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Teaching Intercultural Competency to Chaplains in a Hospital Sitting: Providing Spiritual Care to African American Women and Families Experiencing Perinatal Loss

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by

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Atlanta, Georgia
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Teaching Intercultural Competency to Chaplains in a Hospital Sitting: Providing Spiritual Care to African American Women and Families Experiencing Perinatal Loss

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Abstract

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The importance of recognizing the cultural perspective of grief and loss is well supported in literature about adult loss of life, but much less so in perinatal loss (PNL). PNL is defined as a baby's death leading up to or soon following the birth of a baby. A spiritual care relationship based on authentic positive regard and a sensitive cultural approach to care is particularly necessary for women experiencing PNL. Pastoral care responses are complex and include a plethora of variables that can lead to successful spiritual interventions. Intercultural competency is a foundation to spiritual trustworthiness and facilitates emphatic resonance. A crucial element of teaching intercultural competency to chaplains' entails facilitating their understanding of how culture, individual uniqueness and human characteristics interact to influence the chaplain-patient dyad. Developing intercultural competency on the part of the chaplain helps lower the mother's defenses and increases the mother's availability for productive engagement with her chaplain.

Literature that addresses the cultural perspective of perinatal loss and grief among African American women, and the ramifications for their families, is practically

nonexistent. This study assesses the pertinence and effectiveness of an educational intervention intended to enhance a cohort of chaplains' cultural perspective of PNL and grief among African Americans.

The research sample consisted of 13 chaplains involved in spiritual care with hospitalized patients. In addition to a training curriculum, chaplains completed pre- and post-intervention questionnaires to assess the benefits of the training interventions by way of the chaplains' self-reports. This information will also be used to inform future research and training. Study questions included the following: A. Following the training, will the chaplains report an increase in culturally relevant knowledge about: 1) African American women who experience PNL?; 2) African American women of childbearing age?; 3) health issues and medical care among African American women and PNL?; 4) how PNL is perceived and managed in the African American community?; and 5) experiences of African American women in the medical care system in relationship to PNL? B. Do chaplains report that the training increased their skills in companioning with African American women experiencing PNL? C. Do chaplains report that training in this area is needed? D. Will the training generate ideas for further directions in training that will enhance chaplains' spiritual care with African American women experiencing PNL?

At the conclusion of the study, the chaplains' responses suggest that they gained culturally relevant information. The chaplains reported increased knowledge about African American women of childbearing age, their health issues and medical care, and their experiences in the American health care system. Chaplains reported that the training would improve their spiritual care within the African American PNL community in general, and particularly their ability to companion with African American women experiencing PNL.

All chaplains indicated that they acquired new information about health disparities, and social and cultural characteristics of African Americans in comparison to other racial and ethnic groups. Further, the chaplains unanimously agreed that intercultural training is important and needed. They offered ideas for future training to further enhance their spiritual care with African American women experiencing PNL.

Dedication

Love the Lord your God with all your heart and with all your soul and with all your mind. This is the first and greatest commandment. And the second is like it: Love your neighbor as yourself.
Matthew 22:37-39 New International Version (NIV)

I dedicate this doctoral ministry project to God, the source of my strength, my husband, my children, my granddaughter, and my mother. Thank you for your love, support, prayers, and encouragement. A special dedication is extended in memoriam of my late sister and angel, Janet Peoples Davis. Janet, you were my greatest supporter! I miss and love you.

M.P.W.

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This ministry project has become a reality with the generous support and help of many individuals. I would like to extend my sincere thanks to all of them.

Foremost, I want to offer this endeavor to God Almighty for the strength, wisdom, provisions, resources, and motivation to finish this research.

I offer special appreciation and thanks to Reverend Amani D. Legagneur and family. Your encouragement, prayers, and generosity of time and wisdom helped me to continue when I felt like giving up. Thank you does not seem adequate so I offer this prayer: I pray that God will give you good measure, pressed down, shaken together and running over.

I am highly indebted to Dr. Carolyn Akua LeeNettie McCrary and Dr. F. Keith Slaughter for their counsel, guidance and support in completing this endeavor. Thank you for providing pastoral care when it was needed, and for reminding me to breathe and believe that I can do all things through Christ who strengthens me.

My soul is filled with special gratitude for Dr. Lannie J. Pryor Brown. Thank you for your time, patience, the gentle way you guided me, for being my mentor, encourager, friend, and most of all for being a prayer warrior. Thank you for sharing your readings from the book of Ezekiel, reminding me to pay attention to details. I pray that God will continue to give you good health, peace, joy and love. I am forever grateful!

Special recognition goes to Northside Hospital chaplains, CPE Supervisors, and the 2017 Summer Clinical Pastoral Education (CPE) students for their support, willingness, availability, and participation in this study.

I deeply appreciate the kindness of my siblings—Clairetta, Clarence, Karl, and Christopher. Thank you for supporting me in your unique way.

I thank Pastor Ava Harvey, Dr. Dolo Diaminah and Mrs. Melody Berry for encouraging me, and their willingness to help whenever I called.

Last but certainly not least, a special thanks to daughters Gabrielle and Ashley, sons Joshua and Isaiah, granddaughter Hannah, and Georgia Nash Jackson for always praying, supporting, and encouraging me.

Table of Contents

List of Tables

Glossary of Terms

African Americans: Rosenblatt & Wallace (2005, xxv) define African Americans as people who: (a) grow up in the United States; (b) have African ancestors; and (c) identify themselves as part of a community that is distinctively rooted in the culture of people of African descent who have lived in the United States for many generations.

Association of Professional Chaplains (APC): On its website, APC is described as a national, not-for-profit professional organization of chaplains who are dedicated to chaplaincy care for all persons, respecting their diverse cultures, identities, abilities, and beliefs. APC advocates for quality chaplaincy care for all persons in health care facilities, correctional institutions, long-term care units, rehabilitation centers, hospice, the military, and other specialized settings.

Association for Clinical Pastoral Education (ACPE): On its website, APCE is defined as a multicultural, multi-faith organization devoted to providing education and improving the quality of ministry and pastoral care offered by spiritual caregivers of all faiths through the clinical educational methods of Clinical Pastoral Education.

Attuned Communication: Sigel (2007, 164) defines attuned communication as the coordination of the input from another mind with the activity of one's own; a resonance process involving the middle prefrontal areas of the brain.

Blacks: Rosenblatt & Wallace (2005, xxv) define Blacks as all people who have African ancestors, including those who are from the Caribbean and West Africa and have cultural roots in those regions.

Board of Chaplaincy Certification Inc. (BCCI): On its website, BCCI is defined as a certification program designed to elevate professional standards, enhance individual performance, and designate professional chaplains who demonstrate the knowledge essential to the practice of chaplaincy care.

Care Outcomes: Roberts (2014, 343) defines care outcomes as a method of chaplaincy care that emphasizes achieving, describing, measuring, and improving outcomes that result from a chaplain's work [of] assessment, interventions and outcomes.

Clinical Pastoral Education (CPE): In the *Journal of Healthcare Chaplaincy*, CPE is defined as theological experiential education for students interested in developing their identity, authority, and skills as pastoral caregivers in a variety of settings.

Companioning: Heustis & Jenkins (2005, x-xi) define companioning as a framework, an attitude, a presence. It is a shifting of philosophy: we no longer will view perinatal loss patients as needing treatment or intervention. Rather, we will see their loss as a life-changing event, one that is an intensive part of our OB culture. Our care evolves away from protocols and standards and towards family-directed care.

Compassion: Hunter, Malony, Mills, & Patton (1990, 206) define compassion as the inclination toward informed, intelligent actions and the willingness to risk and give of oneself to alleviate suffering.

Culture: Lartey (2003, 31) defines culture as the way in which groups of people develop distinct patterns of life and give 'expressive form' to their social and material life experience….This includes ideas, values and meanings embodied in institutions and practices, in forms of social relationships, in systems of belief, in mores and customs, in the way objects are used and physical life is organized.

Empathy: Wimberly (1997, 6) defines empathy as the way in which the caregiver takes on the other's point of view so completely that the caregiver's own interest, attitudes, concerns, and problems are prevented from interfering with those of the other person.

Empathic Resonance: On its website, Undivided Journal, empathic resonance is defined as being in attunement with another being. In attuning to another being, we bring a feeling or empathy with another's feelings as well as a kinesthetic and emotional sensing of another. The listener de-fixates from his or her experience and let's go of the mind's thinking long enough to enter into another's experience and world. We engage in a reciprocal interaction of emotional expression or affect and an exchange of felt resonance—we feel felt.

Grief: Rosenblatt & Wallace (2005, 51) define African Americans' grief as a personal, painful, long-term, largely private response to missing the person who died.

Grief Responses: Rosenblatt & Wallace (2005, 51) define grief responses as allowing oneself to have whatever feelings one has, to acknowledge and to accept them. Grief responses may include wailing, weeping, and passing out.

Hospital Chaplain: Hunter, Malony, Mills, & Patton (1990, 136) define a hospital chaplain as a clergyperson or layperson who has been commissioned by a faith group or an organization to provide pastoral services in an institution, organization, or governmental entity.

Intercultural Competency (cultural competency): On its website, HealthCare Chaplaincy, cultural competency is defined as the state of being capable of functioning effectively in the midst of cultural differences. It is being sensitive not to impose one's personal values on someone else because they are different. It is the ability to establish relationships with people in the midst of diversity. It is celebrating differences, the recognition of similarities, and a clear commitment to seeing differences as differences and not deficits.

Interpersonal Resonance: Siegel (2007, 164) defines interpersonal resonance as the way in which the structure of our neural architecture reveals how we need connections to other people in order to feel in balance and to develop well. The brain integrates input from other people with the process of regulating the body, balancing emotional states, and the creation of self-awareness. Simply stated, it is the way two people attend to each other's intentions in the process of attunement.

Interpersonal Resonance Response: The researcher is defining interpersonal resonance response as the Chaplains' ability to establish patient-chaplain trust to help alleviate suffering in individuals, and to bring integration and healing into the many layers of our interconnections with each other. *(Some terminology adapted from Dan Siegel,* Mindfulness, Psychotherapy and the Brain*).*

Love: On its website, Merriam Webster Online Dictionary defines love as warm attachment, enthusiasm, or devotion for another.

Ministry of Presence: Hunter, Malony, Mills, & Patton (1990, 950) define the ministry of presence as a form of servanthood characterized by suffering alongside of and with the hurt and oppressed – *a being*, rather than a doing or a telling.

Mixed Methods Research: Lunenburg & Irby (2008, 106) define mixed method research as those studies that have engaged both quantitative and qualitative research questions and/or that have used both probability and purposeful sampling.

Pastoral Care: Hunter, Malony, Mills, & Patton (1990, 836) define pastoral care as originating from the biblical image of shepherd and refers to the solicitous concern expressed in the religious community for persons in trouble or distress. Historically and within the Christian community, pastoral care is in the cure-of-souls tradition. Here cure may be understood as care in the sense of carefulness or anxious concern; not necessarily as healing, for the soul, i.e., the animating center of personal life and the seat of relatedness to God.

Perinatal Loss: Rando (1986, 131) defines perinatal loss as the death of a baby due to miscarriage, stillbirth, or neonatal death.

Qualitative Research: Osmer (2008, 49-50) defines qualitative research as seeking to understand the actions and practices in which individuals and groups engage in everyday life and the meaning they ascribe to their experience.

Quantitative Research: Osmer (2008, 49*)* defines quantitative research as gathering and analyzing numeric data to explore relationships between variables.

Standards of Practice for Professional Chaplains: On its website, Professional Chaplains, the Standards of Practice for Professional Chaplains state what it means to be a professional chaplaincy care provider, pastoral counselor, or educator.

Spiritual Care: Lartey (2003, 151) defines spiritual care as assisting in the exploration of the dynamic journey that we are on in relation to ourselves, others, things, around us, and transcendent reality.

Spiritual Distress: The online Medical Dictionary defines spiritual distress as a disruption in the life principle that pervades a person's entire being (e.g., may express concern with the meaning of life and death; questions the meaning of suffering or of his or her own existence, may verbalize inner conflict about beliefs and express anger toward God or other Supreme Being.

Spiritual Intervention: On its website, APC defines spiritual intervention as an in-depth look at the patient's spiritual makeup with the goal of identifying potential areas of spiritual concern and determining an appropriate treatment plan.

Surface Level Spiritual Care (SLSC): The researcher is coining and defining this term as the chaplain's attempt to provide spiritual care without having adequate knowledge of the person's culture, religion or grief responses.

Theology of Hospitality in Perinatal Loss: The researcher is defining the theology of hospitality as preparing to meet and care for strangers whose babies have died with compassion, empathy, and love without the need to provide answers. It means knowing that God is with us in our suffering. It means welcoming grief and inviting it to stay as long as needed in order for healing to take place.

Trust in Pastoral Relationships: Hunter, Malony, Mills, & Patton (1990, 1288) define trust in pastoral relationships as reliance upon the integrity, compassion, ability, strength and confidence of another person in the caring process. In pastoral care the sharing of anxious longings, contradictory emotions, and secrets can only be risked in the atmosphere of trust. While often in tension with doubt, trust enables persons to share their stories, gain insight into situations of conflict, and receive guidance and strength for creative living.

Welcoming Grief: The researcher is defining the welcoming of grief as acknowledging grief's presence and surrendering to the emotions that accompany it.

Chapter 1

Introduction

Cultural competency is an essential component of spiritual care. [Note that spiritual care may be used interchangeably with pastoral care.] Intercultural spiritual care can result in a patient experience that is supported in a theology of hospitality. The caregiver (i.e., chaplain, minister, pastor) seeks to offer spiritual care based on the uniqueness of the person's or patient's culture with grace, substantive concern, and authentic resourceful helping skill. As quoted in the preamble of *Standards of Practice for Professional Chaplains*: "Chaplaincy care is grounded in initiating, developing and deepening a spiritual and empathic relationship with those receiving care. The development of a genuine culturally knowledgeable relationship is at the core of chaplaincy care. Trusting relationships underpin, even enable, all other dimensions of meaningful chaplaincy to occur."[1] African American women who trust their Chaplain may allow for the establishment of a spiritual and empathic relationship to occur.

The establishment of a spiritual care relationship based on a sensitive cultural approach to care is particularly necessary for a women experiencing perinatal loss (PNL). PNL is defined as a baby's death leading up to or soon following a birth. Literature relevant to creating culturally aware, effective spiritual care pathways for chaplains who serve this

[1] Dan Murphy, "Standards of Practice for Professional Chaplains in Health Care Settings," Association of Professional Chaplains, accessed November 26, 2017, http://www.professionalchaplains.org/content.asp?pl=198&sl=200&contentid=200.

population of women is nearly non-existent. A number of medical researchers have corroborated this observation:

> The importance of recognizing the cultural perspective of loss and grief is well supported in the adult loss and grief literature (Butler 2012; Stroebe 1998; Walter 2010), however only limited attempts have been made to explore the cultural context of perinatal loss. Seminars in Fetal and Neonatal Medicine (October 2008) published a series of discussion papers on cultural perspectives of care in fetal and neonatal medicine, (Evans 2008; Gatrad 2008; Husain 2008; Laing 2008; McGraw 2008; Nelson 2008; Rennie 2008; Shinwell 2008; Steer 2008; Vaughan 2008; Williams 2008). They include the importance of sensitive cultural approaches and encourage further research in this area of perinatal care. Others (Chichester 2005; Laing 2008) caution imposing a 'Western grief culture' which values engagement with death and grief onto other cultures. Staff's knowledge and understanding of key religious and cultural rituals can greatly facilitate difficult discussions and decision-making around the time of death of a baby.[2]

This study was undertaken with the explicit objective of addressing the gap in resources aimed at augmenting the benefit of teaching intercultural competency in hospital chaplaincy. The researcher's interest in this subject is based on personal and professional observations of the need to expand the body of research about providing spiritual care with cultural awareness. This subject is also of interest to the researcher because of the need to develop clinical pastoral education resources for spiritual care providers in hospitals that will support their spiritual care interactions with African American women experiencing PNL.

The researcher isolated the care of African American women enduring PNL as the focus population for this study with great intention. An argument can be made that in general, women experiencing PNL may not receive optimum spiritual care because of lack

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[2] Laura Koopmans, Trish Wilson, Joanne Cacciatore and Vicki Flenady, "Support for Mothers, Fathers and Families after Perinatal Death," Cochrane Database of Systematic Reviews, accessed February 23, 2017, http://www.cochrane.org/CD000452/PREG_support-for-mothers-fathers-and-families-after-perinatal-death.

of training and sensitivity of their spiritual care responders (who are most often chaplains in the hospital context and parish clergy beyond hospital walls). However, the particularities of cultural perception in American life that have historically disenfranchised African Americans in receiving healthcare on par with European American peers and other ethnicities are well-documented[3] and provide a backdrop for this inquiry. When caregivers are not sensitive to the dynamic of systematic oppression of African Americans by the American medical establishment, they may overlook opportunities to adequately care for these patients. This study seeks to establish a rational for optimizing cultural competency of hospital chaplains responding to PNL in African American women, and to develop a curriculum that effectively assists in reducing, if not alleviating probable disparities in their spiritual care.

Spiritual care responses are complex. They include a plethora of variables (e.g. trust, empathetic resonance, hospitality, and companioning) that can lead to successful or unsuccessful interventional outcomes. The interpersonal relationship between a chaplain and patient is the vehicle through which spiritual needs are assessed and an intervention is delivered. Spiritual assessment is "an in-depth look at the patient's spiritual makeup with the goal of identifying potential areas of spiritual concern and determining an appropriate treatment plan."[4] Without trust, it would be difficult (if not impossible) for chaplains to

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[3] "National Healthcare Quality & Disparities Reports," Agency for Healthcare Research and Quality, accessed November 29, 2017, http://www.ahrq.gov/research/findings/nhqrdr/index.html.

[4] Mark Larocca-Pitts, "FACT: A Chaplain's Tool for Assessing Spiritual Needs in an Acute Setting," accessed January 26, 2017, https://www.professionalchaplains.org/files/publications/chaplaincy_today_online/volume_28_number_1/28_1laroccapitts.pdf.

conduct a spiritual care assessment.

Trust can be cultivated over time, but people naturally make an initial decision about whether to trust someone within the first milliseconds of an encounter. Intercultural competency is a foundation to spiritual trustworthiness in spiritual care. Once trust is established between a patient and her spiritual care provider, empathic resonance can take place to facilitate the efficacy of spiritual assessment and interventions. Empathic resonance is defined as attuning to another being, feeling with another's feelings, as well as a kinesthetic and emotional sensing of another.[5] Therefore, for the purpose of this study, a crucial element of sharing information about intercultural competency with chaplains entails facilitating their understanding regarding how "culture, individual uniqueness and human characteristics work together to influence persons" in the chaplain-patient dyad.[6] Emphatic resonance allows for the chaplains to extend an invitation of hospitality to their patients.

Actively contributing to a patient's experience of hospitality helps to lower the patient's defenses and increases her availability for productive engagement with her chaplain. When the idea of being hospitable is professionally employed through the lens of a *theology of hospitality* which undergirds a skilled praxis of professional empathic companioning, the patient is likely to sense that she is authentically supported by the spiritual care provider. Hospitality is defined as the "act of being hospitable," from the Old

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[5] Will Joel Friedman, "Resonance: Welcoming You in Me – A Core Therapeutic Competency," *Undivided, The Online Journal of Nonduality and Psychology* (December 18, 2012): Accessed November 29, 2017, http://undividedjournal.com/2012/12/18/resonance-welcoming-you-in-me-a-core-therapeutic-competency/.

[6] Emmanuel Yartekwei Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling* (London: Jessica Kingsley Publishers, 2003), 171.

French *hopsitalite*', "hospitality; hospital"; from Latin *hospitalitem* (nominative *hospitalitas*), "friendliness to guest"; from *hospes* (genitive *hospitis*), "guest; host."[7] In the ancient world the practice of hospitality meant graciously receiving an alienated person into one's land, home, community and providing directly for that person's needs."[8] In the world of perinatal loss, hospitality goes beyond this definition. Regardless of religious tradition, for those who hold an embedded theology of God's omniscience, goodness, and love, the core dilemma presented in the loss of a baby is that a Supreme more-powerful-than-her Being has participated in or allowed her innocent baby to suffer and die. This dilemma is at the center of existential crises that often occur for mother whose babies die. They often feel that they must bear some guilt for their losses. They may feel messy, defective, isolated, unglued, lost, afraid, disoriented, angry, and so many other emotions that are not easy for loved ones or communities to metabolize with appropriate care. As a result, spiritual care to African American women who are experiencing perinatal loss ideally includes a gentle, non-judgmental invitation to "come as you are" in the midst of such catastrophic loss.

Hospitality becomes necessary in order for perinatal loss to be examined through the lens of theodicy. Richard C. Eyer defines theodicy as "the attempt to justify the ways of God to a suffering world."[9] One of the hardest questions to wrestle with is why the

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[7] "Hospitality," Merriam-Webster, accessed January 18, 2018, http://www.merriam-webster.com/dictionary/hospitality.

[8] "Hospitality - Baker's Evangelical Dictionary of Biblical Theology Online," Bible Study Tools, accessed April 26, 2017, https://www.biblestudytools.com/dictionaries/bakers-evangelical-dictionary/hospitality.html.

[9] Richard C. Eyer, *Pastoral Care under the Cross: God in the Midst of Suffering* (St. Louis, MO: Concordia Publishing House, 2014), 46.

innocent suffer. How can a good God allow innocent babies to die? Jacquelyn Grant asserts that Christology has failed to speak to the concerns of Black women. Therefore, it becomes problematic when addressing their reality.[10] In the intimacy of birth and loss, this is particularly true. James Cone proposes that "when theology defines the problem of suffering within the context of philosophical discourse, it inevitably locates the Christian approach to suffering in the wrong way."[11] It means suffering is the result of evil or sin. For Christian mothers, a God who is a close companion in the midst of suffering can be a comfort. Of even more comfort to some is the image of Mary, the mother of Christ, suffering his loss on Calvary. Cone proclaims that "God is present with us in our fight against suffering and will come again fully to consummate the freedom already given in Jesus Christ."[12] For some Christian mothers, a theology of hospitality can include a theology of one day being reunited with their lost child in the afterlife. As a chaplain, a theology of hospitality is employed through companioning, standing in close witness as a comforter to mothers in the midst of their losses.

Garth Baker-Fletcher affirms "there is no place we can hide from God or fail to find God (Psalm 139: 7-12)."[13] Dwight Hopkins asserts that "God is passionately with us because God is compassion."[14] Living into the theology of hospitality in this context means

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[10] Jacquelyn Grant, *White Women's Christ and Black Women's Jesus: Feminist Christology and Womanist Response* (Atlanta, GA: Scholars Press, 1989), 202.

[11] James H. Cone, *God of the Oppressed* (Maryknoll, NY: Orbis Books, 2000), 164

[12] Ibid., 163.

[13] Garth Baker-Fletcher, Quoted in Dwight N. Hopkins and Edward P. Antonio, *The Cambridge Companion to Black Theology* (New York, NY: Cambridge University Press, 2012), 122.

[14] Dwight N. Hopkins and Edward P. Antonio, *The Cambridge Companion to Black Theology* (New York, NY: Cambridge University Press, 2012), 122.N

preparing to meet and care for strangers who babies have died with compassion, empathy and love without the need to provide answers. It means knowing that God is with us in our suffering. To be truly hospitable, a chaplain must be willing to welcome the whole person and encounter the suffering of the patient. Chaplains are in a position of power in relation to the patient for many reasons, least of which is their familiarity with the hospital context itself as a home base that is far less familiar to the patient. Intercultural competency is a vital feature of the theology of hospitality as meted out in spiritual healthcare.

For the purpose of this study, the researcher started by elucidating the unique challenges that many women may experience around the time of their infants' deaths. The researcher then went on to describe the unique situation of African American women enduring PNL in American hospital systems with a focus on the relevance of intercultural competency in forming productive spiritual care relationships. A curriculum was developed as a resource to train chaplain students in this area. The researcher analyzed the chaplain students' self-reports of preparedness for serving African American women experiencing PNL with culturally competent spiritual care before and after the training resourcing intervention. [Note that training, resourcing, and training resourcing may be used interchangeably.]

Background of the Study

Perinatal loss is an under-researched area in spiritual healthcare and it is often generalized in the field of thanatology. The death of an infant at birth is often unhelpfully grouped together with adult losses in the study of grief and loss. No effort is made to understanding the uniqueness of the types of PNL or of the people suffering from the loss

of their children.[15] Irving G. Leon, in his book *When a Baby Dies*, states that "Only recently has our society begun to learn what mourning parents and siblings have discovered by experience: in our culture PNL can be a family trauma with potentially serious consequences if unattended."[16] The literature supports the need for more research in the field of perinatal loss.

In 1990, the year of Leon's publication, very little material had been developed in behavioral science to specifically deal with providing emotional support to patients and subsequently to families suffering PNL. Although the past two decades have yielded more behavioral science research, the researcher only found tangential references to spiritual health in these writings. In ecclesiastical life, PNLs are often sidelined or ignored. In the Black church, PNLs are often unacknowledged, silently grieved or only disclosed to close family members. They are both underreported by parishioners and underserved by clergy. When pastors are informed that PNLs have occurred, it is difficult if not impossible for them to find direction to guide their responses in spiritual care literature. Research reveals:

> Many religiously active persons do not notify their local clergy of their hospitalization (Sivan, Fitchett & Burton, 1996; VandeCreek & Gibson; 1997). Additionally, many patients do not have a religious community to which they can look during healthcare crises. In one study, only 42 percent of hospital patients could identify a spiritual counselor to whom they could turn, and many of them had not talked to their local religious leader about their situation (Sivan, Fitchett & Burton, 1996). For others, attention from their spiritual counselor is limited by being in a hospital far from home (VandeCreek & Cooke, 1996), by patient concerns about privacy or confidentiality, or a fear that their own religious leader would not understand or be supportive.[17]

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[15] Therese A. Rando, *Parental Loss of a Child* (Champaign (Ill.): Research Press, 1986), xi.

[16] Irving G. Leon, *When a Baby Dies: Psychotherapy for Pregnancy and Newborn Loss* (New Haven, CT: Yale University Press, 1992), xiii.

[17] C. H. Association et al., "A White Paper. Professional Chaplaincy: Its Role and Importance in Healthcare," *Journal of Pastoral Care*, 2001, accessed February 27, 2017, http://www.ncbi.nlm.nih.gov/pubmed/11303456.

Womanist theologian Emily Townes posited culturally specific strategies for providing spiritual care to African American women in her book, *Breaking the Fine Rain of Death*: *African American Health Issues and a Womanist Ethic of Care*. Yet, the researcher did not find particular references to PNL, in her writings. Again, the written historical records of ministry for this issue remain scarce.

Although we do not have much direct historical data or literature about ministry to women suffering PNL, the concept of ″companioning" in spiritual care has gained momentum. The body of literature about how a chaplain's companioning techniques affect spiritual care outcomes is growing. Companioning techniques for chaplains include, but are not limited to, "meeting the family on their faith terms, listening, prayer, and solace."[18] Another tenant of companioning involves the chaplain's ability to be self-aware.

During the latter part of the twentieth century, self-awareness, the "conscious knowledge of one's own character, feelings, motives, and desires"[19] has become a hot topic, especially in the area of Clinical Pastoral Education (CPE). CPE is a requirement for board certification by the Association of Professional Chaplains (APC), an organization that has long provided the gold standard requirements for chaplains seeking board certification. CPE is "theological experiential education for students interested in developing their

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[18] Jane Heustis, Marcia Jenkins, and Alan Wolfelt, *Companioning at a Time of Perinatal Loss: A Guide for Nurses, Physicians, Social Workers, Chaplains, and Other Bedside Caregivers* (Fort Collins, CO: Companion, 2005), 26-27.

[19] "Self-awareness," Merriam-Webster, accessed February 21, 2017, https://www.merriam-webster.com/dictionary/self-awareness.

identity, authority, and skills as spiritual caregivers in a variety of settings."[20] In CPE great emphasis is placed on development of students' self-awareness, and in the APC certification process, the chaplain's self-awareness and other-awareness are evaluated with great attention. The use of self is recognized in both educational and professional chaplaincy organizations as a foundational feature of effective spiritual care. As Chaplain Brent Perry asserts, "Who we are as chaplains is as essential to our efficacy as what we do and the context in which we do it. There may be healthcare disciplines in which there is little correlation between the type of person doing the work and the outcomes achieved by that work. Chaplaincy is not one of them."[21] Training in interpersonal cultural competency may help chaplains become more self-aware; thus enabling them to provide culturally competent spiritual care to African American women and families experiencing PNL.

Statement of the Problem

Women enduring the trauma of PNL may suffer spiritual distress due to the absence of culturally sensitive spiritual care. "Spiritual distress is a disruption in the life principle that pervades a person's entire being and that integrates and transcends his or her biological and psychosocial nature (e.g., may express concern with the meaning of life and death, question the meaning of suffering or of his or her own existence, verbalize inner conflict about beliefs, express anger toward God or other Supreme Being)."[22] Spiritual distress in

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[20] Katherine R. B. Jankowski et al., "Change in Pastoral Skills, Emotional Intelligence, Self-reflection, and Social Desirability across a Unit of CPE," *Journal of Health Care Chaplaincy* 15, no. 2 (2008): 133, accessed February 21, 2017, doi: 10.1080/08854720903163304.

[21] Brent Perry, "Outcome Oriented Chaplaincy: Intentional Caring," *Professional Spiritual & Pastoral Care a Practical Clergy and Chaplain's Handbook,* ed. Stephen B. Roberts, (Woodstock, VT: SkyLight Paths Publishing, 2014), 344.

[22] "Spiritual distress," The Free Dictionary, accessed September 2, 2016, https://medical-dictionary.thefreedictionary.com/spiritual+distress.

African American women suffering PNL is likely adversely influenced by culturally specific conditions of insensitivity to their pain and other health needs in American medical systems. Little attention has been paid to this population in the literature of chaplaincy and spiritual care at large. Training and other educational resources are needed to improve spiritual care to African American women and their families who encounter PNL.

Purpose of the Study

The purpose of this study is to address the need for improved intercultural competent care for African American women experiencing PNL through intercultural competency training resourcing for chaplain spiritual care responders. This study seeks to explore how hospital chaplains' grasp of culture-driven spiritual care barriers and ability to form authentic cross-cultural and intercultural relationships will influence their awareness and ultimately, spiritual care outcomes for African American women experiencing PNL. Data was collected to serve the following purposes: a) assess the pertinence and effectiveness of the education intervention intended to enhance a cohort of chaplains' understanding of cultural competency as relates to the care of African American women experiencing PNL, and b) to study the chaplains' ratings of proficiency for generating culturally competent spiritual care for African American women experiencing PNL by the chaplains' self-reports on pre-training and post-training questionnaires. During these analyses the following questions are of primary interest:

1. Did chaplains report an increase in culturally relevant knowledge about African American women and their families who experience PNL?
2. Did chaplains report that the content of training increases their skills as spiritual care responders with African American women experiencing PNL?

3. Did chaplains report that training in this area is needed?
4. Did the training intervention generate ideas for improvements and/or further directions in training that may enhance chaplains' spiritual care with African American women experiencing PNL?

Significance of the Study

This study is vital in contributing valuable research to support the development of more culturally competent spiritual care companioning for African American women experiencing PNL in particular, and the field of intercultural spiritual healthcare as a whole. Information generated by the study will be used to further develop practical training resources for spiritual care providers (e.g. chaplains, pastors, ministers) who support African American women experiencing PNL. Also, this study may highlight the pressing need for additional research and training in spiritual care with African American women in the midst of PNL, and even other bereaved populations of African Americans who may otherwise receive sub-optimal spiritual care in the midst of loss.

Theoretical Framework

The theoretical framework for this study is largely informed by Dr. Emmanuel Y. Lartey's intercultural approach to pastoral care and counseling as it relates to "*self-in-relationship."* He asserts:

> A crucial assumption in all pastoral care is that the most important resource that care practitioners have is themselves. Training in pastoral care, if it is to be of any real effect, has to enable people to acquire the attitudes and 'ways of being with others' which will be most beneficial to the people they are with. Attitude formation involves the developing of cognitive (thinking), affective (feeling) and conative (behavior patterns) abilities. Pastoral formation necessarily is attitude formation. It is who the pastoral caregiver is, and who they are becoming, that is the crucial thing. This is especially so in the way they relate with others.[23]

[23] Emmanuel Y. Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling* (London, England: Jessica Kingeley Publishers), 69.

Hypothesis

It is hypothesized that training in intercultural spiritual care will: 1) increase chaplains' awareness and 2) improve their skills for providing more competent intercultural spiritual care to African American women experiencing PNL.

Scope and Potential Limitations of the Study

This study explains the connection between intercultural resourcing with chaplains and the successful spiritual care interventions and outcomes by chaplains serving African American women experiencing PNL. The research includes information about cultural barriers to care for African American women experiencing PNL. The research informed the content of a curriculum that was developed for resourcing with chaplains working as spiritual care responders with a patient population at Northside Hospital, Atlanta, GA. The chaplains may employ the knowledge they glean from the training resourcing to make more effective spiritual care connections and interventions with the target patients. The study has the following limitations:

1. Data may vary due to disparities between staff-chaplains and CPE student-chaplains' training and experience in general, and also in working with women experiencing PNL.

2. Chaplains' cultural competency and interpersonal resonance empathic response skills may not have been measured in depth by the study's questionnaires.

3. There is a scarcity of resource literature relevant to this project.

4. A sample of convenience rather than a random sample of chaplains is used and the sample size is relatively small. Therefore, the results may only suggest trends and may not be generalized to the population of all spiritual care providers.

5. The small size of the participant cohort limits quantitative statistical analyses.

Delimitations

There is a scarcity of literature relevant to effective spiritual care techniques for chaplains who care for women experiencing PNL in general, and for the especially vulnerable subset of African American women within this patient population, in particular. Therefore, it is hard to establish a robust theoretical dialogue with other scholars and theologians who have produced writing and research directly related to this subject. One reason for this is that research requires both intellectual curiosity by someone in a position to do it and the resources to fund it. The daily press of other concerns in the lives of African American women, and the relatively small amount of money that is dedicated to their wellness in medical, psychosocial and spiritual circles compounds the delimitations of this project pursuit. Carroll A. Watkins Ali asserts that "the pastoral care needs for African Americans can best be identified from the perspective of poor Black women. Inasmuch as poor Black women (and their children) are positioned at the lowest levels of social, political, and economic status in this country, it is their eyes through which spiritual caregivers need to gain a view of what the critical needs are in Black America."[24] The delimitations of this study present a further illustration of the need for it to progress.

Assumptions

The following assumptions are made during this study. The Chaplains: a) will respond to the pre- and post-questionnaires accurately and honestly based on their knowledge and skills in intercultural spiritual care and in working with African American women experiencing PNL; b) will understand the terminology and concepts on intercultural competency in spiritual care used throughout the study; and (c) are grounded

[24] Carroll A. Watkins Ali, *Survival & Liberation: Pastoral Theology in African American Context* (St. Louis, MO: Chalice Press, 1999), 12.

in the concepts and use of companioning skills in spiritual care.

Organization of the Study

This research study is presented in 5 chapters, preceded by a glossary of terms. Chapter 1 - contains information regarding: the background of the study; a problem statement; the purpose of the study; and the significance of the study. This chapter also describes the theoretical framework, research questions, limitations, delimitations, and assumptions of the study.

Chapter 2 - presents the literature review. The literature review includes African American health (past to present), health of African American women of childbearing age, PNL, African American grief responses, ministry of presence, establishing chaplain-patient trust, interpersonal resonance and cultural competency.

Chapter 3 - describes the methodology used for this research study. It includes the selection of participants, instrumentation, data collection, and data analysis documents and procedures.

Chapter 4 - presents the research findings. This chapter includes the demographics of subjects and the results of analyses for all questions on the pre- and post-intervention research questionnaires.

Chapter 5 - presents a summary of results, and an integration and discussion of trends that are observed. The chapter also contains conclusions and offers recommendations for further research.

Chapter 2

Review of Literature

This chapter presents the rationale for conducting research to support the development of more culturally competent spiritual care providers for African American women experiencing PNL in particular, and in the field of intercultural spiritual healthcare as a whole. Researchers in the Department of Religion, Health & Human Values have provided a wealth of research and grief literature on the cultural perspective of loss and grief in adults, but only limited attempts have been made to explore the cultural context of PNL. This study sought to build upon the body of research in spiritual care, intercultural competency and PNL. A search for similarities, differences and gaps in research was also undertaken.

This study was used to develop practical training resourcing for spiritual care providers (e.g. chaplains, pastors, ministers) who offer spiritual care to African American women experiencing PNL. The study also serves to highlight the pressing need for additional research in spiritual care to African American and other populations of women who may receive sub-optimal care in the midst of PNL due to the lack of relevant research in this area.

The following review represents literature pertinent to the research study. This chapter is organized into 8 sections: (a) African American Health: Past to Present, (b) Health of African American Women: Childbearing Age, (c) PNL: Unrecognized as a Global Health Issue, (d) African American Grief responses, (e) Ministry of Presence,

(f) Establishing Patient-Chaplain Trust, (g) Interpersonal Resonance, and (h) Cultural Competency.

African American Health: Past to Present

For the purpose of this study, the researcher began by building the literary framework for understanding why having a culturally competent spiritual care provider is essential when providing spiritual care to African American women and families experiencing PNL. In order to understand the present health crisis of African Americans, it is necessary to revisit the past. As Dr. Carolyn A. LeeNettie McCrary profoundly asserts:

> Even though the phenomena of racism, slavery and oppression in the United States of America has over-stressed the ego (not to mention other dimensions) of African American persons to the point that some persons in the African American community have adopted attitudes and behaviors that may typify a fractured ego, many African Americans have developed and maintained a personal and interpersonal sense of community which enables living beyond survival and growth toward wholeness.[1]

The historical impact of disparities, racism, slavery and oppression continues to effect the African American community growth toward wholeness.

Dr. F. Keith Slaughter references Wade Nobles' (2006) assertion that "it is difficult to perceive the extent of debilitation caused by White supremacy without understanding the African/Black understanding of time and the interconnectivity of events."[2] Dr. Slaughter proclaims that "history then becomes an important resource for understanding how Black people have come to be presently."[3] Bear in mind the poignant fact that "the

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[1] Carolyn Aku LeeNettie McCrary, "Interdependence as a Norm for an Interdisciplinary Model of Pastoral Counseling" (ThD diss., The Interdenominational Theological Center, 1989), 2, accessed January 15, 2018, http://digitalcommons.auctr.edu/itcetds/.

[2] Wade W. Nobles, *Seeking the Sakhu: Foundational Wrings for an African American Psychology* (Chicago, IL: Third World Press, 2006), 10-12.

[3] F. Keith Slaughter, *Therapeutic Dimensions of Black Preaching and the Liberating Impact on a People of Color* (Augusta, GA: Get-Success Publishing LLC, 2014), 80-81.

first African Americans were brought to the USA in chains as slaves. The transport itself from Africa to the New World remains one of the best examples of the ability of one sector of humanity to destroy the health of another (Noonan, Velasco-Mondragon, & Wagner, 2016)."[4] As a result, the end of slavery did not that mean systematic discrimination and oppression ended, or that African Americans would have better access to healthcare and lead healthier lives. Unfortunately, healthcare disparities in the African American community still exist.

"Health and healthcare disparities refer to differences in health and healthcare between population groups. Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation."[5] Consequently, healthcare disparities are higher for Hispanics, Blacks, American Indians/Alaska Natives, and low-income individuals. According to the Centers for Disease Control (CDC), these populations are more likely to be uninsured relative to Whites and those with higher incomes. People with low income and people of color also face increased barriers to accessing care, receive poorer quality care, and experience worse health outcomes. Also, the CDC reports that "for blacks in the United States, health disparities can mean earlier deaths, decreased quality of life, loss of economic opportunities, and perceptions of injustice. For society, these disparities translate into less

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[4] Allan S. Noonan, Hector Eduardo Velasco-Mondragon and Fernando A. Wagner, "The State of Black Health in America," African American News Black News Colored News Negro News, April 04, 2017, accessed July 19, 2017, http://aframnews.com/the-state-of-black-health-in-america/.

[5] Petry Ubri and Samantha Artiga Published: Aug 12, 2016, "Disparities in Health and Health Care: Five Key Questions and Answers." The Henry J. Kaiser Family Foundation. August 17, 2017, accessed September 25,, 2017, https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.

than optimal productivity, higher health-care costs, and social inequity."[6] These disparities effect African American women of childbearing age more than any other ethnic group.

Health of African American Women: Child Bearing Age

Michele Norris (2011) found that "white women's health outcomes improve as they climb the socioeconomic ladder and give birth in their 20s and early 30s, rather than in their teen years. In addition, African American women's health problems seem to compound with age. African-American women of childbearing age in particular, in their 20s and early 30s, often already suffer from chronic disease."[7] Norris summarizes the cumulative impact of being "disadvantaged" in the following way:

> The cumulative impact of constantly dealing with "disadvantages" causes birth outcomes for Black women to deteriorate with maternal age. Black women in low-income communities have enormous stressors that make everyday tasks more difficult. The stressors may include: 1) Raising children, 2) Taking care of ailing elders, 3) Working/Earning income, 4) Dealing with material hardship, as well as 5) Social policies, housing policies, economic policies, urban planning policies all impact health through various roots and mechanisms.[8]

These resources are not intended to be conclusive because African American women continue to suffer with the cumulative impact of dealing with "disadvantages."

PNL: "Unrecognized as a Global Health Issue"

A result of chronic "disadvantages" for child bearing African American women means the possibility of experiencing preterm, premature delivery and infant mortality higher than that of European American women. The CDC claims:

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[6] "Health Disparities Experienced by Black or African Americans in the United States," Centers for Disease Control and Prevention, accessed July 19, 2017, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5401a1.htm.

[7] Michele Norris, "Why Black Women, Infants Lag in Birth Outcomes," NPR, accessed July 12, 2017, http://www.npr.org/2011/07/08/137652226/-the-race-gap.

[8] Ibid.

> Preterm, or premature, delivery is the most frequent cause of infant mortality, accounting for more than one third of all infant deaths during the first year of life. The infant mortality rate among black infants is 2.4 times higher than that of white infants, primarily due to preterm birth. In the United States, the risk of preterm birth for Non-Hispanic black women is approximately 1.5 times the rate seen in white women.[9]

The CDC report supports the need for continual research and training resourcing as it relates to caring for African American women and families experiencing PNL.

Also, in 2011, *The Lancet* reported that "across the globe, around 3 million babies are stillborn every year--more than 8,200 babies a day. These are shocking statistics, but there is also a shocking lack of awareness that it is happening. "There are twice as many stillbirths as deaths due to HIV/AIDS, which have rightly received so much global attention and action. By contrast, stillbirths are almost invisible, unrecognized as a global health issue."[10] "Fetal death refers to the intrauterine death of a fetus prior to delivery. Fetal mortality is generally divided into three periods: early (less than 20 completed weeks of gestation), intermediate (20–27 weeks of gestation), and late (28 weeks of gestation or more)."[11] It is important for the chaplain to know how the gestational age of the baby influences the mother's grief response.

The importance of knowing the gestational period in which the fetal death occurred has a direct connection with how the mother relates to the child-to-be. For example, Irving

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[9] "African-American Women and Their Babies at a Higher Risk for Pregnancy and Birth Complications," accessed May 9, 2017, https://www.cdc.gov/media/subtopic/matte/pdf/CDCMatteReleaseInfantMortality-508.pdf.

[10] Janet Scott, "Stillbirths: Breaking the Silence of a Hidden Grief," *The Lancet* 377, no. 9775 (April 23, 2011), doi:10.1016/s0140-6736(11)60107-4.

[11] Marian F. Dorman and Elizabeth C.W. Gregory, "Fetal and Perinatal Mortality: United States, 2013," National Vital Statistics Report, July 23, 2015, accessed March 2, 2018, https://www.cdc.gov/nchs/data/nvsr64/nvsr64_08.pdf.

G. Leon describes how the mother refers to the child-to-be in terms of Object Relations Theory. He uses the exploration of Object Relations Theory and integrates his work on narcissism to describe how the mother relates to the child-to-be. Leon describes narcissism in fetal mortality as "losing a part of oneself." He asserts that "unlike object loss, this death cannot be resolved by an adaptive identification."[12] Therefore:

> The unique relationship of the mother to her child-to-be makes the loss of an unborn child different from any other. The object, as opposed to the narcissist experience of the fetus is increasingly established during the second half of pregnancy, particularly, owing to the baby's movement in the womb. This object relationship is quite special in that it coexists with an intense narcissist's attachment to the child and is much more heavily laden with projective contents than are other relationship because of the relative lack of concrete stimuli (that is, interaction with an "outside" baby) and the activation of maternal and infantile identifications. The object loss is thus colored by the loss of the fantasized child-to-be and needs to be further distinguished from the narcissistic loss.[13]

Object Relations Theory helps the chaplains to understand the connection between the loss of the baby and the possible loss of the mother's self-identity.

Moreover, it is essential for the spiritual care provider to understand object relations from the cultural perspective of African American women experiencing PNL. Butler (2006) warns that utilizing psychodynamic personality theories to evaluate the African American community without making any theoretical modifications will result in: 1) "inappropriate assessments and inaccurate conclusions; and 2) African Americans experience oppressive forces that are not implicit in the psychodynamic personality theories. The theories, therefore, must be modified to consider the life of the African American community appropriately. Even with these modifications, the theories may not

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[12] Leon, 39.

[13] Ibid., 31.

fully address the dynamics of the culture."[14] Although there is no guarantee that these modifications will address the dynamics of the culture, it may be in the best interest of the patient-chaplain relationship to apply a cultural perspective to personality theories before attempting to offer spiritual care.

African American Grief Responses

There is a significant gap in empirical literature about grief responses of American minority groups to PNL. In a comparative study of middle class, mostly college-educated African American women, there are some commonalities with the middle to upper-middle class population of white women such as, indicating the importance of sharing grief with family and support networks, keeping memorabilia and nurturing memories of the baby, and feeling considerable apprehension when considering a subsequent pregnancy. However, the African American women demonstrated a greater reliance on and efficacy of prayer and spiritual connection. Further, 30% of the African American women had never talked with anyone about the loss--a finding more frequent than in the study's population of middle to upper-middle class women; and they reported "going inside myself" for inner healing more often than the other women in the study.[15] In another study of African American parents with low-income, the researchers found additional psychosocial stressors, including economic hardship, and other recent illness or death. Also, the parents misread signs of pregnancy complications, and viewed their medical treatment as

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[14] Lee H. Butler, *Liberating Our Dignity, Saving Our Souls* (St. Louis, MO: Chalice Press, 2006), 81-82.

[15] Paulina Van and Afaf I. Meleis, "Coping With Grief After Involuntary Pregnancy Loss: Perspectives of African American Women," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 32, no. 1 (2003):,doi:10.1177/0884217502239798.

substandard.[16] Clearly there is a need for the spiritual care providers to be aware of the historical, cultural, and social factors that help shape African Americans families' grief responses and needs. Factors may include: "historical distrust, culturally linked concept of family structure and the decision-making process, diverse communication styles, the perception of health as physical, oral/spiritual balance, and a code of ethics that is different, but not wrong or inferior."[17] These factors can make it difficult for the chaplain to make a culturally competent grief assessment.

In sum, the spiritual care providers should keep in mind that African American women's grief reactions can be misleading. Therefore, the spiritual care provider's ability to conduct an effective plan of care may depend on how culturally competent he/she is. African American women experiencing PNL grief responses may include:

> Putting it aside: women avoid thoughts about the loss. There was a purpose: an attempt to find meaning in the loss. Heal yourself: actions women use to feel better. Baby is in a good place: based on religion and spirituality. Personal reactions may be: "I am ok", "I talked", "I haven't dealt with it", "I prayed" and "going inside myself."[18]

It is also beneficial to know that it is not uncommon for African Americans, rather than seeking the help of professionals in times of distress, too often rely on their social support system of family, friends, and others who act as fictive kin, as the "family" often extends beyond the so-called nuclear family.[19] For most African Americans, family equates to

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[16] Karen Kavanaugh and Patricia Hershberger, "Perinatal Loss in Low-Income African American Parents," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 34, no. 5 (2005): doi:10.1177/0884217505280000.

[17] Jodi Shaefer, "Cross Culture Expressions of Grief and Loss II: When an Infant Dies (Volume 2)," November 2003, accessed July 14, 2017, https://www.ncemch.org/suid-sids/documents/cross__cultural_2007.pdf.

[18] Ibid.

[19] Ibid.

community.

Ministry of Presence

Even in consideration of traditional cultural responses to grief, it is essential for spiritual caregivers to be aware of the potential influence of their presence when working with African American women experiencing PNL. Roberts (2013) notes that:

> In the 1960's, as societal norms and institutions enjoyed far less consensus, there arose a new paradigm for professional chaplaincy. It was based upon client-centered therapy of Humanist psychologist Carl Rogers. Chaplains embraced a method of care giving built primarily on the three principles of congruence/ genuineness by the helper paired with empathic understanding of an unconditional positive regard for the client. Prominent among Chaplains during this era has been a strong emphasis on the "ministry of presence." It stressed the healing sufficiency of a calm and caring chaplain. Gleason called this the "Rogerian paradigm," which he explained dominated through the latter part of the twentieth century.[20]

The ministry of presence is one of many tools chaplains employ in their spiritual care with grieving African American mothers.

The ministry of presence is a term often used to describe what chaplains do. Ministry of presence is often misunderstood as "just being" with patients or families. However, in the African American context; the concept of pastoral care is much more complex than the ministry of presence or simply being with patients/families (or those in need). Carol Watkins Ali asserts that, the functions of ministry in the African American context needs to be expanded beyond the traditional view of ministry as healing, sustaining, and guiding to include aspects that are nurturing, empowering, and liberating.[21] Going beyond the traditional view of ministry will increase chaplains' success in providing a more

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[20] Martha R. Jacobs, "Creating a Personal Theology to Do Spiritual/Pastoral Care," *Professional Spiritual & Pastoral Care a Practical Clergy and Chaplain's Handbook,* ed. Stephen B. Roberts, (Woodstock, VT: SkyLight Paths Publishing, 2014), 9.

[21] Carroll A. Watkins Ali, *Survival & Liberation* (Saint Louis, MO: Chalice Press, 1999) 129.

culturally sensitive approach to caring for African American women experiencing PNL.

In the same way, the ministry of presence can also be regarded as companioning. Jane Heustis and Marcia Jenkins, in their book *Companioning at a Time of PNL: A Guide for Nurses, Physicians, Social Workers, Chaplains and Other Bedside Caregivers,* propose that "companioning helps us better see what families need to get through while giving us permission to be the compassionate souls we hope to be. As companions, we let go of preconceptions and begin to see grief as a natural event...We see ourselves as guides rather than rescuers."[22] In the companioning model, the chaplain is the student (listening, learning, and liberating).

Establishing Chaplain-Patient Trust

Before the spiritual care provider can begin to companion African American women experiencing PLN, trust must be established. Hunter & Ramsey (2005) define trust in pastoral relationships as "reliance upon the integrity, compassion, ability, or strength of another person and confidence in the caring process."[23] They assert that:

> In pastoral care the sharing of anxious longings, contradictory emotions, and secrets can only be risked in the atmosphere of trust. While often in tension with doubt, trust enables persons to share their stories, gain insight into situations of conflict, and receive guidance and strength for creative living.[24]

Research shows that human beings make unconscious choices about whether or not to trust someone within the first few seconds of contact. In addition, emerging behavioral and

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[22] Jane Heustis, Marcia Meyer Jenkins and Alan D. Wolfelt, *Companioning at a Time of PNL: A Guide for Nurses, Physicians, Social Workers, Chaplains and Other Bedside Caregivers,* (Chicago: Independent Publishers Group, 2004) x.

[23] Rodney Hunter, Malony H. Newton, Liston O. Mills, and John Patton, eds., *Dictionary of Pastoral Care and Counseling*, (Nashville: Abingdon Press, 2005), 1288.

[24] Ibid.

neuroscience studies tell us that the amygdala, or "reptilian brain" that governs the defense system by which people decide to "fight-or-flight" from a dangerous other, sends signals about trustworthiness.[25] Similarly, Freeman, Stolier, Ingbretsen & Hehman contend that:

> With only a glance, humans instantly form impressions of another's face. Such impressions occur spontaneously and are often beyond our conscious control. They help us distinguish friend from foe, or those whom we should trust from those of whom we should be wary. Indeed, a mere 50 millisecond (ms) exposure to a face permits trait inferences that are highly correlated among multiple perceivers, indicating that facial cues provide reliable signals about another's underlying disposition.[26]

When offering spiritual care to African American women, establishing trust is the foundation upon which the spiritual care relationship is established.

Watkins Ali (1999) points out that when attempting to establish trust with African American women experiencing PLN the spiritual care provider should, in the words of Seward Hiltner's preface to Pastoral Theology, "show tender and solicitous concern." Watkins Ali states that the spiritual care provider should try to have "genuine communication, empathy and concern that generate a clear intention of advocacy; educate yourself about the cultural context before you give any sort of guidance and seek to understand what has already been endured in the lives of your patient/family."[27] When trust is established, the patient feels connected to her chaplain which allows for interpersonal resonance to take place.

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[25] J. B. Freeman et al., "Amygdala Responsivity to High-Level Social Information from Unseen Faces," *Journal of Neuroscience* 34, no. 32 (2014), accessed February 22, 2017, doi:10.1523/jneurosci.5063-13.2014.

[26] Ibid.

[27] Carroll A. Watkins Ali, *Survival & Liberation* (Saint Louis, MO: Chalice Press, 1999), 136-137.

Interpersonal Resonance

In the same way, it is important for the spiritual caregivers to find a way to connect with the cultural context of African American women experiencing PNL. Dan Siegel proposes that interpersonal resonance is the way in which the structure of our neural architecture reveals how we need connections to other people in order to feel in balance and to develop well. The brain integrates input from other people with the process of regulating the body, balancing emotional states, and the creation of self-awareness.[28] Similarly, Carolyn L. McCrary refers to interdependence as an innate need for all creation.[29] McCrary's interdisciplinary model of pastoral counseling draws on the theological concept of establishing community as well as reconciliation as defined by Howard Thurman. Reconciliation for Thurman is the rejoining of self to God, of self to others, and of self to self.[30] McCrary talks about establishing community as a theological norm in relation to reconciliation.

In this vein of establishing community as well as reconciliation, interpersonal resonance can be understood as the mechanism by which the neurological self employs an apparatus for connection with another in a way that is healthy and life-affirming. It is a necessary undergirding path to feeling comforted, beheld, and loved in the empathic companioning relationship between a patient and her chaplain.

The success of establishing empathic companioning relationships can depend on

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[28] Dan Siegel, "Mindfulness, Psychotherapy and the Brain," iThou.org, accessed May 9, 2017, http://www.ithou.org/node/2730.

[29] McCrary, ThD diss., 1989, v.

[30] For Howard Thurman's concept of reconciliation see *Disciplines of the Spirit* (New York, NY: Harper & Row, 1963).

the chaplain's ability to integrate his or herself within the patient's experience. Philip Culbertson uses Object Relations Theory to illustrate interconnectedness of self-within-community. Culbertson asserts that Object Relations Theory is "the interpersonal that becomes the intrapsychic;" that is, the events and characteristics of the "factual" relationship between two people that, once internalized, become the templates through which relationships are conducted, and through which one comes to perceive one's own identity and what to expect out of life."[31] Culbertson discussion of Object relations theory helps to explain the concept of the need for our connection to God and to others.

John Calvin asserts: "without knowledge of self, there is no knowledge of God… no man can survey himself without forthwith turning his thoughts towards the God in whom God lives and moves; because it is perfectly obvious, that the endowments which we possess cannot possibly be from ourselves; nay, that our very being is nothing else than subsistence in God alone."[32] The ability to recognize inner images of the self and others and how they manifest themselves in interpersonal situations is how an empathic companioning relationship between a patient and her chaplain can be established.

In her discussion about successful therapeutic relations with Black families Watkins Ali points out that "successful therapeutic relations with Black families require that the therapist has the ability to use one's self in therapy. This will entail being very aware of one's own culture, the dynamics of one's own family of origin, and the issues that

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[31] Philip Leroy Culbertson, *Caring for God's People: Counseling and Christian Wholeness* (Minneapolis, MN: Fortress Press, 2000), 75.

[32] "Book I Chapter 1 Calvin's Institutes," Book I Chapter 1 Calvin's Institutes, accessed January 24, 2017, http://www.reformed.org/books/institutes/books/book1/bk1ch01.html.

may arise as a result of these awareness."[33] This type of self-awareness can bring to the chaplains' consciousness the multicultural dynamics between them and African American women and families experiencing perinatal loss, thus; enabling them to establish trust and successful therapeutic relations.

For instance, Cooper-White encourages the chaplain or any spiritual caregiver to look to the self and the use of the self as the primary tool for pastoral care practice. Cooper-White asserts:

> It is important to understand one's own neurotic vulnerabilities (from which no one is immune), and to become sensitized to one's own "button" or tender places within ourselves that are vulnerable to being used by others. This is the classical contribution to the understanding of counter transference, which has been fruitfully taught in CPE and pastoral care curricula for generations, however; counter transference is not only a hindrance to be worked through or analyzed away. It is also a valuable instrument for listening for the other, because in the unconscious relationship that grows between helper and helpee, our own thoughts and feelings and fantasies literally absorb the thought life of the other, as we soak together in the intimacy of the helpee's shared confidences. [34]

Connecting with African American families experiencing perinatal loss means having some knowledge of African American culture and having the ability to integrate that knowledge into their spiritual care. It means listening with compassion and being aware of one's own bias while allowing the "shared wisdom" to be the key that opens the door to "mindful intercultural communication".

Cultural Competency

When caregivers are not culturally competent and sensitive to the dynamic of systematic oppression of African Americans by the American medical establishment, they

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[33] Carroll A. Watkins Ali, *Survival & Liberation* (Saint Louis, MO: Chalice Press, 1999), 93.

[34] Pamela Cooper-White*, Shared Wisdom: Use of the Self in Pastoral Care and Counseling* (Minneapolis, MN: Fortress Press, 2004), vi.

may overlook opportunities to adequately care for these patients. Cultural encounter is the deliberate seeking of face-to-face interactions with African-American patients. Ting-Toomey (1999) contends that effective cultural encounters should consist of "mindful intercultural communications". She argues that "the opposite of mindful cross-cultural communication is 'mindless stereotyping,' which is a closed-ended, exaggerated over-generalization of a group of people based on little or no external validity."[35]
Chaplains who are culturally competent and aware of their own bias will be less likely to stereotype, thus increasing the likelihood of achieving mindful intercultural communication.

Roberts (2014) defines cultural competency as "the ability to interact successfully with people from various ethnic and/or cultural groups."[36] Emmanuel Y. Lartey defines culture as "the way in which groups of people develop distinct patterns of life and give 'expressive form' to their social and material life experience."[37] Rachel Spector powerfully asserts: "all facets of human behavior can be interpreted through the lens of culture, and everything can be related to and from this context."[38] When caring for African American women and families experiencing PNL, incorporating culture is essential when attempting to understand religious beliefs and grief responses.

Young (1972) argues that African Americans still have distinctive values and

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[35] Stella Ting-Toomey, *Communicating Across Cultures* (New York, NY: Guilford Press, 1999), 16.

[36] Norma Gutierrez, "Cultural Competencies," in Roberts, 409.

[37] Emmanuel Y. Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling* (London, England: Jessica Kingeley Publishers), 31.

[38] Rachel E. Spector, *Cultural Diversity in Health and Illness* (Boston, MA: Pearson, 2013), 22.

characteristics that set them apart from other cultures. A study conducted by researchers at Pace University revealed that these distinctive values survived generations of enslavement and became African Americans' "core values"[39] in our traditions, practices and beliefs.

Although, the core values survived generations of enslavement, intra-cultural diversity within the African American culture still exists and should not be underestimated when caring for African American women experiencing PNL. The diversity in religious beliefs, death rituals, emotional responses and expressions should be considered when providing spiritual care to African American women experiencing PNL. The National Center for Biotechnology Information (NCBI) asserts:

> As intra-cultural diversity among members of a culture is often as great as intercultural differences, individual persons respond to loss differently, sometimes even differently from ways specified by group norms. Quite obviously, social class, economic and even sociopolitical factors will contribute (to greater and lesser extents) to negotiations of group norms guiding how bereavement ideally should be experienced and handled in particular local contexts.[40]

Despite there being great diversity within the African American community, Watkins Ali states that "the pastoral care needs for African Americans can best be identified from the perspective of poor Black women. Inasmuch as poor Black women (and their children) are positioned at the lowest levels of social, political, and economic status in this country, it is their eyes through which pastoral caregivers need to gain a view of what the critical needs are in Black America."[41] Furthermore, the spiritual care provider

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[39] Hugh J. Scott, "The African American Culture – Pace University," accessed July 11, 2017, http//:www.pace.edu./emplibraryVP-TheAfricanAmericanCulture_ Hugh_J_Scott.pdf &p=DevEx,5067.1.

[40] Osterweis M, Solomon F, Green M, "Bereavement: Reactions, Consequences, and Care", Washington (DC): National Academies Press (US); 1984, CHAPTER 8, Sociocultural Influences, accessed July 11, 2017, https://www.ncbi.nlm.nih.gov/books/NBK217844/.

[41] Ali, 12-13.

may discover that this requires a change in methodology. The change calls for a communal approach to ministry (both in terms of those who give pastoral care and those who receive it.)"[42] Ali asserts that this approach to ministry goes beyond the traditional aspect of shepherding (healing, sustaining and guiding) to include nurturing, empowering, liberating, and reconciling.[43] If the chaplains omit the inclusion of liberation and reconciliation cultural insensitivity may result.

Research reveals cultural insensitivity is usually not intentional. It is often caused by not having the knowledge one needs to understand another person's frame of reference.[44] Research on the topic of cultural sensitivity points out:

> Knowledge of cultural differences refers to specific 'facts' we may know about a given cultural group, such as "mainstream Caucasians tend to be future-oriented" or many Hispanics place the highest priority on family relationships." Knowledge is different from Awareness in that someone may 'know' a piece of information about a culture but not be aware of when and how that information comes into play in real life. In other words, knowledge is what you may bring with you to an encounter, while awareness emerges during the encounter. Relying too much on knowledge alone can be risky, since one can never know all there is to know about another culture, let alone every culture, and the knowledge you have will never apply to every member of a culture.[45]

Knowledge and awareness are sometimes used interchangeably, therefore chaplains should be cautious when relying solely on their knowledge when offering spiritual care. Relying too heavy on knowledge could prevent the natural unfolding of awareness to occur. Chaplains who are culturally competent and sensitive to the culture

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[42] Ibid., 13.

[43] Ibid., 9.

[44] Susan Wintz and the Rev. Earl Cooper, "Cultural & Spiritual Sensitivity -- A Learning Module for Health Care Professionals and Dictionary of Patients' Spiritual & Cultural Values for Health Care Professionals," Pastoral Care Leadership and Practice Group of HealthCare Chaplaincy, accessed March 7, 2017, https://www.healthcarechaplaincy.org/docs/publications/laning_page/cultural_sensitivity_learning_Module-7-10-09.pdf.

[45] Ibid.

of African American women and families will use their knowledge to create spiritual pathways that will benefit both chaplain and patient.

Chapter 3

Methods

The primary goal of this study was to determine if exposing hospital chaplains to a curriculum on intercultural competency would enhance their knowledge and skills when offering spiritual care to African American women and families experiencing perinatal loss; and specifically to gather descriptive information relevant to research questions presented in Chapter 1. This chapter will describe: (a) selection of participants, (b) instrumentation, (c) data collection, and (d) data analysis.

Selection of Participants

Purposive sampling and heuristic rule of thumb were used as guides to determine both the type and the number of subjects appropriate for this study. Purposive sampling involves selecting a sample based on the researcher's experience or knowledge of the group to be sampled.[1] Heuristic rule of thumb suggests 1 to 20 participants for qualitative research.[2] Homogenous sampling was also used to select participants very similar in experience or philosophy, thus yielding a narrow, homogenous sample that also made data collection and analysis simpler.[3] The purposive sample model provided the researcher with the means for selecting chaplains who practically and/or theologically understand the

[1] Fred C. Lunenburg and Beverly J. Irby, *Writing a Successful Thesis or Dissertation: Tips and Strategies for Students in the Social and Behavioral Sciences* (Thousand Oaks, CA: Corwin Press, 2008), 178.

[2] Ibid.

[3] Ibid.

challenges associated with providing spiritual care in a hospital setting. A total of 13 chaplains comprised the study. The non-randomly chosen group was from the Spiritual Health and Education Department at NSH, Atlanta Campus. They included 10 CPE students who were completing their Summer Intensive Unit. Within this group of CPE students, 5 students were interns and 5 students were residents. Also, there was a Board Certified Staff Chaplain, a Professional Staff Chaplain (non-board certified), a PRN Chaplain (PRN means “pro re nata;" a Latin phrase that roughly translates to "as needed" or "as the situation arises”), [4] and a Supervisor Training Education Student (SES). The study groups at pre- and post-training intervention were relatively proportionate in the number of male and female participants. At pre-intervention there were 7 males and 6 females. One male chaplain did not complete the post-intervention questionnaire. Overall, females were younger in chronological age than males. The chaplains ranged in age from 24 to 71 years old.

The researcher also chose this group of chaplains because they represented various cultural perspectives. The sample was fairly representative of the general population in terms of race/ethnicity although limited somewhat by the small sample size and nonrandom sampling. Proportionately, there was a slightly higher representation of African American chaplains. Tables 1 and 2 contain information about the sample regarding sex, age, and ethnic status at pre- and post-intervention.

[4] “PRN,” Merriam-Webster, accessed November 29, 2017, http://www.merriam-webster.com/dictionary/prn.

Table 1. Demographic Characteristics of Sample

	Mean (M)	**Range**	**M (Male)**	**M (Female)**
Age	42	24-71	61	47.5
Pre-Intervention				
Gender	*Number (N)*	*Percentage (%)*	*M Age*	*Range*
Male	7	54	61	24-68
Female	6	46	47.5	25-71
Total	13			
Post-Intervention				
Gender	*Number (N)*	*Percentage (%)*	*M Age*	*Range*
Male	6	50	61	24-68
Female	6	50	47.5	25-71
Total	12			

Table 2. Race and Ethnicity of Sample

Race	**Pre-Intervention**		**Post-Intervention**	
	N	**%**	**N**	**%**
Caucasian	6	50	6	50
African American/Black	3	25	3	25
Asian American	1	8	1	8
Latino/Hispanic	1	8	1	8
Other	2	16	1	8

The participants were also chosen because of the diversity in their education and training. In addition to the prerequisite that minimally, all chaplains either had been or were enrolled in at least one unit of Clinical Pastoral Education (CPE) at the time of the study, all participants also met education and work criteria mandated by the Association for Clinical Pastoral Education (ACPE) as follows: [5]

1. Interns for 2017 Summer Intensive Internship CPE Program: 6 hours of group work 2–3 times per week; 1 hour of individual supervision weekly; 40+ hours of clinical experience weekly.

[5] "CPE Programs," Care and Counseling Center of Georgia, accessed September 13, 2017, http://cccgeorgia.org/clinical-pastoral-education/cpe-programs/.

2. Residency CPE students: 1 unit of CPE; involved in successful completion of 52 full-time weeks of CPE Level I/II training for 3 credit units of Clinical Pastoral Education; 6 hours of group work 2-3 times per week; and 40+ hours of clinical experience weekly.
3. Supervisory Education Student (SES): Ordination/religious certification by an ecclesiastical body; denominational/faith group endorsement to train in the program; graduation from an accredited seminary, rabbinic or divinity school; conferment of a Masters of Divinity (M.Div.) degree or M.Div. equivalency as confirmed by an ACPE certification committee; successful completion of Level I CPE and distinguished progress addressing Level II outcomes; usually at least 4 units of Level II CPE; successful pastoral experience as a professional minister after completion of the initial theological degree, usually not less than 3 years. It is preferred that one's pastoral experience be in both an institutional and congregational context.
4. PRN and Board Certified Chaplains (BCC): Undergraduate degree from Council of Higher Education (CHEA)-accredited school; 72 semester credit hours (108 quarter credits) from a graduate-level theological college, university or theological school; 4 units of Clinical Pastoral Education (CPE) through ACPE, National Association of Catholic Chaplains (NACC) or Canadian Association for Spiritual Care (CASC), and 2000 hours of work experience.[6]

[6] "BCCI," Association of Professional Chaplains, accessed September 13, 2017, https://www.professionalchaplains.org/files/2017%20Common%20Qualifications%20and%20Competencies%20for%20Professional%20Chaplains.pdf.

5. Professional Staff Chaplain (non-board certified): Undergraduate degree from a college, university, or theological school accredited by a member of the Council for Higher Education Accreditation, and a graduate-level theological degree from a college, university or theological school accredited by a member of the Council for Higher Education Accreditation; a minimum of 4 units (Levels I & II) of CPE accredited or approved by the Association for Clinical Pastoral Education (ACPE).[7] Table 3 illustrates the education and work requirements of the chaplains.

Table 3. Chaplain Education and Work Requirements

	Intern	**Resident**	**SES**	**BCC**	**Staff**	**PRN**
Undergraduate/CHEA	Yes	Yes	Yes	Yes	Yes	Yes
Theological/CHEA	No	Yes	Yes	Yes	Yes	Yes
CPE/ACPE/NACC/CASC	No	1 Unit	4 Units	4 Units	4 Units	4 Units
Work Experience	No	No	Yes	Yes	No	Yes

Finally, the researcher sought and received approval from NSH Research Oversight Committee (ROCA) and Institutional Review Board (IRB) to conduct the study (see Appendix A). An agreement to participate voluntarily in the study was signed by the researcher and the participants (see Appendix B). The study was conducted during the CPE Summer Intensive Unit, from June 1 to August 31, 2017.

Instrumentation

A training resourcing curriculum and pre and post-intervention questionnaires were developed for study purposes. Each is described here.

[7] Ibid.

The resourcing curriculum is comprised of 3 training Modules as outlined below: Module 1. *Intercultural Competency in Spiritual Care*. The objective of the training resourcing is to expose chaplains to a curriculum intended to enhance their knowledge and skills in working with African American women experiencing PNL. The curriculum addresses the following areas:

A. Basic Theory of Intercultural Care: Knowledge and Awareness [8]
    1. Knowledge: Knowledge of culture differences refers to specific "facts" we may know about a given cultural group, such as whites are not as emotional in their grief, or African Americans tend to have a greater emotional expression during their grieving process.
    2. Awareness: Awareness emerges during the encounter with a given culture group.
    3. The Difference: "Knowledge is different from Awareness in that someone may 'know' a piece of information about a culture but not be aware of how that information comes into play in real life."
B. Spiritual Care: Understanding the cultural perspective of African American women experiencing PNL[9]
    1. Perspectives of poor Black women

[8] For the Basic Theory of Intercultural Care: Knowledge and Awareness see "The African American Culture – Pace University;" Rosenblatt and Wallace, *African American Grief,* 167-172; Cultural Spiritual Sensitivity Learning Module 7-10-09;" Norma Gutierrez, "Cultural Competencies," in Roberts, 410. See chapter 4 for chaplains' comments regarding training.

[9] For the cultural perspective of African American women see Watkins Ali*, Survival and Liberation: Pastoral Theology in African American Context,* 17-38. For the effects of slavery, racism, oppression and health disparities on African American women and their babies see Norris, "Why Black Women, Infants Lag in Birth Outcomes.

2. A communal approach to ministry
3. Spiritual care that goes beyond the traditional aspects of shepherding to include liberation

C. African Americans' expressions of grief [10]

1. Attitude: "Be strong"
2. Values: Reliance on family and community for spiritual and emotional support
3. Verbal Cues: Crying, praying and/or quoting scripture

Module 2. *Perinatal Loss*. The objective of this curriculum is to provide a brief historical perspective of what has created barriers to spiritual care for African American women experiencing perinatal loss. The module focuses on:

A. The influence of African American history

1. Transport from Africa: The ability of one sector of humanity to destroy the health of another[11]

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[10] For African American expressions of grief see Rosenblatt and Wallace, *African American Grief*, 153-166; In comparison to other ethnicity see "Cultural Guidelines for Working With Families Who Have Experienced Sudden or Unexpected Death," accessed July 11, 2017, https://dmh.mo.gov/media/pdf/cultural-guidelines-tips-working-families-after-sudden-or-unexpected-death; Spector, *Cultural Diversity in Health and Illness*, 265-288; Shaefer, "Cross Culture Expressions of Grief and Loss II: When an Infant Dies (Volume 2)," accessed July 14, 2017, https://www.mchlibrary.org/collections/suid-sids/documents/cross_cultural_2003.PDF; For culture influences on bereavement see Paulina Van and Afaf I. Meleis, "Coping With Grief After Involuntary Pregnancy Loss: Perspectives of African American Women," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 32, no. 1 (2003): , doi:10.1177/0884217502239798. See Chapter 4 for discussion on this topic.

[11] For the influence of African American history see Slaughter, *Therapeutic Dimensions of Black Preaching and the Liberating Impact on a People of Color,* 80-81; McCrary, "Interdependence As a Norm For an Interdisciplinary Model of Pastoral Counseling" (1989), 2; Noonan, Velasco-Mondragon and Wagner, "The State of Black Health in America."

2. Systematic discrimination in healthcare for African American women today[12]
    a. Lack of access to healthcare
    b. Worse health outcomes
3. Cumulative impact of healthcare deficiencies[13]
    a. Chronic disease (e.g. high blood pressure)
    b. Pre-term or premature delivery
    c. Higher infant mortality rate
    d. Healthcare disparities
    e. Racial disparities in birth outcomes

B. African American women's infant mortality rate in comparison with other ethnic groups[14]
    1. Black women are approximately 60% more likely than white women to deliver their babies early.
    2. Black infants are approximately 230% more likely than white infants to die

[12] For the health of African American women and the stressors caused by systematic discrimination see Artiga, Aug 12 2016 Petry Ubri and Samantha, "Disparities in Health and Health Care: Five Key Questions and Answers; Norris, "Why Black Women, Infants Lag in Birth Outcomes.

[13] For the cumulative impact of healthcare deficiencies see Norris, "Why Black Women, Infants Lag In Birth Outcomes."

[14] For health disparities experienced by Black or African Americans see "Health Disparities Experienced by Black or African Americans in the United States," Centers for Disease Control and Prevention, accessed March 01, 2018. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5401a1.htm. Topic discussed in chapter 2 of this study. See chapter 4 for chaplains' comments.

before their first birthdays.[15]

3. Blacks and American Indians/Native Americans received worse health care than Whites for approximately 40% of measures.
4. Asians received 20% worse care than Whites.
5. Hispanics received 60% worse care than non-Hispanic Whites.
6. Low-income individuals received 80% worse care than high-income individuals.[16]

C. Challenges for African American women during childbearing years[17]

1. White women's health outcomes improve as they climb the socioeconomic ladder and give birth in their 20s and early 30s, rather than in their teen years.
2. African American women's health problems appear to compound with age.
3. African-American women of childbearing age in particular, in their 20s and early 30s, are more likely to suffer from chronic disease.

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[15] For African Americans infant mortality rate see "African-American Women and Their Babies at a Higher Risk for Pregnancy and Birth Complications," accessed May 9, 2017, https://www.cdc.gov/mediasubtopic/matte/pdf/CDCMatteReleseInfantMortality-508.pdf; Scott "Stillbirths: Breaking the Silence of a Hidden Grief." *The Lancet* 377, no. 9755 (April 23, 2011): 1386-388.doi.10.1016/s0140-6736(11)60107-4; "National Vital Statistics Reports," assessed March 15, 2017, https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_08.pdf; Rosenblatt and Wallace, *African American Grief*, 5.

[16] For economic disparities experienced by Black or African Americans in the United States see "Health Disparities Experienced by Black or African Americans in the United States," Centers for Disease Control and Prevention, accessed March 01, 2018, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5401a1.htm.

[17] For challenges for African American women during childbearing age see Norris, "Why Black Women, Infants Lag in Birth Outcomes."

4. African-Americans at age 35 have the rates of disability of white Americans who are 55.

Module 3. *Companioning.* The objective of the curriculum is to increase knowledge and understanding of delivering culturally competent spiritual care to African American females experiencing perinatal loss. This module addresses:

A. Culturally sensitive spiritual care[18]
    1. Be aware of the potential magnitude of perinatal loss within the populations for whom spiritual care is provided.
    2. Be cautious utilizing psychodynamic personality theories to evaluate the African American community without making any theoretical modifications. It may result in inappropriate assessments and inaccurate conclusions.
    3. Pastoral care for African Americans requires caregiving that addresses the crises they face in terms of survival as a people and liberation from all kinds of oppression.
B. Establishing trust and companioning
    1. Establishing Trust[19]
        a. Show tender and solicitous concern.
        b. Try to have genuine communication, empathy and concern that

[18] For culturally sensitive spiritual care see Leon, *When a Baby Dies: Psychotherapy for Pregnancy and Newborn Loss*, 39; Butler, *Liberating Our Dignity, Saving Our Souls*, 81-82; Ali, *Survival and Liberation: Pastoral Theology in African American Context*, 129.

[19] For establishing chaplain-patient trust see Ali, *Survival and Liberation: Pastoral Theology in African American Context*, 136-137. See chapter 2 for discussion on this topic.

generates a clear intention of advocacy.

c. Educate yourself about the cultural context before you give any sort of guidance.

d. Seek to understand what has already been endured in the lives of your patient/family.

2. Companioning[20]

a. Companioning is about being present with another person's pain; it is not about taking away the pain.

b. Companioning is about going to the wilderness of the soul with another human being; it is not about thinking you are responsible for finding the way out.

c. Companioning is about honoring the spirit; it is not about focusing on the intellect.

d. Companioning is about listening with the heart; it is not about analyzing with the head.

e. Companioning is about bearing witness to the struggle of others; it is not about judging or directing those struggles.

f. Companioning is about walking alongside; it is not about leading or being led.

g. Companioning means discovering the gifts of sacred silence; it does not mean filling up every moment with words.

[20] For Alan Wolfelt's Tenets of Companioning the Bereaved see Heustis and Jenkins, *Companioning at a Time of PNL: A Guide for Nurses, Physicians, Social Workers, Chaplains and Other Bedside Caregivers*, xiii.

h. Companioning is about being still; it is not about frantic movement forward.

i. Companioning is about respecting disorder and confusion; it is not about imposing order and logic.

j. Companioning is about learning from others; it is not about teaching them.

k. Companioning is about curiosity; it is not about expertise.

C. Do's and Don'ts: Helpful and harmful things chaplains can do and/or say

1. The Do's [21]

a. Acknowledge there was a baby.

b. Encourage the mother to rest and take time to heal both physically and emotionally.

c. Listen.

d. Pray (if applicable).

e. Refer to the baby by name.

f. Speak gently.

g. Be genuine and caring.

h. Can say "I am so sorry for your loss."

2. The Don'ts – Avoid saying the following [22]

[21] For helpful things chaplains can do and/or say see Donielle Baker, "What to Say When Someone Loses a Baby," accessed April 16, 2017, https://www.naturalfertilityandwellness.com/what-to-say-when-someone-loses-a-baby/.

[22] For harmful things chaplains can do see Tom Fuenst, "10 Things You Should Never Say to a Grieving Person," Ministry Matters, accessed February 22, 2017, https://www.ministrymatters.com/all/entry/5552/10-things-you-should-never-say-to-a-grieving-person

"I know how you feel."

a. "God has a will in this." / "There is a reason for everything. / God is in control."

b. "He/She is in a better place."

c. "You can have another child." / "At least you have other kids."

d. "It was his/her time to go."

e. "You have to be strong."

f. "God never gives us more than we can handle."

g. "Is there anything I can do for you?"

D. Theological theories about loss [23]

1. Suffering and loss are times of testing: *"Blessed is the man who perseveres under trial, because when he has stood the test, he will receive the crown of life that God has promised to those who love him." James 1:12*

a. Upside:

(1) Gives meaning in the midst of meaninglessness

(2) Ties experience to a sense of purpose that may help parents feel less lost

(3) Helps see loss as a temporary experience with a clear reward at the end

[23] For the theological theories about loss see Thomas Moe, *Pastoral Care in Pregnancy Loss: A Ministry Long Needed*, (New York, NY: The Hayworth Pastoral Press, 1997), 48.

(4) Helps find commonality with other people who have been tested, and thus avoid self-blame; everyone is tested, good or bad.

(5) Provides a sense of hope

b. Downside:

(1) May feel subject to evil powers (e.g. Job)

(2) No room for doubt: Many people feel and need to express doubt. Their world-view is more complex and does not fit neatly into this perspective. Without room to express difference or doubt without failing the "test" they may retreat from the church or community that promotes this view.

2. Suffering and loss are times of training: *"…God disciplines us for our good that we may share in his holiness. No discipline seems pleasant at the time, but painful. Later on, however, it produces a harvest of righteousness and peace for those who have been trained by it." Hebrews 12:10-11*

a. Upside:

(1) A completely packaged meaning to suffering

(2) May express distress more freely than the "tested"

b. Downside:

(1) Package may be inadequate

(2) In perinatal loss, families have no reason that child must die so they can improve.

(3) Anger at God may lead some to intentionally fail "training" in other ways

(4) Uneasy questions of theodicy may cause existential crisis.

Pre- and Post-Intervention Questionnaires. Since the researcher could not find a validated instrument that could measure the cultural competency of chaplains providing spiritual care to African American women experiencing perinatal loss, two questionnaires were developed for the overarching purpose of assessing the usefulness of the resourcing intervention (see Appendix C: Pre-Intervention Questionnaire; and Appendix D: Post-Intervention Questionnaire). The researcher combined spiritual care resourcing methodologies similar to those employed in Clinical Pastoral Education programs and the standards from the APC Board Certification requirements for Professional Chaplains to create the resourcing curriculum and pre- and post-intervention questionnaires. In constructing the questionnaires, initially a list of questions was developed in primary areas of concern about chaplaincy services to the patients of interest. A final selection of questions was made based on their relevance to the goals of the study, clarity (i.e., written in formats understandable to the chaplains), and ability to be quantified.

The pre-intervention questionnaire contained a total of 14 questions, some of which included as many as 4 sub-questions, in Sections B thru E: (1) Social-Cultural Knowledge, (2) Spirituality and Healing Traditions, (3) Attitude, and (4), Skills Regarding Perinatal Loss among African American Patients. On the pre- and post-questionnaires a Likert Scale was used for rating each inquiry in Sections B through E, (i.e., Questions 1 through 14). The 5-point scales contained the following response categories: 1 = “Not at all”; 2 = “A little”; 3 = “Somewhat”; 4 = “Quite a bit”; and 5 = “A lot”. Also included on the pre- and post-questionnaires were questions to ascertain sample demographics including age, sex, and race/ethnicity (using the 2000 year census categories). While the pre- and post-questionnaires were similar in content, the post-intervention questionnaire did not reassess

Section B, Question 1, and Parts a through d of question 1): i.e., "How much training in cultural diversity have you had overall?" etc., as found in the pre-intervention questionnaire. Further, the pre-intervention questionnaire did not contain Section F-Questions 15, 16, and 17 related to the overall perception of the helpfulness of training, formatted "yes/no"; recommendations for future trainings; and comments, respectively.

After several revisions, the curriculum modules and the pre- and post-intervention questionnaires were screened for ambiguity, wording, and content overlap. To enhance content validity, the researcher consulted with 5 experts who further evaluated the training curriculum and the surveys' contents. The experts included: Manager of Spiritual Health and Education Department NSH, CPE Coordinator NSH, Clinical Psychologist, Research Program Director of NSH Research Oversight Committee, and NSH Institutional Review Board Member. Following this process, both the training modules and questionnaires were finalized.

The decision to use a descriptive questionnaire that employed Likert Scale Ratings was prompted by published supporters of descriptive research and the successful use of the descriptive surveys by previous investigators (Glass & Hopkins, 1984; Borg & Gall, 1989; Cochenour, Hakes, and Neal's, 1994; Signer's, 1991, Nolan, McKinnon, and Soler's, 1992; Robinson, 1994 and Lee, 1994).[24] The descriptive technique has both advantages and disadvantages. Some of the advantages of this technique are that it is "effective in analyzing a completely natural and unchanged natural environment and the opportunity to integrate non-quantified topics and issues; it provides the opportunity to observe the phenomenon in

[24] "What is Descriptive Research," Education in Communications and Technology, accessed September 14, 2017, https://members.aect.org/edtech/ed1/41/41-01.html.

the qualitative and quantitative methods of data collection."[25] Some of the disadvantages of descriptive techniques are that the "studies cannot test or verify the research problem statistically; research results may reflect certain level of bias due to the absence of statistical tests; and the majority of descriptive studies are not 'repeatable' due to their observational nature."[26]

Data Collection

This study employed a qualitative and quantitative methodology in data collection and analysis. At the beginning of the study the researcher was required to send a Project Proposal and Informed Consent Form to NSH ROC and IRB committees for approval. The IRB committee assisted the researcher with revising the consent form in order to meet their guidelines. The researcher was also required to take the Human Research Subject (HRS) exam and obtain a Certificate of Completion before the IRB granted approval for the study (see Appendix E). Following approval by the IRB, the researcher consulted with the NSH Spiritual Health and Education Manager and the CPE Coordinator for best times and location to meet with Staff Chaplains and CPE students to begin the study. After a schedule was established, first the researcher met with staff and CPE students to describe the research study requirements and obtain their permission to participant in the study. Thirteen participants signed the *Consent to Participate in Research Study Form*. Immediately thereafter, the researcher gave each chaplain the pre-intervention questionnaire. The CPE Coordinator asked all participants to complete their questionnaire and the instruments were

[25] "Descriptive Research," Research Methodology, accessed September 14, 2017, https://research-methodology.net/descriptive-research/.

[26] Ibid.

returned to the researcher the same day. After the pre-intervention questionnaire responses were tallied for all questions, the researcher used the data to further develop and complete the 3 modules of the resourcing curriculum. The researcher conducted 2 training sessions; the first session was 3 hours in length and the second session was 2 hours long. The researcher then gave each chaplain the post-intervention questionnaire and asked that it be returned to the researcher within 5 days. Twelve of the 13 chaplains complied and returned the questionnaires to the researcher.

Chaplains were asked on the post-resourcing intervention assessment (Section F) to describe their feelings about the training; about desired further training on providing spiritual care and support to African American women experiencing perinatal loss; and to offer any other comments. These questions were designed to help the researcher identify potential areas for future training intervention and refinement, and constituted a qualitative component of the research.

Data Analysis

The small, nonrandomized sample and method of sample selection (previously described in this chapter under “Selection of Participants”) precluded the use of the more robust types of statistical analyses; the type that would allow the researcher to say whether the results found between the pre- and post-resourcing intervention were statistically significant; i.e., whether the training curriculum made a difference(s) and, if so, the difference(s) did not occur by chance. For example, if the results of the analyses showed that the chaplains acquired new and/or additional information from the curriculum, then it

could be hypothesized that the outcome occurred largely because of the intervention. Exploratory Data Analysis (EDA)[27] methods were used to glean what the data suggested.

As was encouraged by John Turkey,[28] data of this type allowed the researcher to see what the data could tell the researcher beyond the formal modeling or hypothesis testing. Instead the results were summarized by their main characteristics, often with visual methods, and basic descriptive statistics were used to report observations. Those statistics—raw tallies, means, medians, modes, and percentages were used to describe some observations about data gleamed from the two questionnaires. The researcher found EDA a highly useful and informative method for analyzing the chaplains' responses to the questionnaires that will certainly be beneficial to further study in this area.

Quantitative analysis of the data included comparing the number, and then the percentage of chaplain respondents in each of the 5 Likert groups, and when the groups were combined. The researcher looked at each scale category from 1-5 to compare and contrast differences based on the percentages of responses by the combined percentages for the total groups in each category. First, the responses for all chaplains on the Likert scale were tallied and summed for both pre- and post-questionnaires. They were then compared and contrasted for gems of information about any shifts in responses from lower to higher categories, and vice versa, for each category after the resourcing intervention.

A further analysis of the data using quantitative, descriptive statistics was performed. Two groups were formed for the overarching purpose of making further

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[27] Ibid.

[28] Iver Iversen, "Tactics Of Graphic Design: A Review Of Tufte's The Visual Display of Quantitative Information," *Journal of the Experimental Analysis of Behavior*, (1988): 49, (1):171-189.doi:10.1901/jeab.49-171.

comparisons from the Likert Scale. The first group included Likert categories 1, 2, and 3 for chaplains who reported that they were "Not at all", "A little", or "Somewhat" knowledgeable about the patients. The second group comprised categories 4 and 5 of the Likert where subjects reported they had "Quite a Bit" to "A Lot" of knowledge relative to the target patients. Numbers (N) for each of the two groups were then summed and converted to percentages. The resulting information facilitated a study of trends among both individual categories and the combined categories.

Qualitative analyses included a review of narrative statements on the post-intervention questionnaires. Chaplains' responses to Questions 15, 16 and 17 were studied and considered for further research. They were useful individually and collectively, and were felt to be of good heuristic value.

Summary

This chapter restates the primary goal of the research study, i.e., to provide a training resource for chaplains intending to enhance their skills in the delivery of spiritual care to African American females experiencing perinatal loss by infusion of new or expansion of their existing information to help them be more culturally aware and knowledgeable. This was accomplished through a didactic intervention with the chaplains and pre/post assessment response comparisons. Several preliminary steps to gain approval for the study and participants were discussed. Purposive sampling and heuristic rule of thumb were used to select and determine if participants were appropriate for this study. Thirteen chaplains participated in the study. The researcher developed a 5 hour didactic curriculum intervention, and pre- and post-questionnaires to discover if the intervention would demonstrate positive trends for the study's goals. The study employed both

qualitative and quantitative methodologies for data collection and analysis, but was limited to the use of Exploratory Data Analysis (EDA) and other descriptive statistics of results rather than parametric analyses. The results of the data analyses are presented in the following chapter.

Chapter 4

Results

Keeping in mind the overarching goal of exploring the potential impact of cultural knowledge and awareness resourcing for chaplains who offer spiritual care to African American women experiencing PNL, the following information provides some of the results of this study. As previously described, the results from two questionnaires, one given before the researcher intervened with a curriculum to heighten an understanding of African American women experiencing PNL, and one given following the training, were used to explore potential benefits for the chaplains.

A brief description of how the researcher gained information from the pre- and post-intervention questionnaires using a Likert Scale follows:

1. The reader is reminded that the Likert Scale allowed chaplains to answer most of the research questions on a 5-point response scale, i.e., a scale that allowed them to choose from one of the following response categories:

   1 = Not at all

   2 = A little

   3 = Somewhat

   4 = Quite a bit

   5 = A lot

2. The chaplains' responses were *summed for each category*, and *percentages were calculated* to describe the total percentage of responses that were given by

3. chaplains for all questions and sub-questions at each of the 5 points on the Likert scale. Please see Chapter 3 for a full description of the questionnaires.
4. Using the pre- and post-questionnaires, the researcher created two comparison groups to explore trends in the data, largely because of the small sample size. A Low Group and a High Group was created for the pre-questionnaire and for the post-questionnaire:
    - **Low Group** or Group 1: Chaplains' responses that included Likert categories 1, 2, and 3 who reported ***lesser to no knowledge*** for a particular question.
    - **High Group** or Group 2: Chaplains' responses that included Likert categories 4 and 5 who reported having ***greater knowledge*** when responding to a question.

Finally, it is important to note that exploratory information gathered from the study will not be shared in the most exhaustive manner, i.e., by commenting on every outcome. Rather the results that are elaborated on will focus on the more interesting trends and discoveries. Why this approach? First, the research was exploratory in nature. Further, the sample size was small and the results may sometimes show only small, to no effects largely due to the limited number of respondents. Finally, the questionnaires for assessing pre- and post-intervention data contained up to 17 questions, several of which also contained up to 4 sub-questions, and most questions were rated on the 5-point scale. This may contribute to small measurable changes that, in some instances, may become more meaningful when combined. However, all results from the study are provided to the reader in charts. Responses on the pre- and post-questionnaires are discussed in order of their respective

sections including: Demographic Characteristics of the Subjects; Select Socio-Cultural Knowledge; Spirituality and Healing Traditions; Attitudes; Skills Regarding Perinatal Loss among African American Patients; and Other. At times, comments from participants are included in the text and are notated with a circle bullet symbol, "•", as shown in this example: • *"Helped me recognize how deeply embedded our implicit biases are."*

A. Demographic Characteristics of the Subjects

The chaplain subjects were not randomly selected, but was a sample of convenience. The study group was evenly distributed in terms of the number of male and female participants. The subjects were racially diverse including Caucasian, African American/Black, Asian American, Latino/Hispanic, and Others at both pre and post assessment. Subjects were also nearly equal in terms of age range. However, female chaplains were younger than their male counterparts by an average of 13.5 years. One participant did not participate in the post-survey assessment. Please refer to Chapter 3, Tables 1 and 2 for further descriptions of the sample.

B. Select Socio-Cultural Knowledge

Table 4 summarizes the data regarding the chaplains' socio-cultural knowledge and their means of acquiring it. Chaplains were asked: *"How much training in cultural diversity have you had overall?"* They were also asked to specify where they acquired their training and were given options including: *College; Conferences/workshops/classes; On the job/church/faculty member;* and *Other*. Note that these questions **1, 1a, 1b, 1c,** and **1d** on the pre-intervention questionnaire (see Appendix C) were not included on the post-intervention questionnaire (see Appendix D).

Table 4. Chaplains' Ratings of Socio-Cultural Knowledge at Pre-Training (Question 1)

1. How much training in cultural diversity have you had overall?

	1 Not at all	2 A little	3 Somewhat	4 Quite a bit	5 A lot	Total
N:	1	0	2	6	3	12
%:	**8**	**0**	**17**	**50**	**25**	

Group: **Low = 25%** **High = 75%**

a. In college?

	1 Not at all	2 A little	3 Somewhat	4 Quite a bit	5 A lot	Total
N:	3	3	3	4	0	13
%:	**23**	**23**	**23**	**31**	**0**	

Group: **Low = 69%** **High = 31%**

b. Conferences/workshops/classes?

	1 Not at all	2 A little	3 Somewhat	4 Quite a bit	5 A lot	Total
N:	1	0	4	7	0	12
%:	**8**	**0**	**33**	**58**	**0**	

Group: **Low = 41%** **High = 58%**

c. On the job/church/faculty member?

	1 Not at all	2 A little	3 Somewhat	4 Quite a bit	5 A lot	Total
N:	0	2	6	2	3	13
%:	**0**	**15**	**46**	**15**	**23**	

Group: **Low = 61%** **High = 38%**

d. Other?

	1 Not at all	2 A little	3 Somewhat	4 Quite a bit	5 A lot	Total
N:	2	3	1	5	0	11
%:	**18**	**27**	**9**	**45**	**0**	

Group: **Low = 54%** **High = 45%**

The brief assessment of prior social-cultural training revealed that 75% of the chaplains (N=9 of 12) were in the High Group and reported having had "quite a bit" to "a lot of training." Over 50% of this group indicated that their knowledge was acquired in

conferences/workshops/classes versus in college, on the job/church/faculty member, or by other means.

Summaries of results for Questions **2a, 2b,** and **2c** on the pre- and post-questionnaires are shown in Table 5.

Table 5. Chaplains' Ratings of Socio-Cultural Knowledge (Question 2)

2. How much training have you had in the social and cultural characteristics of:

a. Diverse racial and ethnic groups?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	1	1	1	0	3	6	3	2	0	2	12	12
%:	**8**	**8**	**8**	**0**	**25**	**50**	**28**	**17**	**0**	**17**		

Group:	**Low**	**High**
Pre:	**41%**	**58%**
Post:	**58%**	**42%**

b. African Americans?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	2	1	2	0	4	5	3	4	0	2	13	12
%:	**15**	**8**	**15**	**0**	**31**	**42**	**28**	**33**	**0**	**17**		

Group:	**Low**	**High**
Pre:	**61%**	**38%**
Post:	**50%**	**50%**

Table 5 Continued. Chaplains' Ratings of Socio-Cultural Knowledge (Question 2)

c. African Americans of childbearing age?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	3	1	3	3	4	5	3	3	0	0	13	12
%:	**23**	**8**	**23**	**25**	**31**	**42**	**23**	**25**	**0**	**0**		

Group:	**Low**	**High**
Pre:	**77%**	**23%**

Post:	**75%**	**25%**

On question **2** chaplains were asked to indicate how much training they had in the social and cultural characteristics of: (a) diverse racial and ethnic groups; (b) African Americans; and (c) African Americans of childbearing age. On question **2a,** a comparison of percentages at pre- and post-intervention revealed an upward shift in the Low Group from 41% to 58%, and a downward shift in the High Group from 58% to 42%. Examination of percentages for each of the 5 points on the scale revealed that 17 % of the group felt that their knowledge increased "a lot" (0% at pre- versus 17% at post-intervention on scale point 5). *Overall, the results suggested that chaplains gained information about the social and cultural characteristics of diverse racial and ethnic groups post-intervention.*

When examining changes in knowledge regarding social and cultural traditions of African Americans on question **2b,** at pre-intervention 61% of chaplains reported being in the Low Group. After training, the percentage dropped to 50. Conversely, 38% of chaplains in the High Group at pre-intervention increased to 50%. The shift downward for this group will be discussed elsewhere. *Overall, the results suggested positive movement in this area of cultural knowledge for the chaplains. Most participants requested to learn more.* One chaplain noted, for example: • "Big Eye opener to an area I never understood before. Want to learn more.*"* Another chaplain in the High Group indicated that: • "The brief training showed me how much I don't know—and how much I would like to know."

Question **2c** requested chaplains to describe their cultural knowledge specifically regarding African Americans of childbearing age. *At post-assessment 2 participants shifted their assertion of knowing "A lot" downward when asked specifically about childbearing*

age African Americans. The least knowledgeable group ("Not at all") seemed to benefit most during the training as 2 of the 3 chaplains in this group shifted to a higher point on the scale. Further, the chaplains seemed to be aware that they did not have extensive, or perhaps even adequate cultural knowledge of African Americans of childbearing age. It may be that their awareness was more acute after the training intervention.

Question **3** on the pre- and post-questionnaires asked chaplains to describe their knowledge about: a) health disparities among racial and ethnic groups; and b) the historical and contemporary impact of racism, bias, prejudice, and discrimination in health care including (1) various population groups in the U.S., and (2) African Americans. Data in Table 6**,** question **3a** suggests that some participants may have discovered that they miscalculated how much they knew about health disparities among racial and ethnic groups. One participant who knew "Nothing at all" seemed to have learned "A little" or "Somewhat" as a result of the resourcing intervention. A larger shift was observed in the "Somewhat" group who comprised 9% before the intervention, and 33% after the intervention.

Overall, *participants appeared to benefit from exposure to the brief statistical findings reported in literature about health disparities among various racial and ethnic groups via the training experience.* There was a pre/post intervention shift from 53% to 58% in the High Group, as shown in Table 6, question **3,** section **b,** number **1**. *The information was helpful, and motivated several chaplains to make comments such as the following:*

- "Helped me recognize how deeply embedded our implicit biases are."
- "I was especially aware of the comments from some of the other participants regarding …their lack of knowledge of people of color."

- "It has made me aware of ingrained teachings of bias and the privilege I have as a white person."

- "I …was unaware of prevalent biases in healthcare and social systems for African-Americans and the health issues they face."

- "It brought important conversations about race to the table. It also forced white folks to check their biases."

The chaplains requested more information about:

- "Cultural diversity in racial ethnic groups," and the

- "Historical impact of prejudices, bias & discrimination in health care experienced."

Table 6. Chaplains' Ratings for Knowledge of Healthcare Disparities among Racial and Ethnic Groups (Question 3)

3. Describe your knowledge of:

a. Health disparities experienced by diverse racial and ethnic groups

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	2	1	3	2	3	4	5	4	0	1	13	12
%:	**18**	**8**	**27**	**17**	**9**	**33**	**45**	**33**	**0**	**8**		

Group:	**Low**	**High**
Pre:	**54%**	**45%**
Post:	**58%**	**41%**

b. Historical and contemporary impact of racism, bias, prejudice, and discrimination in healthcare experienced by:

(1) Various population groups in the United States:

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	2	1	2	3	2	1	5	4	2	3	13	12
%:	**15**	**8**	**15**	**25**	**15**	**8**	**3**	**33**	**15**	**25**		

Group:	**Low**	**High**
Pre:	**45%**	**53%**

					Post:		**41%**		**58%**					
	(2) African Americans?													
	1		2		3		4		5					
	Not at all		A little		Somewhat		Quite a bit		A lot		Total N			
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post		
N:	2	1	0	3	3	0	6	5	2	3	13	12		
%:	**15**	**8**	**0**	**25**	**23**	**0**	**46**	**42**	**15**	**25**				
					Group:		**Low**		**High**					
					Pre:		**61%**		**38%**					
					Post:		**33%**		**67%**					

Continuing in Section B of the pre- and post-questionnaires with questions **4**, **5**, and **6**, chaplains were asked to describe their knowledge of health risks of African American females of childbearing age; common physical health problems among African American neonates; and knowledge of PNL among African Americans, respectively.

Study question **4** regarding chaplains' knowledge of health problems experienced by African American females of childbearing age revealed that although percentages in both the Low and High Groups were the same at pre- and post-intervention, *a considerable positive shift in knowledge occurred in this area, with only brief resourcing.* (see Table 7). This shift was seen by an examination of each Likert category and revealed that at pre-intervention 23% of the participants reported their training as "Not at all". Post-intervention this figure dropped to 8%. Pre-intervention for "A little" was 31% and post-intervention it was 17%. "Somewhat" pre was 38% and post was 67%--a large change in knowledge. The highest category, "A lot" remained at 0%. *Overall the didactic intervention was perceived as helpful for advancing the chaplains' knowledge of health risks for African American females of childbearing age based on their self-reports.* Chaplains made comments such as the following: • *"Statistical data provided helps one see even more clearly potential challenges."*

Table 7. Chaplains' Ratings for Knowledge of Health Risks among African American Females of Childbearing Age (Question 4)

4. Describe your knowledge of health risks experienced by African American females of childbearing age.

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	3	1	4	2	5	8	1	1	0	0	13	12
%:	**23**	**8**	**31**	**17**	**38**	**67**	**8**	**8**	**0**	**0**		

Group:	**Low**	**High**
Pre:	**92%**	**8%**
Post:	**92%**	**8%**

On question **5,** *a majority of respondents reported growth in their knowledge about common physical health problems among African American neonates*. As shown in Table 8, for the Low Group ratings declined from 5 to 2 participants in the "Not at all" category; increased from 3 to 4 in the "A little" category and from 4 to 6 in the "Somewhat" category. *Overall the reported change illuminated a trend in growth in knowledge on this topic within the Low Group. A chaplain wrote:*

- *"It made me aware of how high the infant mortality rate is for African Americans."*
- *"… [and of] physical health problems among African American neonates."*

Table 8. Chaplains' Ratings for Knowledge of Common Physical Health Problems among African American Neonates (Question 5)

5. Describe your knowledge of common physical health problems among African Americans neonates

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	5	2	3	4	4	6	1	0	0	0	13	12
%:	**38**	**8**	**23**	**25**	**31**	**50**	**8**	**0**	**0**	**0**		

Group:	**Low**	**High**
Pre:	**92%**	**8%**
Post:	**100%**	**0%**

Regarding question **6**, PNL among African Americans, while none of the chaplains reported having "A lot" of knowledge on this topic, at pre- to post-intervention the "Not at all" category declined from 3 to 1; the "A little" category from 6 to 3; and the "Somewhat" category increased from 2 to 6 which reflects a positive change of 35% (see Table 9). *The chaplains reported that the training resourcing in this area increased their knowledge.* One chaplain gained insight particularly from the frequency of critical care and loss in this group; i.e., • *"Statistics about loss & NICU frequency."*

Table 9. Chaplains' Ratings for Knowledge of Perinatal Loss among African Americans Pre and Post Training (Question 6)

6. Describe your knowledge of perinatal loss among African Americans.

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
N:	3	1	6	3	2	6	2	2	0	0	13	12
%:	**23**	**8**	**46**	**25**	**15**	**50**	**15**	**17**	**0**	**0**		

Group:	**Low**	**High**
Pre:	**84%**	**15%**
Post:	**83%**	**17%**

C. Spirituality and Healing Traditions

Inquiries in Section C, questions **7** and **8**, focused on a pre- and post-intervention assessment of chaplains' knowledge of spirituality and healing traditions in the African American community and their ability to create spiritual interventions in circumstances of PNL for African Americans.

Regarding question **7**, the chaplains' basic knowledge of different religious traditions, common beliefs and practices in the African American community about grief and loss, 7 respondents who initially were in "A little", "Somewhat", and "Quite a bit" categories shifted to higher ratings of their knowledge post-intervention. All (N=4) of the

participants who assessed their knowledge as "A little" rated themselves upward from that category at post-assessment. The "Somewhat" category increased by 15%. The "Quite a bit" category increased by 2 or 15%, and the "Quite a bit" group increased by 1, totaling 25% (vs 15%) at post-test. Overall, only 1 respondent reported having no knowledge of the religious traditions and common beliefs about grief and loss in African American communities. Additionally, 1 respondent at pre- and post-intervention reported having "A lot" of knowledge. At post-intervention, 1 participant remained in the "Not at all" category, and 1 in the "A lot" category (see Table 10).

Table 10. Chaplains' Ratings for Knowledge of Different Religious Traditions, Beliefs and Practices in African Americans Regarding Grief and Loss (Question 7)

7. Do you have basic knowledge of different religious traditions and common beliefs and practices in the African American Community?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	1	1	4	0	5	7	2	3	1	1	13	12
%:	**8**	**8**	**31**	**0**	**38**	**58**	**15**	**25**	**8**	**8**		

Group:	**Low**	**High**
Pre:	**77%**	**23%**
Post:	**66%**	**33%**

The intervention experience prompted one participant to note the need for more resourcing in:

- *"Religious and traditions and beliefs, practices in the American community regarding grief loss"*

On the question (**8**) of the chaplains' ability to create spiritual interventions for African Americans relevant to PNL, the strongest trend reported by respondents suggests that a majority experienced a positive growth in knowledge. *Post-intervention, respondents*

felt better prepared to create spiritual interventions for African Americans relevant to PNL.

"Not at all" and "A little" raters decreased by 2 respondents in each category. Those who felt "Somewhat" prepared changed from 2 to 7, from 17% to 58% (see Table 11).

Table 11. Chaplains' Ratings of Ability to Create Spiritual Interventions for African Americans Relevant to PNL (Question 8)

8. Can you create spiritual interventions for this population relevant to perinatal loss?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	3	1	3	1	2	7	4	2	0	1	12	12
%:	**25**	**8**	**25**	**8**	**17**	**58**	**33**	**17**	**0**	**8**		

Group:	**Low**	**High**
Pre:	**67%**	**33%**
Post:	**74%**	**25%**

D. Attitudes

Questions in section D were intended to assess chaplains' attitudes about the importance of socio-cultural issues in patient interactions; personal awareness of stereotypes, prejudice, and biases; importance of training in cultural diversity; and comfort in providing spiritual care to African American families.

Question **9** revealed a consensus among respondents that socio-cultural variables are important in interactions with patients. At pre-intervention 92% held this belief, and at post-intervention 100% indicated the importance of this area in care with patients. With such a high value, chaplaincy training relevant to socio-cultural domains bares attention in healthcare chaplaincy work and in particular as concerns this study, to African American women and families experiencing PNL (see Table 12).

Table 12. Chaplains' Ratings of the Importance of Socio-cultural Issues in Interactions with Patients (Question 9)

9. *How important do you believe sociocultural issues are in your interactions with*

patients?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	1	1	4	0	5	7	2	3	1	1	13	12
%:	**8**	**8**	**31**	**0**	**38**	**58**	**15**	**25**	**8**	**8**		

Group:	**Low**	**High**
Pre:	**77%**	**23%**
Post:	**66%**	**33%**

Questions **10a**, **b** and **c** investigated chaplains' awareness of their own racial cultural identity, stereotypes and prejudices. The pre- and post-questionnaire responses were similar on the question (**10a**) of racial, ethnic and cultural awareness. The respondents reported 84% consensus at pre- and post-intervention. Question **10b** results revealed that at pre-intervention most respondents felt they were "Quite a bit" (67%) to "A lot" (25%) aware of racial, ethnic or cultural stereotypes (Total N=92%). However, at post-intervention this overall figure declined to 83%. "Quite a bit" responses declined by 4, "A lot" increased by 3, and "Somewhat" increased from 0 to 2 respondents. Results are summarized in Table 13. The results may suggest that the respondents were open to study the question of race and biases. We may begin to examine, explore in more depth, and even challenge our own view in these areas, particularly when offered the opportunity to do so constructively. Regarding chaplains' awareness of their own biases and prejudices, question **10c,** most respondents rated their awareness in these areas similarly at pre- and post-intervention. One respondent reported growth from "Quite a bit" before to "A lot" after the intervention.

Table 13. Chaplains' Ratings of Self-Awareness Regarding Racial, Ethnic and Cultural Identity, Stereotypes, and Prejudices (Question 10)

10. How aware are you of your own:

a. Racial, ethnic or cultural identity?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	0	0	0	0	2	2	5	4	5	6	12	12
%:	**0**	**0**	**0**	**0**	**16**	**16**	**42**	**33**	**42**	**50**		

Group:	**Low**	**High**
Pre:	**16%**	**84%**
Post:	**16%**	**84%**

b. Racial, ethnic or cultural stereotypes?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	0	0	1	0	0	2	8	4	3	6	12	12
%:	**0**	**0**	**8**	**0**	**0**	**16**	**67**	**33**	**25**	**50**		

Group:	**Low**	**High**
Pre:	**8%**	**92%**
Post:	**16%**	**83%**

c. Biases and prejudices?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	0	0	1	0	1	1	6	6	4	5	12	12
%:	**0**	**0**	**8**	**0**	**8**	**8**	**50**	**50**	**33**	**42**		

Group:	**Low**	**High**
Pre:	**16%**	**83%**
Post:	**8%**	**92%**

On question **11** chaplains were asked to indicate how important they felt it was for them to receive resourcing in cultural diversity and/or multicultural health care. All respondents reported that it was important to be trained in these areas as shown in Table 14.

Table 14. Chaplains' Ratings of the Importance of Resourcing in Cultural Diversity and/or Multicultural Healthcare (Question 11)

11. ***How important do you feel it is for chaplains to receive training in cultural diversity and/or multicultural healthcare?***

1	2	3	4	5

	Not at all		A little		Somewhat		Quite a bit		A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	0	0	0	0	0	0	0	2	12	10	13	12
%:	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17**	**100**	**83**		

Group:	**Low**	**High**
Pre:	**0%**	**100%**
Post:	**0%**	**100%**

Question **12** inquired about chaplains' comfort in spiritual care with African American families. Chaplains who rated their feelings of comfort as "A little" and "Somewhat" at pre-training, rated their comfort level as "Quite a bit" and "A lot" post-intervention.16% reported feeling uncomfortable at pre-training in the 1-3 categories. At post-training 100% were in the 4-5 categories. *Chaplains felt that resourcing was helpful. Most participants expressed a wish for further resourcing.* Results are summarized in Table 15.

Table 15. Chaplains' Comfort with Providing Spiritual Care to African American Families and/or Multicultural Healthcare (Question 12)

12. How comfortable are you with providing spiritual care to African American families?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	0	0	1	0	1	0	6	6	4	6	12	12
%:	**0**	**0**	**8**	**0**	**8**	**0**	**50**	**50**	**33**	**50**		

Group:	**Low**	**High**
Pre:	**16%**	**83%**
Post:	**0%**	**100%**

E. Skills Regarding Perinatal Loss Among African American Patients

Section E of the assessment focused on chaplains' skills for providing spiritual care with African American women experiencing PNL. This section included questions **13** (skills in identifying appropriate interventions) and **14a through c**, which examined skill

set nuances relative to the African American PNL patient and family. Starting with question **13**, in response to the question of chaplains' self-rated skills in identifying appropriate interventions for African American women experiencing PNL, 59% of respondents rated themselves in categories 1-3 while 41% were in categories 4-5 at pre-training. At post-intervention, the changes were 66% and 33%, respectively. The greatest shift in self-reports of competence was in the "Somewhat" category, initially at 17%, and post-intervention at 58%. While the total percentages in categories 1-3 and 4-5 appear to suggest a loss in knowledge, the number of individuals in the" Not at all" group at pre-intervention was 0 at post-intervention; 2 at pre-intervention was 1 at post-intervention in "A little"; 2 at pre-intervention was 7 at post-intervention in the "Somewhat" group. Results are summarized in Table 16.

Table 16. Chaplains' Ratings of Skills in Identifying Appropriate Interventions for African American Women Experiencing PNL (Question 13)

13. How skilled are you in identifying appropriate interventions for African American women experiencing PNL?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	3	0	2	1	2	7	4	3	1	1	12	12
%:	**25**	**0**	**17**	**8**	**17**	**58**	**33**	**25**	**8**	**8**		

Group:	**Low**	**High**
Pre:	**59%**	**41%**
Post:	**66%**	**33%**

On self-rated skills assessment in caring for African American mothers who have experienced PNL (**14a**), *although the overall percentages of the Low and High Groups did not change, there was a notable shift in the chaplains' feelings of increased skills at post assessment.* Approximately 66% of chaplains reported feeling "Not at all" to "Somewhat"

skilled in this area. Chaplains demonstrated a shift upward to "Somewhat" at 58% after the intervention vs 33% in this category before the intervention. Please refer to Table 17.

There was a remarkable shift in knowledge and skills post-intervention for chaplains' responses relative to their self-rated skills in caring for African American family members and significant others in the circumstance of PNL (**14b**). At least 3 participants who reported "A little" skill at pre-training moved to the next higher category of "Somewhat" more skilled (see Table 17).

Regarding chaplains' skills for interpreting different cultural expressions of pain, distress and suffering in African American mothers of PNL (**14c**), the results are as follows. A majority of chaplains rated themselves in categories 1-3 for interpreting negative emotions pre-resourcing. The results changed to improved feelings of competence at post-intervention assessment. The 1 respondent in the "Not at all" category shifted higher on the scale at post-intervention. The 4 participants in "A little", was only 1 chaplain post-intervention. The 3 participants in the "Somewhat" category shifted to 8 participants post-intervention. However, the 5 chaplains in "Quite a bit" category shifted down to 3 at post-assessment, where perhaps some respondents over-estimated their skill level and were enlightened to this during training. *Overall, the results suggest that even brief training seems beneficial for chaplains who work with the target population.* Please refer to Table 17.

As far as the chaplains' self-rated skills for establishing trust with African American women experiencing PNL (**14d**) are concerned, *the results suggest an advance in learning for participants in the* "Somewhat" knowledgeable category post-intervention from "A little" (N=4) to "Somewhat" by 2 respondents (see Table 17). *A majority of*

chaplains felt that the brief resourcing was beneficial. Their call for more training in caring for African Americans impacted by PNL is reflected in the comments in Table 18, remarks that provided insights for future resourcing.

Table 17. Chaplains' Self-Ratings of Skills in Providing Spiritual Care with African Americans Who Experience PNL (Question 14)

14. ***How skilled are you in:***

a. Caring for the mothers?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	2	0	2	1	4	7	3	2	1	2	12	12
%:	**17**	**0**	**17**	**8**	**33**	**58**	**25**	**17**	**8**	**17**		

Group:	**Low**	**High**
Pre:	**67%**	**33%**
Post:	**66 %**	**34%**

Table 17 Continued. Chaplains' Self-Ratings of Skills in Providing Spiritual Care with African Americans Who Experience PNL (Question 14)

b. Caring for the family members/significant others?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	1	1	4	1	3	7	3	3	1	1	12	12
%:	**8**	**8**	**33**	**8**	**25**	**58**	**25**	**25**	**8**	**8**		

Group:	**Low**	**High**
Pre:	**66%**	**33%**
Post:	**66%**	**33%**

c. Interpreting cultural expressions of pain/distress, suffering in mothers?

	1 Not at all		2 A little		3 Somewhat		4 Quite a bit		5 A lot		Total N	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre	Post
N:	1	0	4	1	3	8	5	3	0	0	12	12
%:	**8**	**0**	**31**	**8**	**23**	**67**	**38**	**25**	**0**	**0**		

Group:	**Low**	**High**
Pre:	**62%**	**38%**
Post:	**75%**	**25%**

d. Establishing trust with the mothers?

	1		2		3		4		5		
	Not at all		A little		Somewhat		Quite a bit		A lot		Total N
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	Pre Post
N:	0	0	4	0	3	8	4	2	2	2	12 12
%:	**0**	**0**	**31**	**0**	**23**	**67**	**31**	**17**	**15**	**17**	

Group:	**Low**	**High**
Pre:	**54%**	**46%**
Post:	**67%**	**34%**

F. Other

Table 18. Chaplains' Comments about Subjects of Interest for Future Training in the Spiritual Care of the African American PNL Patient and Significant Others. (Question 15, Part 1)

- *"Religious and traditions and beliefs, practices in the American community regarding grief loss*"
- *"Resources for training faith communities to better care for African American Women experiencing perinatal loss."*
- *"...how to establish trust"*
- *"I really would like training about how African American Women recover and heal after a perinatal loss. What is being done after the[y] leave the hospital."*
- *"What help is available for them in light of cultural biases to professional counseling."*
- *"The best way, as a white person, to meet an African-American woman in grief who has experienced a PNL.*
- *"...more direct examples of care"*
- *"I will also like to dive deeper with African males and grief/PNL"*
- *"...physical health problems among African American neonates."*
- *" What ways does AA perinatal loss differs among others/various population groups."*

- *"Statistics of all side by side and how I can better improve my quality of care to AA/s experiencing perinatal loss."*
- *"How does an African American mother or father experiencing perinatal loss think or feel when a white chaplain enters the room?"*
- *"More ways to provide intervention and care"*

On the first question (**15**) of 3 questions in Section F (questions **15, 16,** and **17**) of the post-intervention questionnaire, chaplains were asked if they felt that the resourcing better prepared them for providing spiritual care and support to African American women experiencing PNL. *There was unanimous (100%) agreement among the chaplains that the resourcing was helpful for the intended purpose.* The chaplains were then asked to identify at least two ways in which the brief resourcing was helpful. Their verbatim responses are recorded in Table 19. *The responses were wide-ranging and did not readily fit into neat categories of thought. Indeed, they were thought provoking about the interplay or interaction between race, culture and spiritual healthcare.*

Table 19. Chaplains' Comments: Benefits of Training (Question 15, Part 2)

- "African American are communal – they connected w/ each other."
- "…'Seeing the person' exercize was valuable. Seeing our biasis and thoughts about a person based on first glance was eye opening."
- "Discussion on our own experience with racism and diversity was helpful in order to gain personal insight. (The safe environment to share stories was important)"
- "Statistical data provided helps one see even more clearly potential challenges."
- "Identification of patterns of behavior common in African American culture when dealing with grief (i.e., "I just need to be strong")."
- "Bringing up the difference between awareness and knowledge."

- "The idea of asking yourself how is this case like all other cases, like some cases, like no other case."

- "By paying closer attention to the patient and not what the nurses tell me. What do I see and listening to the Holy Spirit."

Table 19 - Continued. Chaplains' Comments: How was the Training Helpful? (Question 15, Part 2)

- "Listen for what was not being said in the room."

- "I was especially aware of the comments from some of the other participants regarding their lack of knowledge of people of color."

- "Broadened view on causes of PNL's in AA Community."

- "Statistical Data on this issue enlightening."

- "good cultural awareness"

- "helpful thoughts about "companioning"—I liked this image."

- "It has made me aware of ingrained teachings of bias and the privilege I have as a white person."

- "It made me aware of how high the infant mortality rate is for African Americans."

- " I …was unaware of prevalent biases in healthcare and social systems for African-Americans and the health issues they face."

- "It brought important conversations about race to the table. It also forced white folk to check their biases."

- "It brought awareness of race, PNL's, and different expressions of grieving."

- "Helped me recognize how deeply embedded our implicit *biases are."*
- "Ma[de] me acknowledge my own bias and how much the injustice of the health care system forces me to deny my own identity."

- "I was unaware of the frequency of NICU babies among African Americans."

- "I was acutely awoken to the reactions of African American men and loss."

- Illuminating an area I never was exposed to before. Will help in my Chaplaincy & caregiving & pastoral presence."

- "Big Eye opener to an area I never understood before. Want to learn more"

Table 19 - Continued. Chaplains' Comments: How was the Training Helpful? (Question 15, Part 2)

- "I enjoyed this topic and wish to learn more in the future. Thank you for teaching us!"

- "Thank you for sharing this information with us. More of this type of Cultural Awareness is needed."

- "Excellent and enjoyable"

- "Mishella, you Rock! Great job!"

Summary

In this chapter, the results of a resourcing intervention with chaplains that focused on their reports of cultural competency in spiritual care with African American women and family's experiencing perinatal loss (PNL) were discussed. A curriculum was developed by the researcher and was the primary tool that was used to convey information about grief responses in African American women, their families and communities in general, and particularly as they relate to PNL. The researcher developed pre- and post-intervention questionnaires that were completed by the chaplains. The questionnaires aided in the analyses of the resourcing intervention from the chaplains' perspectives, and provided important information for future resourcing for chaplains regarding culturally informed spiritual care with African American women and families experiencing PNL. Several questions on the pre- and post-intervention questionnaires contained 5-point Likert Scale format and was a means to quantify chaplains' responses to research questions, compare pre- and post-intervention results, and search for trends in the chaplains' responses. The

post-intervention questionnaire also provided opportunities for chaplains to give their own comments to some of the questions. The chaplains' comments were helpful, particularly for informing future research and resourcing with chaplains about culturally competent spiritual care with African American women and families experiencing PNL.

Responses on the pre- and post-questionnaires were analyzed in 5 sections with overarching results as follows: Section 1 was used to obtain demographic information about the chaplain sample. The chaplain group was small (N= 12) at post-resourcing, and chaplains were not randomly selected from the larger population of chaplains. The chaplains were not uniform in their training and experience. The chaplain sample was racially/ethnically diverse, and contained an equal number of males and females who were nearly equal in age range. The sample selection method and small size contributed to the need to explore trends in the chaplain's responses to the resourcing intervention, rather than testing to determine if there were statistically significant differences between chaplains' responses when compared before and after the resourcing intervention.

The pre- and post-resourcing intervention results indicated the following trends. Regarding select **socio-cultural knowledge**, before the resourcing, 3/4ths of the chaplains reported that they had "Quite a bit" to "A lot" of training, acquired primarily in conferences, workshops, and classes versus other setting (e.g., college, job, church). After resourcing, the results suggested that chaplains acquired new information about the social and cultural characteristics of diverse racial and ethnic groups, and about social and cultural traditions of African Americans. An interesting observation was that chaplains who felt that they already knew "Quite a bit" to "A lot" about African American women of

childbearing age before resourcing, acknowledged that they gained new information in this area and they wanted to know more after the intervention.

Further, a majority of chaplains reported that they gained new information from their brief exposure to statistics reported in literature about health disparities among various racial and ethnic groups. Also following resourcing, there was a sizeable shift in knowledge about the impact of racism, bias, prejudice and discrimination in healthcare for African Americans. The data analyses suggested that most of the chaplains felt the information was particularly enlightening, informative, and useful for their patient care work. They requested more resourcing in that area.

A majority (100%) of chaplains reported growth in their knowledge about common physical health problems among African American neonates. They also learned about the high infant mortality rate for African Americans.

In the areas of **spirituality and healing traditions in the African American community, and chaplains' abilities to create spiritual interventions in circumstances of PNL for African Americans**, most chaplains reported being "a little" to "somewhat" knowledgeable at pre-intervention; indicated that resourcing was helpful; and rated themselves at higher points on the Likert at post-intervention. However, one chaplain noted the need for more resourcing, and another chaplain reported not having any knowledge this subject matter either both before or after the resourcing intervention. Following resourcing, a majority of chaplains reported an increase in knowledge about how to create spiritual interventions for African Americans relevant to PNL.

Finally, responses from chaplains about their **attitudes** in the following 4 areas were analyzed at pre- and post-resourcing and revealed the following data trends. (1) In

analyzing the *importance of social-cultural variables*, the chaplains reported that social-cultural variables are important in interactions with patients with 92% consensus at pre-intervention and 100% consensus at post-intervention. The results suggested that *the chaplains placed a high value on chaplaincy resourcing relevant to socio-cultural domains in healthcare chaplaincy work in general, and particularly on African American women and families experiencing PNL.* (2) The analyses also suggested that *the chaplains were receptive to becoming more aware of their own racial, ethnic or cultural identity stereotypes*; and that they might have overestimated their awareness in this area, to some extent, prior to the resourcing intervention. (3) *The chaplains' personal awareness of their own stereotypes, prejudice, and biases* was similar at pre/post assessment except for one chaplain who reported an increased level of awareness. *The chaplains'* responses suggested that resourcing in cultural diversity is important. (4) Chaplains' ratings of their *skills in identifying appropriate interventions for African American women experiencing PNL* showed a positive shift at post- assessment.

A majority of chaplains rated themselves as having improved skills in their abilities to interpret different cultural expressions of distress and suffering in African American mothers of PNL; and those who initially reported having only "a little" knowledge about how to establish trust with the African American mothers of PNL, reported that they felt "somewhat" more skilled after the resourcing experience. Overall, all of the chaplains reported that the curricular intervention was beneficial to their work with the target patients/families. They identified ways in which the training was personally helpful, requested more resourcing in "cultural awareness" and spiritual care, and offered

suggestions for specific content that should be the focus of future resourcing about African Americans women and families who experience PNL.

Chapter 5

Discussion

This chapter summarizes (1) the study's inspiration, purpose, and specific content that was addressed; (2) a discussion of the findings; (3) implications of the results for practice; (4) limitations of the research and recommendations for further research; and (5) the conclusion. The purpose for this chapter is to expand upon the concepts associated with the chaplaincy work of providing spiritual care to African American women and families experiencing perinatal loss (PNL), and promote understanding of the need for more in depth intercultural training resourcing for chaplains who care for them.

The inspiration for the study was of personal and professional importance to me. I am an African American woman who experienced two perinatal losses. I was not offered spiritual care by chaplains during either of my perinatal losses, or support from my local church. I was invited by my pastor, family and friends to "get over" both losses quickly. However, similar to the perspective of others mentioned in Chapter 2 (i.e., Rando, 1989; Leon, 1990), my experience may not have been for lack of real concern among chaplains or ministers, but perhaps due to a lack of training resourcing in providing appropriate care to this group of women in spiritual distress.

Another personal inspiration for this study stemmed from my personal interactions in receiving spiritual care due to my daughter's battle with lupus. My daughter is often hospitalized, with a minimum stay of one week at best. My personal

interactions with the hospital chaplains made me curious about why most of them often appeared concerned but disconnected. Although my daughter's grief was not a result of PNL, it was still applicable to this study as it relates to African American women and grief responses. The reader may recall the National Center for Education and Child Health (ncemch.org) article regarding African American women's grief responses and Hunter & Ramsey's (2005) assertions about the importance of establishing trust. Further, Watkins Ali (1999) pointed out that the key to establishing trust with African American women involves (a) tender and solicitous concern, (b) genuine communication and empathy, (c) concern that generates a clear intention of advocacy and (d) educating oneself about the cultural context before attempting to offer guidance and/or advice.

The second inspiration for the research was professional. I am responsible for helping to mentor and train CPE students. I believe it is a fair assumption that the chaplains' spiritual assessment of patients could be tainted by their feelings, attitudes, values, and assumptions, resulting in what I have coined as "Surface Level Spiritual Care (SLSC)"; that is, spiritual care without basic knowledge of the person's culture, religion or grief responses. I am also aware that inviting chaplains to examine things within themselves that some may define as racist, sexist, homophobic, or in some other way incongruent with the chaplain's ability to companion with a patient is ambitious, but necessary for optimally supporting patients from diverse backgrounds.

Further, I am aware of the danger of surface level spiritual care and believe that it is a real threat when it comes to caring for African American women experiencing PNL. I believe that self-awareness among spiritual care providers may open a pathway of

communication that will help them identify influences that may prevent them from conducting a culturally competent spiritual distress assessment and response.

The purpose of this study was to assess the pertinence and effectiveness of an education intervention intended to enhance a cohort of chaplains' cultural perspective of loss and grief as relates to the care of African American women experiencing PNL and their families, an area where relevant literature is practically nonexistent, yet where the importance of recognizing the cultural perspective of loss and grief is well supported (e.g., Butler 2012; Stroebe, 1998; Walker, 2010; Evans, 2008). In doing so, I hoped that the chaplains would be better prepared to offer culturally competent care to the study's target group of patients. In effort to achieve this purpose, I developed a curriculum that consisted of three modules (see Chapter 3 for an outline of the training Modules). Module 1 focused on Intercultural Competency in Spiritual Care, and was created to enhance chaplains' knowledge in basic theory of intercultural care; cultural perspectives of PNL among African American females experiencing PNL; and cultural influences on bereavement among African Americans. Module 2 provided a brief historical perspective of factors that create barriers to spiritual care with this population, including a perspective of healthcare from slavery to present day among African Americans; healthcare disparities between African Americans and other ethnicities; African American infant mortality rates in comparison to other groups; racial disparities in healthcare for African American females versus other females; and challenges for African American women during their childbearing years. Finally, Module 3 on Interpersonal-Resonance Companioning was intended to increase knowledge and understanding for delivering culturally competent care where recipients of the care felt spiritually supported during PNL; where chaplains were

enabled to enhance their identification with African American patients and establish trust, were taught helpful and harmful things that chaplains do or say, and learned theological theories about loss. Chapter 3 provides additional details about the resourcing intervention.

Pre- and post-training questionnaires were developed to assess the usefulness of the resourcing intervention. A full description of how the questionnaires were developed is contained in Chapter 3 and later considered in this discussion. A total of 13 chaplains participated in the resourcing intervention and 12 completed pre- and post-intervention questionnaires. The sample was one of convenience and included a non-randomly selected group of CPE Residents and Interns, and Staff Chaplains. The research design was not intended for hypothesis testing per se. Exploratory Data Analysis procedures were used to gather and analyze information about the usefulness of resourcing for cultural competency and companioning, and to identify patterns and trends in the data that informed and pointed to areas in need of further study. The results were both qualitative and quantitative. Chapter 3 further describes how the results were analyzed.

Discussion of Results

Based on the chaplains' self-reports at pre- and post-intervention, this study examined the following questions:

1. Will chaplains report an increase in culturally relevant knowledge about African American women who experience PNL?
    a. African American women of childbearing age
    b. Health issues and medical care among African American women and PNL
    c. How PNL is perceived and managed in the African American community
    d. Experiences of African American women in the medical care system in relationship

to PNL

2. Do chaplains report that the resourcing increased their skills in companioning with African American women experiencing PNL?
3. Do the chaplains report that intercultural resourcing in this area is needed?
4. Will the intervention (see Chapter 3 for outline) generate ideas for further directions in training that may enhance chaplains' spiritual care with African American women experiencing PNL?

In vivo observations during the intervention, and both oral and written comments from participants revealed remarkably positive responses to learning about cultural components of patient care with the patient population. Results relevant to the research questions will follow a brief review of the questionnaires.

Questionnaires: The results from two questionnaires (see Chapter 4), one given to the chaplain subjects before I intervened with a curriculum to heighten their knowledge of African American women experiencing PNL, and a second one given following the training, were used to explore potential benefits of training intervention for the chaplains. The pre- and post-resourcing intervention questionnaires were similar in content. However, the post-intervention questionnaire did not reassess questions **1**, **1a**, **1b, 1c,** and **1d** (i.e., how much training in cultural diversity the chaplains had) as found in the pre-intervention questionnaire). Further, the pre-intervention questionnaire did not contain questions **15**, **16**, and **17** related to the overall perception of the helpfulness of training, formatted "yes/no"; recommendations for future trainings; and comments, respectively. Overall, there were positive trends for all of the study questions referenced above, and additional information of value to me.

Regarding study question #1: “Will chaplains report an increase in culturally relevant knowledge about African American women who experience PNL?” On the questionnaire, question **2a**, **2b** and **2c** address this inquiry. On questions **2a**, **2b** and **2c,** a comparison of percentages at pre- and post-intervention suggested that chaplains acquired new information about the social and cultural characteristics of diverse racial and ethnic groups during the training intervention. Most of the chaplains gave qualitative statements, variously acknowledging their “surprise”, “enlightenment”, “privilege as a white American” and expressions of the need to know more about the socio-cultural aspects bearing on those with whom they companion in grief and sorrow. Question **3** results reveal that overall, chaplains appeared to benefit from exposure to the brief statistical findings reported in literature (Norris 2011) about health disparities among various racial and ethnic groups that they received via the resourcing experience. As previously mentioned in Chapter 4, following the resourcing intervention, there was a sizeable shift in knowledge about healthcare for African Americans and the impact of racism, bias, prejudice, and discrimination in health care. The data suggests that most chaplains felt the information was helpful.

The results of question **4** on the questionnaire regarding chaplains’ knowledge of health problems experienced by African American females of childbearing age revealed a considerable positive shift in knowledge after exposure to literature findings (Ubri and Artiga, "Disparities in Health and Health Care”) presented in Chapter 2. Overall the resourcing was perceived as helpful for advancing the chaplains’ knowledge of health risks for African American females of childbearing age based on their self-reports.

On questions **5** and **6**, a majority of respondents reported increased knowledge about common physical health problems among African American neonates and perinatal loss among African Americans. All of the chaplains (100%) reported change, illuminating a positive trend of growth in knowledge on these topics.

Inquiries for questions **7** and **8**, focused on assessment of chaplains' knowledge of spirituality and healing traditions in the African American community and their ability to create spiritual interventions in circumstances of PNL for African Americans. Only 1 respondent reported that she/he did not acquire any knowledge about the religious traditions and common beliefs about grief and loss in African American communities after the resourcing experience; again pointing to the benefits of training. Regarding chaplains' skills for interpreting different cultural expressions of pain, distress and suffering in African American mothers of PNL (**14c**), the results suggest that even brief training resourcing seems beneficial for chaplains who work with the target population.

As pertains to study question #2: "Do chaplains report that the training increased their skills in companioning with African American women experiencing PNL?", the results of their self-rated skills assessment (**14a**) suggest that there was a notable shift in the chaplains' assertions of having increased their companioning skills at post-intervention, even though the overall percentages for the Low and High groups did not change. Approximately two-thirds or 66% of chaplains reported feeling "Not at all" to "Somewhat" skilled in this area before the intervention. Chaplains demonstrated a shift upward to "Somewhat" at 58% after resourcing versus 33% in this category before the resourcing intervention.

Chaplains reported a remarkable gain in knowledge and skills in caring for African American family members and significant others in the circumstance of PNL (**14b**), post-intervention. At least 3 participants who reported "A little" skill at pre-intervention moved to the next higher category of "Somewhat" more skilled.

As far as the chaplains' self-rated skills for establishing trust with African American women experiencing PNL (**14d**) are concerned, the results suggest an advance in learning for participants in the "Somewhat" knowledgeable category post-resourcing from "A little" (N=4) to "Somewhat" by 2 respondents. A majority of chaplains indicated that the brief resourcing was beneficial. Their call for more resourcing in caring for African Americans impacted by PNL is reflected in the comments in Table 18, remarks that provided insights for future training.

On question **15** of the post-questionnaire, chaplains were asked if they felt that the resourcing better prepared them for providing spiritual care and support to African American women experiencing PNL. There was unanimous (100%) agreement among the 6 male and 6 female chaplains that the resourcing was helpful for the intended purposes.

Question **12** asked chaplains to assess their comfort in spiritual care with African American families. Most gratifying was the trend in data for chaplains who rated their feelings of comfort as "A little" and "Somewhat" at pre-intervention, to report and increase in their comfort in spiritual care with the families to the higher level "Quite a bit" and "A lot" post-intervention. Sixteen percent reported feeling uncomfortable at pre-intervention in the 1-3 categories. At post-intervention 100% were in the 4-5 categories. Chaplains reported that resourcing was helpful and expressed a wish for further training resourcing.

On question **13**, in response to the question of chaplains' self-rated skills in identifying appropriate interventions for African American women experiencing PNL, 59% of respondents rated themselves in categories 1-3 while 41% were in categories 4-5 at pre-training. Post-training, the changes were 66% and 33%, respectively. The greatest shift in self-reports of competence was in the "Somewhat" category, initially at 17%, and post-intervention at 58%. While the total percentages in categories 1-3 and 4-5 appear to suggest a loss in knowledge, the number of individuals in the "Not at all" group at pre-intervention was 0 at post-intervention; 2 at pre- was 1 at post in "A little"; 2 at pre- was 7 at post in the "Somewhat" group.

Study question #3, "Do the chaplains report that training in this area is needed?" was addressed in question **11** where chaplains were asked to indicate how important they felt it was for them to receive training resourcing in cultural diversity and/or multicultural healthcare. All (100%) respondents reported that it was important to be trained in this area at pre- and post-intervention. Interestingly, several chaplains had no training in this regard.

Finally, study question #4 investigated whether the resourcing experience generated ideas for improvements and/or further directions in resourcing that may enhance chaplains' spiritual care with African American women experiencing PNL. On question **16**, chaplains were asked to identify at least two ways in which the brief resourcing was helpful. Their verbatim responses are recorded in Table 19. The responses were wide-ranging and did not readily fit into neat categories of thought. Indeed, they were thought provoking about the interplay among race, culture and spiritual healthcare, and they were of great value for further research and training. For this question and in the comments

offered in question **17**, the chaplains made a resounding call for more research, and expressed appreciation for this resourcing experience.

While not directly bearing on the research questions, a few other trends are noteworthy:

1. *Results from question* **1**, assessing how much training in cultural diversity the chaplains had acquired overall, revealed that over half of them indicated that his/her knowledge was acquired in conferences/workshops/classes versus in college, on the job/church/faculty member, or by other means. The reader should recall the theoretical foundation of this study that was based on Dr. Lartey's (2003, p. 69) emphasis on an intercultural approach to spiritual care where the chaplains would possess knowledge to facilitate his/her being at one with those who are the recipients of spiritual care. Responses to Question **9** revealed a consensus among respondents that socio-cultural variables are important in interactions with patients. At pre-resourcing 92% held this belief, and at post-resourcing 100% indicated the importance of knowledge in this area in care with patients. It is interesting to note however, that while nearly all of the chaplains felt that knowledge of socio-cultural variables are important in their work, most of them did not have such knowledge. With training in this area, all chaplains classified this knowledge as important in their interactions with patients. Further, for this group of chaplains, the acquisition of culturally diverse knowledge did not come through their college curriculum. This is particularly interesting to me as the study contained chaplains as young as 24 years, in an era where many liberal arts colleges offer courses in multiculturalism. If not through college, it seems that knowledge of culture must be individually garnered through the initiative and/or life experience(s) of the chaplain. Therefore, the results raise the question

of whether ministerial education in Liberal Arts colleges and universities should include multicultural curricula. If not, should this be a requirement for ministers who may provide spiritual care with multi-cultures?

2. The pre- and post-questionnaire responses were similar on question **10a** regarding the chaplains' awareness of their own race, ethnic or cultural identity, **10b** stereotypes and **10c** biases/prejudices. The chaplains reported 84% consensus at pre- and post-resourcing. Question 10b results revealed that at pre-resourcing most respondents felt that they were "Quite a bit" (67%) to "A lot" (25%) aware of their own racial, ethnic or cultural stereotypes (Total N=92%). However, at post-intervention this overall figure declined to 83%. "Quite a bit" responses declined by 4, "A lot" increased by 3, and "Somewhat" increased from 0 to 2 respondents. This finding is particularly interesting and reflects a pattern for chaplains who initially reported the higher to highest levels of cultural awareness pre-intervention. Ratings for this group shifted downward on several questions at post-intervention, while the chaplains with lower ratings at pre-intervention tended to shift to higher categories on the Likert Scale. This may suggest that the chaplains who rated themselves at the higher to highest end of the Likert (categories 4 and 5) at pre-resourcing, came to understand that they were not as knowledgeable as they initially believed they were following the resourcing intervention; i.e., that they did not know what they did not know.

3. On Question **10c** regarding chaplains' awareness of their own biases and prejudices, most respondents rated their awareness in these areas similarly at pre- and post-intervention. One chaplain reported change from "Quite a bit" before to "A lot" after the resourcing. This question may warrant further study.

Limitations of the Study

The scope and limitations of the study were examined through the lens of studying the connection between intercultural knowledge and awareness of chaplains caring for African American women experiencing PNL. The research included training about cultural barriers to spiritual care for African American women experiencing PNL. This research will inform the content of a training resourcing program for chaplains and CPE student chaplains working as spiritual care responders with this patient population at Northside Hospital, Atlanta. However, the study was subject to the following limitations:

1. Scarce extant resource literature relevant to this project.
2. Training intervention was brief.
4. Assessment Instrumentation was limited.
5 Sample size was not optimal for reliably delineating finer changes on some dimensions.

Scarcity of Literature: There was a paucity of literature relevant to effective spiritual care techniques for chaplains who provide care for women experiencing PNL in general, and for the especially vulnerable subset of African American women within this patient population in particular. Therefore, it was hard to establish a robust theoretical dialogue with other scholars and theologians who have produced writing and research directly related to this subject. One reason for this is that research requires both intellectual curiosity by someone in a position to do it, and the resources to fund it. The daily press of other concerns in the lives of African American women and the relatively small amount of money that is dedicated to their wellness in medical, psychosocial, and spiritual circles compound the delimitations of this project pursuit.

The Training Intervention: The resourcing intervention's length and depth was time-limited and very brief. Therefore, areas of interest to the research participants were not covered in depth and often raised sometimes new, compelling questions that could not readily be explored. Participation and interest was high among the chaplain sample. Further, there was considerable enthusiasm for participants' sharing around a variety of themes relevant to chaplaincy services in the context of culture topics of discussion--a desirable occurrence. However, as participants were discovering and/or exploring their existing and new awareness, there was not time to delve into several themes that were touched up in the training. The resourcing provided only limited opportunity to examine in depth several areas of inquiry that may have enabled measurably larger positive outcomes. The murky area between categories 2 (A little), and 3 (Somewhat) that often reflected positive changes, might have resulted in more distinct, higher shifts. This observation seems further supported by an overwhelming 100% of participants reporting that the resourcing better prepared them for providing spiritual care and support to African American women experiencing PNL.

The Assessment Instrumentation and Research Design: (1) The Likert Scale pre- and post-intervention questionnaires were created and utilized to offer a more objective, and quantifiable assessment of the resourcing experience for participants. There was no existing instrument, standardized or otherwise, remotely related to the interests of the study. However, other research designs for assessing resourcing outcomes may have been helpful. For example, (1) pre/post curriculum intervention assessment by the patients for whom chaplains provided spiritual care support; (2) real time ratings between chaplain and patient during patient care visits; and (3) qualitative measurement assessment, such as

patient interviews and narratives are examples of research models amenable to assessment that may be helpful in future studies, but were not possible within the timeframe and resources of this research.

Sample Selection: The sample was not randomly selected. It was a "sample of convenience" consisting of participants who were available to me. However, I cannot assert that the distribution of chaplains was a representative sample of the normal distribution of chaplains who offer spiritual care in healthcare settings. Additionally, chaplains were of various racial and ethnic groups, ages, and experience in chaplaincy, where experience may have been a potentially confounding factor. The participants also differed in their frequency of contact with African American women in general, and particularly with African American females and families who had experienced PNL.

Sample Size: The sample size was small. It was not optimal for reliably delineating finer differences on some dimensions, such as differences due to race, sex, and age.

Data Analysis: The research was exploratory in nature and intended to inform future training resourcing interventions in terms of content, structure and analysis by discovery of trends in the data. However, it is largely due to the small, and non-randomly selected sample, that the data was much less amenable to parametric statistical analyses with tests of statistical significance for questions of interest in the data (i.e., statistics which allow me to conclude within a certain level of probability that the results of the resourcing did not occur by chance).

Future Study

In future training resourcing about African American women and families in the context of PNL, the chaplains' interests varied but certainly pointed to needs for more in

depth exposure and future training resourcing. As I reflect on my work with this sample group of chaplains, it attests to the need for further resourcing in terms of research, teaching, caring, engaging in dialogue, and recognizing the gifts, feelings, questions, and growth experienced by all in the process, and more. There was a strong concern among the chaplains that training resourcing about the culture for the target patients be continued. According to their interests, future resourcing may elaborate in more depth about the grief response among African Americans in general, and in particular regarding PNL—how and why it may differ from others; religious traditions and beliefs and how that relates to practices in the African American community regarding grief and loss; how does a chaplain of another race or ethnicity meet an African American woman in grief about a PNL, and how is the chaplain perceived by the patient and family. One chaplain wanted to know more about the African American male's grief response to PNL. Another chaplain wanted more direct examples of care and others wanted to know more about how to establish trust to partner with the patient and family. All of these areas and more requested by the chaplains are worthy of further study and potential training resourcing. Further, some of the questions have not been researched, and provide an opportunity to do the work for example, of studying the grief response of African America males to PNL.

Summary

Unpacking the cultural dynamics in doing this study was not a simple task. As noted in Chapter 1, the chaplains were from different educational, ethnic, gender, age, experiential and racial orientations. There were also differences that stemmed from chaplains' various types of life experience, professional attainment, and socio-cultural

exposure. As a result, they functioned from different sets of presuppositions when they became participants in the study.

As a chaplain researcher, I was pursuing a response to a point of critical and prescient inquiry that is the fulcrum upon which chaplaincy care is balanced. In other words, how does who we are affect how we serve? Chaplains can no longer assume shared understandings or mutual positive regard among colleagues in our field or for those whom we serve.

Who a chaplain is, how he or she is trained, and his/her maturity of self-awareness has a direct influence on patient care outcomes. If chaplains cannot self-define in a coherent way as a group, and if individual chaplains are not self-aware enough to engage in deep processes of practice and honest self-reflection, then how can we expect other cognate groups to adopt clear, accessible appreciation of who chaplains are and what our care may accomplish? As we take culture seriously, we may enhance our awareness of ourselves as multi-faceted instruments from which to tune appropriate spiritual care responses.

Chaplains should take into consideration how their feeling, attitudes, values, and assumptions impact the patients they serve. The ability to give voice to those things that some may define as racist, sexist, homophobic is ambitious but necessary in self-awareness. In order for chaplains to conduct a no-bias spiritual assessment they must be able to identify and separate “their stuff” from the “patient’s stuff.” Self-awareness can assist spiritual care providers by helping them identify influences that may prevent them from conducting a culturally competent spiritual distress assessment.

The temptation of many chaplains or ministers of any stripe who have experienced a specific kind of suffering that is mirrored in the population that they serve is to assume

that those they serve need what they were given. I am aware of this temptation and the importance of resisting it. I also assert that it is crucial for chaplains to check out their intentions with patients, to invite them to be the leaders in their own healing journey and to come alongside them with any food for the soul that will be optimally nourishing and appropriate at the time. This study is by no means an exhaustive answer to the question, "How can a chaplain best provide culturally competent care to African American women and their families facing pregnancy crises and PNL?" My hope is that this study will shine light on an underserved population who can be better helped by chaplains who are even more equipped to "be as one" with them as recipients of spiritual care, enhanced by intercultural awareness.

APPENDICES

APPENDIX A

Approval Letter Northside Hospital Research Oversight Committee (ROC)

NORTHSIDE HOSPITAL

July 11, 2017

Chaplain Mishella Williams
3067 Dogwood Drive
East Point, GA 30344

Re: The Ministry of Presence: Assessing How Hospital Chaplains' Proficiency in Developing Interpersonal Resonance Influences Chaplain-Patient Trust with African American Women Experiencing Perinatal Loss

Dear Ms. Williams:

The Northside Hospital Research Oversight Committee (ROC) reviewed the research protocol noted above. The Research Oversight Committee performs a scientific, operational, and feasibility assessment to evaluate the risks and benefits involved with carrying out the research project to protect the interests of Northside Hospital (NH) and its patients involved in the research program.

Based upon review of the Research Oversight Committee Application (ROCA) and other information provided, this research project has been granted approval. The project will proceed to the NH Institutional Review Board (IRB) for review and approval.

This determination, although made, does not provide you with authority to begin work on the research project. Only after the NH IRB has granted approval may the research project begin enrolling patients.

If you have any questions or concerns, please do not hesitate to call me at 404-236-8312.

Sincerely,

Margaret Ferreira
Research Program Director
Northside Hospital

1000 JOHNSON FERRY ROAD, N.E., ATLANTA, GEORGIA 30342-1611 (404) 851-8000 WEBSITE: www.northside.com

APPENDIX B

Consent to Participate in a Research Study

PRINCIPAL INVESTIGATOR

Rev. Mishella P. Williams, Doctor of Ministry student at The Interdenominational Theological Center
Northside Hospital Spiritual Health and Education Department
1000 Johnson Ferry Road, NE
Atlanta, Georgia 30342
404-754-3319

INTRODUCTION AND PURPOSE OF STUDY

You are being asked to voluntarily participate in a research study. The main purpose of this study is to investigate how hospital chaplains' interpersonal resonance influences chaplain-patient trust and care outcomes when caring for African-American women experiencing perinatal loss. This research will add to the body of knowledge about intercultural and diverse insights related to the issue of Spiritual Care. This research could potentially assist with a greater awareness of how to provide spiritual care to African American Women experiencing perinatal loss.

You are being asked to take part in this study because you are a hospital chaplain that deals with patients experiencing perinatal loss.

This research is being done because little particular attention has been paid to this population in the literature of chaplaincy and spiritual care at large.

You will be one of approximately 15 people involved in this research project.

Your participation will last for approximately six weeks.

DESCRIPTION OF PROCEDURE

If you agree to participate you will be asked to sign this consent form. You will then be asked to complete a survey where you will be asked questions about your socio-cultural knowledge, spirituality and healing tradition, and your experience in working with African-American patients dealing with perinatal loss. The investigator will then meet with you and provide training on cultural competency emphasizing African-American culture and training on ministry of presence. After training, you will then be asked to complete another survey with similar questions that you were asked before the training. It will take you approximately 10-15 minutes to complete each survey and the in-person training will take approximately 4-6 hours.

POSSIBLE RISKS

This study is considered minimal risk for participants. Sometimes questions on surveys make people uncomfortable. You do not have to answer any questions you do not want to answer. Another possible risk is potential loss of confidentiality because your name will be included on this consent form and possibly on the survey (optional) and could link you to the study. But, precautions will be taken to protect your confidentiality. All study records will be kept in locked drawers in the investigator's office.

POSSIBLE BENEFIT

There may be no direct benefit to you from participation in this study. This research could potentially assist with a greater awareness of how to provide spiritual care to African American Women experiencing perinatal loss. It is hoped that this study will result in a better understanding of chaplain-patient trust that may help others in the future.

ALTERNATIVE PROCEDURES

You are not required to participate in this study. Your alternative is to not participate.

COMPENSATION AND COSTS TO SUBJECT

No compensation is being provided for participation in this study. You will not incur any costs due to participation. The training described will be provided at no charge.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW

Your participation in this study is voluntary. You have the right to choose not to participate or withdraw from the study at any time. Deciding not to participate or later withdrawing from the study will involve no penalty or loss of benefits to which you are otherwise entitled and will not affect your employment at Northside Hospital, now or in the future. You will be informed of any significant new findings that may affect your willingness to continue in the study.

Your time and involvement is profoundly appreciated. At any time you may request to see or hear the information collected for the study.

STATEMENT OF NON-WAIVE

By signing this consent form, you have not waived any of your legal rights or released any party from liability for negligence.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. Absolute confidentiality cannot be guaranteed, however confidentiality will be maintained to the extent permitted by local, state, and federal law.

No personal health information will be used or disclosed to others for this research study.

Data collected may be included in the final dissertation report or other later publications. However, under no circumstances will your name or identifying characteristics appear in these writings. If, at a subsequent date, biographical data were relevant to a publication, a separate release form would be sent to you.

STUDY CONTACT PERSON TO HAVE QUESTIONS ANSWERED

If you have further questions or want more information concerning the research study, you may contact Mishella P. Williams at 404-754-3319.

INSTITUTIONAL REVIEW BOARD REVIEW STATEMENT AND CONTACT PERSON

An Institutional Review Board (research review board) at Northside Hospital has reviewed this study in the context of certain federal regulations relating to experimentation involving human subjects. Approval of this study by the Northside Hospital Institutional Review Board (NSH IRB) is not an endorsement of this study or its outcome. If you have any questions or concerns about this study or your rights as a research subject, you should contact the Chairman of the Northside Hospital Institutional Review Board at 404-851-6848.

STATEMENT OF VOLUNTARY CONSENT

I have read all of the above or have heard it read to me. I have had the opportunity to ask questions about this study and my questions have been answered to my satisfaction. A signed copy of this consent form will be given to me.

_____ _____

Participant signature Date

INVESTIGATOR STATEMENT OF INFORMED CONSENT PROCESS

I have explained to the person named above, the nature of the research described above. To the best of my knowledge, the person signing this consent form understands the nature, demands, benefits, and risks involved in participating in this study.

_____ _____

Investigator Signature (or designee) Date

APPENDIX C

Pre-Intervention Questionnaire

Chaplaincy with African American Women and Families Experiencing Perinatal Loss Survey

Reverend Mishella Williams

Code: _____ **Name** (Optional)_____

A. Demographic Characteristics

1. Age: _____
2. Sex: ____ Male ____ Female
3. Race/Ethnicity (2000 Year Census Categories)

____ Caucasian
____ African American/Black
____ Asian American
____ Latino/Hispanic
____ American Indian/Alaska Native
____ Native Hawaiian/Other Pacific Islander
____ Other

Directions: Please circle the number that best describes your proficiency for each question.

B. Select Socio-Cultural Knowledge

	Not at all	A little	Somewhat	Quite a bit	A lot
1. How much training in cultural diversity have you had overall?	1	2	3	4	5
a. In college?	1	2	3	4	5
b. Conferences/workshops/classes?	1	2	3	4	5
c. On the job/church/faculty member?	1	2	3	4	5
d. Other?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
2. How much training have you had in the social and cultural characteristics of:					
a. diverse racial and ethnic groups?	1	2	3	4	5
b. African Americans?	1	2	3	4	5
c. African Americans of childbearing ages?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
3. Describe your knowledge of:					
a. Health disparities experienced by diverse racial and ethnic groups.	1	2	3	4	5
b. Historical and contemporary impact of racism, bias, prejudice, and discrimination in health care experienced by:					
(1) various population groups in the United States	1	2	3	4	5
(2) African Americans	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
4. Describe your knowledge of health risks experienced by African American females of childbearing age.	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
5. Describe your knowledge of common physical health problems among African American neonates.	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
6. Describe your knowledge of perinatal loss among African Americans?	1	2	3	4	5

C. Spirituality and Healing Traditions

	Not at all	A little	Somewhat	Quite a bit	A lot
7. Do you have basic knowledge of different religious traditions and common beliefs and practices in the African American community regarding grief and loss?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
8. Can you create spiritual interventions for this population relevant to perinatal loss?	1	2	3	4	5

D. Attitudes

	Not at all	A little	Somewhat	Quite a bit	A lot
9. How important do you believe socio-cultural issues are in your interactions with patients?	1	2	3	4	5

10. How aware are you of your own:	Not at all	A little	Somewhat	Quite a bit	A lot
a. Racial, ethnic or cultural identity?	1	2	3	4	5
b. Racial, ethnic or cultural stereotypes?	1	2	3	4	5
c. Biases and prejudices?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
11. How important do you feel it is for Chaplains to receive training in cultural diversity and/or multicultural health care?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
12. How comfortable are you with providing spiritual care to African American families?	1	2	3	4	5

E. Skills Regarding Perinatal Loss Among African American Patients:

	Not at all	A little	Somewhat	Quite a bit	A lot
13. How skilled are you in identifying appropriate interventions for African American women experiencing perinatal loss?	1	2	3	4	5

14. How skilled are you in:	Not at all	A little	Somewhat	Quite a bit	A lot
a. Caring for African American mothers who have experienced perinatal loss?	1	2	3	4	5
b. Caring for African American family members/significant others in the circumstance of perinatal loss?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
c. Interpreting different cultural expressions of pain, distress, and suffering in African American mothers of perinatal loss?	1	2	3	4	5
d. Establishing trust with African American women experiencing perinatal loss?	1	2	3	4	5

Thank you very much for your participation.

APPENDIX D

Post-Intervention Questionnaire

Chaplaincy with African American Women and Families Experiencing Perinatal Loss – Post Survey

Reverend Mishella Williams

Code: _____ **Name** (Optional)_____

A. Demographic Characteristics

1. Age: _____

2. Sex: ____ Male ____ Female

3. Race/Ethnicity (2000 Year Census Categories)

____ Caucasian
____ African American/Black
____ Asian American
____ Latino/Hispanic
____ American Indian/Alaska Native
____ Native Hawaiian/Other Pacific Islander
____ Other

Directions: Please circle the number that best describes your proficiency for each question.

B. Select Socio-Cultural Knowledge

	Not at all	A little	Somewhat	Quite a bit	A lot
1. How much training in cultural diversity have you had overall?	1	2	3	4	5
	Not at all	**A little**	**Somewhat**	**Quite a bit**	**A lot**
2. How much training have you had in the social and cultural characteristics of:					
a. diverse racial and ethnic groups?	1	2	3	4	5
b. African Americans?	1	2	3	4	5
c. African Americans of childbearing ages?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
3. Describe your knowledge of:					
a. Health disparities experienced by diverse racial and ethnic groups.	1	2	3	4	5
b. Historical and contemporary impact of racism, bias, prejudice, and discrimination health care experienced by:					
(1) various population groups in the United States	1	2	3	4	5
(2) African Americans	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
4. Describe your knowledge of health risks experienced by African American females of childbearing age.	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
5. Describe your knowledge of common physical health problems among African American neonates.	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
6. Describe your knowledge of perinatal loss among African Americans?	1	2	3	4	5

C. Spirituality and Healing Traditions

	Not at all	A little	Somewhat	Quite a bit	A lot
7. Do you have basic knowledge of different religious traditions and common beliefs and practices in the African American community regarding grief and loss?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
8. Can you create spiritual interventions for African Americans relevant to perinatal loss?	1	2	3	4	5

D. Attitudes

	Not at all	A little	Somewhat	Quite a bit	A lot
9. How important do you believe socio-cultural issues are in your interactions with patients?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
10. How aware are you of your own:					
a. Racial, ethnic or cultural identity?	1	2	3	4	5
b. Racial, ethnic or cultural stereotypes?	1	2	3	4	5
c. Biases and prejudices?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
11. How important do you feel it is for Chaplains to receive training in cultural diversity and/or multicultural health care?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
12. How comfortable are you with providing spiritual care to African American families?	1	2	3	4	5

E. Skills Regarding Perinatal Loss Among African American Patients:

	Not at all	A little	Somewhat	Quite a bit	A lot
13. How skilled are you in identifying appropriate interventions for African American women experiencing perinatal loss?	1	2	3	4	5
14. How skilled are you in:					
a. Caring for African American mothers who have experienced perinatal loss?	1	2	3	4	5
b. Caring for African American family members/significant others in the circumstance of perinatal loss?	1	2	3	4	5

	Not at all	A little	Somewhat	Quite a bit	A lot
c. Interpreting different cultural expressions of pain, distress, and suffering in African American mothers of perinatal loss?	1	2	3	4	5
d. Establishing trust with African American women experiencing perinatal loss?	1	2	3	4	5

F. Other

15. Do you feel that this training better prepared you for providing spiritual care and support to African American women experiencing perinatal loss? _____YES _____NO

    If yes, please identify at least two ways in which this brief training was helpful. If not, why not?

16. In future trainings about African American women experiencing perinatal loss, please identify one or more topics that you desire to learn more about:

17. Other Comments?:

Thank you very much for your participation. Your cooperation is appreciated immensely

APPENDIX E
Human Subject Assurance Training: Modules 1-3

Human Subject Assurance Training

Exit

Return to Table of Contents

This certifies that Mishella Williams has completed the Human Subject Assurance online training, Module 1.

Wednesday, July 12, 2017

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Human Subject Assurance Training

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This certifies that Mishella Williams has completed the Human Subject Assurance online training, Module 2.

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This certifies that Mishella Williams has completed the Human Subject Assurance online training, Module 3.

Wednesday, July 12, 2017

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