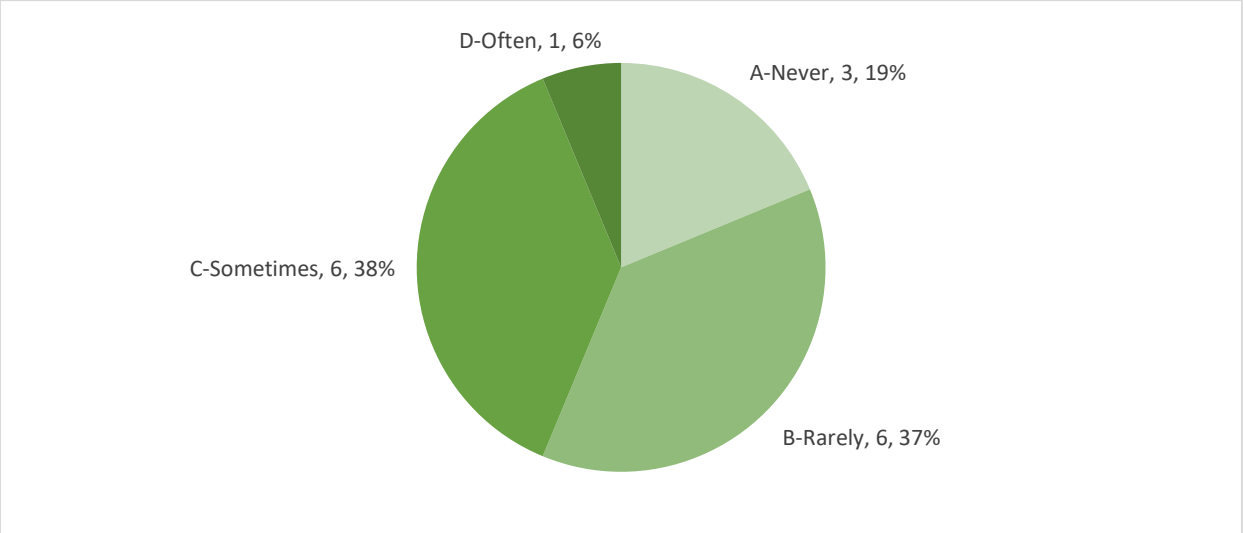
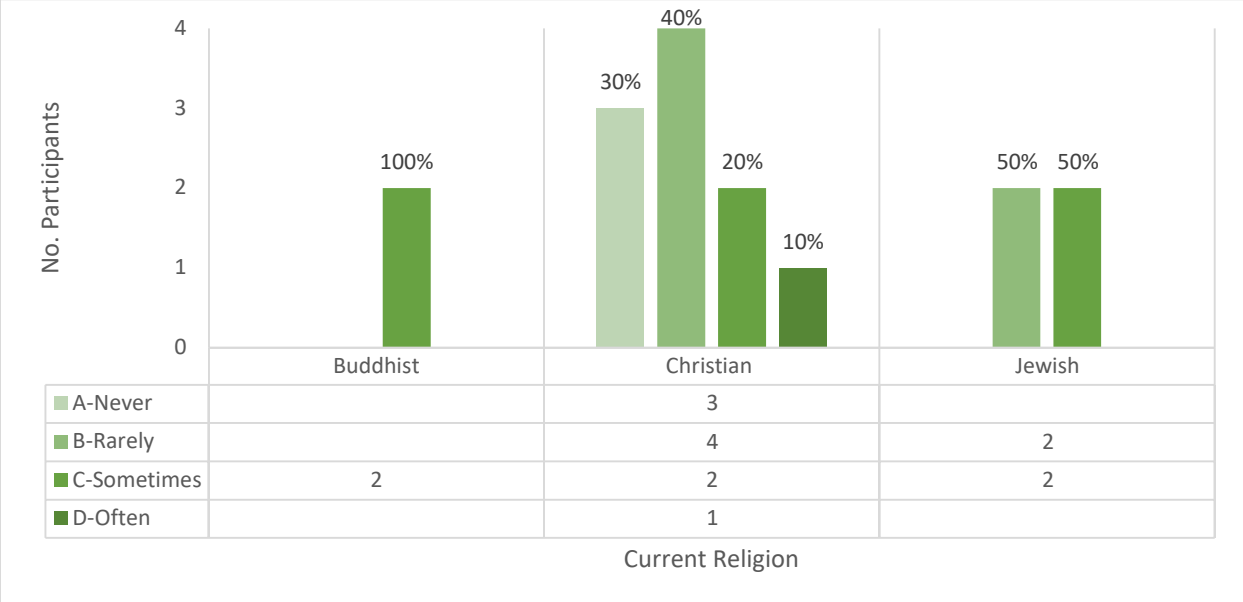


Figure 10b

Frequency of Hesitation Praying With a Patient - By Religion.



In Figure 11a (Question 5) we see 31% of chaplain group never hesitate praying with a patient, 38% rarely do. and 31% of the chaplains sometime do. By religion, in Figure 11b, we see 40% of the Christian and 25% of the Jewish chaplains never hesitate offering a prayer to a patient of another faith.

Figure 11a

Frequency of Hesitation in Offering a Prayer for a Patient of Another Faith.

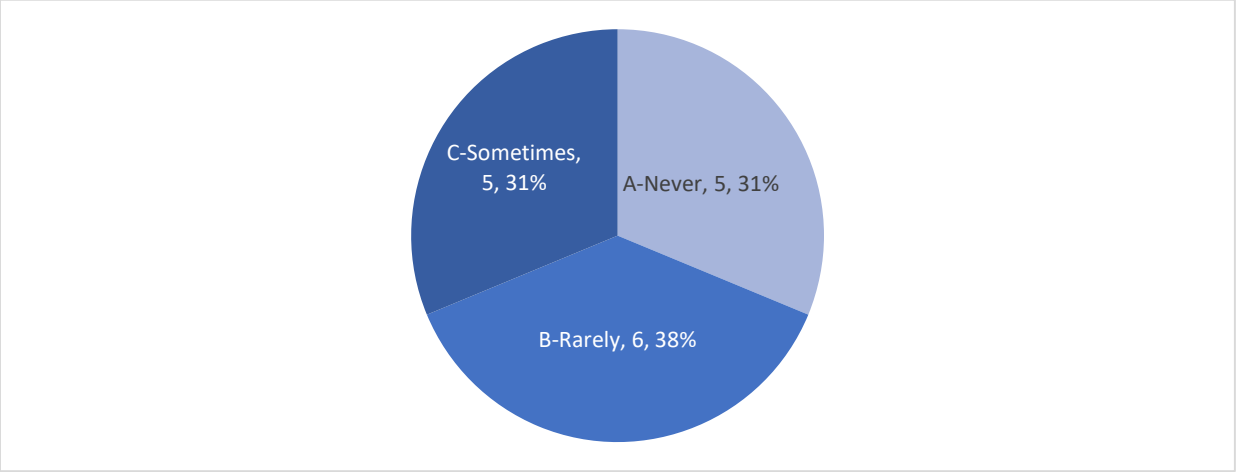
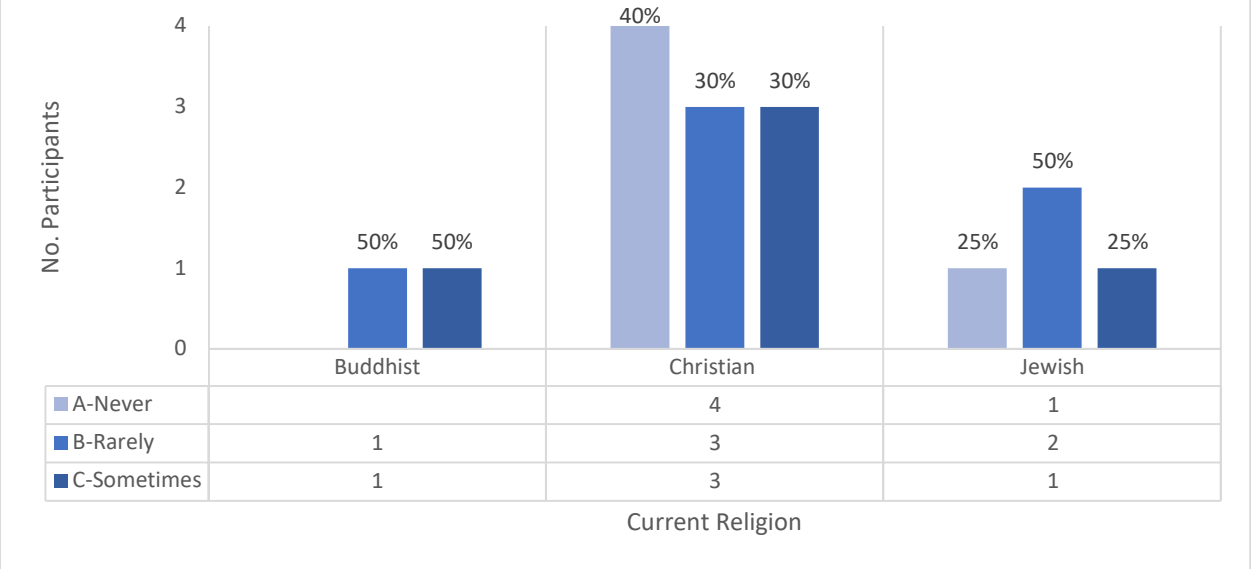


Figure 11b

Frequency of Hesitation in Offering a Prayer for a Patient of Another Faith - By Religion.



Figures 12a and 12b (Question 6) show 56% of chaplain participants sometimes or often hesitate to interact with non-English-speaking patients, 19% never hesitate, 25% rarely hesitate. No one always hesitated. By religion, it was only within the Christian participants that we found chaplains who never hesitated to interact with a non-English-speaking patient (30%) or often hesitated (10%).

Figure 12a

Frequency of Hesitation to Interact With a Patient Because They Are Non-English Speaking.

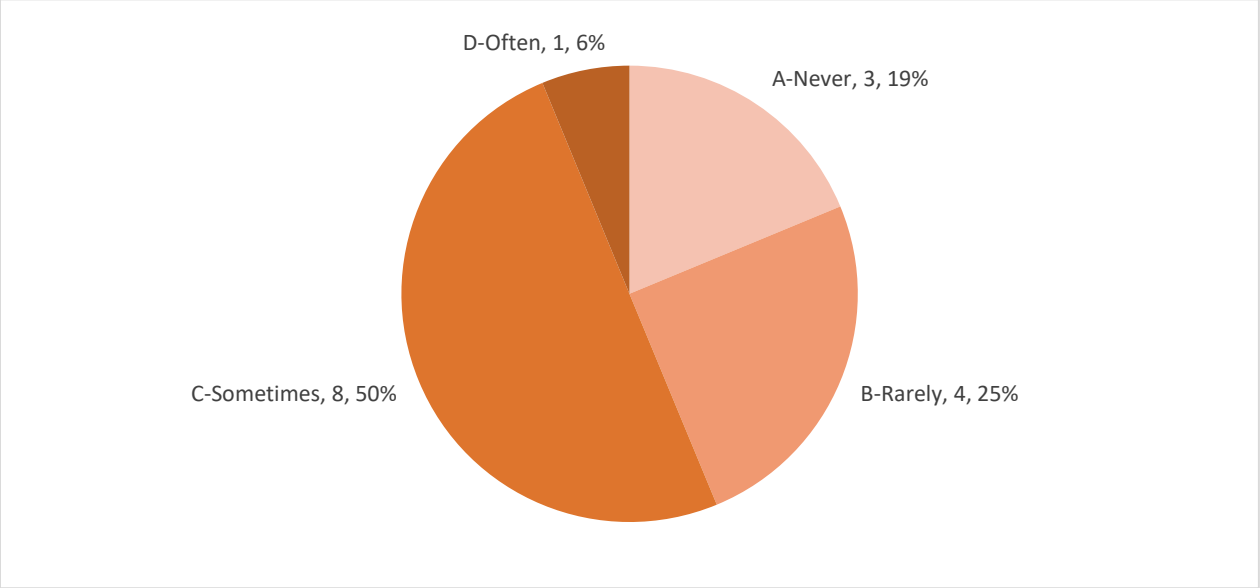
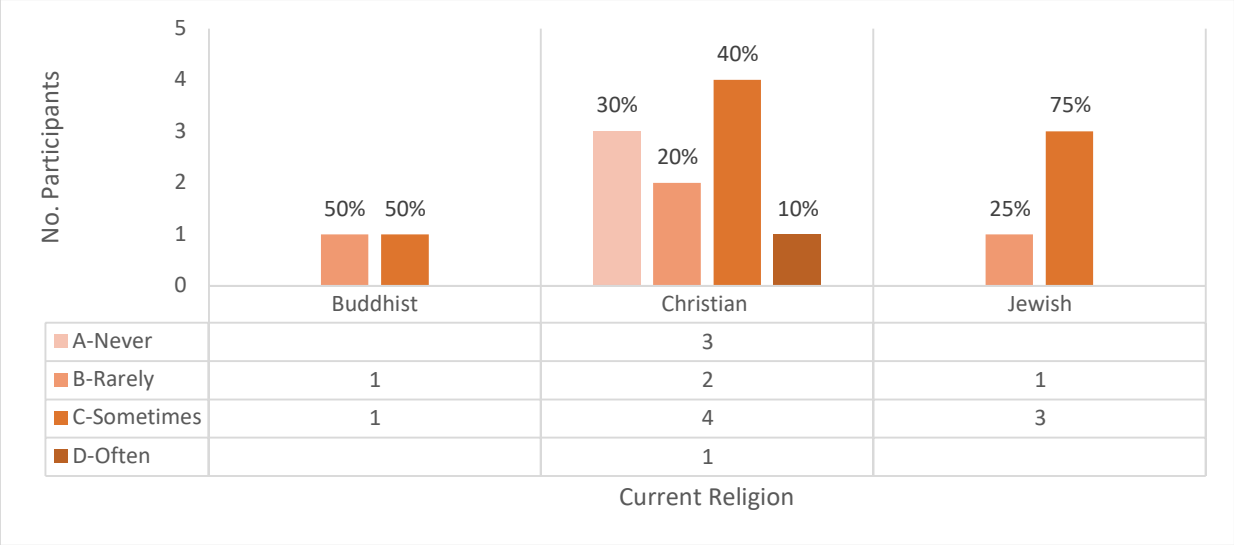


Figure 12b

Frequency of Hesitation to Interact With a Patient Because They Are Non-English Speaking - By Chaplain's Religion.



In Figures 13a, 13b, and 13c (Question 7), we see 25% of chaplains never hesitate to pray with a non-English-speaking patient, 50% rarely hesitate, 19% sometimes hesitate, 6% often hesitate. By job title, one director (6%) and 3 staff chaplains (19%) never hesitate. One chaplain (6%) resident often hesitates. By religion, both Buddhist chaplains (13%) rarely hesitate, 80% of Christian chaplains never or rarely hesitate, 50% of the Jewish chaplains never or rarely hesitate, one Christian chaplain (6%) often hesitates praying with non-English-speaking patients.

Figure 13a

Frequency of Hesitation to Pray With a Patient Because They Are Non-English Speaking.

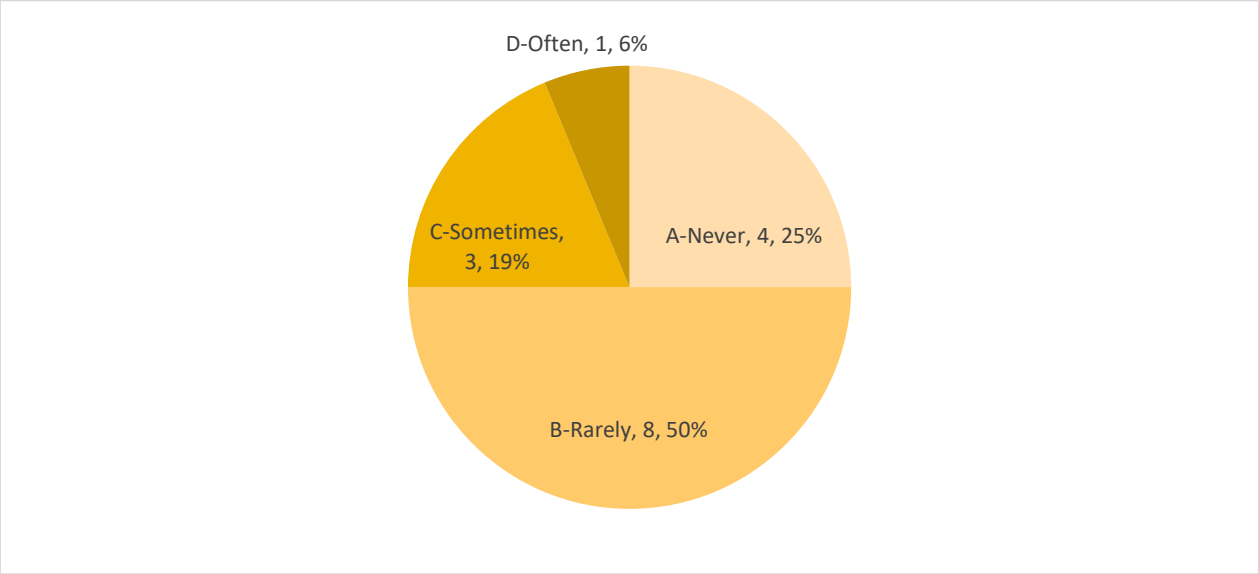


Figure 13b

Frequency of Hesitation to Pray With a Patient Because They Are Non-English Speaking - By Job Title

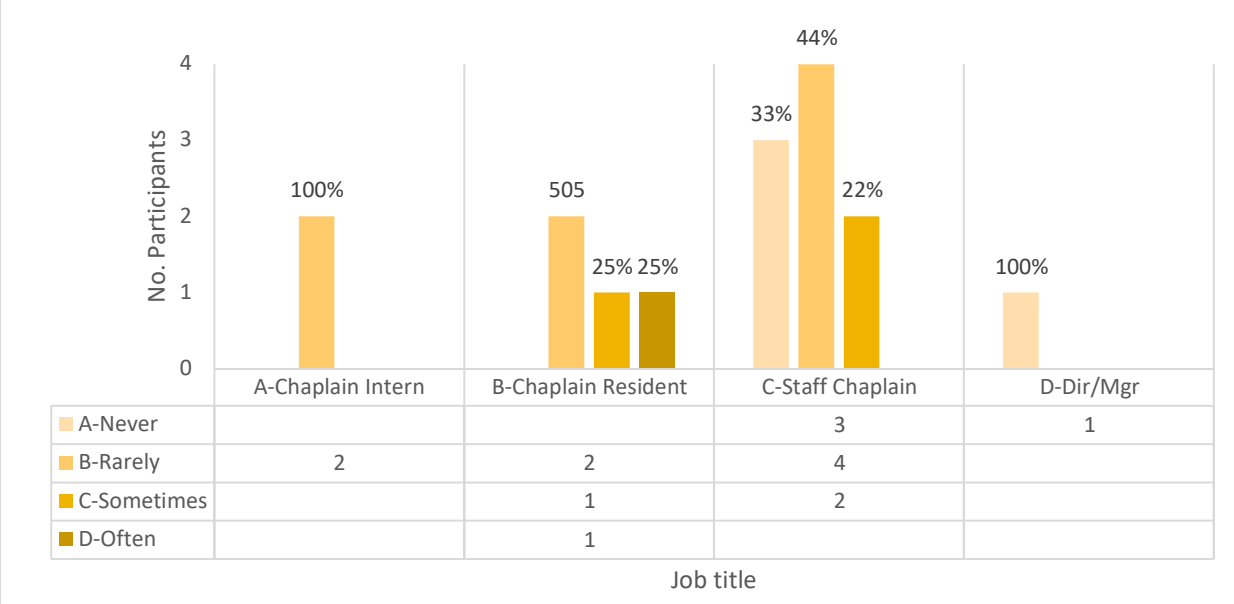
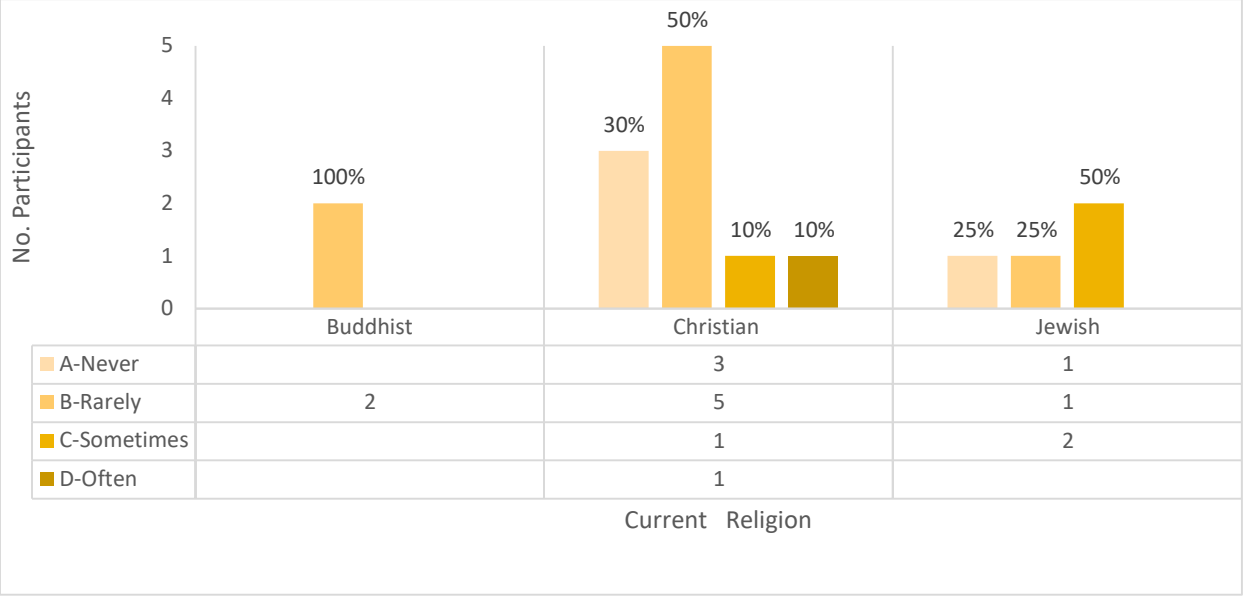


Figure 13c

Frequency of Hesitation to Pray With a Patient Because They Are Non-English Speaking - By Chaplain's Religion.



In Figures 14a, 14b, 14c (Question 8), we see that while three participants (or 19%) stated that they never feel inauthentic as a chaplain, 75% (or 13) acknowledged that at some point they have. One chaplain did not respond to the question. 44% of the participants responded that they sometimes and often do feel inauthentic (see Figure 14a). As shown in Figure 14b, most of the staff chaplains (2:1) expressed they rarely or never felt inauthentic as a chaplain. While each of the four chaplain residents expressed a different relationship with feeling inauthentic. In Figure 14c, the two chaplains that often feel inauthentic are both in their 40s. But generally, the distribution of inauthenticity appears not to show any particular pattern/trend with regard to age.

Figure 14a

Frequency of Feeling Inauthentic As Chaplain

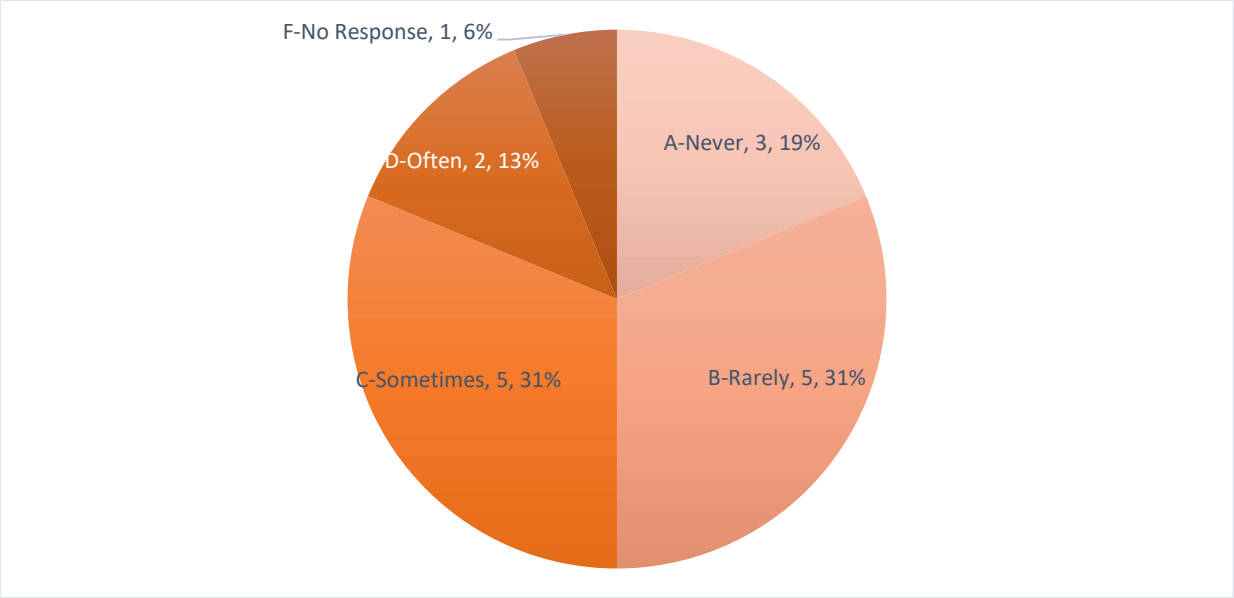


Figure 14b

Frequency of Feeling Inauthentic As Chaplain - By Job Title

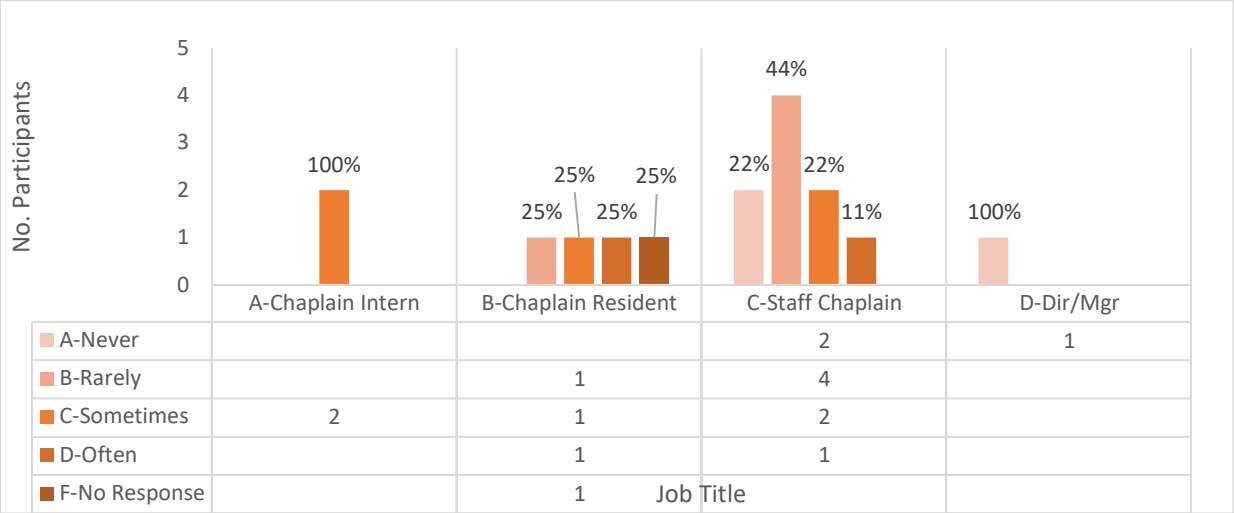
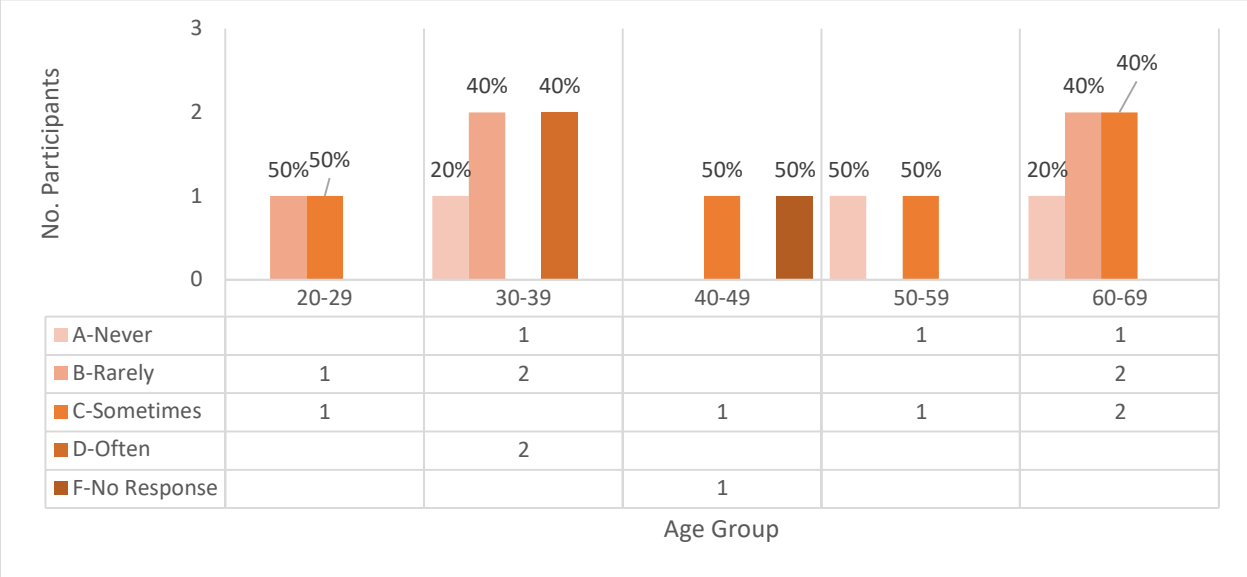


Figure 14c

Frequency of Feeling Inauthentic As Chaplain - Within Age Group



As shown in Figure 15a (Question 9) none of the chaplain-participants *often* felt inauthentic praying, but 31% or 5 of them sometimes felt inauthentic with 6 or 38% feeling that they rarely feel inauthentic praying at the patient's bedside. Though 31% or 5 never feel inauthentic, 69% or 11 rarely or sometimes feel inauthentic. Though the chaplain director never feels inauthentic praying at bedside, staff, resident, and intern chaplains all express some level of inauthenticity. It appears that greater experience is inversely proportional to feeling inauthentic at the bedside (see Figure 15b). As shown in Figure 15c, only the 20- to 29-year-old chaplains never feel inauthentic praying at bedside. 40–49 year old chaplains are the only age group that do not have a chaplain that never feels inauthentic praying at bedside. But increasing age does not appear to bear a relationship with feeling more or less inauthentic praying at bedside. In Figure 15d, 40% of Christian and 25% of Jewish faith reported never feeling inauthentic praying at bedside,

Figure 15a

Frequency of Participant Feeling Inauthentic Praying at Bedside

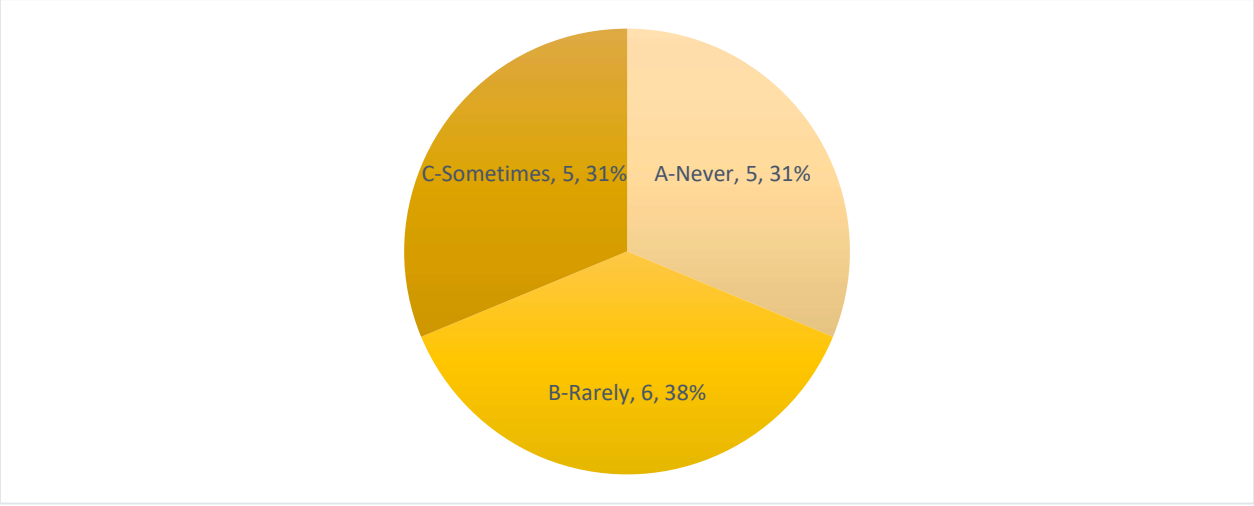


Figure 15b

Frequency of Participant Feeling Inauthentic Praying at Bedside - By Job Title

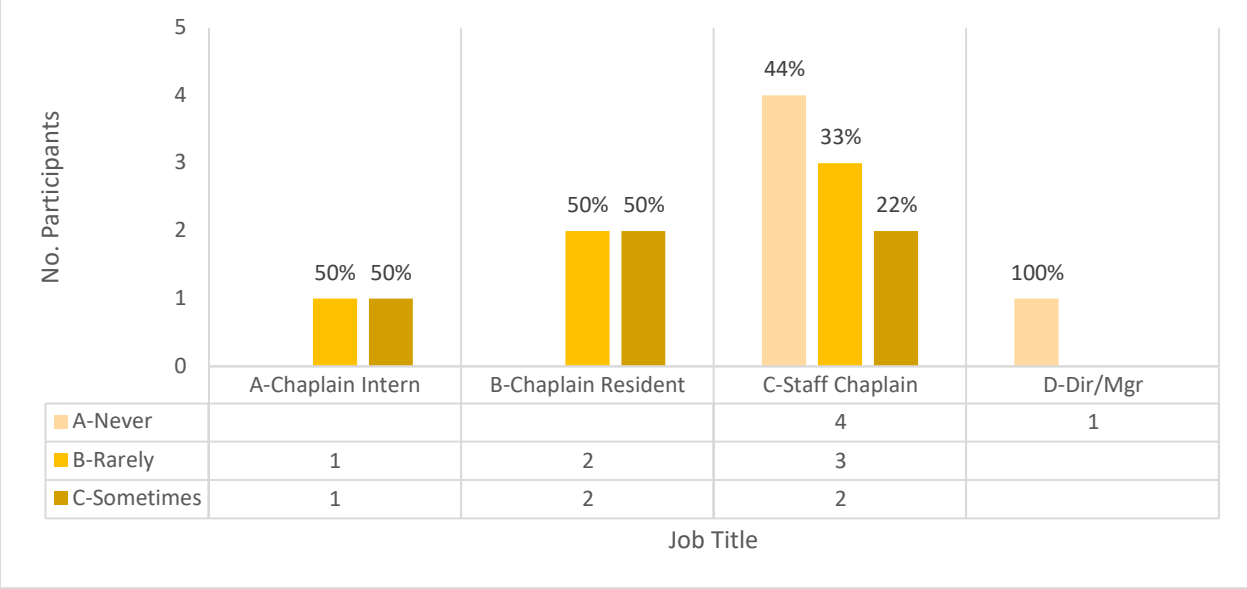


Figure 15c

Frequency of Participant Feeling Inauthentic Praying at Bedside - By Age Group

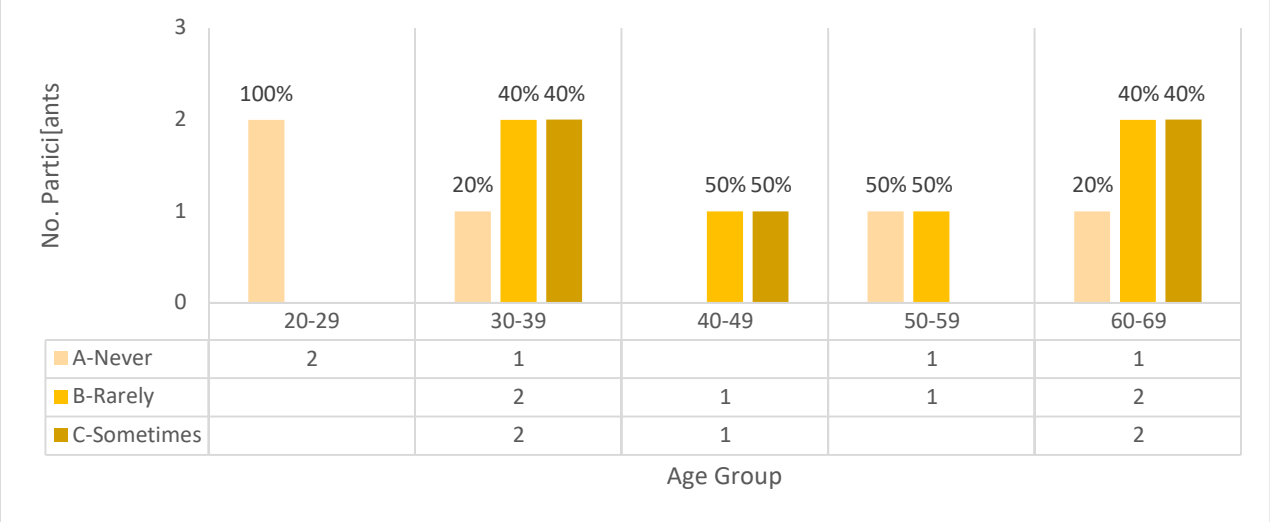
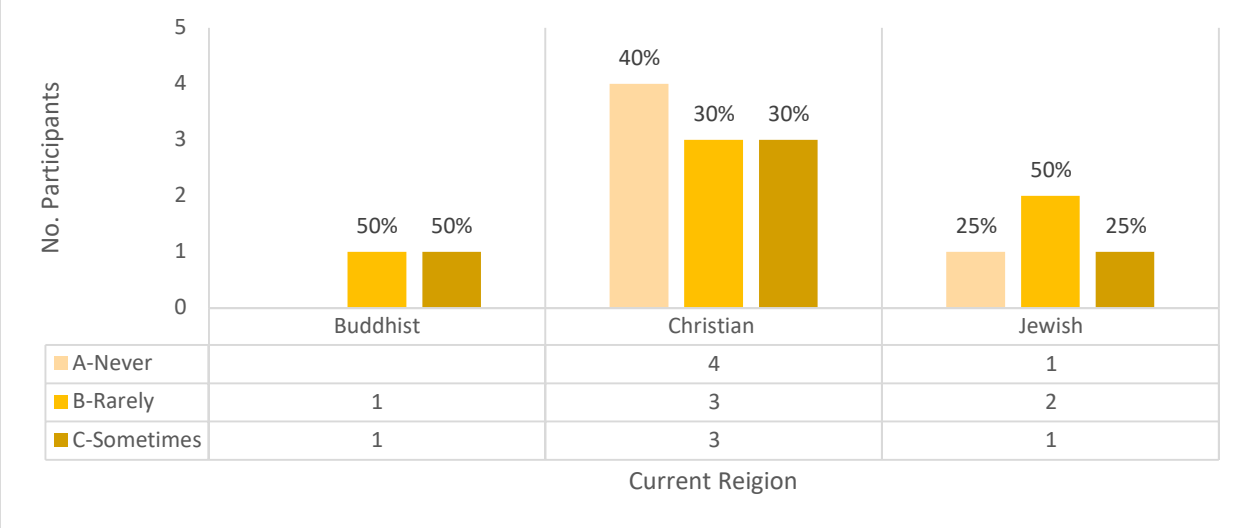


Figure 15d

Frequency of Participant Feeling Inauthentic Praying at Bedside - By Current Religion



Figures 16a through 16d (illustrating Question 10) reflects 31% of participants feeling inauthentic praying with a patient of nonconcordant religion; 38% reported rarely feeling inauthentic, with 31% reported feeling never (see Figure 16a). In Figure 16b, participants reported that only 44% of chaplain residents and the director/manager always feel authentic praying with patients of a different faith. In Figure 16c, the 20-to-29-year-old participants were the only age where chaplains reported always feeling authentic. From Figure 16d we see Christians in the survey appear to feel less inauthentic than Jews or Buddhists when praying in a nonconcordant religion (see Figure 16d).

Figure 16a

Frequency of Participants Feeling Inauthentic Praying With a Patient of Nonconcordant Religion

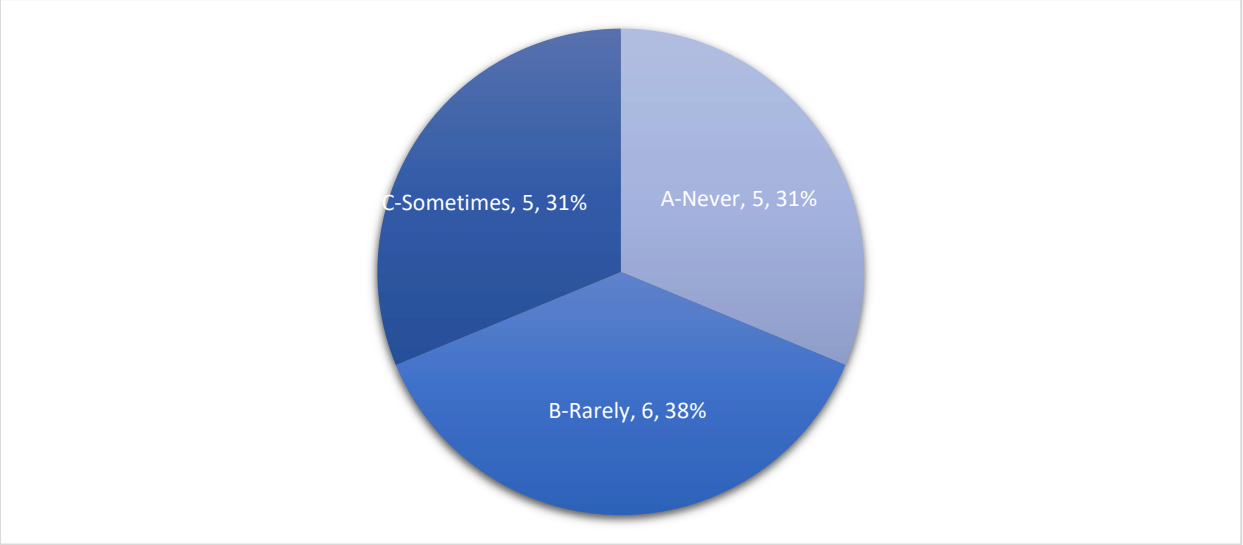


Figure 16b

Frequency of Participants Feeling Inauthentic Praying With a Patient of Nonconcordant Religion -By Job Title

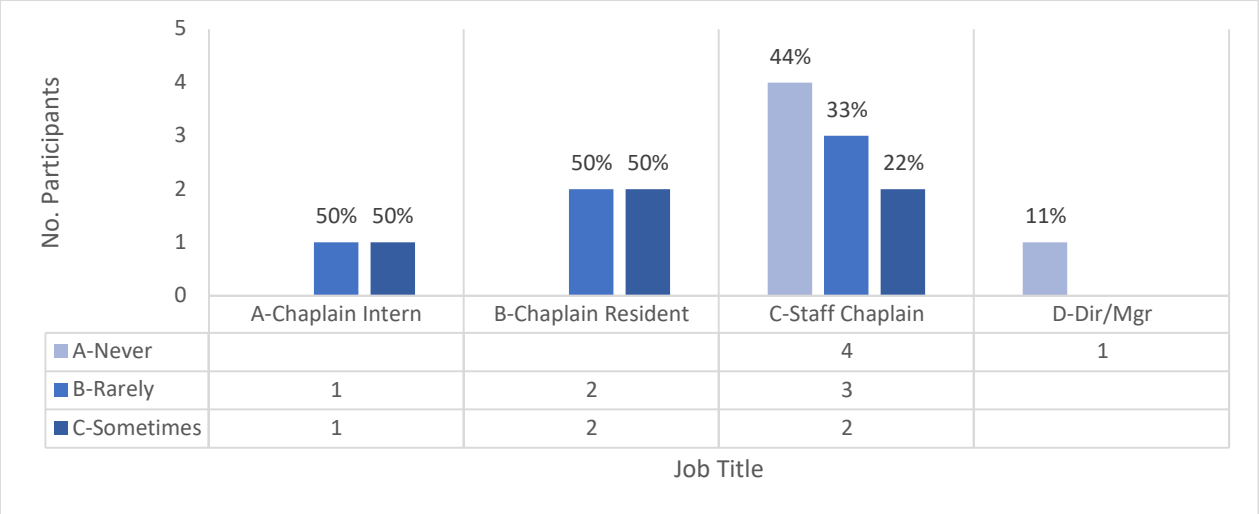


Figure 16c

Frequency of Participants Feeling Inauthentic Praying With a Patient of Nonconcordant Religion - By Age Group

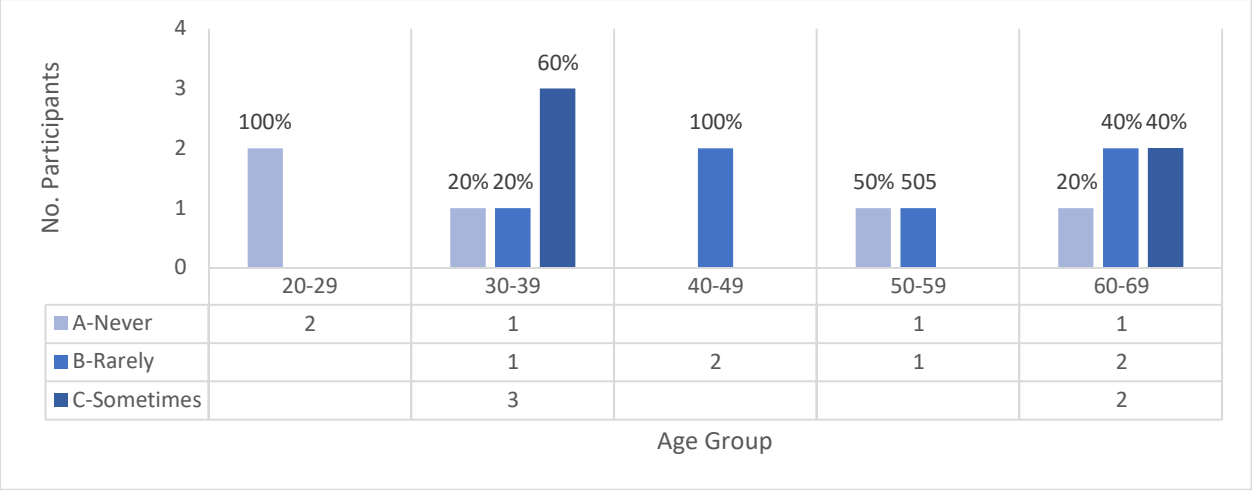
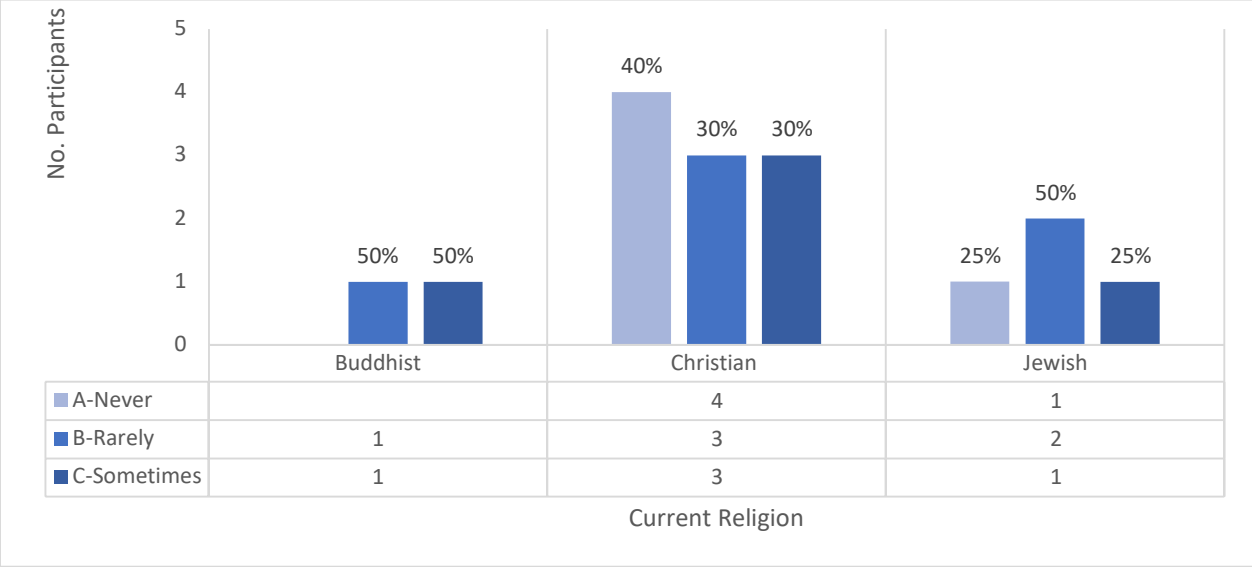


Figure 16d

Frequency of Participant Feeling Inauthentic Praying With a Patient of Nonconcordant Religion-By Current Religion



Comparing Figures 15a, 15b, 15c, 15d with 16a, 16b, 16c, 16d respectively, we see nearly identical results: The level of feeling inauthentic at bedside remains the same whether or not prayer is in a nonconcordant religion.

Participants with staff chaplain and chaplain intern titles appear more inclined to facilitate spontaneous prayer rather than fixed prayer (this refers to Question 11). Staff residents appear to show no preference; director/managers rarely preferred spontaneous prayer (see Figure 17a). Spontaneous prayer is preferred (always, often, sometimes) by 75% of chaplains. Both Buddhist chaplain interns often use spontaneous prayer and not fixed prayer. It's clearly preferred by Christian chaplains. But the Jewish chaplains appear to be divided 50/50 between spontaneous and fixed (see Figure 17c). Spontaneous prayer is rarely the chaplain manager's preference (see Figure 17b).

Figure 17a

Frequency of Preference to Facilitate Spontaneous Prayer Over Fixed Prayer

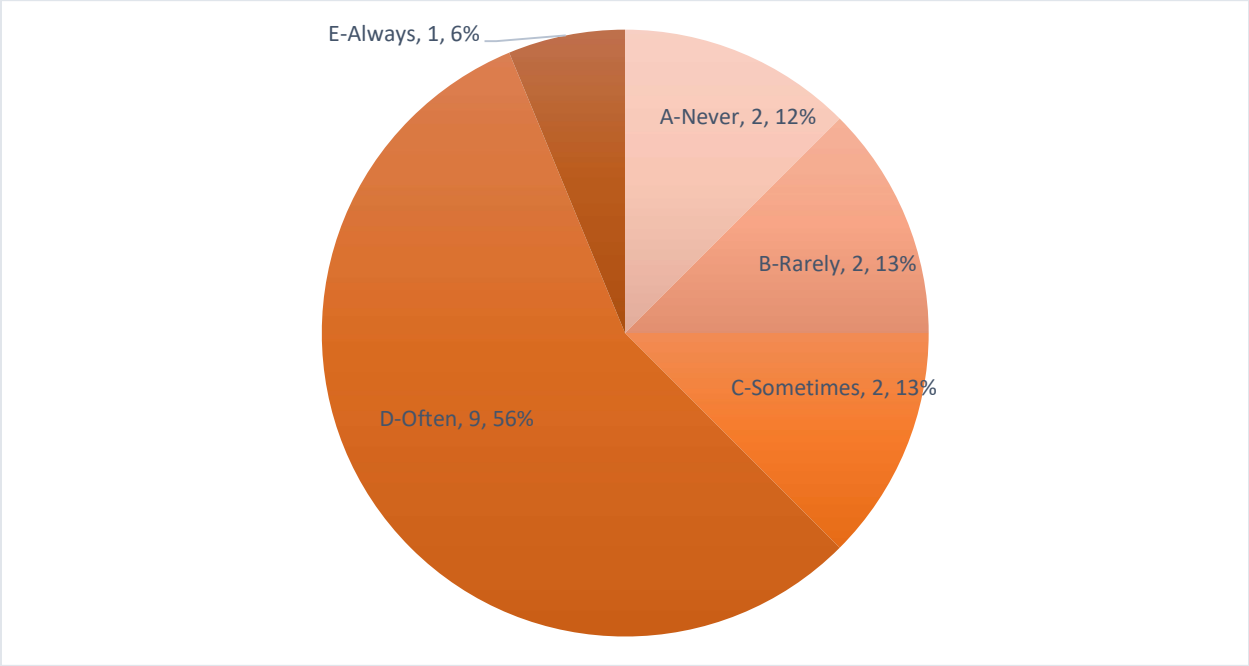


Figure 17b

Frequency of Preference to Facilitate Spontaneous Prayer Over Fixed Prayer - By Job Title

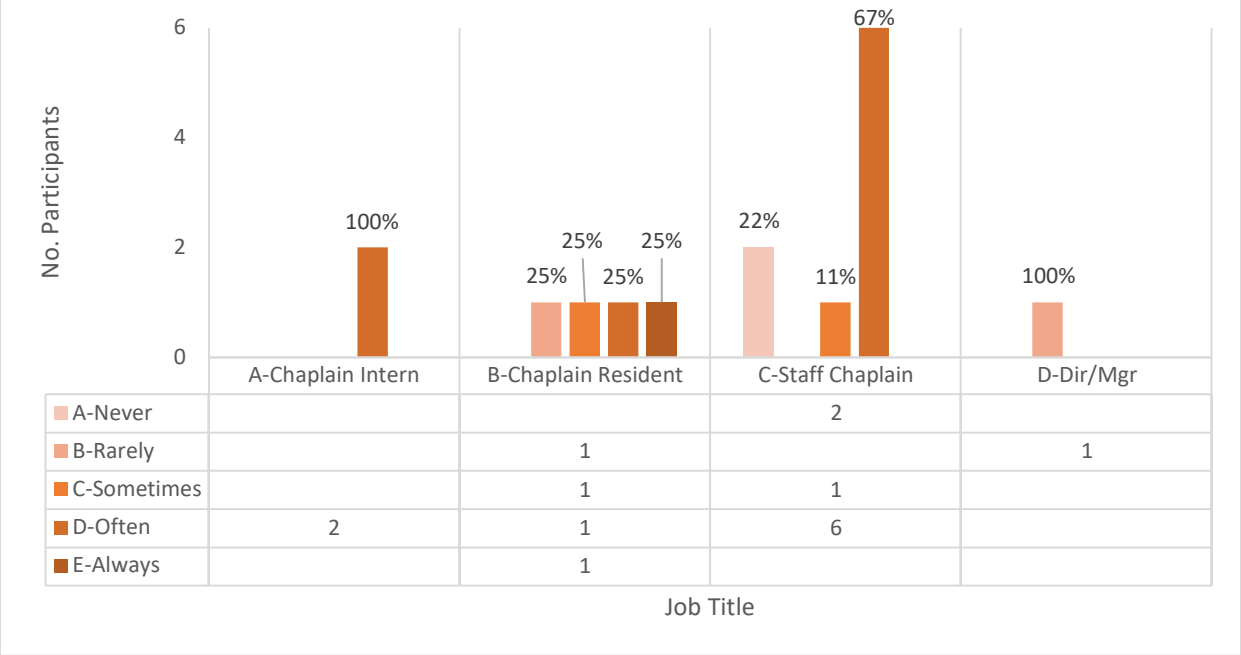
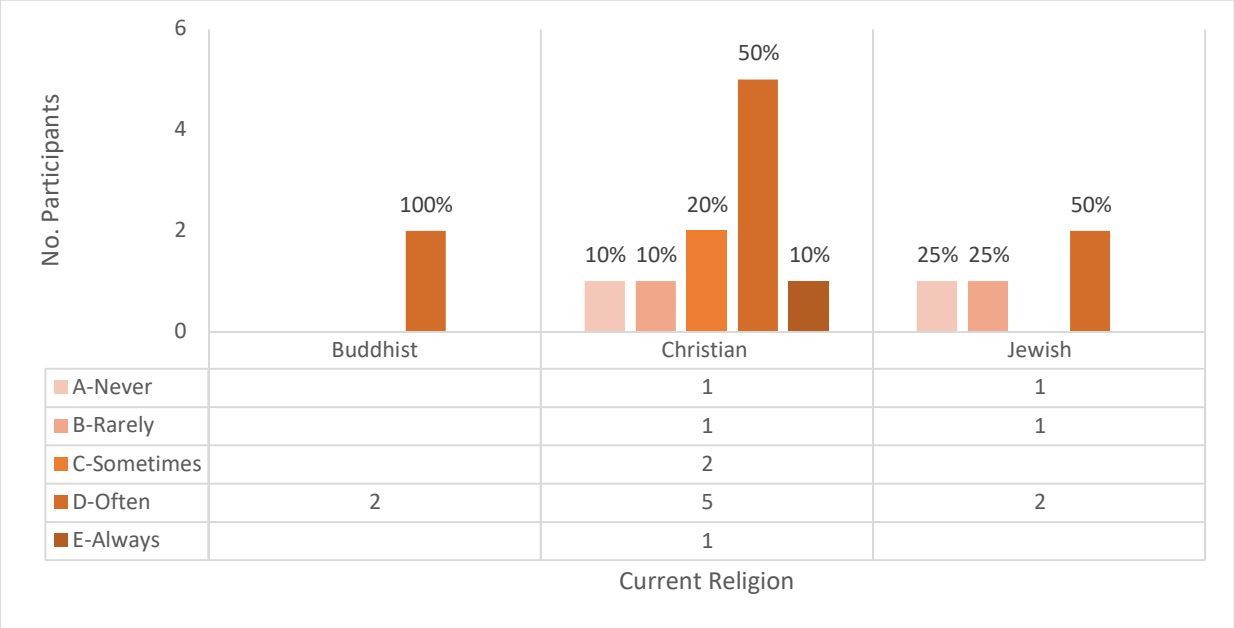


Figure 17c

Frequency of Preference to Facilitate Spontaneous Prayer Over Fixed Prayer - By Current Religion



In Figure 18a (referring to Question 12), we see that 68% of the chaplain participants rarely or never hesitate to use both spontaneous and fixed prayer to some degree. But hesitation to use both is seen across all job titles (see Figure 18b).

Figure 18a

Frequency of Hesitation Utilizing Both Fixed and Spontaneous Prayer

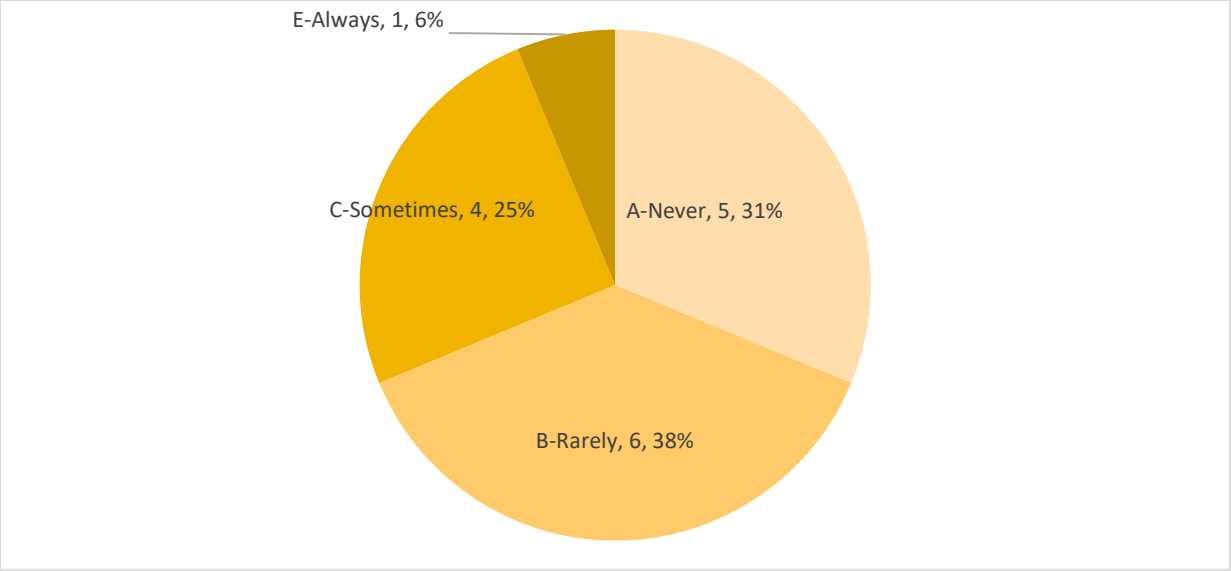
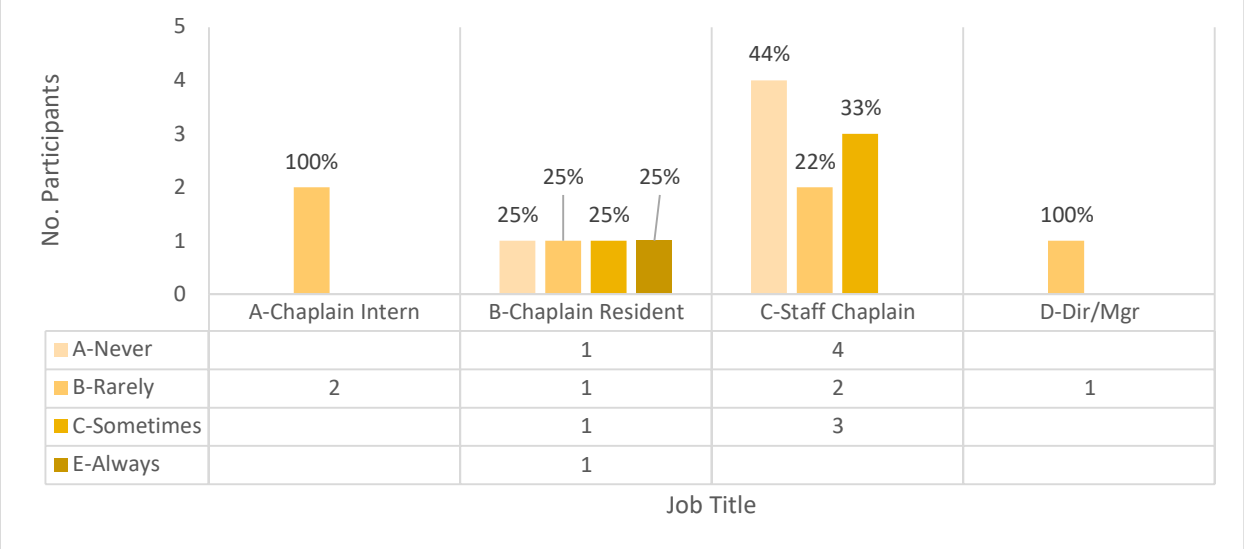


Figure 18b

Frequency of Hesitation Utilizing Both Fixed and Spontaneous Prayer - by Job Title



Figures 19a through 25 show the yes/no response breakdown to various questions asked to the participants.

Responding to Question 13, we find that 25% of the chaplain participants interviewed stated that they don't pray for a patient if not of their faith. While only one of the staff chaplain participants said that they don't pray with patients of another faith tradition, the chaplain resident and intern participants are split in their praying with those patients and family members of a different faith tradition (see Figure 19a). Looking at the participants by religion, we see that the Jewish participants always prayed with patients of another religion (see Figure 19b).

Figure 19a

Participants Who Did Not Pray Because the Patient/Family Member Was Not of Their Religion/Faith Tradition - By Job Title

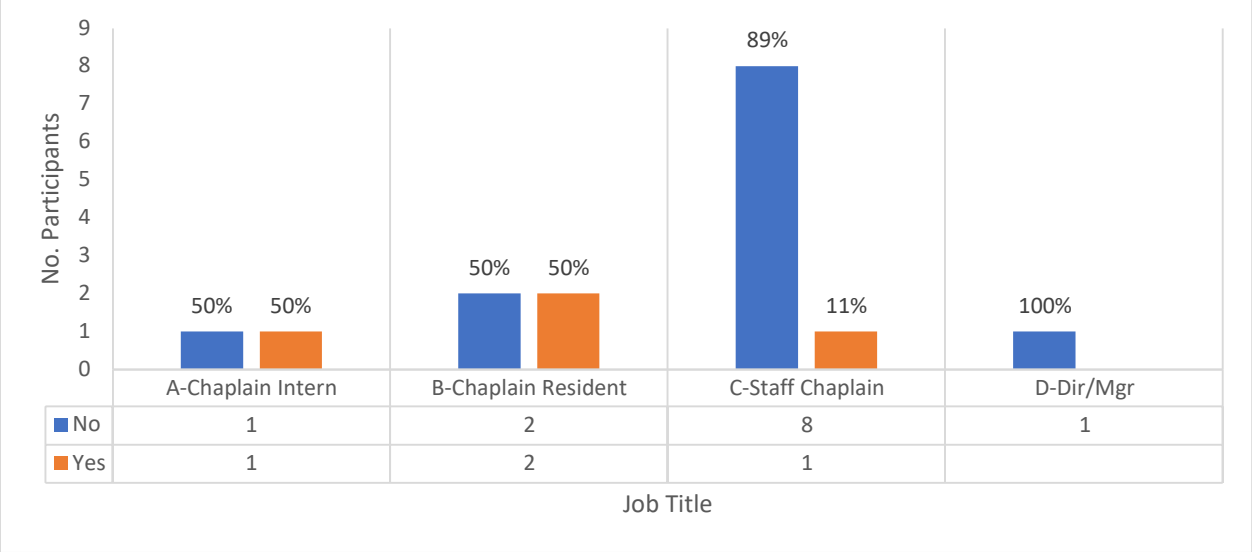
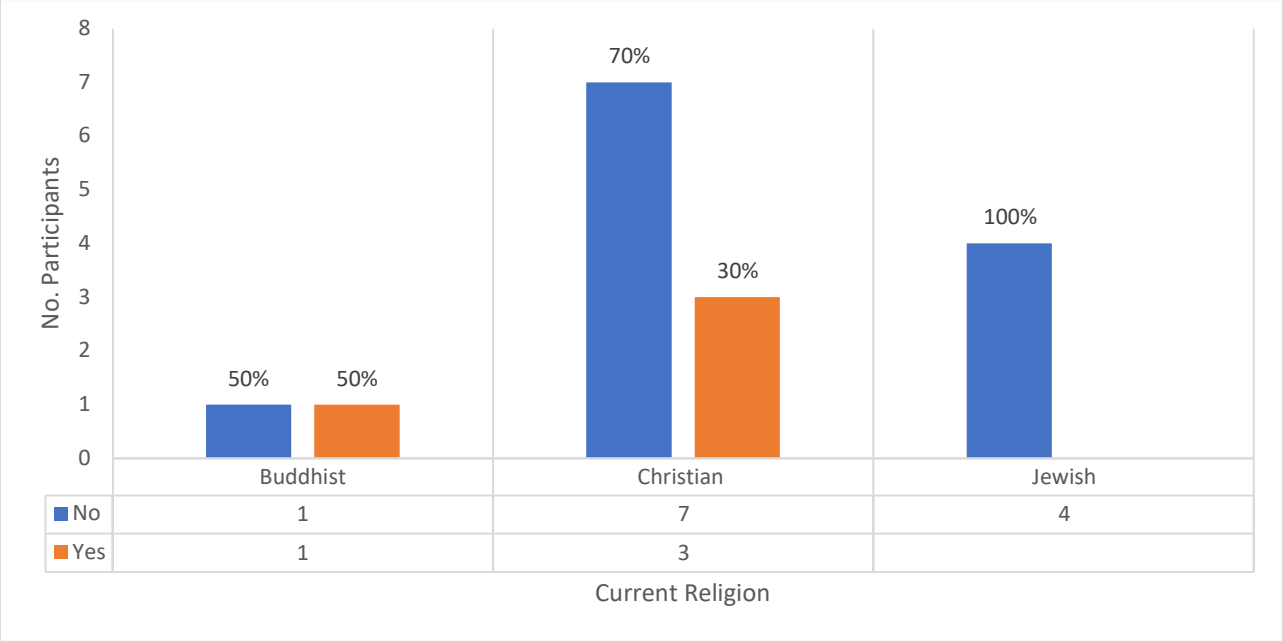


Figure 19b

Participants Who Did Not Pray Because the Patient/Family Member Was Not of Their Religion/Faith Tradition - By Chaplain's Current Religion



Responding to Question 14, 25% of our participants also said they did not pray spontaneously with patients and family who are not of their religion. That group is made up of chaplain interns and staff chaplains (see Figure 20a). But as seen in Figure 20b, this behavior existed for chaplains from each of the religious faiths represented by the participants (see Figure 20b).

Figure 20a

Participants Who Did Not Pray Spontaneously Because the Patient Was Not of Their Religion/Faith Tradition - By Job Title

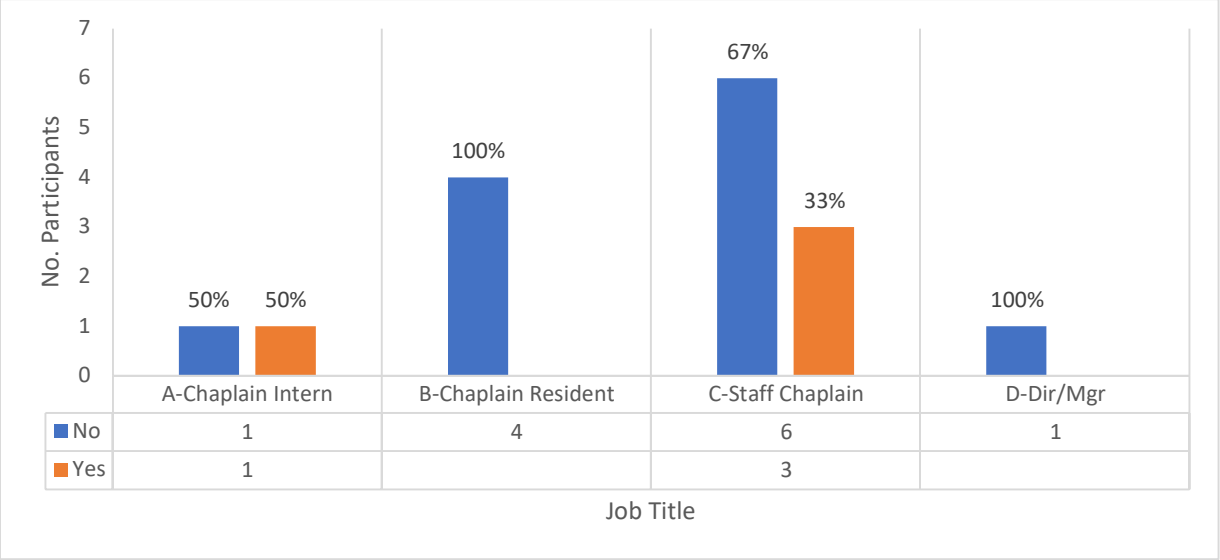
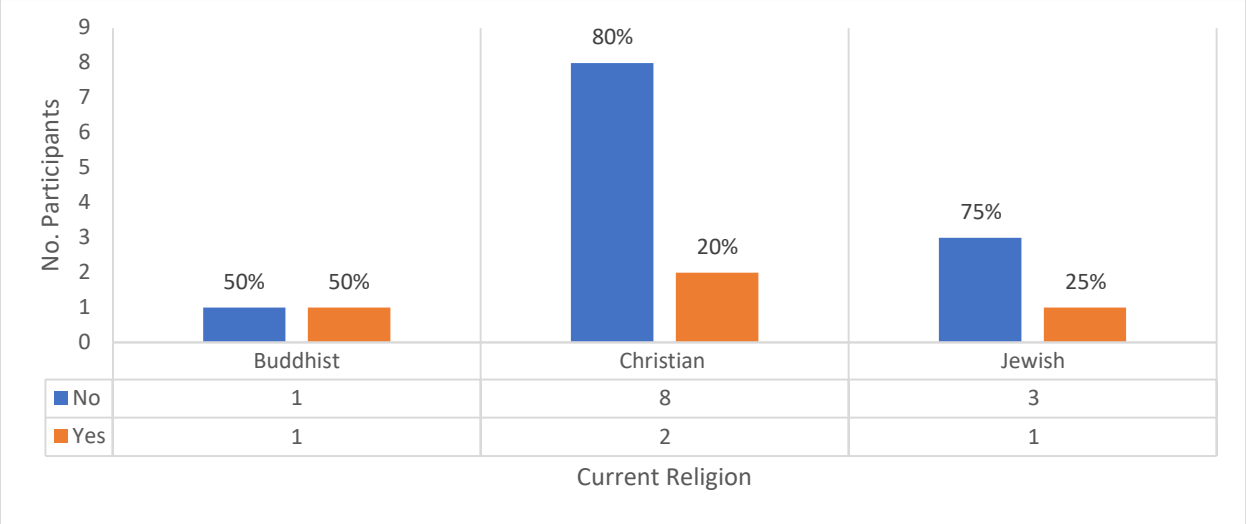


Figure 20b

Participants Who Did Not Pray Spontaneously Because the Patient Was Not of Their Religion/Faith Tradition – By Current Religion



Responding to survey question 15, all participants said they prayed when asked for patients who were not in their religion/faith tradition. But responding to Question 19, 50% of participants said they have felt uncomfortable praying in nonconcordant religions. In Figure 21a, we see 75% of the chaplain resident participants were ever uncomfortable, while the other chaplain job titles were split more evenly. The director participant never felt uncomfortable praying with a patient in another faith. In Figure 21b, we see that participants in each current religion group felt discomfort praying for a patient not in their faith, with 75% of the Jewish participants who felt discomfort.

Figure 21a

Participants Who Were Ever Uncomfortable Praying in Nonconcordant Religion - By Job Title

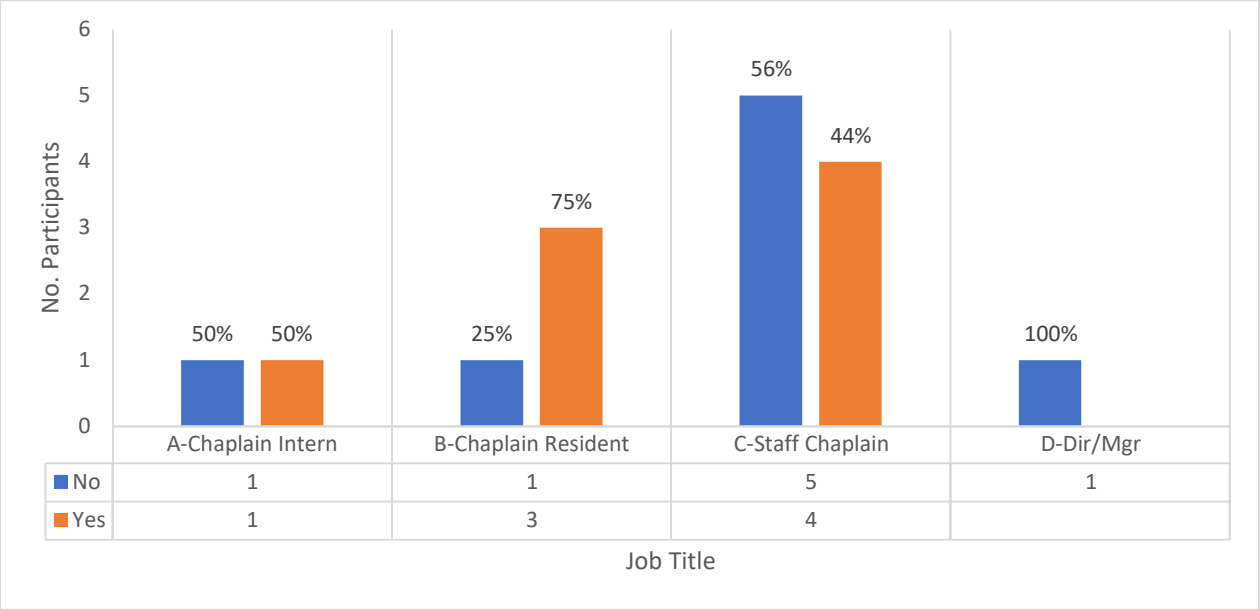
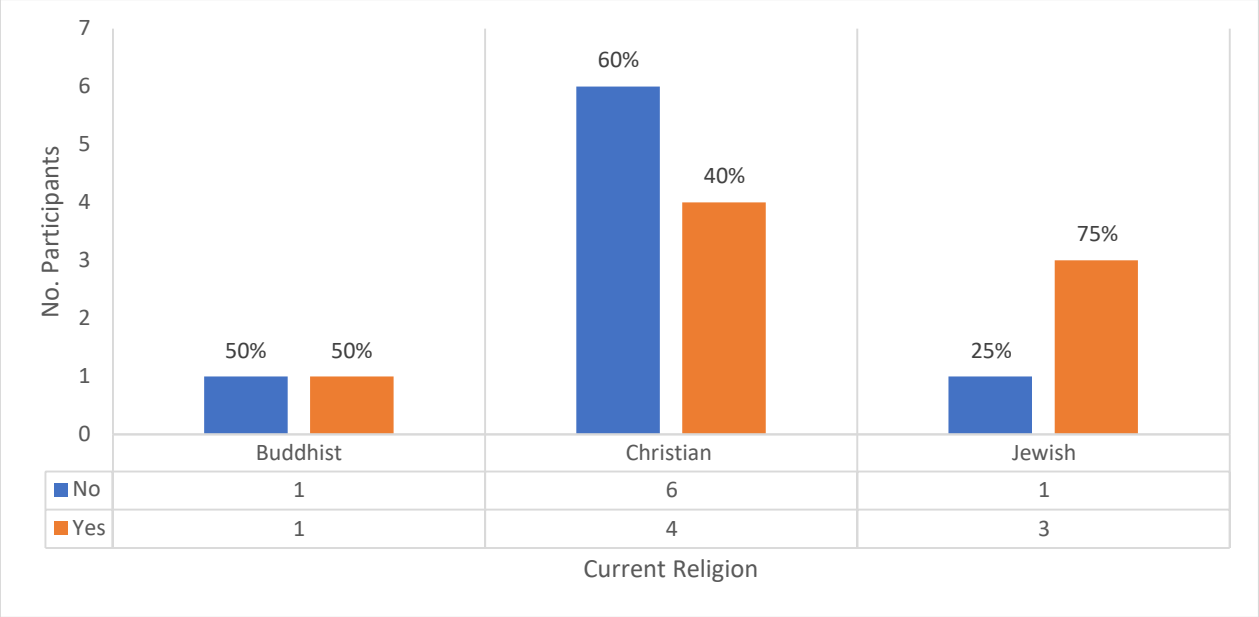


Figure 21b

Participants Who Were Ever Uncomfortable Praying in Nonconcordant Religion-By Current Religion



Responding to Question 21, 81% of participants said they felt comfortable using another religion's sources for prayer. In Figure 22a, we see that the chaplain resident participants as a group were less comfortable than the others. Out of the 19% of chaplains by current religions who do not feel comfortable utilizing other religion's sources for prayer, two thirds were Christian; one third, Jewish (see Figure 22b).

Figure 22a

Participants Feeling Comfortable Utilizing Other Religion's Sources for Prayer – By Job Title

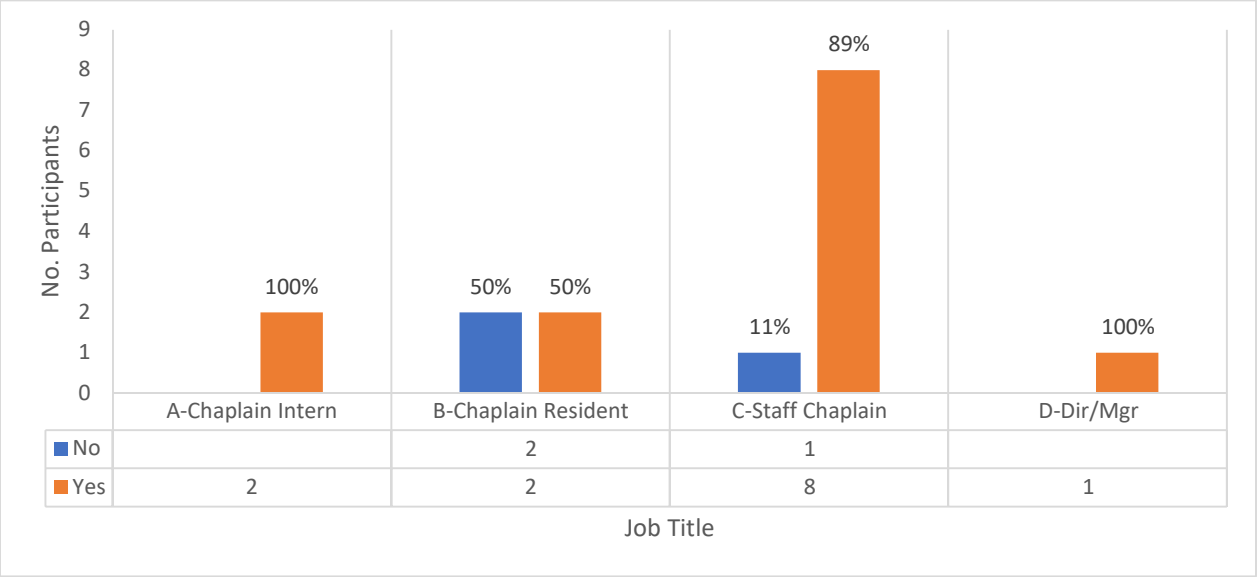
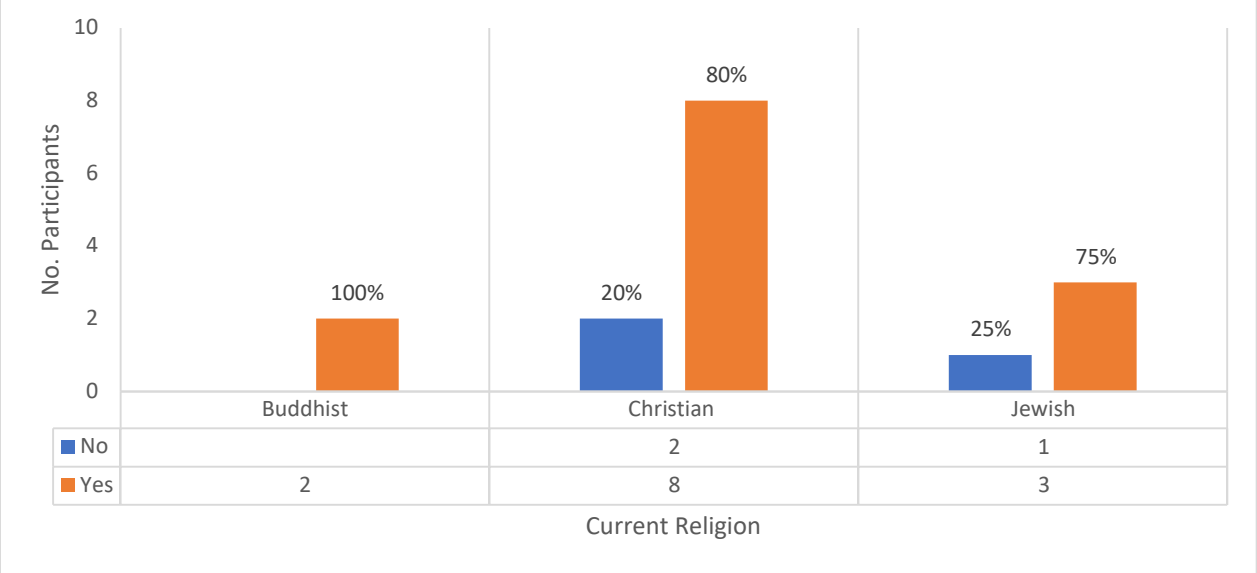


Figure 22b

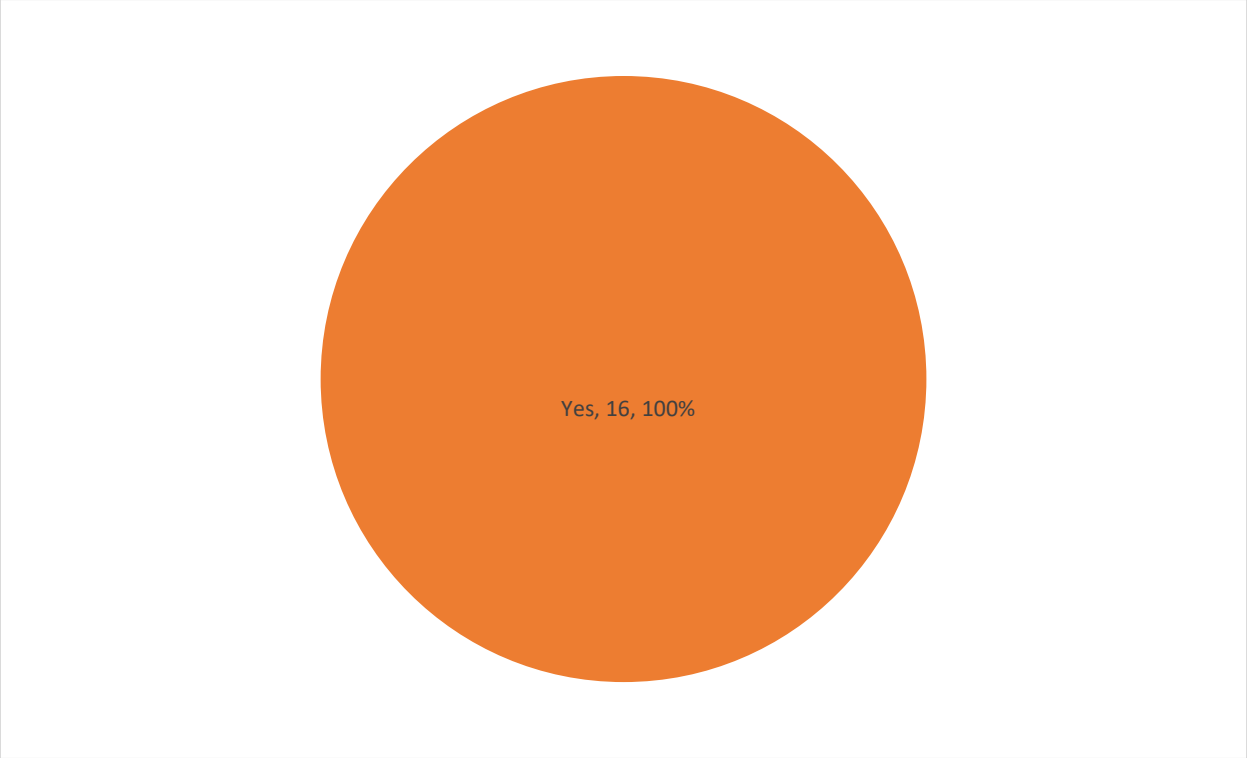
Participants Feeling Comfortable Utilizing Other Religion's Sources for Prayer – by Current Religion



In response to Question 23, all 16 of the chaplain participants (100%) in the survey thought it would be useful to have a resource for multifaith prayers (see Figure 23).

Figure 23

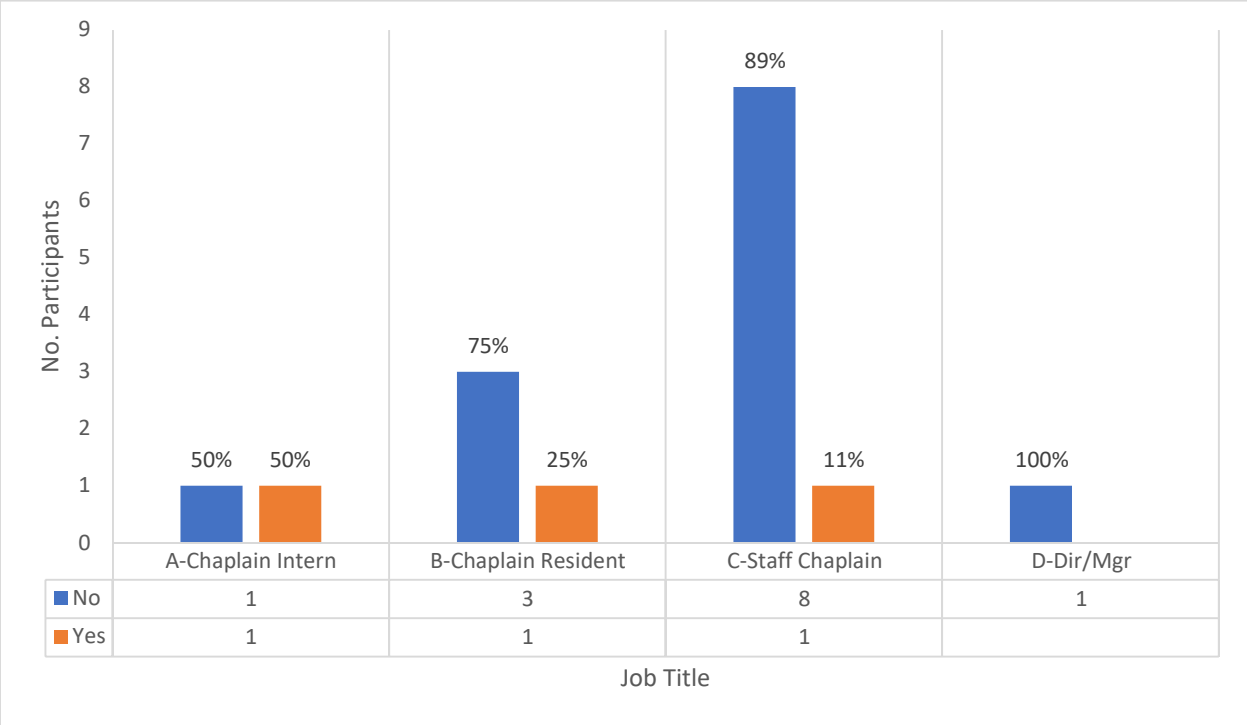
Participants Who Think It Would Be Useful to Have a Source for Multifaith Prayers for Chaplains



Responding to Question 24, 19% of chaplain participants said they had at some point not prayed with a patient because they were non-English speaking (see Figure 24).

Figure 24

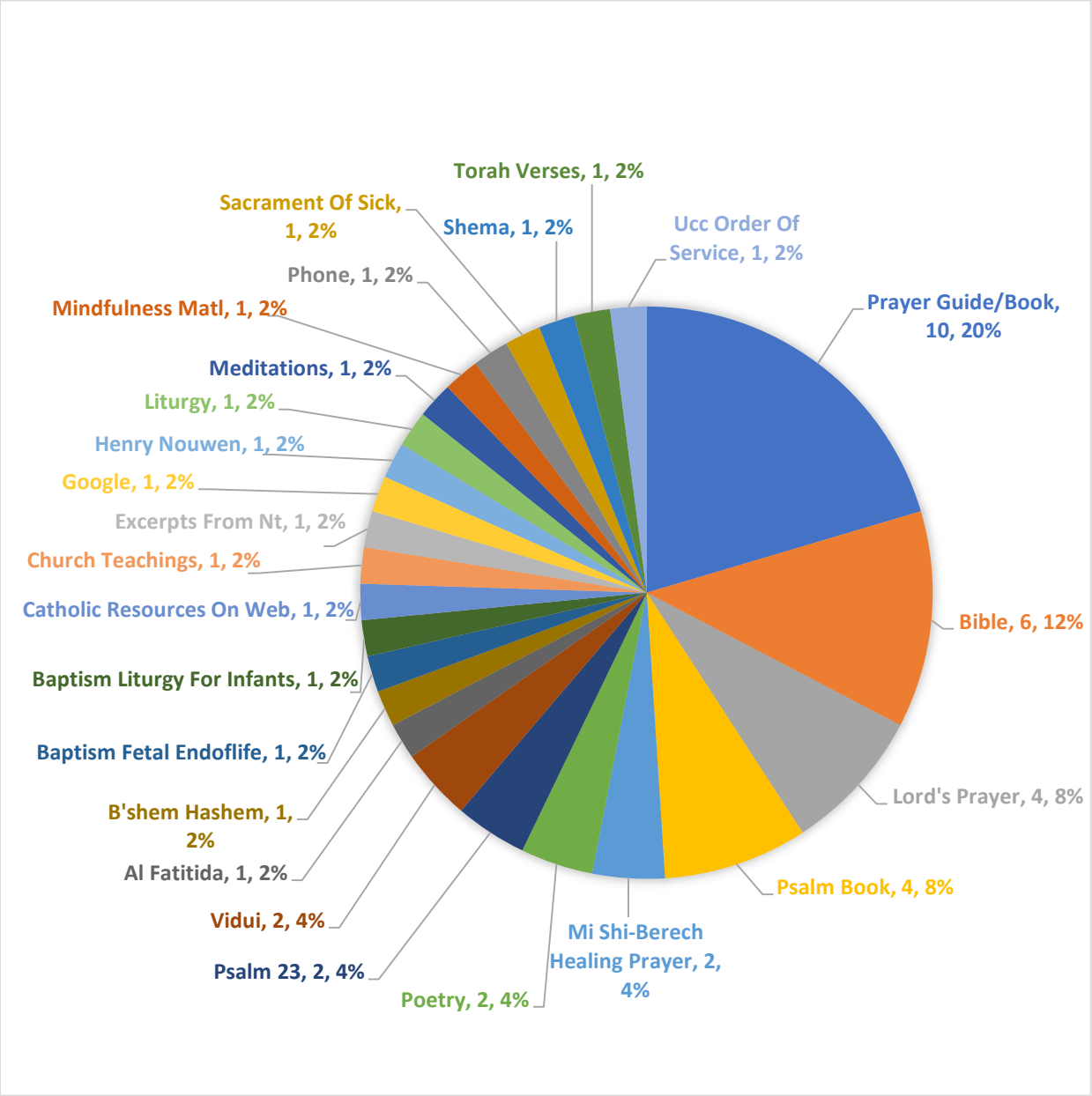
Participants Who Had Not Prayed With a Patient Because They Were Non-English Speaking



From Question 26, we find that the four written support materials most used by chaplain participants at the bedside (see Figure 25) were a prayer guide or book (20%), the Bible (12%), the Lord's Prayer (8%), and psalm book (8%).

Figure 25

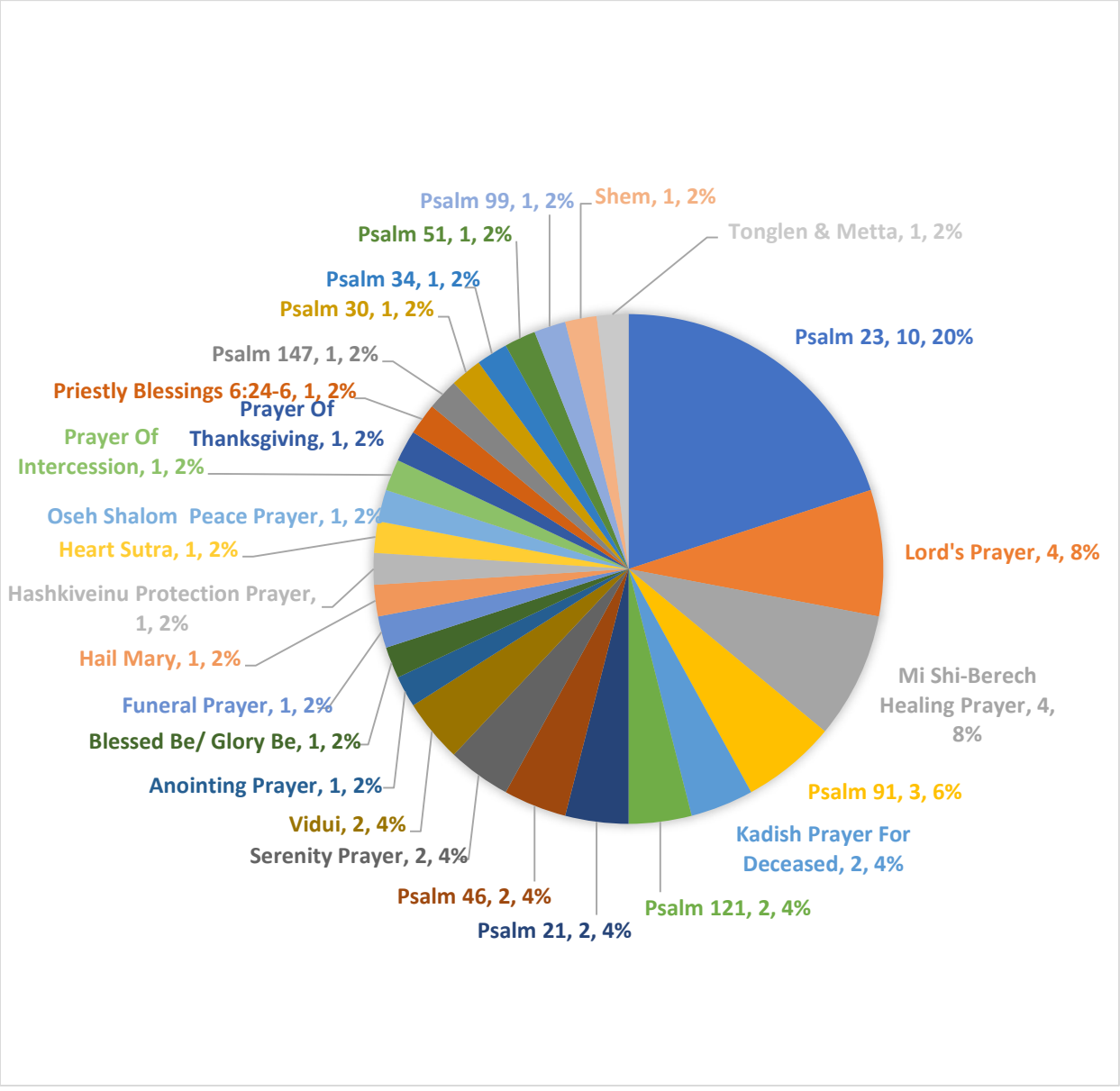
Participants' Most Used Written Support Materials at Bedside



From Question 28 the most used prayers and/or psalms from the chaplain participants' own religion were: Psalm 23 (23%), the Lord's Prayer (8%), Mi Shi-Berech (8%), and Psalm 91 (6%). See Figure 26.

Figure 26

Most Used Prayers and/or Psalms of Participants From Own Current Religion



Question 29 reveals the faith traditions most represented in patient population, as reported by the participants: Christian (44%), Jewish (18%), Muslim (14%), Spiritual (8%), Hindu (5%), Buddhist (3%), none (5%). Figure 27a shows the standardized responses from those specifically reported, which are shown in Figure 27b.

Figure 27a

Religions That Most Represent Chaplain's Patient Population – Standardized Response

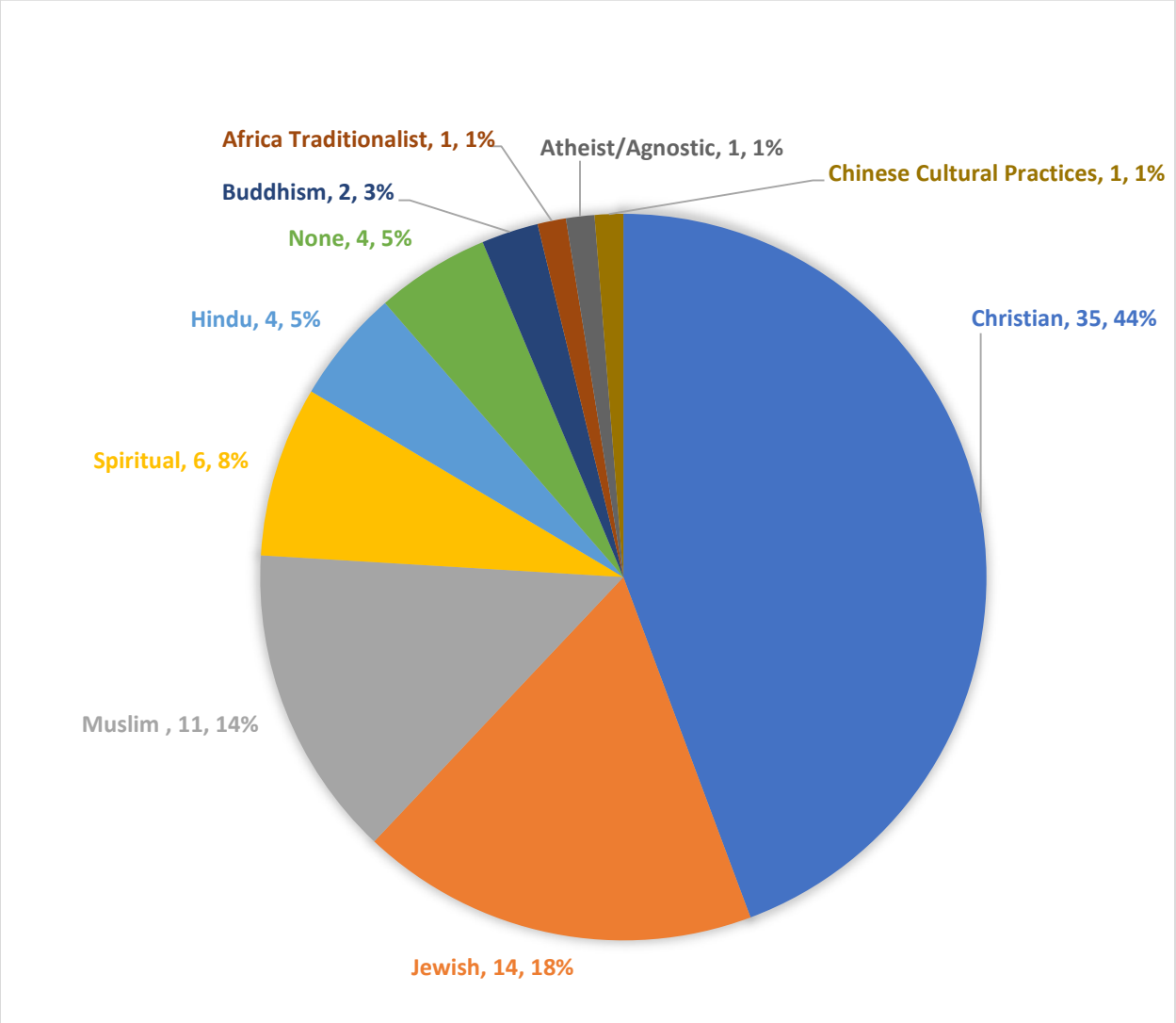
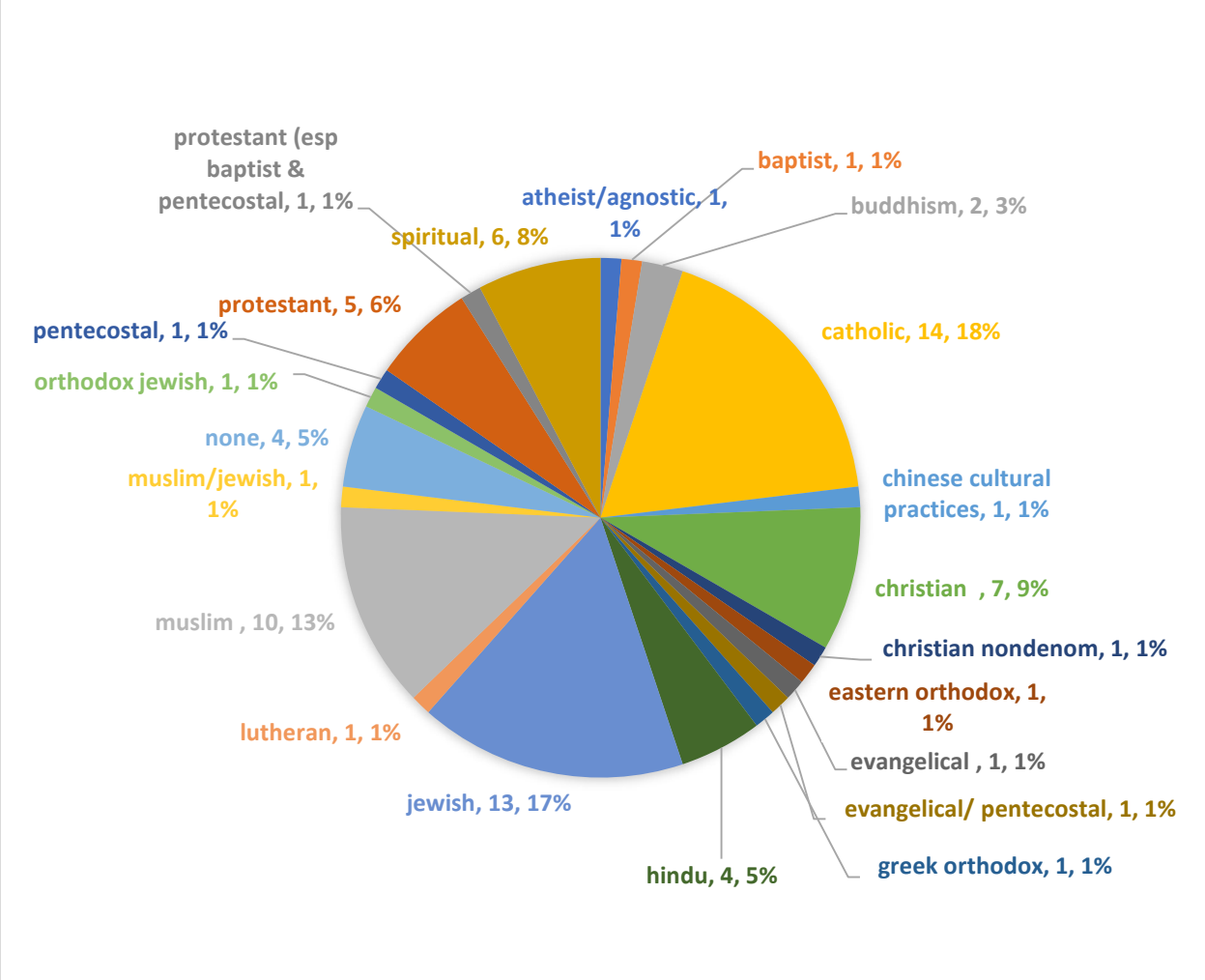


Figure 27b

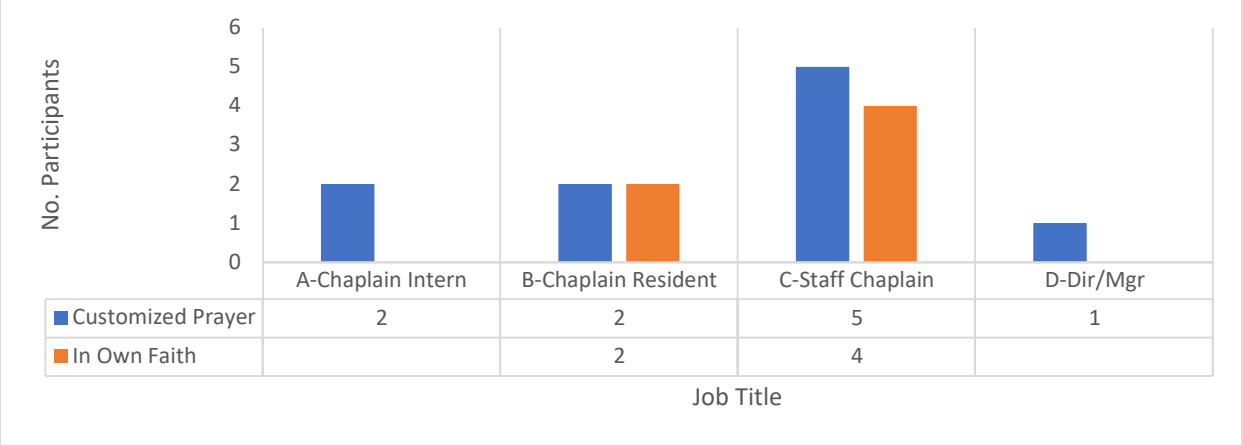
Religions That Most Represent Chaplain's Patient Population – Detailed Response



In response to Question 30, we find 63% of chaplain participants are more comfortable reciting customized prayer than reciting a prayer in their own faith. The 37% who prefer reciting prayer in their own faith was composed only of chaplain residents and staff chaplains (see Figure 28).

Figure 28

Participants' Most Comfortable Reciting Prayer: Customized vs. Own Faith



From Question 31 we examined the 16 participants' desire for various prayer sources. Figure 29a shows the desire for each of the three options, independent of each other. Fourteen participants or 88% wanted a mobile app as one of their prayer sources, 11 participants or 69% of the population wanted a prayer book, and 9 participants or 56% of the population wanted a website. Though the desire for a prayer website was strong, it is interesting is that in the age of the internet, the preference for a prayer *book* is 13% or two participants higher than for a prayer website.

Comparing each job title across the three panels of Figure 29b, we see:

- The prayer app and prayer book were equally desired by chaplain intern participants, each by 50% of all participants. None preferred the web as a source.
- The prayer app was desired by all chaplain resident participants. The other options were each desired by 75% of the chaplain resident participants.
- The prayer app was most desired by 89% of staff chaplain participants. A prayer book was desired by 78%, and a prayer website was desired by 67% of the staff chaplain participants.

- Prayer app was the only option desired by the one (all) director/manager participant.
- A website was requested by more than half (56%) of participants.

Figure 29a

Individual Prayer Source Desired by All Participants

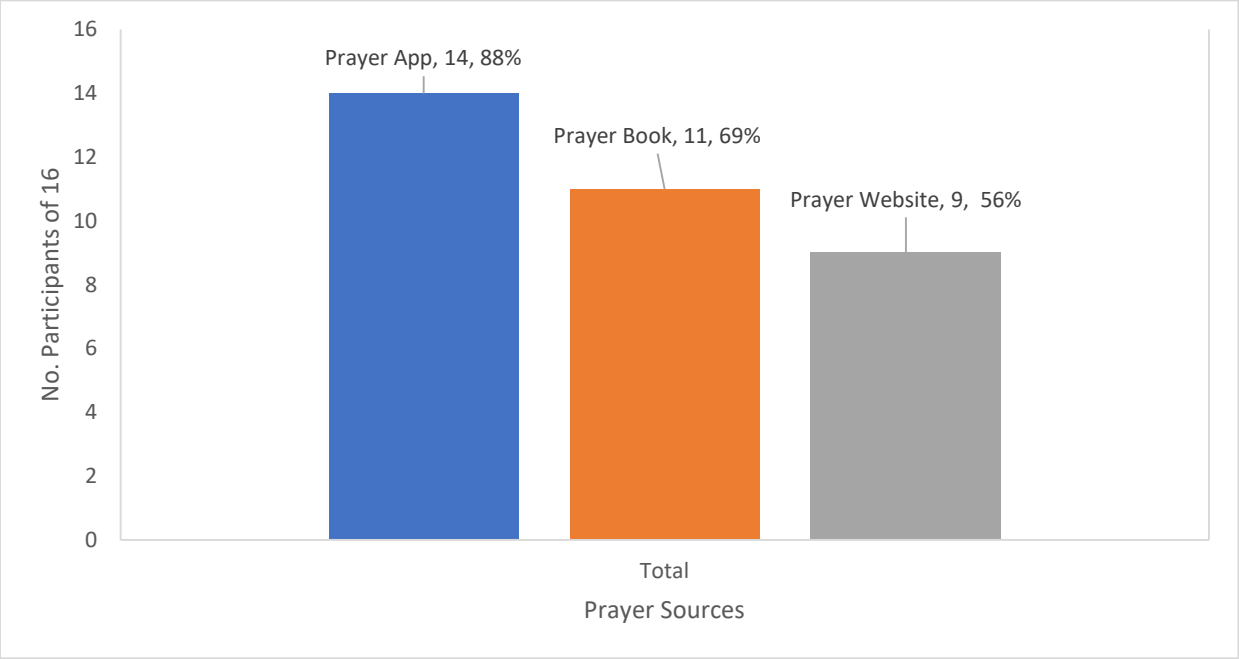
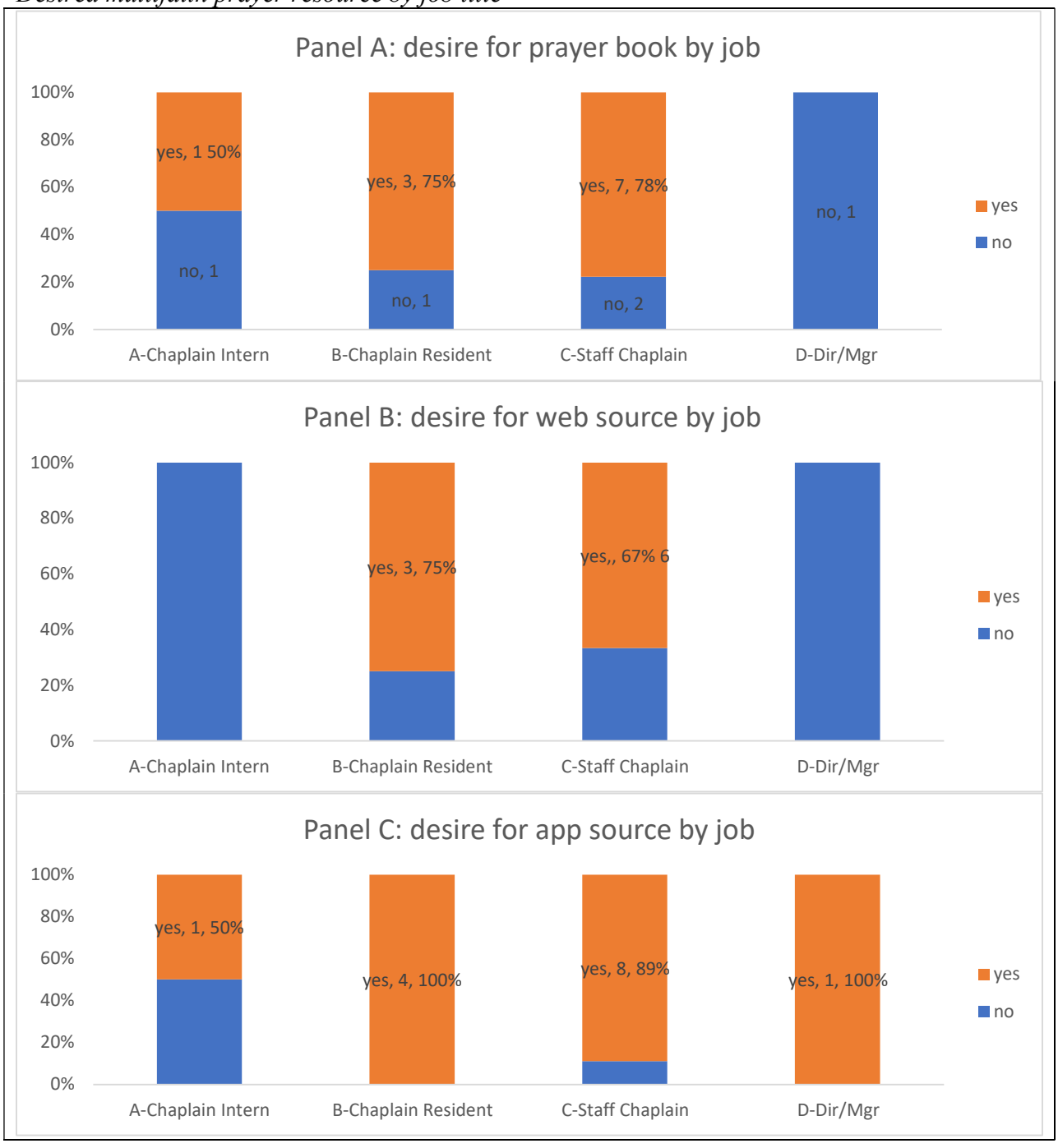


Figure 29b

Desired multifaith prayer resource by job title

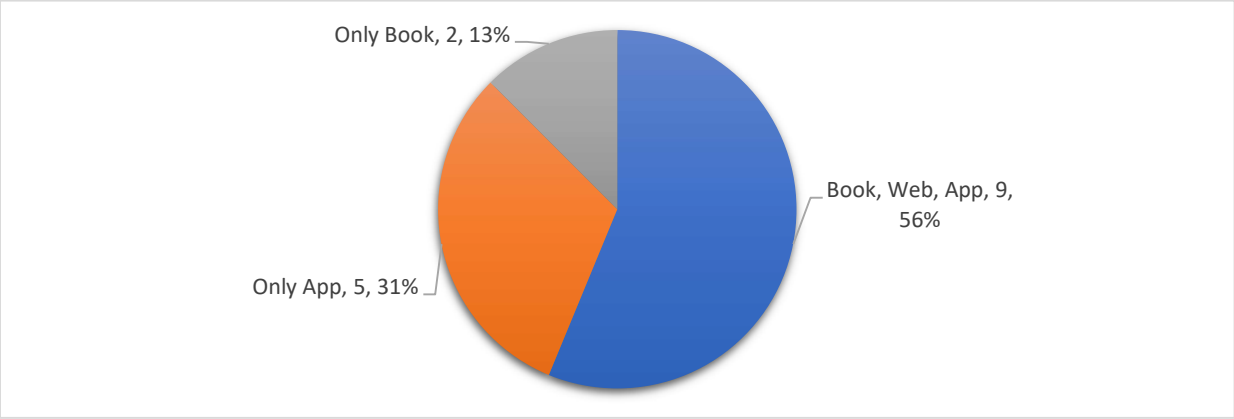


The prayer sources reported in Question 31 were also examined by their combinations desired by the participants.

Only three different combinations of prayer sources were favored by the survey participants. When we look at the combination of prayer sources desired, shown in Figure 29c, 56% of all participants favored a combination of all three prayer sources: book, web, app. 31% of the group wanted only a prayer app, while 13% want the prayer source to be in book form. In aggregate, a mobile app was wanted by 87% of the survey group.

Figure 29c

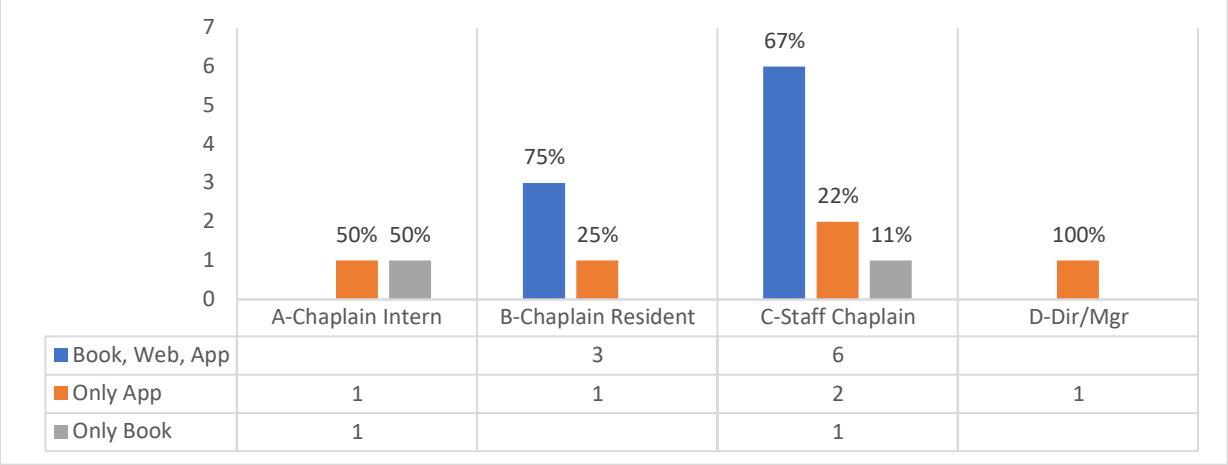
Prayer Source Combinations Preferred by All Participants



Half of all chaplain intern participants favored only a prayer book, while the other half favored only a mobile app. Of the chaplain resident participants, three-fourths favored the combination of the three prayer sources. Of the staff chaplain participants, two-thirds favored a combination of all three prayer sources. Of the director/manager participants, all favored only a mobile app. See Figure 29d.

Figure 29d

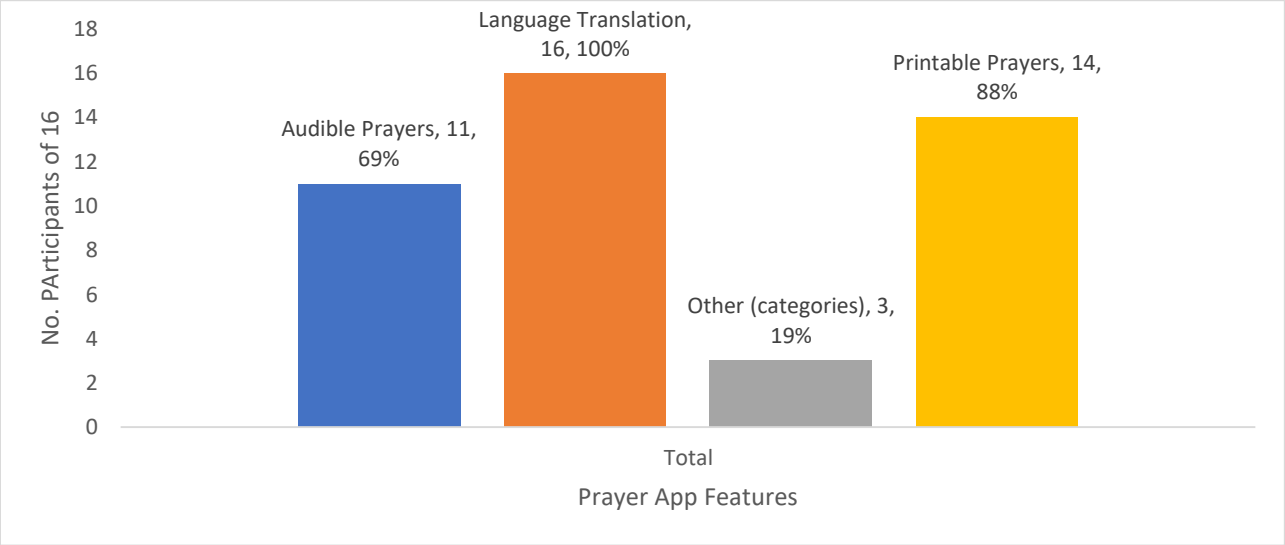
Prayer Source Combinations Preferred by Job Title



Question 32 looked at the features of a mobile prayer app that the participants want to have. Researcher analyzed these individually and in combination. Individually, a language translation feature was the most desired—by all 16 participants. Second popular was printable prayers. Prayer Categories was the only requested "other" feature. See Figure 30a.

Figure 30a

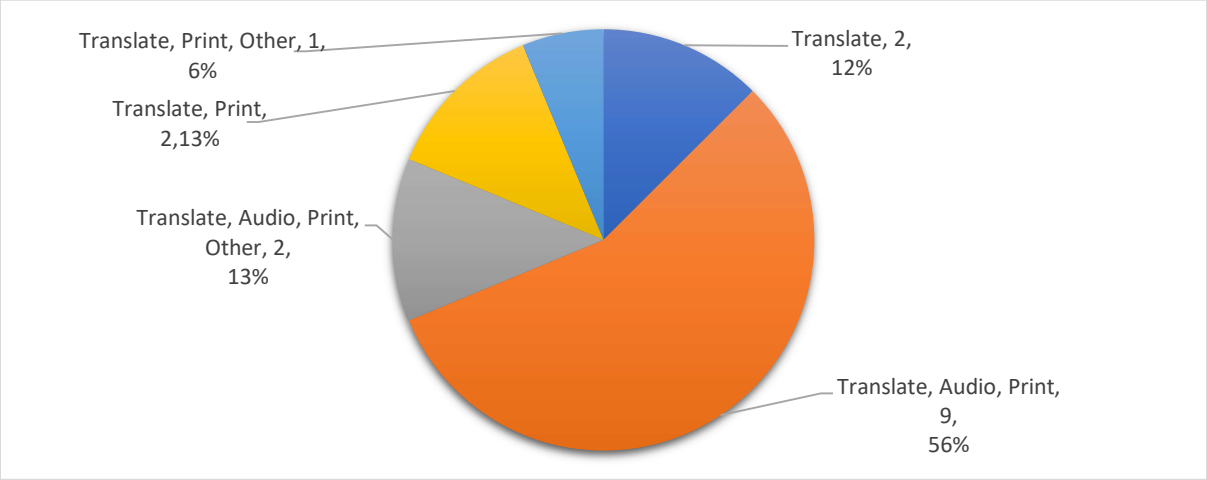
Desired Individual Features for Prayer App



The most popular combination of features for a mobile prayer app was the one with language translation, audible prayers, and printable prayers, at 56% of participants. When asked if any other feature was desired, the only response was to have prayers by category (by 2, or 13%, of the participants). See Figure 30b.

Figure 30b

Desired Combination of Prayer App Features



"K-means clustering is an *unsupervised learning algorithm* that tries to cluster data based on their similarity. *Unsupervised learning* means that there is no outcome to be predicted, and the algorithm just tries to find patterns in the data."[7] K-means cluster analysis was used to see if there were certain individuals who grouped together statistically. In Figures 31a and 31b, participant #20's relationship with question #9 emerged as being in a lone cluster by himself (outlier). All the others would fit into one cluster together according to the optimal solution for numeric variables (i.e., Questions 1 through 25).

[7] https://www.linkedin.com/pulse/types-cluster-analysis-techniques-k-means-using-r-irrfan-khan

Participant #20 as outlier could mean that he is uncomfortable with prayer outside of his tradition. Regardless of #20's discomfort and/or feeling inauthentic, the outlier/chaplain does concur with the other chaplains that a multifaith prayer source (mobile app) would be beneficially supportive.

Figure 31a

Participant #20 as Outlier

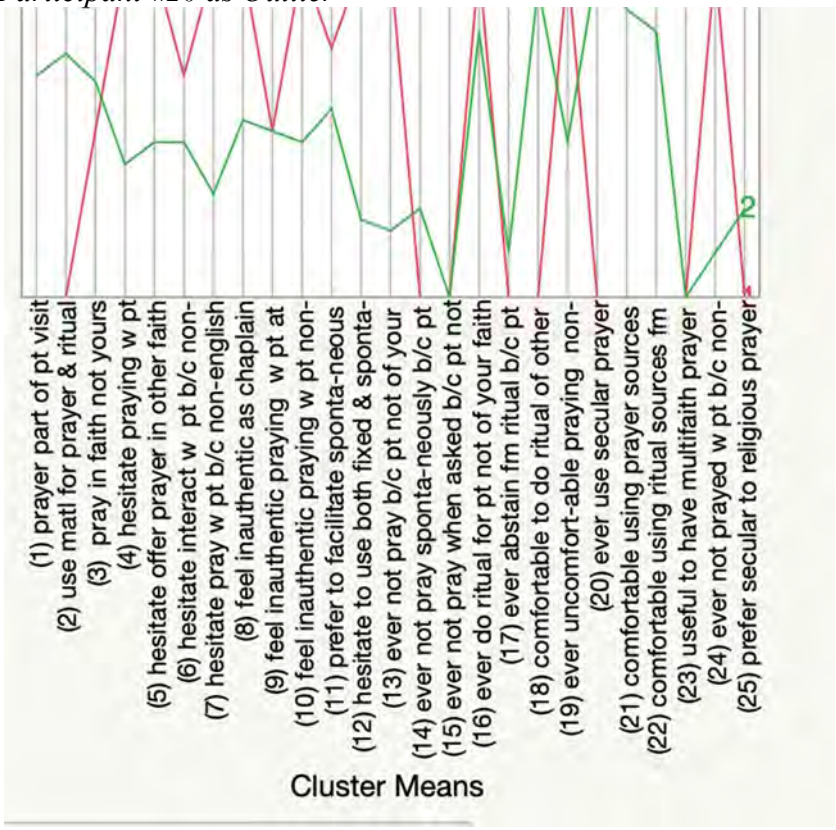
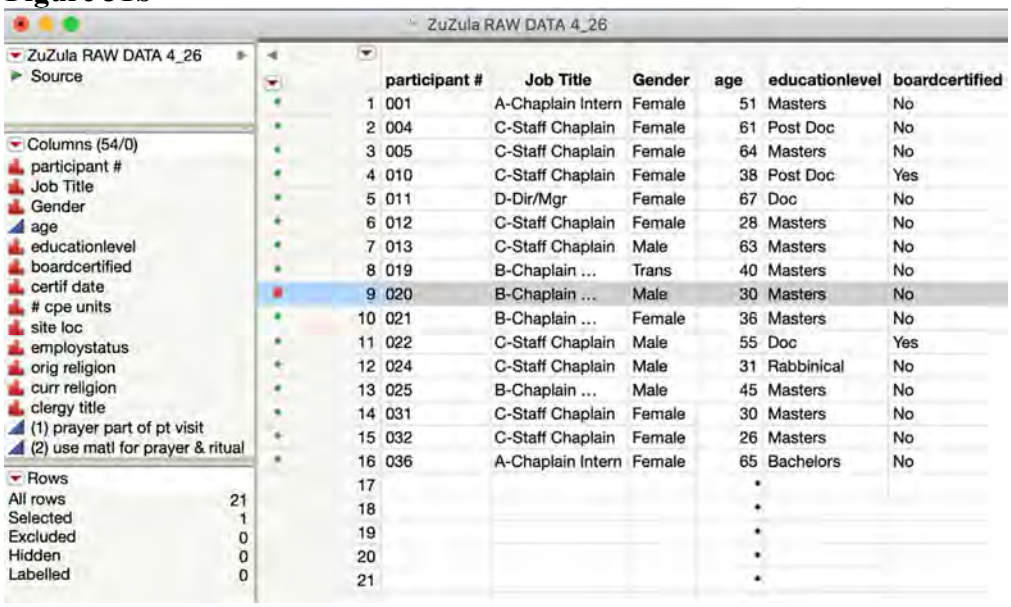


Figure 31b



	participant #	Job Title	Gender	age	educationlevel	boardcertified
1	001	A-Chaplain Intern	Female	51	Masters	No
2	004	C-Staff Chaplain	Female	61	Post Doc	No
3	005	C-Staff Chaplain	Female	64	Masters	No
4	010	C-Staff Chaplain	Female	38	Post Doc	Yes
5	011	D-Dir/Mgr	Female	67	Doc	No
6	012	C-Staff Chaplain	Female	28	Masters	No
7	013	C-Staff Chaplain	Male	63	Masters	No
8	019	B-Chaplain ...	Trans	40	Masters	No
9	020	B-Chaplain ...	Male	30	Masters	No
10	021	B-Chaplain ...	Female	36	Masters	No
11	022	C-Staff Chaplain	Male	55	Doc	Yes
12	024	C-Staff Chaplain	Male	31	Rabbinical	No
13	025	B-Chaplain ...	Male	45	Masters	No
14	031	C-Staff Chaplain	Female	30	Masters	No
15	032	C-Staff Chaplain	Female	26	Masters	No
16	036	A-Chaplain Intern	Female	65	Bachelors	No
17						
18						
19						
20						
21						

"Hierarchical regression is a way to show if variables of your interest explain a statistically significant amount of variance in your Dependent Variable (DV) after accounting for all other variables."[8] A hierarchical regression analysis was run to try to predict what contributed to Question #9, "Do you feel inauthentic praying with patients and or family at the bedside?" Figure 32a notes the single red dot is a separate cluster in that one individual who stands out alone. Figure 32b shows the two main contributing factors were responses to Question #6, Do you hesitate to pray with a patient because they are non-English speaking? and to Question #7, Do you hesitate to interact with a patient because they are non-English speaking? at the 90% confidence level.

[8] https://data.library.virginia.edu/hierarchical-linear-regression/

Figure 32a

Chaplains feeling inauthentic praying at patient's bedside.

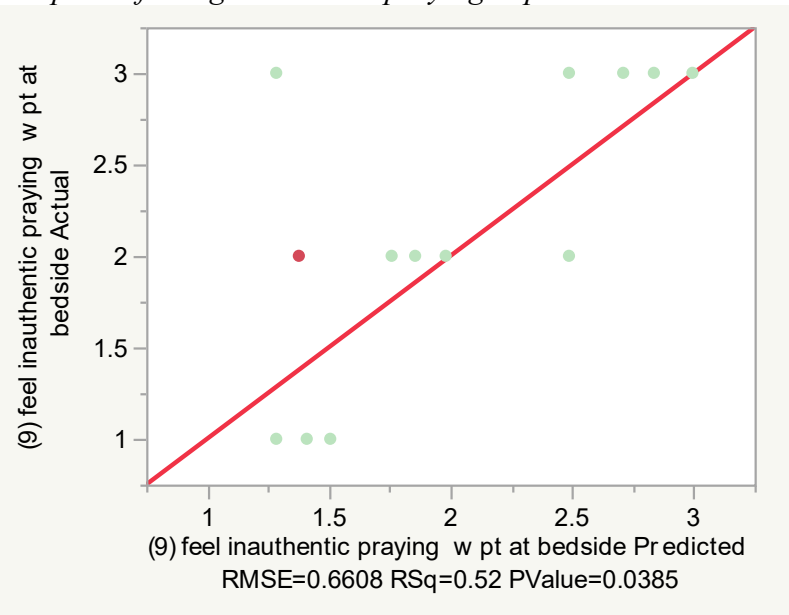


Figure 32b

Chaplains feeling inauthentic praying with non-English speaking patients.

Source	LogWorth	PValue
(6) hesitate interact w pt b/c non-english	1.986	0.01033
(7) hesitate pray w pt b/c non-english	1.049	0.08934
(5) hesitate offer prayer in other faith	0.689	0.20444

In Figures 33a and 33b**,** Question #6 has a positive beta weight indicating a positive relationship between hesitating to interact with a non-English-speaking patient to feeling inauthentic praying with them. Question #7 has a negative beta weight indicating a negative relationship between hesitating to pray with a non-English-speaking patient to feeling inauthentic praying with them. It is not clear why the latter occurred: Are chaplains willing to pray with non-English-speaking patients and families even though they are feeling inauthentic?

Figure 33a

Chaplains interacting with non-English speaking patients.

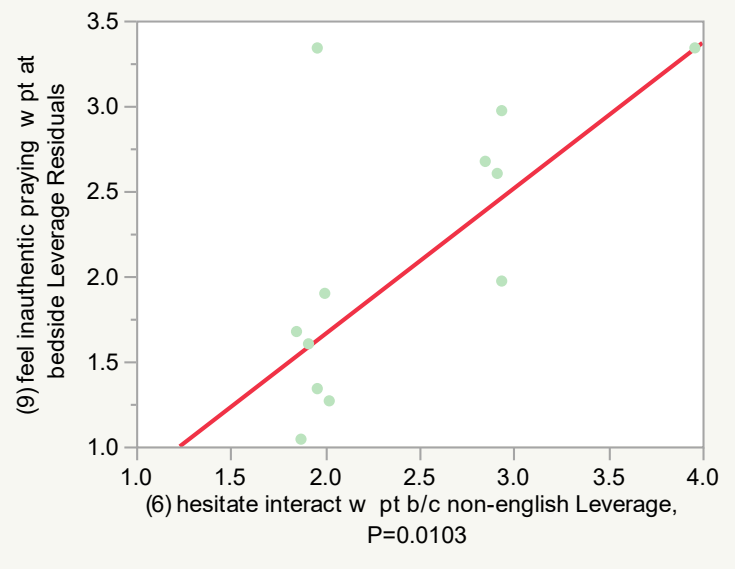
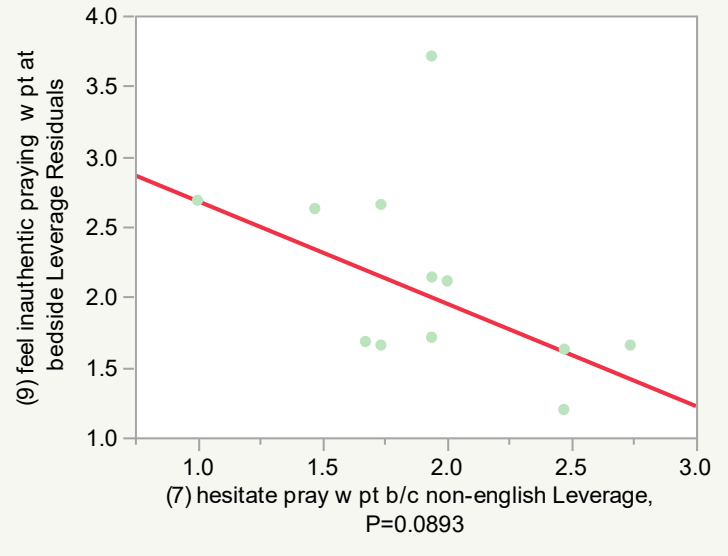


Figure 33b

Chaplains feeling inauthentic praying with non-English speaking patients.



Some of the most interesting correlations were that of age with some of the pastoral care variables. As shown in Figure 34, there was a positive correlation with age of moderate significance with "pray in faith not yours," "ever not pray spontaneously because patient not of your religion or faith," "comfortable to do ritual of other religion if had source guide," "comfortable using prayer sources from other religions," and "comfortable using ritual sources from other religions." There was a negative correlation with age of moderate significance with "hesitate to interact with patient because they were non-English speaking" and "hesitate to pray with patient because they were non-English speaking." These correlations suggest that an app would benefit chaplains to better interact with a diverse spectrum of patients, especially those not from their own faith or who speak another language.

Figure 34

	age
age	1.0000
(1) prayer part of pt visit	-0.1615
(2) use matl for prayer & ritual	-0.0108
(3) pray in faith not yours	0.3836
(4) hesitate praying w pt	0.2324
(5) hesitate offer prayer in other faith	0.1355
(6) hesitate interact w pt b/c non-english	-0.2846
(7) hesitate pray w pt b/c non-english	-0.5835
(8) feel inauthentic as chaplain	-0.1671
(9) feel inauthentic praying w pt at bedside	0.2276
(10) feel inauthentic praying w pt non-concordant w your relig	0.1084
(11) prefer to facilitate sponta-neous prayer vs fixed prayer	0.2401
(12) hesitate to use both fixed & sponta-neous prayer w pt	0.0559
(13) ever not pray b/c pt not of your religfaith	-0.0247
(14) ever not pray sponta-neously b/c pt not of your relig/faith	0.4402
(15) ever not pray when asked b/c pt not of your relig/faith	0.0000
(16) ever do ritual for pt not of your faith	-0.0014
(17) ever abstain fm ritual b/c pt discordant w your religion	-0.1975
(18) comfortable to do ritual of other relig if had source, guide	0.3918
(19) ever uncomfort-able praying non-concordant w your relig	-0.0428
(20) ever use secular prayer	0.2765
(21) comfortable using prayer sources fm other relig	0.4376
(22) comfortable using ritual sources fm other relig	0.4205
(23) useful to have multifaith prayer source	0.0000
(24) ever not prayed w pt b/c non-english	0.0562
(25) prefer secular to religious prayer	0.2226

Hypotheses

There are four hypotheses posited in this investigation:

1. Multifaith chaplains will affirm overall comfort facilitating prayer.
2. Multifaith chaplains will prefer facilitating spontaneous prayer over fixed prayer.
3. Multifaith chaplains will affirm comfort facilitating prayer with those of disparate faiths.
4. Multifaith chaplains will affirm the benefit of a multifaith prayer resource in their provision of care.

First Hypothesis

The first hypothesis posits that multifaith chaplains will affirm overall comfort facilitating prayer. One hundred percent of multifaith chaplain participants stated that prayer is part of their patient visit (63% often, 37% sometimes). See Figures 7a and 7b. While it was confirmed that 56% chaplain participants affirmed that they were comfortable and rarely hesitate praying with a patient, 44% or almost half, reported they are sometimes or often not comfortable praying with a patient (see Figures 10a and 10b).

While 50% of the participants rarely hesitate and 25% never hesitate praying with non-English-speaking patients, 25% do hesitate (see Figures 13a, 13b, 13c). Interestingly, it was found that though 75% of the participants may not hesitate to pray with a non-English-speaking patient, it was found that 56% of these multifaith chaplain participants shared they sometimes or often hesitate to interact with a patient because they are non-English speaking (see Figure 12a).

Thirty-one percent of the multifaith chaplain participants stated sometimes feeling inauthentic praying at a patient's bedside, 38% reported rarely feeling inauthentic, while 31% stated they never feel inauthentic (see Figures 15a, 15b, 15c, 15d). Feeling inauthentic praying was evenly distributed over age groups and chaplain job titles with the exception being the

director/manager designation.

Though use of fixed prayer and spontaneous prayer will be further discussed in the results section, it's worth noting now that 32% of the chaplain participants hesitate to use both spontaneous and fixed prayer. Sixty-eight percent of the chaplain participants rarely or never hesitate to use both spontaneous and fixed prayer (Figures 18a and 18b).

Second Hypothesis

The second hypothesis theorizes that multifaith chaplains will prefer facilitating spontaneous prayer over fixed prayer. It was confirmed that 75% (see Figure 17a) of the participants stated a preference for spontaneous prayer (56% often, 13%, sometimes, 6% always), while 25% rarely or never prefer spontaneous prayer. In Figures 20a and 20b, 75% of the chaplain participants stated praying spontaneously with patients of nonconcordant religions. Interestingly, 63% of chaplains also stated a preference for offering customized or spontaneous prayer at the bedside over prayers of their own religion (see Figure 28).

Third Hypothesis

The third hypothesis postulates multifaith chaplains will affirm comfort facilitating prayer with those of disparate faiths. One hundred percent of the participants affirmed, when asked, that they pray with patient and or family members who are not in their religion/faith tradition. However, 50% of the participants reported being uncomfortable praying with a patient of a nonconcordant religion (See Figures 21a and 21b).

In Figure 9a, 63% of the participants often or always pray in another's faith tradition. While 25% of the participants said they sometimes pray in another's faith tradition, 12% said they rarely or never do. In Figure 9b, one (25%) of the Jewish chaplains never prays in another faith tradition. The Buddhist chaplain participants, or 12% of the group, often/always pray with

patients of another faith tradition.

Thirty-one percent of the chaplain participants sometimes hesitate offering a prayer for a patient of another religion, 38% rarely do, and 31% never hesitate offering prayer (See Figure 11a). Though the chaplain director reported never feeling inauthentic praying at bedside, staff, resident, and intern chaplain participants all express some level of inauthenticity. It appears that greater experience is inversely proportional to feeling inauthentic at the bedside.

Of the Christian participants, 40% never feel inauthentic. Of the Jewish participants, 25% reported never feeling inauthentic; the two Buddhist participants never felt inauthentic (see Figure 11b).

Eighty-one percent of participants reported feeling comfortable utilizing other religions' sources for prayer (See Figures 22a and 22b).

Fourth Hypothesis

The fourth hypothesis posits that multifaith chaplains will affirm the benefit of a multifaith prayer resource in their provision of care. This was confirmed by 100% of all the chaplain participants (see Figure 23). Twenty-nine percent preferred to solely have a mobile app as a multifaith prayer resource. Thirteen percent of the participants wanted a prayer book as a resource rather than a technology-based resource. However, 57% wanted a mobile app, as well as a website and prayer book. Eighty-seven percent affirmed wanting a prayer app. (See Figures 29a, 29b, 29c, 29d.)

One hundred percent of the multifaith chaplain participants have reported praying at a patient's bedside when asked. However, participants expressed varying degrees of discomfort and inauthenticity around patients of nonconcordant religions and patients who speak another language. Fifty percent of the participants have felt uncomfortable performing a prayer that is not

concordant with their religion (see Figures 21a and 21b), with 25% of all participants having not prayed with patients because they were not of the same religion (see Figures 19a and 19b). When asked if participants ever felt inauthentic praying at bedside, none stated often or always, 31% reported never, 38% stated rarely, and 31% reported sometimes (See Figures 16a, 16b, 16c, 16d).

Nineteen percent of the participating chaplains had not prayed with a non-English-speaking patient (see Figure 24). Fifty percent of participants rarely hesitate to pray with a non-English-speaking patient, but 50% state that sometimes they hesitated interacting with a patient because they did not speak English (see Figures 13a, 13b, 13c).

Discussion

Research results inform a need for a chaplain-focused prayer native mobile phone app, printed prayer book, and/or web application, providing multiple platforms for multifaith chaplains (and clinicians, students, and practitioners of all faiths) to access prayer and ritual support almost immediately from almost any location. These will provide options to multifaith chaplains to further acknowledge and serve patients and family members with a prayer of their religion.

Chaplain participants reported wanting access to prayers of diverse religions that were translated into different languages, printable, audible, and categorized. The study did not focus on directly relating the participants' discomfort with inaccessibility. However, the participants reported hesitating and feeling inauthentic praying with patients and families because of language, religious barriers, and perhaps their own anxiety. A future investigation will need to more directly query the participants' anxiety.

Interestingly, participants reported results that can be interpreted as contradictory regarding prayer with non-English-speaking patients. It was reported that 75% of the participants did not hesitate to pray with a non-English-speaking patient, but the same group of participants stated that 56% of the multifaith chaplains sometimes or often hesitate *interacting* with a patient because they are non-English speaking. With 56% of the participants sometimes or often not interacting with non-English-speaking patients, further study might explore how this contradictory finding impacts the percentage of prayer facilitation with non-English-speaking patients.

Perhaps chaplain participants avoid praying with patients because a language barrier contributes to their feeling inauthentic. It appears that even if a chaplain who feels inauthentic

with a non-English-speaking patient and or family would still offer prayer. There needs to be more research regarding the dynamics of chaplains hesitating to visit and their relationship to praying with non-English-speaking patients; e.g., does the hesitation to visit a non-English-speaking patient further diminish the probability that a chaplain may pray with them? We suspect that the group hesitates to interact, but we don't know how/if that impacts their hesitation praying.

Also of note is that most of the participants requested a mobile app prayer resource. In this age of technology, participants also requested a prayer resource in printed book form, with more than half the participants requesting access to a website. Chaplain participants also stated that they were most comfortable reciting customized prayer instead of reciting a prayer in their own faith. This was surprising because of this researcher's presumption regarding the mulitfaith chaplains' deep familiarity with their own unique faith-based prayer tradition.

Limitations

While this study offered an examination into a chaplain's relationship with prayer, it became clear during its research and review of its survey that the study would have benefited from a more detailed questionnaire, as well as being conceived as a mixed study. Mixed methods research "incorporates elements of both qualitative and quantitative approaches" (Creswell, 2014, p. 3). Questions could have addressed the chaplains' knowledge and use of other multiprayer resources. Precise wording of questions would have supported clarity of reporting. Questions directly asking if language or religion nonconcordance prompted chaplain participants feeling uncomfortable and or inauthentic would have provided further clarity. A qualitative approach could have provided more nuanced responses regarding the participants' discomfort and inauthenticity, including response explanations and their cultural and religious

understandings.

A limitation of this study was the number of its participants, all of whom were multifaith chaplains from the same hospital system. They were given a one-time opportunity to answer the survey and with a fifteen-minute time limit. This one-time opportunity was in the middle of their workday and was voluntary. Had participation in the survey been mandatory, the study could have been administered to all the multifaith chaplains in the hospital system and generated a more significant outcome.

It could have also proved interesting to survey a larger, more diverse population including hospital chaplains throughout the tri-state area, not just urban-based hospital chaplains. Noticeably absent are chaplain participants whose current religions could include Islam, Hindu, Sikh, and Baha 'I, as well as nonsectarian and atheist. Also, it would be helpful to further delineate Christian religions, exploring and comparing responses within each Christian denomination, as well as acknowledging the Orthodox Jewish faith separately.

Utilizing the online platform SurveyMonkey could provide the ability to reach a larger, more diverse range of chaplain participants, support each participant's completion of the survey, clock the chaplain's test response time, and allow for easier navigation/investigation of data. Using SurveyMonkey would have also, perhaps, provided participants with a stronger feeling of anonymity.

The survey was meant to be inclusive regarding gender designation and included such language in collection of demographics, but failed to meet that standard by the use of "he/she" instead of "they" in survey.

While a $5 Starbucks gift card was given as a thank you to participants at the end of taking the survey, it was suggested by participants that an announcement of the gift card

beforehand would have attracted more chaplain participants from the Department of Spiritual Care and Education.

Concluding Thoughts

Silton et al. (2012) stated, "Although prayer is one of the most common chaplain interventions, there is a dearth of information pertaining to prayer in the chaplaincy literature." While there is very little in prayer/chaplain research, there is a scarcity in research exploring the chaplain and patient use of fixed and spontaneous prayer. Aspects of Cognitive Prayer (Ladd & Spilka, 2002), researched types of prayer (confession, thanksgiving, intercession, petition, etc.) but did not study the role of fixed and or spontaneous prayer within each type of prayer.

Though there is not a chaplain-focused multifaith prayer resource app or book, www.chaplainsonhand.org provides a similar function. Interestingly, not one chaplain participant mentioned it in their resource list. Two interfaith prayer books (compiled by Ted Brownstein and Matt Sanders, respectively) are available, but are not chaplain-focused and do not include some of the participants' in this survey's most utilized prayers. A website, though asked for by more than half of the participants, was the least requested of the prayer resources.

Next steps for this doctor of ministry project include taking this research further as a hospital-systemwide study including recruitment of an expanded, more diverse group of participants that may yield more significant results for a multifaith prayer resource. The pursuit of grants would be necessary for research and development of multifaith prayer resources (designated mobile app, website, book) with plans for implementation, design, and marketing. Conversation has begun within this hospital's Palliative Care Institute in exploring collaboration with this institution's Department of Spiritual Care and Education regarding future research and development. There has also been an introduction made to the creative team of Vital Tips, a

mobile app whose template and design could well serve this project.

The highlight of this paper was the privilege of my beginning to swim with the expansive and enlightened minds and hearts of Dr. Ann Belford Ulanov and Rabbi Abraham Joshua Heschel. It was a sacred honor to read and learn from them as I researched this paper. I am humbled by and in awe of their wisdom, intelligence, and light. They made every day of writing this paper a healing. I am deeply grateful.

This was a meaningful project for me because I came to understand my love for our beautiful multifaith hospital chaplains, who bravely open themselves to be with another's pain, sorrow, and helplessness, so these patients and their families (and our colleagues) don't have to be alone with their deepest suffering. Restating Pargament (2007), we "find expressions of deep longing for God that go hand in hand with pleas for wisdom, comfort, safety, and forgiveness. Through their association with the sacred, very human goals become elevated to greater meaning" (p. 69). I look forward to exploring and creating further resources to support this compassionate chaplain community and feel blessed to be a part of it.

To conclude, I'd like to quote Ulanov, re-cite Heschel, and share a bodhicitta dedication prayer in my Tibetan Buddhist tradition:

"Everybody prays. People pray whether or not they call it prayer. We pray every time we ask for help, understanding, or strength, in or out of religion" (Ulanov & Ulanov, 1982, p. 1).

"There is a book which everyone talks about . . . a book which has the distinction of being one of the least known books in our literature. It is the prayer book. . . . Almost any word, any passage, has untold resources of meaning, paradoxical beauty and depth" (Heschel, 1954. p. 81).

Any merit that may have been accumulated from this doctor of ministry project I give to

all sentient beings throughout space and time.

May the pure, brilliant sun of bodhicitta

Dawn in each and every heart and mind

Dispelling darkness and confusion,

Unstoppably—until all are illumined and awakened.

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Appendix A

Invitation Email for Participants

Subject: Chaplain Evan Zazula's study

Palliative Care Chaplain Evan Zazula is conducting a study under the supervision of Hebrew Union College-Jewish Institute of Religion, Doctor of Ministry Program. He is inviting all of us to participate. The quantitative study includes 32 questions to assess the chaplains' comfort/discomfort praying with their patient and family population who consist of multiple faiths; and the chaplains' response regarding being supported by multi-faith prayer sources. The survey is made up of Likert scales, yes/no, multiple-choice, and open-ended questions, as well as a brief chaplain profile.

If you'd like to participate, please gather on Friday, November 15 at 10:40am in [redacted]– before Grand Rounds. If you have questions, please reach out to Evan at Evan.Zazula@[redacted]<mailto:Evan.Zazula@[redacted]>

Blessings,
Amy

Appendix B

Follow-up Email for Participants

On Nov 13, 2019, at 11:11 AM, Zazula, Evan <Evan.Zazula@[redacted]<mailto:Evan.Zazula@[redacted]>> wrote:

Hi Chaplains,

I'd like to thank Amy and Co. for warmly supporting my DMin project. I'm so appreciative to all of you who are kind enough to arrive early to grand rounds to participate in my study. If you can, please arrive a little earlier than 10:40am this Friday (the 15th), so you can read and sign the consent form.

Again, thanks for your support,

Evan

Appendix C

Instruction Letter to Participants

Doctor of Ministry Research Project
Hebrew Union College- Jewish Institute of Religion
Evan Zazula, MAPCC
evan.zazula@[redacted]

November 15, 2019
10:40 a.m.

Dear Chaplains,

Thank you for voluntarily participating in my Doctor of Ministry research project. The survey attached comprises a short chaplain's profile and 32 questions.

This survey is confidential. On page 2 of the survey packet is a Consent Form for you to please sign, date, and return to me before responding to the survey. Each consent form has a participant number that corresponds to the participant number on the survey. To support confidentiality, your name will not appear on the survey.

Page 3 contains three definitions of prayer as it pertains to this research project. Definitions are to be read before and, if needed, during the answering of survey questions.

The survey of 32 questions is on 4 stapled pages. Please keep the survey intact and use a pen to answer every question as honestly as possible.

The time allotted for this survey is 15 minutes. Feel free to ask me questions, if you need to, while you complete this survey. It is important to answer every question on the survey. When you are finished, please put down your pen.

With gratitude,

Evan Zazula

Appendix D

Consent Form

#_____

Consent Form

This is a survey being conducted in collaboration with the Hospital and its Director(s) of the Department of Spiritual Care and Education. The information you provide will help serve chaplains and clergy support the spiritual care of patients and their family throughout the trajectory of their hospitalization and/or illness.

The Directors and researcher will guard information collected and the identities of all the participants will be kept anonymous by substituting a code number for each name. Your name will only appear on the consent agreement, which will be removed before the data is tabulated. All information will be anonymous and held in confidence by this researcher. Please be as truthful as possible.

This study is a requirement for the degree of Doctor of Ministry, and is done under the supervision of Hebrew Union College-Jewish Institute of Religion, Doctor of Ministry Program. The researcher, Evan Zazula, can be reached at 917-841-6857 or at evanzazula@aol.com. If there are any questions, please don't hesitate to contact. The results of the study will be made available to participants upon their request.

Kindly complete all questions. Thanks for your willing participation!

Statement of Consent:

By signing the consent form, I understand my involvement in the project and agree to participate.

Name_____

Signature _____ Date_____

Signature of Researcher_____ Date_____

Appendix E

Definition of Prayer Questionnaire

Questionnaire: Definition of Prayer

(Entry 1 of 2)

1a(1): an address (such as a petition) to God or a god in word or thought said a *prayer* for the success of the voyage

(2): a set order of words used in praying

b: an earnest request or wish

2: the act or practice of praying to God or a god kneeling in *prayer*

3: a religious service consisting chiefly of prayers —often used in plural

4: something prayed for

5: a slight chance; haven't got a *prayer*

As per Rabbi Arthur Green (2003), prayer is usually allocated into two classifications:

Spontaneous, or customized prayer: words that pour openly from the heart in response to our life's events and or crises. These prayers, whether spoken or quiet, are an authentic expression of the pain or joy felt in a particular moment, and their strength lies within it being shared in that moment.

Liturgical or fixed prayer . . . assigned words to be spoken regularly at certain times in the day, week, or year. These prayers evoke powerful responses in us precisely because of their familiarity.

Appendix F

Chaplain Questionnaire

Complete on the computer or print out.

Instructions for computer entry: Cursor to each entry field to be filled. Click in a Check box to place an X in it (click again to uncheck). You can also use the Tab key to move forward from each fillable entry field to the next (Shift+Tab to tab backward). Note that Text fields are longer than they appear.

Name

Job Title *(e.g. chaplain, resident)* _____

Gender/Sex
☐ Male ☐ Female ☐ Other *(specify)* _____

Age ___

Education *(highest completed)*
☐ Bachelors ☐ Masters ☐ Doctorate ☐ Post-doctorate ☐ Other *(specify)* _____

Board-certified Chaplain? ☐ Yes ☐ No

Date Certified, if available *(m/d/yyyy)* _____

 # Clinical Pastoral Education Units
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5

Site of Employment _____

Employment Status ☐ Full-time ☐ Part-time ☐ Volunteer

Religion of Origin _____

Religion Currently _____

Clergy Title *(if any)* _____

	always	*often*	*sometimes*	*rarely*	*never*
1. Prayer is a part of your patient visit.	☐	☐	☐	☐	☐
2. You use materials for prayer or ritual.	☐	☐	☐	☐	☐
3. You pray in another's faith tradition (not your own).	☐	☐	☐	☐	☐
4. You hesitate praying with a patient.	☐	☐	☐	☐	☐
5. You hesitate offering a prayer for a patient of another faith.	☐	☐	☐	☐	☐
6. You hesitate to pray with a patient because he/she is non-English speaking.	☐	☐	☐	☐	☐

7. You hesitate to pray with a patient because he/she is non-English speaking.	☐	☐	☐	☐	☐
8. You feel inauthentic as a chaplain.	☐	☐	☐	☐	☐
9. You feel inauthentic praying with patients and or family at the bedside.	☐	☐	☐	☐	☐
10. You feel inauthentic praying with a patient not concordant with your religion.	☐	☐	☐	☐	☐
11. You prefer facilitating spontaneous prayer at the bedside, rather than fixed prayer.	☐	☐	☐	☐	☐
12. You hesitate to utilize both fixed prayer and spontaneous prayer with patient and or family.	☐	☐	☐	☐	☐

	yes	*no*
13. Did you ever not pray because the patient/family member is not of your religion/faith tradition?	☐	☐
14. Did you ever not pray spontaneously on your part because the patient was not in your religion/faith tradition?	☐	☐
15. Did you ever not pray, even though you were asked, because the patient was not in your religion/faith tradition?	☐	☐
16. Did you ever perform a ritual for a patient/family not in your faith tradition?	☐	☐
17. Did you ever abstain from performing a ritual when asked because of patient being discordant with your religion?	☐	☐
18. Would you feel comfortable performing a ritual of another religion (confession, forgiveness, at death, post death) if you had an appropriate source/guide?	☐	☐
19. Are you ever uncomfortable performing a prayer that is not concordant with your religion?	☐	☐
20. Do you ever utilize secular prayer?	☐	☐
21. Do you feel comfortable utilizing other religion's sources for prayer?	☐	☐
22. Do you feel comfortable utilizing other religion's sources for ritual?	☐	☐
23. Do think it would be useful to have a source for multifaith prayers for chaplains?	☐	☐
24. Have you ever not prayed with a patient because he/she was non-English speaking?	☐	☐
25. Do you prefer secular prayer to fixed religious prayer?	☐	☐

26. What 3 to 5 written materials do use for prayer to support patients at the bedside?

a) _____

b) _____

c) _____

d) _____

e) _____

27. What 3 to 5 objects do use for prayer or ritual to support patients at the bedside?

    a) _____

    b) _____

    c) _____

    d) _____

    e) _____

28. What are the 3 to 5 prayers/psalms that you use most from your religion?

    a) _____

    b) _____

    c) _____

    d) _____

    e) _____

29. What 5 religions most represent your patient population?

    a) _____

    b) _____

    c) _____

    d) _____

    e) _____

30. You are most comfortable reciting or facilitating prayer

    ☐ In your own faith ☐ Using spontaneous prayer ☐ In another faith tradition

31. What would your preferred multifaith prayer source for chaplains be?

    ☐ Prayer book

    ☐ Prayer website

    ☐ Prayer app (phone)

    ☐ All of the above

    ☐ None of the above

32. If a multifaith prayer app were to be created, what features would you like it to include (check all that apply)?

    ☐ Language translations

    ☐ Audible prayers

    ☐ Printable prayers

    ☐ Other *(specify)* _____

    ☐ All of the above