

Journal of Health Care Chaplaincy

ISSN: 0885-4726 (Print) 1528-6916 (Online) Journal homepage: www.tandfonline.com/journals/whcc20

A mixed-method evaluation of implementation determinants for chaplain intervention in a hospital setting

Jennifer S. Mascaro, Marianne P. Florian, Erin Brauer, Patricia K. Palmer, Marcia J. Ash, Maureen Shelton, Roman Palitsky, Deanna M. Kaplan, Shaheen Rana, Cam Escoffery, Charles L. Raison & George H. Grant

To cite this article: Jennifer S. Mascaro, Marianne P. Florian, Erin Brauer, Patricia K. Palmer, Marcia J. Ash, Maureen Shelton, Roman Palitsky, Deanna M. Kaplan, Shaheen Rana, Cam Escoffery, Charles L. Raison & George H. Grant (2024) A mixed-method evaluation of implementation determinants for chaplain intervention in a hospital setting, Journal of Health Care Chaplaincy, 30:3, 226-244, DOI: 10.1080/08854726.2024.2323375

To link to this article: https://doi.org/10.1080/08854726.2024.2323375

© 2024 The Author(s). Published with license by Taylor & Francis Group, LLC

View supplementary material

Published online: 15 Apr 2024.

Submit your article to this journal

Article views: 2607

View related articles

View Crossmark data

Citing articles: 1 View citing articles

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=whcc20

JOURNAL OF HEALTH CARE CHAPLAINCY
2024, VOL. 30, NO. 3, 226–244
https://doi.org/10.1080/08854726.2024.2323375

Routledge
Taylor & Francis Group

OPEN ACCESS Check for updates

A mixed-method evaluation of implementation determinants for chaplain intervention in a hospital setting

Jennifer S. Mascaro[a,b], Marianne P. Florian[c], Erin Brauer[a], Patricia K. Palmer[b], Marcia J. Ash[d], Maureen Shelton[b], Roman Palitsky[b], Deanna M. Kaplan[a,b], Shaheen Rana[e], Cam Escoffery[d,e], Charles L. Raison[b,f], and George H. Grant[b,g]

[a]Department of Family and Preventive Medicine, Emory University School of Medicine, Atlanta, GA, USA; [b]Department of Spiritual Health, Emory University Woodruff Health Sciences Center, Atlanta, GA, USA; [c]Department of Religious Studies, University of South Florida, Tampa, FL, USA; [d]Department of Behavioral, Social, and Health Education Sciences, Rollins School of Public Health, Emory University, Atlanta, GA, USA; [e]Winship Cancer Institute, Emory University, Atlanta, GA, USA; [f]School of Human Ecology, University of Wisconsin-Madison, Madison, WI, USA; [g]Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, GA, USA

ABSTRACT

Healthcare chaplains address broad social and emotional dimensions of care within a pluralistic religious landscape. Although the development and evaluation of chaplaincy interventions has advanced the field, little research has investigated factors influencing the implementation of new chaplain interventions. In this mixed-method study, we examined attitudes about evidence-based interventions held by chaplain residents (n = 39) at the outset of an ACPE-accredited residency program in the southeast United States. We also used semi-structured interviews (n = 9) to examine residents' attitudes, beliefs, and decision-making processes after they trained in the delivery of a novel manualized intervention, Compassion-Centered Spiritual Health (CCSH). Most residents reported favorable attitudes toward manualized approaches prior to training. Interviews revealed complex decision-making processes and highlighted personal motivations and challenges to learning and implementing CCSH. Implementation science can reveal factors related to motivation, intention, and training that may be optimized to improve the implementation of healthcare chaplaincy interventions.

KEYWORDS

Chaplains; compassion; determinants of implementation behavior; implementation science; mixed-methods; spiritual health

Introduction

Modern-day chaplains are valued members of interdisciplinary hospital teams and are called upon to address broad social and emotional patient care and staff care needs within a pluralistic religious landscape (Center, 2015; Liefbroer et al., 2019; Pesut et al., 2016). Although an estimated 70% of patients would like to be seen by a chaplain during their hospitalization, recent research highlights a gap in access: more patients

CONTACT Jennifer S. Mascaro jmascar@emory.edu Division of Family and Preventive Medicine, Emory University School of Medicine, 1841 Clifton Road NE, Suite 507, Atlanta, GA 30329, USA.

Supplemental data for this article can be accessed online at https://doi.org/10.1080/08854726.2024.2323375

© 2024 The Author(s). Published with license by Taylor & Francis Group, LLC
This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

report a desire for chaplain services than the number of patients who are actually able to access to them, with religiously affiliated patients more likely to receive spiritual health care (Piderman et al., 2013; Piderman et al., 2010; White et al., 2022). The need to reduce gaps in access and to demonstrate the effectiveness of chaplain consults have been part of the impetus for improving the rigor of spiritual health research. Leaders in health care chaplaincy have called for an increase in evidence-based approaches to chaplaincy care to both improve quality and to demonstrate the impact of spiritual health consults on patient outcomes (Damen et al., 2018; Fitchett, 2011; Fitchett et al., 2014; Snowden et al., 2017; St. James O'Connor & Meakes, 1998), and the last decade has seen an increase in the volume and rigor of research within the field of health care chaplaincy (Pesut et al., 2016).

The development and evaluation of manualized spiritual health interventions has been paramount for increasing evidence-based practice (Damen et al., 2018). For example, interventions have been developed and manualized to facilitate spiritually informed, structured life reviews (Kruizinga et al., 2019; Kruizinga et al., 2013; Piderman et al., 2015), to augment meaning and meaning-making among caregivers (Steinhauser et al., 2016), and to facilitate spiritual care for patients with specific needs (e.g., mechanically ventilated patients (Berning et al., 2016)). The primary focus of much of this existing research has been on evaluating intervention effectiveness (Sharma et al., 2016); however, very little research has characterized the social, psychological, and structural factors that impact implementation of spiritual health interventions. Systematic investigations of implementation conditions are needed to identify factors that enhance or impede the success of the implementation of new spiritual health interventions (Kilbourne et al., 2007; Proctor et al., 2013). Examining the pre-conditions necessary for implementation of evidence-based chaplaincy interventions is particularly important given the variation of implementation contexts across medical systems. Chaplains work in heterogeneous hospital systems, where they fulfill diverse functions on interdisciplinary medical teams, and studies show that there is wide variability in chaplains' beliefs and preferences about using interventional approaches (Damen et al., 2018; Fitchett et al., 2014).

Implementation science provides frameworks for rigorous research with a goal of identifying and characterizing contextual factors that influence the successful implementation of an intervention. One such model, The Replicating Effective Programs (REP) framework, denotes four major phases of implementation: pre-conditions prior to pilot study (e.g., evaluating organizational need, identification of barriers to implementation), pre-implementation (e.g., refining interventionist training, refining intervention after a pilot test), implementation (e.g., evaluation of outcomes and return on investment), and maintenance/evolution (e.g., identifying sustainability strategies) (Kilbourne et al., 2007). Here, we evaluate aspects of the early phases - the pre-conditions and pre-implementation phases - during which the focus is generally on characterizing the need for a new intervention, identifying an intervention that fits the setting and priorities of the stakeholders, and intervention packaging (Huynh et al., 2018; Kilbourne et al., 2007). In examining these early phases, we use an implementation science framework, namely, the determinants of implementation behavior (DIB) framework, that evaluates behavior-change factors thought to influence implementation behavior, such as an interventionist's knowledge, skill, beliefs about the consequences of the intervention, and social influences (Atkins et al., 2017; Michie et al., 2005).

Our goal in this mixed-method research study was two-fold. First, we aimed to characterize the attitudes about evidence-based interventions held by chaplain residents at the outset of an ACPE-accredited CPE (clinical pastoral education) residency program (i.e., a core aspect of the *pre-conditions* for chaplain intervention). Second, with a focus on the pre-implementation phase, we aimed to examine chaplain residents' attitudes, beliefs, and decision-making processes after they learned to deliver a novel manualized intervention, Compassion-Centered Spiritual Health (CCSH^{TM}), designed for the practice of chaplains working within clinical settings.

Methods

Study overview

This study was part of a randomized, wait-list controlled clinical trial (NCT03529812) to examine a Compassion-Centered Spiritual Health (CCSH) intervention delivered by healthcare chaplains to hospitalized patients. It was reviewed and approved by our university's Institutional Review Board and all participants provided informed consent. The study was conducted with two cohorts of spiritual health residents enrolled in 2018–2019 and 2019–2020 academic years. Spiritual health residents learned to deliver the intervention during the early part of their CPE program and then delivered the intervention during consultations with patients. Results of the clinical trial evaluating the effectiveness of CCSH will be reported in a separate manuscript.

After being trained in CCSH, residents began using the intervention in their consultations under supervision built into the CPE program, in which residents prepared reflections on their CCSH consultations and received feedback and mentoring from their educators. In the setting where this research took place, chaplain residents in the CPE program are assigned to one of five hospital locations in a large city in the southeastern United States. They primarily engage in instructional and clinical activities at their assigned hospital. Within these five hospital locations, chaplains and chaplain residents provide consultations to patients of any or no faith. They aim to consult with all inpatients upon their admission to the hospital. Additionally, consultations are conducted based on patient or family requests, as well as requests from clinical staff when they have concerns about a patient's well-being. Chaplains also respond to cardiac arrest codes and deaths, often providing spiritual support to patients, families, and staff during these difficult situations. Further, chaplains also assist patients in completing advance directives and with end-of-life planning, facilitating discussions about values, beliefs, and preferences regarding treatment plans and the final stages of life. From 2017 to 2020, chaplains and chaplain residents in this healthcare system averaged a combined 72,811 patient/family consultations per year. In 2019 alone, they conducted 77,683 consultations with patients and their family. During the CCSH training period, chaplain residents conducted CCSH consultations. Reflections coupled with mentored feedback were built into the CPE residency.

Study design

Here, we used an explanatory sequential, mixed-method study design (Fetters et al., 2013) to examine chaplain residents' attitudes toward standardized interventions and to

explore residents' experiences learning and using a novel standardized spiritual health intervention. At the beginning of CPE, prior to learning to deliver CCSH, residents completed quantitative surveys to assess the pre-conditions of learning to deliver a novel intervention. After chaplain residents learned to deliver CCSH, we conducted qualitative, semi-structured interviews to understand the context for learning and implementing a spiritual health intervention.

CCSH (Compassion-centered spiritual health)

CCSH augments spiritual health education and best practices with CBCT® (Cognitively-Based Compassion Training), a comprehensive and evidence-based method for training compassion that draws on the *lojong* tradition of Indo-Tibetan Buddhism (Ash et al., 2021; Mascaro et al., 2022; Mascaro et al., 2012; Pace et al., 2010; Pace et al., 2009). CBCT was developed to be accessible to those of any or no faith tradition, and it combines exercises for stabilizing attention and calming the mind with contemplation of aphorisms, visualizations, self-inquiry, and related meditative exercises for reinforcing and internalizing compassionate perspectives. CCSH interventions are delivered by CPE-trained spiritual care professionals who are also trained in CBCT (see supplemental materials for more information about CCSH).

Quantitative measurement of pre-conditions

Prior to the residents learning to deliver CCSH, we administered a scale previously used to measure practitioner attitudes and intent to deliver a manualized intervention (Haug et al., 2008). The scale includes three subscales: (1) a 3-item subscale that measures positive attitudes and beliefs about the *outcome* of using a manualized intervention; (2) a 3-item subscale that measures negative attitudes about the *process* of using a manualized intervention; and (3) a 6-item subscale that assesses beliefs about *organizational barriers* to the adoption of evidence-based practices. The Positive Outcome subscale includes items such as, "Using standardized methods helps a chaplain to evaluate and improve his or her clinical skills." The Negative Process subscale includes items such as, "Standardized methods make chaplains more like technicians than caring human beings." Example items from the Organizational Barriers subscale include, "The idea of evidence-based practices sound good in 'theory,' but in reality, it's virtually impossible to scientifically test a phenomenon as complex as spiritual consultation" and "Evidence-based practices seem overly complicated and hard to put into practice." These 12 items are rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree); item ratings are averaged within subscales. In the case of the Organizational Barriers subscale, lower scores correspond with a belief that the organization is ready to adopt evidence-based spiritual health interventions. The only change we made to the original scale was to modify language to relate to chaplains and spiritual health, for example, substituting *chaplain* for *therapist* and *patient* for *client*. Cronbach's alphas for the 3 subscales were: 0.81, 0.88, and 0.60, respectively.

Qualitative evaluation of CCSH implementation

To contextualize self-report data and to evaluate the residents' attitudes and preferences for manualized intervention, all residents were invited to participate in individual semi-structured, face-to-face interviews. The research team conducted interviews with chaplain residents (n = 9) after they were trained in delivering CCSH, approximately 8 months into their CPE residency. Interviews were conducted by a member of the research team (M.P.F.) and followed a semi-structured discussion guide that probed (1) chaplain residents' preferences for using CCSH (versus another strategy for assessing needs and providing care), (2) decision-making processes for using CCSH (versus another strategy), (3) their personal motivations to learn and implement CCSH, and (4) factors (ideas, attitudes, resources, or circumstances) inside and outside of the hospital that influenced their use of CCSH.

Analysis

For quantitative analysis of self-report surveys, we calculated the mean response and frequency counts (agreed, unsure, disagreed) for each sub-scale. For qualitative analysis of the interviews, the research team first created a deductive codebook using the determinants of implementation behavior (DIB) framework (Huijg et al., 2014), which queries 18 behavior-change factors thought to influence implementation behavior, based on the Theoretical Domains Framework (Atkins et al., 2017; Michie et al., 2005). The research team then developed further inductive codes that aligned with patterns that emerged from the transcripts. Each interview was independently coded by two researchers (P.K.P. and E.B.) using the qualitative software program, MAXQDA version 2022 (Software, 2021). The research team discussed codes to compare and reconcile any coding differences and to ensure concordance. After coding was complete and apparent code saturation was reached (i.e., no new codes were identified), a code relation browser was run in MAXQDA to find overlaps in the codes (e.g., 'preferences for using an intervention' *and* 'patient characteristics' codes) and to identify themes.

Results

Quantitative measurement of pre-conditions

Thirty-nine residents completed the measure assessing attitudes toward and beliefs about manualized interventions. The mean response for the Positive Outcome subscale was 3.69 (standard deviation [*SD*] = 0.84), indicating moderate agreement that evidence-based interventions enhance the effectiveness of chaplain services. Most chaplain residents (n = 28, 72%) had a mean response indicating favorable attitudes toward standardized methods (see Figure 1). The mean for the Negative Process subscale was 2.32 (*SD* = 0.99), indicating general disagreement with the idea that evidence-based interventions negatively impact the therapeutic process of spiritual health clinicians. Eight chaplains (21%) had a mean response above the midpoint of the scale, indicating a belief that standardized interventions negatively impact the therapeutic process, with 67% of chaplain residents indicating general disagreement with such negative effects

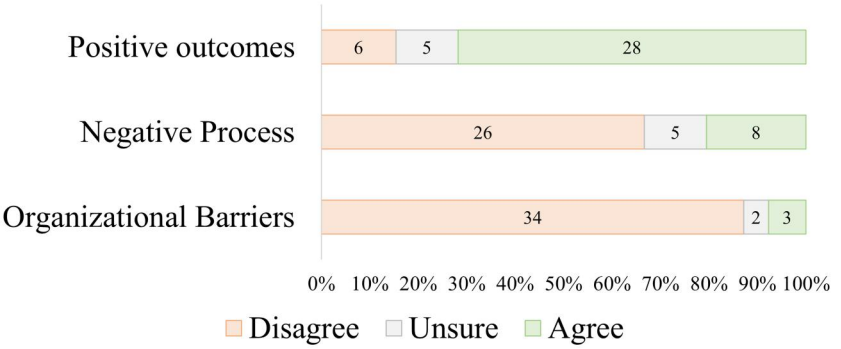


Figure 1. Proportion of chaplain residents that agreed, disagreed, and were unsure that standardized interventions result in positive outcomes, that standardized interventions have a negative impact on the process of spiritual health care, and that their organization is unready to adopt standardized interventions.

and five residents (13%) indicating they were unsure. The mean for the Organizational Barriers subscale was 2.11 (SD = 0.61), indicating that chaplain residents generally believe that their organizations are ready to adopt evidence-based spiritual health interventions. Three chaplains (8%) had a mean response indicating that they tended to agree that there are organizational barriers to implementing evidence-based practices, whereas 34 chaplains (87%) tended to disagree. Two chaplains' (5%) scores indicated that they were not sure.

Qualitative evaluation of CCSH implementation

Although the majority of chaplain residents expressed positive attitudes about standardized interventions, the semi-structured interviews revealed the complexity of residents' decision-making processes around and experiences with the CCSH intervention. Codes and subcodes, their definitions, their relationship with the DIB framework, and frequencies of coding are listed in Table 1. Below, codes are organized according to the primary themes that emerged: (1) motivation to learn CCSH; (2) decision-making processes to use (or not to use) CCSH; and (3) barriers and facilitators of using CCSH with patients. Representative quotes are found in the supplemental section.

Motivation to learn CCSH

Three primary sub-themes emerged when chaplain residents were asked about their personal motivation to learn the CCSH intervention: appreciation of CCSH core aspects, belief in its effectiveness, and desire for additional tools to help patients. Several residents expressed that they were motivated to learn CCSH because of core aspects of the intervention itself. For example, three residents reported that they specifically appreciated how CCSH gives the patient strategies to help themselves when on their own, whether at the hospital or when they went back home. Another said he liked that CCSH provides the spiritual health clinician the flexibility to work within their own personalities.

Table 1. Codes and subcodes, their definitions, their relationship with the DIB framework, and frequencies of coding.

Codes	Sub-codes	Definition	DIB domain alignment	Frequency
Outcome		Description or discussion of an example outcome from using CCSH (or another specific intervention) with a patient or other population.	(DIB 6) Beliefs about consequences	4
Intervention		Instances when the chaplain is talking about specific incidences of delivering the intervention with a particular care seeker		8
Preference to use CCSH		Used when answering specific interview guide question: "Do you prefer consulting with patients or loved-ones in the hospital using the CCSH intervention or do you prefer using your own strategies?"		
	Yes			1
	No			3
	Mixed			5
	Ambiguous			2
Recipient of CCSH		Instances when the chaplain is talking about the importance of who (patient, family) they're delivering to/working with or who they're *not* delivering to/ working with	(DIB 12) Patient Characteristics	
	family			0
	patients			5
Decision to use CCSH		Used when answering specific interview guide question: "How do you decide when to do the CCSH intervention and when not to?"	(DIB 12) Patient Characteristics	13
Motivation to use CCSH		Used when answering specific interview guide question: "What motivates you personally to learn and implement the CCSH intervention?		10
Chaplain influences (inner and outer)		Factors that influence the chaplain's use of the CCSH intervention? These could be ideas, attitudes, resources, or circumstances.		
	Ideas/Beliefs about consequences	A belief or understanding that relates to the anticipated outcomes or consequences of CCSH or what it is for (it's applicability as an intervention).	(DIB 6) Beliefs about consequences (attitude, outcome expectancies, reinforcement)	22
	Beliefs about capabilities	Beliefs about ones true or perceived abilities, talents, or attributes outside of the CCSH training that can be brought to bear when using CCSH.	(DIB 4) Beliefs about capabilities (self-efficacy, perceived behavioral control)	7
	Emotions	Positive or negative affect regarding ideas, beliefs, or behaviors around CCSH.	(D15) Positive emotions and (D16) Negative emotions	8
	Resources	Any resource that the chaplain brings from their personal life or training that is not CCSH, but which has an effect on their ability to implement CCSH.		5

(*continued*)

Table 1. Continued.

Codes	Sub-codes	Definition	DIB domain alignment	Frequency
	Skills	An ability or proficiency acquired through practice. Reporting that they feel trained and practiced to deliver CCSH or not.	(DIB 2) Skills	27
	Chaplain Circumstances	Circumstances in the chaplain's life and work that affect their ability to deliver or learn CCSH.		4
Hospital/worksite Influences		What factors inside the hospital, the chaplain's work environment, or in the hospital system influence their use of the CCSH intervention?		
	Unit/environment characteristics	Characteristics of the physical clinical unit of the hospital environment that could impact the implementation or outcome of CCSH.		3
	Patient characteristics	What characteristics of specific patient populations impact implementation or outcome of CCSH		18
	Time	Instances or discussion of time enabling or constraining the chaplain from implementing CCSH.		13
	Peer Influence	Influences by peers that may affect the implementation of CCSH	(DIB 14) Social influences	0
	Educator Influence	Any type of educator influence on the implementation of CCSH.	(DIB 14) Social influences	0
	Program Influence	Any influence the CPE program has had on implementation of CCSH		14
Recommendations		Recommendations to help the implementation of CCSH intervention in the future		11
Barriers				
	Barriers to CCSH intervention	Any barrier to the effectiveness or outcome of CCSH		26
	Other barriers	Any barrier outside implementation of the CCSH intervention		3
Chaplain's religious affiliation				6
Patient's religious affiliation				6
CBCT		Chaplain may be talking about their experiences with CBCT or may be revealing slippage in their understanding of and distinguishing between CBCT and CCSH		13

A second sub-theme that emerged with respect to personal motivations was a belief in the effectiveness of the intervention. For example, two residents reported that they thought that CCSH was an effective tool and that it gave people peace and hope. Another said CCSH was effective in helping patients shift their perspective and gain insights. One chaplain, who was also working as a pastor, reported wishing he had had the intervention tools earlier. He felt they were more effective, in the congregational as well as hospital setting, than what he had been doing before he was trained in CCSH.

A third sub-theme that emerged was the desire to learn and have additional tools or strategies that would empower and improve the chaplain residents' work with patients.

For example, three residents reported that they were motivated to use CCSH so that they could have more tools for their own personal and professional development. One resident thought CCSH would help foster compassion for himself and others. Similarly, another resident said he used CCSH for personal development. He said he "could not give what [he] did not have." If he had compassion and energy, he reported, then he could give it to someone else to alleviate their suffering. Another resident said that using CCSH made him bold enough to try something new so he could be less reliant on interventions drawn from his faith tradition. Thus, chaplain residents were more motivated to use CCSH because they appreciated its central ideas and techniques, viewed it as effective and helpful, and wanted to have innovative new tools to improve their spiritual health consultations.

Decision-making processes for using the CCSH intervention

With respect to queries around how and why they decided to use CCSH, most of the residents reported that they made a judgement call about whether to use CCSH during a patient encounter after they entered a patient's room. Utilizing the intervention was something that they decided in the moment and was not something that they planned on using (or not using) prior to meeting a patient.

A sub-theme that emerged with respect to residents' decisions to use CCSH was the patient's needs and resources. For example, chaplain residents often reported that they made the decision to use CCSH when patients were in visible distress, and four residents specifically stated that distress was their cue to use the intervention. One chaplain resident explained that he used CCSH when patients were having a difficult time finding hope, or were very anxious, scared, angry, or frustrated. He reported that he would then use centering breaths or similar grounding practices, a core component of the CCSH intervention in the context of acute patient distress. Another chaplain resident said that he would introduce CCSH when a patient has strong anxiety coupled with an apparent openness to CCSH. One resident said they would use the intervention when it seemed like a patient was waiting for the chaplain to do or say something. In this case, the resident said they would use a nurturing moment or a breathing practice. Another said they made the decision to use CCSH when they got the sense that a consult was going to be longer than a cursory introduction and therefore would allow time to engage the patient with CCSH.

In contrast, three chaplains had specific reasons why they might choose *not* to use CCSH during an encounter. One chaplain explained that when someone shuts an idea down or is dismissive and is clearly saying they do not want to engage, then she makes the decision not to use CCSH. She specifically mentioned examples in which patients use a phrase like, "thank you for coming" as a sign of dismissal, which early in a consult was taken to indicate that the patient did not want to engage deeply or at all. Similarly, another chaplain resident said that when a patient had a blank stare or asked why the chaplain was there, then she would not use CCSH. The third resident said he usually would not use CCSH if a patient was doing well and had healthy coping mechanisms and a good support system in place, presumably because there was nothing to target with an intervention.

Other residents reported that they would choose not to use CCSH as a more general rule with certain patient populations. For example, one resident commonly worked with patients in the psychiatric unit and talked extensively about the limitations of CCSH in this particular population. She said she was able to use CCSH for herself to attune to the patients, and sometimes was able to use certain modules like empowerment or entrustment, but reported that she was unsure about using the other modules because of patient characteristics such as belief systems or current psychological state.

Another resident who frequently worked on the neurological rehab unit stated that in many of her consults, all she could give the patients was her presence because patients did not have the cognitive ability to engage with CCSH. Similarly, a third resident noted that it was difficult to use CCSH with patients who had impaired hearing or dementia.

Another common theme that residents referenced in their decisions to use (or not to use) CCSH was the social and religious background of their patients. One chaplain said they would think twice about using CCSH with a Muslim patient because their knowledge of resources from scripture and parable were from Christianity and applying these resources in CCSH wasn't appropriate for someone practicing Islam. However, another chaplain reported that they thought the intervention was a good fit with Christianity and would weave aspects of the intervention in with the patient's religious beliefs to help relieve distress.

Taken together, most residents reported that they made decisions about whether to use the CCSH interventional approach once they had entered the patient's room. Their decisions to use CCSH were often made in response to perceiving the patient's needs, openness, and ability to engage with the intervention. When chaplain residents decided not to use CCSH, they were often perceiving that the patient was not able or willing to converse openly, they felt the patient had no obvious distress or need for the intervention, or the chaplain did not think they could use the intervention in a religiously flexible way.

Barriers and facilitators of using CCSH with patients

A theme that commonly emerged as a barrier toward learning and using CCSH was a feeling of being overwhelmed during CPE. For example, one resident reported feeling overwhelmed by the sheer number of things to remember while learning and trying to practice CCSH. Another said they felt overwhelmed by having more elements added to what the residents were already learning in their CPE curriculum.

The primary theme that emerged when chaplain residents were asked about the factors that influenced their use of CCSH was the importance of practice as a facilitator of delivering CCSH. Although most of the chaplains reported feeling positive about CCSH, the desire for more practice in delivering the intervention was frequently stated. Three chaplains mentioned specifically that they believed they were not proficient enough with the CCSH intervention to employ it well. Others said they wanted more practice to make the intervention easier to use and that would allow them to be more intentional about using it. The three primary reasons for wanting more practice were: needing time to internalize the intervention; to increase comfort in initiating CCSH; to improve transitions through the CCSH modules organically and with flow.

Time to internalize and feel mastery. An emergent theme was residents' beliefs that they needed more time to practice CCSH to feel personal mastery of CCSH. One resident explained that they were not only new to the CCSH intervention, but also to chaplaincy in general, so they felt like they needed more time to make CCSH part of their practice. A second reported that when he felt familiar enough with a patient to admit that he had a new intervention he wanted to try, it enabled him to practice CCSH comfortably, stating that it felt more acceptable to be a "beginner." Another resident said they were taught a lot in a short amount of time, and he needed time to "internalize" and absorb it, so he could incorporate CCSH if and when it seemed like a good fit.

Comfort in initiating CCSH. Three chaplains expressed difficulty making comfortable transitions from supportive conversation to the CCSH intervention and wanted practice to improve these transitions. One resident said their focused practice to date in using the intervention, comprising several weeks, had helped in this regard. However, they reported that it was still difficult to move through transitions. He and others who expressed this preference reported wanting to learn how to implement CCSH in a more natural, conversational way.

Flow during CCSH. Residents used the words "natural" and "organic" many times to explain how they used the spiritual health intervention. Most who mentioned this topic wanted the intervention to feel "organic" – meaning here that they desired the feel of a natural interaction, free from artificial-feeling transitions between core aspects of the intervention. One resident said CCSH felt "natural" to him. He explained that it was something that "is part of who I am." Even though he was still learning, he reported that he felt very natural implementing CCSH. Four residents said they felt that they needed more practice beyond what was provided to them in training to make CCSH an organic part of their chaplaincy work with patients. One chaplain resident did not feel proficient enough to move smoothly through the CCSH intervention modules, and thus he preferred to use his own methods because he felt his methods were more organic. Another resident specifically called the CCSH intervention "non-organic." She felt that CCSH was more like a psychotherapy session where the practitioner has the patient try an exercise instead of prioritizing presence. She mentioned using the word "homework" with a patient and didn't like the way that felt, particularly when a patient is contemplating an illness or having a serious procedure.

Discussion

Our explanatory sequential, mixed-method study design (Fetters et al., 2013) used quantitative data to examine chaplain residents' attitudes toward standardized interventions at the beginning of CPE, followed by qualitative interviews to explore residents' experiences learning and using a standardized spiritual health intervention. Taken together, findings indicated that most chaplain residents beginning their CPE residency expressed positive views about using a standardized intervention while few expressed negative views or perceived organizational barriers to such an intervention. Interviews uncovered chaplain residents' attitudes, beliefs, and decision-making processes for learning and

implementing CCSH. Residents expressed both personal and clinically-oriented motivations for learning the intervention. At the same time, several residents reported contexts in which they chose not to use the intervention, along with complex decision-making processes that consider patients' body language, communication, clinical and cognitive status, and available psychosocial resources or level of need. Residents also highlighted personal challenges to learning and implementing CCSH, and emphasized the importance of being able to implement the intervention in a manner that feels seamless and conversational in the context of the clinical encounter.

By focusing on the pre-conditions for implementation at the outset of CPE (prior to introduction to any specific interventional approach) and using REP and DIB frameworks, the findings from this study may be applicable beyond the implementation of CCSH and may inform the implementation of spiritual health interventions more generally. Prior to learning CCSH, most residents expressed agreement that standardized, evidence-based approaches improve patient outcomes and expressed disagreement with the idea that standardized methods impair the process of delivering spiritual care. The responses observed in this study are largely comparable to the responses observed in other studies with interventionists from varying clinical contexts. For example, addiction treatment providers (counselors, social workers, psychologists, and therapists) reported similar mean responses (3.51 for positive outcome attitudes, 2.02 for negative process attitudes, and 2.34 for organizational barriers) to those observed in this study (Haug et al., 2008). Staff working in primary care to deliver a telemedicine intervention for obesity management reported similar attitudes toward positive outcomes (3.43 for positive outcome attitudes) compared to our sample, and more negative process attitudes (3.70 for negative process attitudes) (Batsis et al., 2020). They also reported relatively lower readiness of their organization for implementing standardized interventions (i.e., higher scores: 3.97 for organizational barriers).

Within spiritual health more specifically, previous studies highlight heterogeneity in the extent to which chaplains endorse evidence-based approaches to spiritual health consults. For example, a recent study found that among almost 500 chaplains queried about research priorities in spiritual health, only 12% mentioned the importance of research on interventions (Damen et al., 2018). Another previous study surveyed attitudes toward evidence-based practices among healthcare chaplains practicing in the Veterans Administration (VA) medical system, Department of Defense (DoD), and in civilian settings, and found that only a little over half of chaplains (63% VA and 54% DoD) report that they would like their spiritual health care to be more evidence-based, compared with 94% of healthcare chaplains working in civilian settings (Fitchett et al., 2014). In that study, researchers also interviewed chaplains about perceived barriers to evidence-based care and found that the most commonly endorsed theme was skepticism that chaplaincy outcomes could be subject to measurement. Although our study used a different scale to measure attitudes and organizational barriers to standardized treatments, 72% of the chaplain residents in our study endorsed positive outcomes based on standardized metrics. Of note, while the CPE program did not emphasize the importance of CCSH to the incoming residents in this study, it is possible that chaplain residents in our study are not representative of practicing spiritual health clinicians or trainees at other institutions. Future research can use this measure of attitudes about

manualized interventions to characterize the pre-conditions for standardized interventions in spiritual health (Haug et al., 2008). Knowing chaplains' attitudes toward evidence-based approaches is vital for evaluating the pre-conditions to implementing a spiritual health intervention, as previous studies have found that attitudes toward evidence-based approaches in general can influence the decision to adopt an interventional approach (Williams et al., 2014).

The qualitative interviews conducted after residents learned and practiced CCSH revealed rich and nuanced beliefs and preferences that contextualize and build upon chaplains' self-reported attitudes prior to learning the intervention. Residents reported that their motivation to learn and use the CCSH intervention was largely based on specific or core aspects of the intervention itself. This finding highlights the importance of informing spiritual health clinicians of the evidence-base and core features of an intervention prior to training. A recent review of 59 spiritual health interventions broadly grouped the existing interventions into those with a religious or spiritual focus and those with a psychological focus (Sharma et al., 2016). There is some evidence that interventions with a spiritual or religious focus, compared to those with a psychological focus, are more positively related to patient satisfaction, although the effect appears to be weak and few of these interventions are standardized or manualized (Sharma et al., 2016). Our findings indicate that non-specific factors such as interventionist knowledge of the core aspects of the intervention influence chaplain motivation, which may have downstream effects on the implementation and effectiveness of the intervention. Our findings are also consistent with previous studies highlighting the importance of theory-informed practice among healthcare chaplains (den Toom et al., 2024).

Residents also reported that they typically decided whether to use CCSH only after entering into the consult, based largely on the patient's body language, distress levels, available resources, cognitive state, social or religious background, and what simply felt "natural" in the context of the encounter. Of note, residents' stated beliefs that CCSH is not a good fit for patients of specific sociodemographic or religious groups or experiencing specific clinical conditions (e.g., psychotic symptoms) does not necessarily indicate that CCSH is not a good fit for these specific patients. In fact, CCSH was developed in large part to expand the spiritual health clinician's intervention to patients of any or no faith tradition, and with flexibility and heuristics to adapt based on a patient's state. For example, CCSH builds on common chaplaincy practice of attuning to a particular faith affiliation by intentionally elucidating and highlighting identified faith resources (for example, a specific scripture) and cultivating a broader awareness of how this resource will remain available in moments of distress. This intentional flexibility arguably distinguishes CCSH from other chaplain interventions designed for specific populations or to obtain specific outcomes (Berning et al., 2016; Kruizinga et al., 2019; Kruizinga et al., 2013; Piderman et al., 2015; Steinhauser et al., 2016). It is clear from previous research that understanding how, when, and why chaplains employ evidence-based and interventional approaches to spiritual health is a rich area of future research, especially during the implementation of new procedures or processes. Interestingly, a study conducted by Fitchett and colleagues found that the majority of chaplains (74%) did *not* consider the individuality or uniqueness of patients to be a barrier to evidence-based practice (Fitchett et al., 2014). Another study found that VA chaplains engage in

complex considerations to match intervention and care-giving procedures with patient needs (Drescher et al., 2018). The interviews in our study reveal at what point these very early users of CCSH decided to employ the intervention, and they underscore the logical connections that residents were drawing between the utility of CCSH for patients with different backgrounds and different levels of distress. These findings also highlight a potential mismatch between the chaplain residents' decision-making process and the core aspects of the CCSH intervention and highlight that future training may benefit from more deliberate discussion of the decision-making process.

In terms of the personal factors that influenced chaplain residents' use of CCSH, the most common emergent themes were related to the importance of feeling mastery and comfort with the delivery of the intervention. Several residents reported the importance of the intervention to feel natural and organic, delivered with a sense of flow and smooth transition. A number of studies found that chaplains describe their care in more process-oriented and less outcome-oriented terms than do physicians, for example emphasizing *presence* (Cadge et al., 2011; Lyndes et al., 2012). In this context, it makes sense that residents prioritize and are attentive to the process of intervention delivery. CCSH has several characteristics qualifying it as a complex intervention, such as including both clinician-facing and patient-facing components, and intentionally incorporating a relatively high degree of flexibility and tailoring (Craig et al., 2008). It was apparent from the interviews that residents were aware of that complexity, and many reported a desire for more practice. Future implementation of CCSH could benefit from this knowledge by incorporating more extensive practice during the training period.

Despite challenges with respect to feeling mastery of delivering CCSH, residents reported a high degree of motivation to learn and implement the intervention. A common theme was the desire to learn new approaches, tools, and strategies for working with patients, especially among a highly culturally, racially, and religiously diverse patient population. This general desire was coupled with a related theme, which was that specific aspects of the intervention provided them the flexibility and adaptability to make the intervention their own and to adapt it for different patients. An important study by Cadge and Sigalow identified two primary strategies used by healthcare chaplains when working in an interfaith context (Cadge & Sigalow, 2013). The first is *neutralizing*, an attempt at bridging religious differences by emphasizing a common humanity and "spiritual-universals" that cross religious and spiritual demarcations. A second strategy they identified was *code-switching*, in this case referring to the practice of navigating between religious differences by using the language, symbols, and rituals of other religions. Of note, CCSH incorporates the flexibility of both strategies. On the one hand, CCSH can include the intentional use of mindful grounding and the cultivation of a sense of nurturance, common humanity, and compassion to self and others that can be described as spiritual universals. On the other hand, and if appropriate, within the CCSH intervention the chaplain also aims to discern and bringing to light elements of the patient's faith tradition (e.g., scriptures or prayers) or non-religious spirituality or worldview (e.g., parables or poems) that support the compassion-based model. The residents' motivations to use CCSH are highly consistent with existing models to understand how healthcare chaplains can navigate religious pluralism and be of benefit to people of any or no faith tradition. Our findings are particularly important

given previous research indicating that faith-discordant encounters are rated just as positively by care-seekers as faith-concordant encounters (Liefbroer & Nagel, 2021), highlighting the importance to chaplains that interventions have flexibility and adaptability for either scenario. It is likely that this adaptability will lead to more frequent use of the intervention or to more effectiveness, or both, and future implementation research can test these hypotheses.

Limitations and future directions

Although we believe these findings can improve the implementation of CCSH interventional approaches and can be brought to bear on healthcare chaplain interventions more generally, our study had several limitations. While our response rate for the quantitative survey was high (89%), semi-structured interviews were only conducted with the subset of residents that volunteered. Our interview sample size was within the range identified in a recent meta-analysis that found the majority of interview datasets reach saturation between 9 and 17 interviews (Hennink & Kaiser, 2022). However, it is possible that more themes would emerge in a larger and more heterogenous set of chaplain interviews. Related, these data came from a single CPE site in a large civilian hospital system in the southeast with a group of chaplains limited to various traditions within Christianity. As reviewed above, previous research indicates that healthcare chaplains' attitudes and beliefs about evidence-based practices can vary greatly depending on factors such as their clinical setting (e.g., VA and DoD compared to civilian (Fitchett et al., 2014). Moreover, assessments of patient-reported outcome measures were beyond the scope of this exploratory implementation study. Future research can consider whether meaningful implementation variables influence patient outcomes (Visser, 2019). Additionally, future research will be necessary to understand CCSH adoption and sustainability among healthcare chaplains.

Conclusions

From resident interviews, we were able to identify factors that influenced their motivation to learn CCSH, as well as the multi-factorial process they use to decide whether to use CCSH. We were also able to identify facilitators and barriers to implementing CCSH. Our findings indicate that the extent to which chaplains feel mastery of and natural with the intervention will be a candidate predictor of great importance, and that the residents believe more practice time with the intervention to be crucial toward achieving this feeling of mastery and organic delivery. Residents had favorable attitudes toward standardized interventions prior to learning CCSH. After learning and practicing CCSH, interviews underscored the importance that interventions have flexibility and adaptability for faith-discordant and faith-concordant encounters. Furthermore, chaplains expressed a desire for extensive practice to gain sufficient mastery of the intervention to be able to apply these built-in features as-needed for a socio-demographically diverse and heterogenous patient population. Accordingly, our findings reveal the importance of conveying and training this flexible and nimble approach to improve upon future implementation efforts.

Acknowledgments

This study was funded by a 2017 PEACE award from the Mind and Life Foundation. Preparation of this manuscript was additionally supported by the National Institutes of Health under grants 5K01AT010488 (Mascaro). Research reported in this publication was also supported in part by the Intervention Development, Dissemination and Implementation Shared Resource of Winship Cancer Institute of Emory University and NIH/NCI under award number P30CA138292. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. We are immeasurably grateful to the chaplain residents and patients whose data were included in this study. We are also grateful to research assistants who helped collect and transcribe data.

Ethics statement

This study involving human participants was reviewed and approved by Emory University Institutional Review Board.

Informed consent

All participants provided their written informed consent to participate in this study.

Authors' contributions

JM conceived of the study, designed and oversaw data collection and analysis, helped with interpretation, and wrote the paper. MPF conducted semi-structured interviews and helped with interpretation of the coding. EB helped code the semi-structured interviews and helped with interpretation of the coding. PKP helped design the study, helped collect data, helped code the semi-structured interviews and helped with interpretation of the coding. MJA helped design the study and helped with data analysis and interpretation. MS helped design the study and interpret the findings. RP helped interpret the coding and analyses and made critical contributions to the paper. DMK helped interpret the coding and analyses and made critical contributions to the paper. SR helped create the semi-structured interview guide, helped reconcile coding discrepancies, and helped with interpretation of the coding. CE helped create the semi-structured interview guide and helped with interpretation of the coding. CLR helped conceive of the study and helped interpret the data. GHG helped conceive of the study and helped interpret the data. All authors made critical contributions to the article and approved the submitted version.

Disclosure statement

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

ORCID

Jennifer S. Mascaro http://orcid.org/0000-0002-6199-8455
Roman Palitsky http://orcid.org/0000-0002-0415-6411
George H. Grant http://orcid.org/0000-0002-4517-7286

Data availability statement

De-identified data that support the findings of this study are available on request from the corresponding author, JSM.

References

Ash, M. J., Walker, E. R., DiClemente, R. J., Florian, M. P., Palmer, P. K., Wehrmeyer, K., Negi, L. T., Grant, G. H., Raison, C. L., & Mascaro, J. S. (2021). Compassion meditation training for hospital chaplain residents: A pilot study. *Journal of Health Care Chaplaincy*, *27*(4), 191–206. doi:10.1080/08854726.2020.1723189

Atkins, L., Francis, J., Islam, R., O'Connor, D., Patey, A., Ivers, N., Foy, R., Duncan, E. M., Colquhoun, H., Grimshaw, J. M., Lawton, R., & Michie, S. (2017). A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems. *Implementation Science*, *12*(1), 1–18. doi:10.1186/s13012-017-0605-9

Batsis, J. A., McClure, A. C., Weintraub, A. B., Sette, D., Rotenberg, S., Stevens, C. J., Gilbert-Diamond, D., Kotz, D. F., Bartels, S. J., Cook, S. B., & Rothstein, R. I. (2020). Barriers and facilitators in implementing a pilot, pragmatic, telemedicine-delivered healthy lifestyle program for obesity management in a rural, academic obesity clinic. *Implementation Science Communications*, *1*(1), 83. doi:10.1186/s43058-020-00075-9

Berning, J. N., Poor, A. D., Buckley, S. M., Patel, K. R., Lederer, D. J., Goldstein, N. E., Brodie, D., & Baldwin, M. R. (2016). A novel picture guide to improve spiritual care and reduce anxiety in mechanically ventilated adults in the intensive care unit. *Annals of the American Thoracic Society*, *13*(8), 1333–1342. doi:10.1513/AnnalsATS.201512-831OC

Cadge, W., Calle, K., & Dillinger, J. (2011). What do chaplains contribute to large academic hospitals? The perspectives of pediatric physicians and chaplains. *Journal of Religion and Health*, *50*(2), 300–312. doi:10.1007/s10943-011-9474-8

Cadge, W., & Sigalow, E. (2013). Negotiating religious differences: The strategies of interfaith chaplains in healthcare. *Journal for the Scientific Study of Religion*, *52*(1), 146–158. doi:10.1111/jssr.12008

Center, P. R (2015). *America's Changing Religious Landscape*. Retrieved from www.pewresearch.org

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: The new Medical Research Council guidance. *BMJ (Clinical Research ed.)*, *337*, a1655. doi:10.1136/bmj.a1655

Damen, A., DeLaney, A., & Fitchett, G. (2018). Research priorities for healthcare chaplaincy: Views of US chaplains. *Journal of Health Care Chaplaincy*, *24*(2), 57–66. doi:10.1080/08854726.2017.1399597

den Toom, N., Visser, A., Körver, J., & Walton, M. N. (2024). The perceived impact of being a chaplain-researcher on professional practice. *Journal of Health Care Chaplaincy*, *30*(1), 19–32. doi:10.1080/08854726.2022.2132036

Drescher, K. D., Currier, J. M., Nieuwsma, J. A., McCormick, W., Carroll, T. D., Sims, B. M., & Cauterucio, C. (2018). A qualitative examination of VA chaplains' understandings and interventions related to moral injury in military veterans. *Journal of Religion and Health*, *57*(6), 2444–2460. doi:10.1007/s10943-018-0682-3

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs—principles and practices. *Health Services Research*, *48*(6 Pt 2), 2134–2156. doi:10.1111/1475-6773.12117

Fitchett, G. (2011). Making our case (s). *Journal of Health Care Chaplaincy*, *17*(1-2), 3–18. doi:10.1080/08854726.2011.559829

Fitchett, G., Nieuwsma, J. A., Bates, M. J., Rhodes, J. E., & Meador, K. G. (2014). Evidence-based chaplaincy care: Attitudes and practices in diverse healthcare chaplain samples. *Journal of Health Care Chaplaincy*, *20*(4), 144–160. doi:10.1080/08854726.2014.949163

Haug, N. A., Shopshire, M., Tajima, B., Gruber, V., & Guydish, J. (2008). Adoption of evidence-based practices among substance abuse treatment providers. *Journal of Drug Education*, *38*(2), 181–192. doi:10.2190/DE.38.2.f

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine (1982)*, *292*, 114523. doi:10.1016/j.socscimed.2021.114523

Huijg, J. M., Gebhardt, W. A., Dusseldorp, E., Verheijden, M. W., van der Zouwe, N., Middelkoop, B. J., & Crone, M. R. (2014). Measuring determinants of implementation behavior: Psychometric properties of a questionnaire based on the theoretical domains framework. *Implementation Science: IS*, *9*(1), 33. doi:10.1186/1748-5908-9-33

Huynh, A. K., Hamilton, A. B., Farmer, M. M., Bean-Mayberry, B., Stirman, S. W., Moin, T., & Finley, E. P. (2018). A pragmatic approach to guide implementation evaluation research: Strategy mapping for complex interventions. *Frontiers in Public Health*, *6*, 134. doi:10.3389/fpubh.2018.00134

Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S., & Stall, R. (2007). Implementing evidence-based interventions in health care: Application of the replicating effective programs framework. *Implementation Science*, *2*(1), 1–10. doi:10.1186/1748-5908-2-42

Kruizinga, R., Scherer-Rath, M., Schilderman, J. B., Hartog, I. D., Van Der Loos, J. P., Kotzé, H. P., Westermann, A. M., Klümpen, H.-J., Kortekaas, F., Grootscholten, C., Bossink, F., Schrama, J., Van De Vrande, W., Schrama, N. A., Blokland, W., De Vos, F. Y., Kuin, A., Meijer, W. G., Van Oijen, M. G., Sprangers, M. A., & Van Laarhoven, H. W. (2019). An assisted structured reflection on life events and life goals in advanced cancer patients: Outcomes of a randomized controlled trial (Life InSight Application (LISA) study). *Palliative Medicine*, *33*(2), 221–231. doi:10.1177/0269216318816005

Kruizinga, R., Scherer-Rath, M., Schilderman, J. B., Sprangers, M. A., & Van Laarhoven, H. W. (2013). The life in sight application study (LISA): Design of a randomized controlled trial to assess the role of an assisted structured reflection on life events and ultimate life goals to improve quality of life of cancer patients. *BMC Cancer*, *13*(1), 360. doi:10.1186/1471-2407-13-360

Liefbroer, A. I., Ganzevoort, R. R., & Olsman, E. (2019). Addressing the spiritual domain in a plural society: What is the best mode of integrating spiritual care into healthcare? *Mental Health, Religion & Culture*, *22*(3), 244–260. doi:10.1080/13674676.2019.1590806

Liefbroer, A. I., & Nagel, I. (2021). Does faith concordance matter? A comparison of clients' perceptions in same versus interfaith spiritual care encounters with chaplains in hospitals. *Pastoral Psychology*, *70*(4), 349–377. doi:10.1007/s11089-021-00947-4

Lyndes, K. A., Fitchett, G., Berlinger, N., Cadge, W., Misasi, J., & Flanagan, E. (2012). A survey of chaplains' roles in pediatric palliative care: Integral members of the team. *Journal of Health Care Chaplaincy*, *18*(1-2), 74–93. doi:10.1080/08854726.2012.667332

Mascaro, J. S., Palmer, P. K., Willson, M., Ash, M. J., Florian, M. P., Srivastava, M., Sharma, A., Jarrell, B., Walker, E. R., Kaplan, D. M., Palitsky, R., Cole, S. P., Grant, G. H., & Raison, C. L. (2022). The Language of Compassion: Hospital Chaplains' Compassion Capacity Reduces Patient Depression via Other-Oriented, Inclusive Language. *Mindfulness*, *14*(10), 2485–2498. doi:10.1007/s12671-022-01907-6

Mascaro, J. S., Rilling, J. K., Negi, L. T., & Raison, C. (2012). Compassion Meditation Enhances Empathic Accuracy and Related Neural Activity. *Social Cognitive and Affective Neuroscience*, *8*(1), 48–55. doi:10.1093/scan/nss095

Michie, S., Johnston, M., Abraham, C., Lawton, R., Parker, D., & Walker, A. (2005). Making psychological theory useful for implementing evidence based practice: A consensus approach. *Quality & Safety in Health Care*, *14*(1), 26–33. doi:10.1136/qshc.2004.011155

Pace, T. W., Negi, L. T., Sivilli, T. I., Issa, M. J., Cole, S. P., Adame, D. D., & Raison, C. L. (2010). Innate immune, neuroendocrine and behavioral responses to psychosocial stress do not predict subsequent compassion meditation practice time. *Psychoneuroendocrinology*, *35*(2), 310–315. doi:10.1016/j.psyneuen.2009.06.008

Pace, T. W. W., Negi, L. T., Adame, D. D., Cole, S. P., Sivilli, T. I., Brown, T. D., Issa, M. J., & Raison, C. L. (2009). Effect of compassion meditation on neuroendocrine, innate immune and behavioral responses to psychosocial stress. *Psychoneuroendocrinology*, *34*(1), 87–98. http://www.sciencedirect.com/science/article/pii/S0306453008002199 doi:10.1016/j.psyneuen.2008.08.011

Pesut, B., Sinclair, S., Fitchett, G., Greig, M., & Koss, S. E. (2016). Health care chaplaincy: A scoping review of the evidence 2009–2014. *Journal of Health Care Chaplaincy*, *22*(2), 67–84. doi:10.1080/08854726.2015.1133185

Piderman, K. M., Jenkins, S. M., Hsu, J. S., & Kindred, A. S. (2013). Hospitalized Young Adults' Expectations of Pastoral Interventions. *Journal of Pastoral Care & Counseling: Advancing Theory and Professional Practice through Scholarly and Reflective Publications*, *67*(1), 1–7. doi:10.1177/154230501306700107

Piderman, K. M., Marek, D. V., Jenkins, S. M., Johnson, M. E., Buryska, J. F., Shanafelt, T. D., O'Bryan, F. G., Hansen, P. D., Howick, P. H., Durland, H. L., Lackore, K. A., Lovejoy, L. A., & Mueller, P. S. (2010). Predicting patients' expectations of hospital chaplains: A multisite survey. *Mayo Clinic Proceedings*, *85*(11), 1002–1010. doi:10.4065/mcp.2010.0168

Piderman, K. M., Breitkopf, C. R., Jenkins, S. M., Lovejoy, L. A., Dulohery, Y. M., Marek, D. V., Durland, H. L., Head, D. L., Swanson, S. W., Hogg, J. T., Evans, J. L., Jorgenson, S. E., Bunkowski, L. J., Jones, K. L., Euerle, T. T., Kwete, G. M., Miller, K. A., Morris, J. R., Yoder, T. J., Lapid, M. I., & Jatoi, A. (2015). The feasibility and educational value of Hear My Voice, a chaplain-led spiritual life review process for patients with brain cancers and progressive neurologic conditions. *Journal of Cancer Education: The Official Journal of the American Association for Cancer Education*, *30*(2), 209–212. doi:10.1007/s13187-014-0686-y

Proctor, E. K., Powell, B. J., & McMillen, J. C. (2013). Implementation strategies: Recommendations for specifying and reporting. *Implementation Science*, *8*(1), 1–11. doi:10.1186/1748-5908-8-139

Sharma, V., Marin, D. B., Sosunov, E., Ozbay, F., Goldstein, R., & Handzo, G. F. (2016). The differential effects of chaplain interventions on patient satisfaction. *Journal of Health Care Chaplaincy*, *22*(3), 85–101. doi:10.1080/08854726.2015.1133203

Snowden, A., Fitchett, G., Grossoehme, D. H., Handzo, G., Kelly, E., King, S. D., Telfer, I., Tan, H., & Flannelly, K. J. (2017). International study of chaplains' attitudes about research. *Journal of Health Care Chaplaincy*, *23*(1), 34–43. doi:10.1080/08854726.2016.1250556

Software, V (2021). *MAXQDA 2022*. In VERBI Software. Available from maxqda.com

O'Connor, T. S., & Meakes, E. (1998). Hope in the midst of challenge: Evidence-based pastoral care. *Journal of Pastoral Care*, *52*(4), 359–367. doi:10.1177/002234099805200405

Steinhauser, K. E., Olsen, A., Johnson, K. S., Sanders, L. L., Olsen, M., Ammarell, N., & Grossoehme, D. (2016). The feasibility and acceptability of a chaplain-led intervention for caregivers of seriously ill patients: A Caregiver Outlook pilot study. *Palliative & Supportive Care*, *14*(5), 456–467. doi:10.1017/S1478951515001248

Visser, A. (2019). Patient-reported outcome measures (PROMs) in healthcare chaplaincy: What, why and how. *Tidsskrift for Praktisk Teologi*, *36*(2), 90–99.

White, K., Jennings, J., Karimi, S., Johnson, C. E., & Fitchett, G. (2022). Examining Factors Associated with Utilization of Chaplains in the Acute Care Setting. *Journal of Religion and Health*, *61*(2), 1095–1119. doi:10.1007/s10943-021-01460-x

Williams, J. R., Blais, M. P., Banks, D., Dusablon, T., Williams, W. O., & Hennessy, K. D. (2014). Predictors of the decision to adopt motivational interviewing in community health settings. *The Journal of Behavioral Health Services & Research*, *41*(3), 294–307. doi:10.1007/s11414-013-9357-8