DISSETATION APPROVED BY

Tim Guetterman, Ph.D., Chair
Wendy Cadge, Ph.D., Committee Member
Jennifer Moss Breen, Ph.D., Director
Gail M. Jensen, Ph.D., Dean
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

By
RUTH JANDESKA

A DISSERTATION IN PRACTICE

Submitted to the faculty of the Graduate School of Creighton University in Partial Fulfillment of the Requirements for the degree of Doctor of Education in Interdisciplinary Leadership

Omaha, NE
April, 22nd, 2019
Abstract

This dissertation was designed to explore the leadership experiences of spiritual care leaders in Catholic Healthcare. Both healthcare and spiritual care continue to evolve prompting spiritual care leaders to consider their leadership approaches as they strive to remain relevant and effective. Given the apparent limited literature available in the area, an interpretative phenomenological approach was used to learn about the meaning participants make of their experiences. The aim of the study was to begin to provide empirically derive evidence that will contribute to the audience’s understanding of spiritual care leadership.

The findings suggested social processes such as relationships are significant in the leadership experience of these leader. The two main themes identified were belonging and being transformational. Belonging involved a supportive and inclusive environment, Catholic identity, and feeling valued and supported, while being transformational included feeling strategic, acting as an advocate, being supportive, and being resilient. These two themes seemed to point to the social process between these leaders and their employees, and the leaders and their own supervisors. They could help determining key aspects needed in establishing and maintaining quality relationships that support a culture of growth and development which is an important aspect of the leadership experience. Future research should expand on this topic to understand which behaviors leaders display to develop these quality relationships. This will ultimately contribute to the development of best practices for spiritual care leadership.

Keywords: Phenomenology, leadership, dissertation
Dedication

Ad majorem Dei gloriam (AMDG): For the greater glory of God.
Acknowledgements

I first want to thank my late father, for his loving support during my first year in the program, I am very sad he will not see me graduate.

I am extremely grateful to my dissertation committee. To Dr. Tim Guetterman for his encouragement, time, energy, feedback and professional support, and to Dr. Wendy Cadge, for her insightful comments and hard questions. I thank former program Director Dr. Isabelle Cherney for her leadership, charisma, and encouragement that were invaluable to me during my first months in this program. I would like to acknowledge to Dr. James Martin, my academic advisor, for his support and helpful advice. Special thanks to my cohort members for the laughter we shared and the encouragement we gave one another. Many thanks to all faculty and program staff that supported and guided me from beginning to end. With special gratitude to Dr. David Lichter, NACC executive director, and to my spiritual care leader colleagues for insightful discussions about my research. My deepest gratitude to the participants who agreed to be interviewed for this study.

Finally, I want to thank my family and friends for cheerleading me to the finish line. This EdD journey was only conceivable because of the unwavering support of my husband Adam and my children Fátima, Santiago, and Andres Sebastián. Your love and sacrifice made all this possible.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Dedication</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>v</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>vi</td>
</tr>
<tr>
<td>List of Tables</td>
<td>x</td>
</tr>
<tr>
<td>List of Figures</td>
<td>xi</td>
</tr>
<tr>
<td>CHAPTER ONE: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Introduction and Background</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>3</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>4</td>
</tr>
<tr>
<td>Research Questions</td>
<td>4</td>
</tr>
<tr>
<td>Aim of the Study</td>
<td>5</td>
</tr>
<tr>
<td>Methodology Overview</td>
<td>5</td>
</tr>
<tr>
<td>Definition of Relevant Terms</td>
<td>6</td>
</tr>
<tr>
<td>Delimitations and Limitations</td>
<td>6</td>
</tr>
<tr>
<td>Leader’s Role and Responsibility in Relation to the Problem</td>
<td>7</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>8</td>
</tr>
<tr>
<td>Summary</td>
<td>9</td>
</tr>
<tr>
<td>CHAPTER TWO: LITERATURE REVIEW</td>
<td>10</td>
</tr>
<tr>
<td>Introduction</td>
<td>10</td>
</tr>
<tr>
<td>Spiritual Care in Healthcare</td>
<td>10</td>
</tr>
</tbody>
</table>
Literature about the Professional Practice Setting .............................................................12
Healthcare Legislation .......................................................................................................12
Secularization of the non-profit sector ...............................................................................14
Second Vatican Council .....................................................................................................14
Leadership Literature .........................................................................................................15
Summary ............................................................................................................................16
CHAPTER THREE: METHODOLOGY ..............................................................................18
Introduction ........................................................................................................................18
Research Question(s) .........................................................................................................18
Research Design .................................................................................................................18
Participants/Data Sources and Recruitment ......................................................................18
Validation strategies ...........................................................................................................20
Design Instruments ............................................................................................................21
Data Collection Procedures ...............................................................................................22
Ethical Considerations .......................................................................................................22
CHAPTER FOUR: FINDINGS ..........................................................................................23
Introduction ........................................................................................................................24
Presentation of the Findings ...............................................................................................24
Theme 1: Leadership experience as Belonging .................................................................24
  Subtheme 1: Supportive and inclusive environment 24
  Subtheme 2: Catholic identity 26
  Subtheme 3: Feeling valued and supported or not 28
Theme 2: Being transformational


Subtheme 1: Feeling strategic and an advocate 30
Subtheme 2: Being supportive 32
Subtheme 3: Being resilient 34

Analysis and Synthesis of Findings .................................................................35
Summary ...........................................................................................................36

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS ......................38

Introduction ..................................................................................................38
Purpose of the Study ..................................................................................38
Aim of the Study ..........................................................................................39
Proposed Solution ......................................................................................39

Senior leadership support ........................................................................41
Recommendation 1: Leaders’ relationship with their leaders 42
Leadership mentoring ..............................................................................42
Recommendation 2: Leaders know thyselfs .............................................43
Recommendation 3: Leaders’ relationship with their followers 45

Support for the Solution ...........................................................................46
Implementation of the Proposed Solution .................................................49
Factors and Stakeholders Related to the Implementation of the Solution 49
Implications ...............................................................................................51

Practical Implications .............................................................................51
Implications for Future Research .............................................................54
Implications for Leadership Theory and Practice .....................................55
Summary of the Study ................................................................................56
References ..........................................................................................................................58
Appendices .........................................................................................................................67
List of Tables

Table 1. Participants’ demographics ................................................................. 24
List of Figures

Figure 1. Conceptual explanation for spiritual care leadership development ....................41
CHAPTER ONE: INTRODUCTION

Introduction and Background

I conducted a phenomenological study to examine and understand the lived experiences of spiritual care leaders in Catholic hospitals. Spiritual care leaders are those who oversee chaplaincy services across healthcare organizations, and ensure that the spiritual and emotional needs of patients, families and staff are addressed through the development and implementation of a continuum of spiritual care services that is in alignment with the organization’s mission. Not only accommodation and respect for patients’ cultural and religious rights are a part of The Joint Commission mandate to all hospitals, they are a fundamental part of Catholic healthcare’s commitment to holistic care, and as such they are at the core of Catholic healthcare identity and mission (The Joint Commission, 2010; Catholic Healthcare Association, n.d.). In a changing healthcare environment, it is important to describe what leaders’ lived experiences and meaning of leading spiritual care services in Catholic organizations are. This will aid with providing evidence about how these leaders think and act, and how they relate and communicate to others so that they can effectively promote and communicate about spiritual care services within Catholic healthcare organizations. It will also help with understanding how well integrated spiritual care services are into the different levels of care, and the aspects of leadership that are required to promote this level of integration.

Since Catholic Healthcare is an extension of the church’s ministry, its mission is to continue the healing ministry of Jesus by facilitating healing and alleviating suffering. This ministry is guided by the principles established in the social, and the pastoral and spiritual responsibilities of the church (United States Conference of Catholic Bishops...
USCCB, 2009). The social responsibilities promote the church’s teaching on the inherent value of every human being, and therefore on viewing healthcare as every person’s right. It holds a preferential attention to the poor and vulnerable, and it seeks to contribute to the common good (USCCB, 2009). These social responsibilities also focus on responsible stewardship of healthcare resources and assert Catholic healthcare organizations’ right to refuse treatment that is contrary to the moral teaching of the church (USCCB, 2009). In turn, the Pastoral and Spiritual responsibilities promote holistic care, while emphasizing care for the spiritual nature of the human being. As such, spiritual and pastoral care focus on compassionate presence, listening skills, and sacramental needs. Chaplains, clergy, deacons, and the laity “have diverse but complementary roles” in attending to the spiritual needs of those hospitalized (USCCB, 2009, p. 15).

Finally, phenomenological research describes a phenomenon as experienced in the lives of a study’s participants (Creswell, 2013). In contrast to existential phenomenology which describes the “essence” of the lived experiences of the phenomenon as shared by the participants, hermeneutical phenomenology is interpretative (Creswell, 2013). It focuses on understanding the lived experiences of the phenomenon as they are lived and the meanings participants make of these lived experiences (Horrigan-Kelly, Millar, & Dowling, 2016). This philosophical underpinning made this methodology the most appropriate approach to fit the research question. Since spiritual care leaders’ lived experiences occur in specific contexts, examining these lived experiences helped reveal the different ways leaders’ think, act,
and reflect in the contexts where they lead and promote the integration of their services, and what meanings these leaders make of these experiences were.

**Statement of the Problem**

Spiritual care leaders in US hospitals need to effectively articulate the impact of their services in their organizations (Cadge, 2012). As healthcare provision continues to evolve in attempts to improve quality and reduce costs, healthcare leaders are encouraged to re-evaluate their work and their strategies (VandeCreek, 2000). Recently, payment systems for healthcare in the United States shifted from a volume-based reimbursement to a value-based one with the passage of the Affordable Care Act (ACA) into law in 2010 (Corbett, 2016). Value-based payment systems are those in which reimbursement is based on cost control, excellent quality, and illnesses’ prevention strategies, while the fee-for-service reimbursement is based on the amount of services that are provided (Corbett, 2016). Valued-based can pose a challenging situation for non-revenue departments such as spiritual care, as services that fail to demonstrate their value to patient care might be eliminated to decrease the cost of healthcare across the country (devries, Berlinger, & Cadge, 2008). A previous health reform significantly affected spiritual care department of both secular and religious hospitals (VandeCreek, 2000). Losses ranged from significant budget cuts and loss of personnel to loss of space and salary increases (VandeCreek, 2000).

Additionally, others aspects such productivity numbers, the number and quality of services provided both inpatient and outpatient, personnel education and training, usage of volunteers, clinical pastoral education programs, as well as these leaders’ own formation and development need consideration (Yanofchick, 2009). Cadge (2012)
proposed that to be effective at promoting spiritual care services, spiritual care leaders need to know how to articulate chaplains’ relevance and their contributions to their organizations. Given the significant empirical gap on spiritual care leadership in Catholic hospitals, it was important to describe spiritual care leaders’ perceptions of their leading roles to understand their day-to-day functioning, thinking, acting and communicating about the services they lead and strive to integrate across the organization.

**Purpose of the Study**

The purpose of this phenomenological study was to understand the lived experiences of spiritual care leaders in Catholic hospitals and the meaning they make of these experiences. The central phenomenon of this study was leading spiritual care services, which I broadly defined as the art of developing and implementing a continuum of spiritual care services in alignment with the organization’s mission (Appendix A). As an interpretative phenomenological approach, the study holds both participants as the experts of their own lived experiences of leading, and the researcher as the reflexive agent questioning participants’ understandings as well as the researcher’s own.

**Research Questions**

The main guiding research question for this qualitative study was:

What are the lived experiences and meaning of leading spiritual care services in Catholic healthcare organizations in the United States?

The following sub-question expanded on the phenomenon of leading spiritual care services within the studied context:

- What are leaders perceived experiences of belonging to their group (both own spiritual services teams and their organizations’ leadership team)?
Aim of the Study

The aim of this dissertation is to provide an emergent empirically derived description of spiritual care leadership in Catholic healthcare. I hope that the results will help other spiritual care leaders reflect on their own experiences, compare them to their own, and learn from the findings described in this study. Particularly, I hope these leaders will contemplate how their leadership does not only depend on their personal qualities and skills, but also on their social realities or contexts. This means incorporating leaders’ perceptions of how their leadership derives from their relational and structural dimensions of their work environments. I also hope that credentialing bodies will use this information on the role of social relations in the workplace when devising competencies and common standards for the leadership formation, development, and professional certification of spiritual care leaders.

Methodology Overview

Hermeneutic phenomenology was the proposed methodology for this dissertation. Since the purpose of this study was to understand the lived experiences of leading spiritual care in Catholic hospitals and the meaning of these lived experiences, interpretation was a necessary process in this approach (Laverty, 2003). “Experience is considered to be an individual’s perceptions of his or her presence in the world at the moment when things, truths, or values are constituted” (Richards & Morse, p. 67). Thus, this methodology closely looked at the reciprocal relationship of participants and their contexts, as they both form and are formed by their mutual interaction (Laverty, 2003). Additionally, the researcher’s own experience enters into dialogue with the collected data, as the researcher examines how the data intersect the researcher’s own experiences.
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

(Laverty, 2003). This process is a fundamental distinction between this approach and other ways to conduct a phenomenological methodology. Finally, this study considered spiritual care leaders in rural and urban Catholic healthcare organizations as the population in study, and used purposive sampling to draw the six participants to be included in this dissertation.

**Definition of Relevant Terms**

The following terms were used operationally within this study:

*Spiritual*: Pertaining to the existential aspects or facets of a person

*Spiritual care*: Attention to and care for emotional and spiritual needs of patients, families and staff in a healthcare organization

*Spiritual care leader*: A person leading spiritual care services in an organization.

*Lived experience*: “a representation and understanding of a researcher or research subject's human experiences, choices, and options and how those factors influence one's perception of knowledge” (Boylorn, 2008, p. 490).

*Urban*: A large, metropolitan area with a population over 250,000.

*Rural*: A small area with population of 250,000 or less

Some departments that attend to the emotional and spiritual care of patients are also referred as pastoral care, they were also referred to as spiritual care through this study.

**Delimitations**

This study only included spiritual care leaders in Catholic hospitals and within today’s healthcare context, therefore its findings cannot be generalized. The duration of the study was 12 months, from January 2018 through January 2019. I used purposive
sampling because there is a small number of successful spiritual care leaders known in
the field, and the purpose of the study was to understand and learn from these leaders’
lived experiences of leading spiritual care services.

Personal biases

As a spiritual care leader myself, I hold my own views and experiences about
leading spiritual care services in a Catholic healthcare organization. For example, I
believe spiritual care leadership is about providing a vision for what spiritual care in
catholic healthcare should be, empowering chaplains, and tapping into their skills and
knowledge to advance that vision. Maintaining the right balance between bracketing my
beliefs and experiences and allowing these experiences interact with those of participants
was essential to adequately employ the chosen methodology.

Leader’s Role and Responsibility in Relation to the Problem

This dissertation especially considered understanding both context and the lived
experiences of leading spiritual care services. The premise was that leadership is
contextual or situational, and therefore leaders’ beliefs, thoughts, and actions are
significantly influenced by their contexts or situations (Northouse, 2013). This is not to
say that leaders’ characters or personality traits are not accounted for in their leadership,
but rather there is a dynamic relationship between their characters and their context that
results in the observed leading behaviors (Haslam, Reicher, & Platow, 2011). While
major personality traits in leaders include intelligence, self-confidence, determination,
integrity and sociability (Northouse, 2013), situations or contexts account for the
individual’s followers, the individual’s task, the individuals’ organization and culture
(Lord, Gatti, & Chui, 2016). At the center of this lies leaders’ social identity that enables
leaders’ to both lead and be led (Haslam, Reicher, & Platow, 2011), and endorses leadership as a process of social interactions that can result in leaders’ ability to influence others’ behaviors (Dasborough & Ashkanasy, 2002).

**Significance of the Study**

This study was significant for three reasons. First, to my knowledge no other study had explored spiritual care leaders’ perceptions of leading spiritual care services in Catholic hospitals. The empirically derived contributions of this study are in the area of leadership formation and development in general, and particularly as context informs it. Additionally, a task force formed by members of the Catholic Healthcare Association (CHA) and the National Association of Catholic Chaplains (NACC) identified field of competences for spiritual care leaders in Catholic Hospitals in 2009. Though these competencies are based on subject-matter-expert knowledge and experiences, research is needed to established them as evidence-based practices. In other words, research is needed to describe and explain these competencies, as well as to learn whether they would be applicable across Catholic healthcare organizations. This study constitutes the first contribution on that direction.

Second, spiritual care leaders want to learn how to lead and how to become effective in today’s healthcare environment. This study provides these leaders with specific insights into the social dimension of leadership, and therefore about their day-to-day thoughts, activities, and overall relationships and interactions with their environments that can lead to an improvement of their own leadership.

The third area where this study significantly contributes to is around Catholic healthcare mission. As an essential part of the mission of the church, Catholic healthcare
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

organizations need to maintain an effective spiritual care presence in their organizations. The findings of this study can assist administrators and/or senior leaders with understanding the needs and the support spiritual care leaders desire to effectively promote spiritual care services in their organizations. This could eventually lead to clear strategies that protect and/or maintain spiritual care departments whenever budgetary changes need to occur.

Summary

It is important to understand the lived experiences of leading of spiritual care leaders in Catholic hospitals, so that spiritual care services can be promoted effectively across the organizations. A phenomenological approach helps with understanding both the lived experiences and the meaning of them within the realm of a specific context. This understanding will in turn contribute to a greater appreciation of the skills, knowledge, behaviors or practices spiritual care leaders need while leading in a changing healthcare environment.
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

CHAPTER TWO: LITERATURE REVIEW

Introduction

The phenomenon of leading spiritual care services in Catholic hospitals has concurrently evolved along with these organizations, since the funding of Catholic healthcare over two hundred years ago. While Catholic sisters and some priests used to lead spiritual care services and to contribute to the overall operation of these hospitals in the past, it is the laity that constitutes most of the executives today. Not only the profile of those running the organizations has changed, the societal structures and healthcare needs of people today challenge Catholic Healthcare organizations’ (CHOs) efforts to remain faithful to their identity and commitment. The following literature review will present findings about the importance of spiritual care in healthcare, the challenges spiritual care leaders face in Catholic healthcare today, and an analysis of the need for spiritual care leadership in promoting chaplaincy amidst the changing healthcare landscape.

Spiritual Care in Healthcare

Spiritual care is fundamental to Catholic healthcare mission (United States Conference of Catholic Bishops, 2009). CHOs’ executives agree that spiritual care is not only essential for CHO们 to provide compassionate care to the communities they serve, it is also important for the promotion of the wellbeing of the workforce (Lichter, 2014). Despite this, CHO们 are reducing the number of chaplains they employ, and thus compromising a part of their identity and mission (O’Gorman, 2015). And yet, while the role of spirituality in healthcare has been very well documented, and there is growing consensus on the overall positive contributions of spiritual care to health and wellbeing
(Puchalsky, 2001), empirical evidence on the contributions of specific spiritual care interventions is slowly emerging (Koenig, 2013). Most of these studies centered around the contributions of spirituality in the areas of mortality, coping, and recovery (Puchalsky, 2001).

Some other studies aim to demonstrate patients’ satisfaction when chaplains attend to their spiritual/emotional needs. A correlational study showed chaplains’ effectiveness in meeting the spiritual, religious, and emotional needs of hospitalized patients (Flannely, Oettinger, Galek, Braun-Storck, & Kreger, 2009). While this study had some significant limitations, such as chaplains’ awareness of the study and thus potentially altering their behavior and interventions during patients’ visits, the study offered significant insight into the effectiveness of chaplains’ interventions as patients perceived it (Flannely et al., 2009). A similar study found that chaplains’ visits significantly influence patients’ perception of overall care, and the authors suggested although spiritual care is not a revenue generating activity, it can significantly influence Medicare payment reimbursement through its contributions to the enhancement of patients’ experience (Marin, Sharma, Sosunov, Egorova, Goldstein, & Handzo, 2015).

The evidence also suggests that despite patients’ desire to have their spiritual/emotional needs met when they are in the hospital, chaplains are being underutilized or brought into the interdisciplinary patient care plan when patients are dying, and thus depriving patients and families of the needed support during the early disease process (Choi, Curlin, & Cos, 2015). The authors suggested providers need to improve physician and chaplain communication, and work on eliminating any barriers that impede chaplains’ involvement with patients promptly after hospital admission (Choi...
et al., 2015). Additionally, role conflict and disagreements with other members of the team can be avoided by providing education on chaplains’ identity and role, and sharing their function with all members of the interdisciplinary team (Wittenberg-Lyles, Oliver, Demiris, Baldwin, & Regehr, 2008).

Finally, chaplains themselves struggle to communicate about the work they do (deVries, Berlinger, & Cadge, 2008). As they advocate for their profession and the importance of their role and presence in healthcare, chaplains need to learn how to articulate not only the nature of their services but how these services improve patients’ health (deVries et al., 2008). The legitimization of their role will continue to be a challenge unless they learn to effectively communicate the value of their work relying on the emergent empirical evidence (Pesut, Reimer-Kirkam, Sawatzky, Woodland, & Peverall, 2012).

**Literature about the Professional Practice Setting**

There are three major contextual events that have continuously challenged the Catholic identity of Catholic healthcare over time and thus spiritual care leadership through the years, and these are legislation, secularization of the non-profit sector, and the Second Vatican Council (Vatican II).

**Healthcare legislation**

The first of such events is healthcare legislation (White, 2000). As a charitable system in the past, CHOs clearly maintained their commitment to social justice through promoting respect to all people, providing care that was free of charge, and consistently depending on charity through both free will donations and mendicant work (Slosar, Repenshek, & Bedford, 2013). What started as a response to a societal need for care and
concern for the sick and the poor in the absence of welfare in the past, has increasingly evolved into complex organizations that seek government funding and compete for a space in the healthcare market today due to healthcare expansion and rising costs (White, 2000).

This increase in healthcare cost challenges CHOs approach to solidarity, an approach that is not unique to Catholic Social Teaching (CST), but that is also present in Europeans’ societies to express the “moral obligation of communities to secure the wellbeing of their members” (Pijnenburg, Bordijn, Vosman, & Ten Have, 2010, p. 315). Adherence to this principle of solidarity means to promote the dignity and respect of every human being, thus in Catholic teaching healthcare constitutes a human right and not a privilege of the few (Denz, 2000). In this regard, human right refers to the required social conditions for human beings to achieve wellbeing, more specifically both the human capacities and the human potentials that are compromised in the face of illness (Denz, 2000). Through the years however, the advent and reimbursements’ regulation of Medicare and Medicaid, the health insurance industry, and the ongoing changes in healthcare legislation have impacted CHOs’ ability to promote solidarity which has led to hospitals’ closures and mergers (O’Gorman, 2015).

These challenges are not only with regards to solidarity, they also affect CHOs ability to contribute to the common good and be responsible stewards (O’Gorman, 2015). Despite the successes in providing coverage to a larger number of individuals and making healthcare more comprehensive, through the implementation of the Patient Protection and Affordable care of 2010, health insurance is still expensive which causes thousands to remain uninsured, Medicaid funds to continue to decrease, and insurances companies to
exit the mandated exchanges (Condit, 2016). In this environment, CHO leaders live in the tension of commitment to solidarity while maintaining healthy and viable organizations (Slosar et al., 2013), and this seems to be an issue that causes the reduction of chaplaincy positions in some organizations (O’Gorman, 2015).

**Secularization of the non-profit sector**

The second and related challenge CHO leaders face today is the secularization of the non-profit sector (White, 2000). At one time a full ministry of the Church, CHO today have become separate entities that remain affiliated to the Catholic Church through some sort of religious sponsorship to which CHO are accountable for maintaining a Catholic identity (O’Gorman, 2015). “Sponsorship is a nontechnical term referring to the way in which religious congregations of women with their declining numbers tried to insure the continuity of Catholic identity of their institutions” (Curran, 1997, p. 96).

Although, mission leaders’ positions were created in the 90s to guide this integration of Catholic Mission and Values through the hospitals’ operations (Curran, 1997), CHO challenges to be authentic in an ever growing secular or pluralistic society still abound, as people’s beliefs and values has changed over time (Curran, 1997). Furthermore, chaplaincy training and formation is not a requirement for this mission leaders, and I wonder how much support from and interactions with mission leadership contributes to spiritual care leaders’ ability to lead effectively.

**Second Vatican Council**

Finally, the last contextual change CHO have faced with time is the change in the diversity of Church ministers that resulted with the Second Vatican Council (Vatican II). Traditionally, the Church was understood as in the World but separated from it,
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

while clergy possessed absolutely leadership on all Church ministries (White, 2000). This conceptual understanding shifted with Vatican II, and the laity was granted responsibility for the Church as well, particularly on social justice issues (White, 2000). The laity gradually began assuming CHOs’ leadership positions that religious sisters used to occupy (White, 2000). Additionally, workforce that was traditionally Catholic became more diverse in terms of creed or lack thereof (White, 2000).

Catholic sisters were not only CHOs administrators and nurses, they were also the spiritual care providers (White, 2000). With Vatican II, lay people entered Church ministries, including hospital ministries, and began acquiring theological and clinical pastoral education to work as hospital chaplains (National Association of Catholic Chaplains, nd). The number of laity involved in ministry is filling the void due to a significant decline in the number of religious and priestly vocations today (O’Gorman, 2015). It is expected that their training and role will continue to evolve as future trends call for the empirical evidence on the impact of religion and spirituality in Catholic healthcare (White, 2000).

Leadership Literature

Spiritual care leaders in Catholic healthcare find themselves at another threshold as their work contexts continue to evolve. Yet, there is a dynamic relationship between characters and their contexts that results in the observed leaders’ leading behaviors (Haslam, Reicher, & Platow, 2011). Theory and research support the notion that “people make their social and cultural worlds at the same time these worlds make them” (Fairhust, & Grant, 2010, p. 173). This is the premise of the social construction of leadership, and it is one in which leaders’ style, personality, and ability to reflect on and
evaluate their contexts are coupled with the social process of communication and interactions to create realities (Fairhurst, & Grant, 2010). Social identity is the foundational aspect of this process, and it guides leaders’ abilities to establish relationships within their social groups which in turn determines their leadership (Reicher, Haslam, & Hopkins, 2005).

These relationships between leader and social group fall into the variety of theoretical frameworks that social exchange encompasses, these frameworks assume that both leaders and social groups invest on each other because they perceive a benefit in doing so (Haslam et al., 2011). These mutual exchanges strengthen the relationships between parties and generate positive behaviors (Mitchell, Cropanzano & Quisenberry, 2012).

Because of this, the utility of these theoretical frameworks can predict employees’ job performance, job attitudes, and turnover intention (Kim & Mor Barak, 2014).

The best practices guidelines NACC established for spiritual care leaders (Cook, Paquette, & O’Gorman, 2017), do not account for the social processes described above, that are necessary to build leadership identity. Since spiritual care is an intrinsic aspect of Catholic healthcare, we need to learn the mechanisms by which today’s spiritual care lay leadership develop positive behaviors that promote high quality social exchanges that ultimately influence employees’ behaviors and improve work relationships.

**Summary**

Spiritual care is an important mission in Catholic healthcare, and as healthcare legislation changes challenging CHOs’ Catholic identity, spiritual care leaders need to demonstrate the significance of their services and their contribution to health outcomes to
remain as viable members of these organizations. It appears that little research however has been done in these areas. The literature review presented here contained mainly theoretical articles and few qualitative articles. While these are limitations, they also demonstrate the need to research in this area.
CHAPTER THREE: METHODOLOGY

Introduction

The purpose of this phenomenological study was to understand the lived experiences of spiritual care leaders in Catholic hospitals and the meaning they made of these experiences. As an interpretative phenomenological approach, the study held both participants as the experts of their own lived experiences of leading, and the researcher as the reflexive agent questioning participants’ understandings as well as the researcher’s own.

Spiritual care is essential to Catholic healthcare, therefore understanding how spiritual care leaders lead and promote spiritual care services will improve the integration of these services across organizations. It is also important to understand how these leaders lead within the context of a changing healthcare landscape. Learning how leaders lead in a value-based reimbursement system will also help with identifying strategies that promote spiritual care services in a new healthcare environment.

Research Questions

- What are the lived experiences and meaning of leading spiritual care services in Catholic healthcare organizations?
- What are leaders perceived experiences of belonging to their group (both own spiritual services teams and their organizations’ leadership team)?

Research Design

This dissertation executed a phenomenological study to gain an understanding of spiritual care leaders’ lived experiences of leading spiritual care in Catholic hospitals. Phenomenological research describes a phenomenon as experienced in the lives of a
study’s participants (Creswell, 2013). While existential phenomenology describes the “essence” of the lived experiences of the phenomenon as shared by the participants, hermeneutical phenomenology is interpretative (Creswell, 2013). It focuses on understanding the lived experiences of the phenomenon as they are lived and the meanings participants make of these lived experiences (Horrigan-Kelly, Millar, & Dowling, 2016). Since spiritual care leaders’ lived experiences occur in specific contexts, examining these lived experiences helped revealing how leaders’ thoughts, actions, and reflections occur in the contexts where they lead, and what the meanings these leaders make of these experiences are. Additionally, I used journaling and note taking to record my own thoughts and interaction with study participants, and firm response, while reflecting on my vicarious experiences from an emic or participant-oriented perspective (Yazan, 2015).

Participants/Data Sources and Recruitment

Sample and procedures

I was the primary researcher for this dissertation. Creswell (2013) describes how researchers need to use *epoche*, bracketing of their own experiences, when using a phenomenological approach to limit bias in their research. As a spiritual care leader, I bracketed my reflections on my own experiences to be able to openly listen to the participants’, yet I reflected on how participants’ experiences and mine intersected. This is because an absolute state of no assumptions is impossible, rather I made an inventory of personal biases and reflected on each data collection session to check on my personal biases (Hycner, 1985). For example to minimize confirmation bias, I listed aspects such as education, support, and cultural diversity that were important in my own leadership
experience. This helped me challenge my observations whenever these aspects were also present in participants’ experience. I performed purposive sampling because my goal was to learn the most from my sample (Merriam, 1998), and use maximum variation to increase the likelihood of collecting different perspectives (Creswell, 2013). Thus, I relied on my own judgment and the assistance of my colleagues to identify spiritual care leaders at Catholic healthcare organizations that have been publicly recognized as effective in promoting spiritual care services across their hospitals in both rural and urban areas.

Since I wanted to produce an in-depth and detailed account of leaders’ perceptions of their leading experiences (Creswell, 2013), I identified six spiritual care leaders that have an active spiritual care leadership appointment in two of the largest Catholic healthcare systems in the country. I contacted them and inquired about their interest in participating in this research, after I obtained Institutional Review Board (IRB) approval through Creighton University (appendix E). I informed participants about the confidentiality of their involvement and the information they would share, and that pseudonyms for their names and their hospitals would be used. I collected demographic information of the participants such as gender, education, and seniority upon reaching participation’s agreement. I read the research inform consent to each of the participants prior to each interview.

Validation strategies

I sought assistance from two of my colleagues to conduct peer debriefing through a small pilot study. One of the goals of this pilot study was to check on the validity of this dissertation by assessing the effectiveness of the one-on-one interview tool and
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

process, and the clarity of the interview questions (Thompson & Weber, 2016). Another goal was to obtain a clearer, improved, and more robust interview questionnaire for the researcher to use with the participants. I also used member checking by having the participants review a summary of their own interview. Lastly, I triangulated the interview data against my own observations and notes (Creswell, 2013).

**Design Instruments**

I conducted a 60-minutes in-depth phone interview protocol to inquire about participants’ lived experiences of leading spiritual care services (Appendix B). As an in-depth interview, questions aimed at exploring the participants’ lived experiences, feelings, beliefs, and convictions (Creswell, 2013). The flexible-worded questions tied back to the research questions and allowed time and space for new or probing questions in accordance with the participants’ emergent worldview or “new ideas on the topic” (Merriam, 1998, p. 82). Even though phenomenological interviews are recommended to be flexible (Creswell, 2013), Bevan (2014) recommends that the questions be asked within a built structure consisting of three domains: “(a) contextualization, (b) apprehending the phenomenon, and (c) clarifying the phenomenon” (p138).

Contextualization refers to the environment or context and personal history of the participant, and allows the participants to share their stories as lived in their contexts (Bevan, 2014). Apprehending the phenomenon, refers to how participants experience the phenomenon, while clarifying the phenomenon refers to how participants make meaning about their experiences (Bevan, 2014). The interview protocol I used followed this structure.
Data Collection Procedures

An iPhone audio-recorder app was used and the files were transcribed using the Rev transcription service. I listened to the recorded files, and made notes within 24 hours of gathering these data. The transcribed files were saved with the participants’ names and the date the interview occurred. These files were deleted after the data analysis occurred. I listened to the recorded files and read the transcriptions multiple times to get a holistic sense of participants’ experience and to continue to check for particular emphases or nuanced meaning in their narration (Hycner, 1985). Finally, the data analysis through categorization included my reflections on the collected data and empathetic interaction with the participants (Creswell, 2013).

Ethical Considerations

In addition to the IRB approval, I developed an informed consent form (Appendix C) that included the following (a) the participant’s involvement in the research, (b) the purpose of the research, omitting to describe what the research questions are, (c) the procedures of the research, (d) the risk and benefits of the research, (e) the voluntary nature of participation, (f) the participant’s right to stop the research at any time, (g) the procedures to protect the participant’s confidentiality, and (h) agreement to be recorded (Babbie, 2014).
CHAPTER FOUR: FINDINGS

Introduction

This hermeneutical phenomenological study sought to answer the question: What are the lived experiences of leading spiritual care services in Catholic healthcare organizations in the United States? The development and execution of this research was an effort to provide an emergent and empirically derived description of the phenomenon of leading spiritual care in Catholic healthcare. Additionally, this study aimed to explore these leaders’ perceptions and meaning of their leadership in their particular context or social realities. This chapter presents the phenomenological findings of this research.

As the interviews began, it became clear that the participants’ experience of being spiritual care leaders was extremely significant and impressed greatly upon them. One participant expressed that “it has been any adjective you can think of,” and collectively they described it as “challenging and rewarding, joyful, a wonderful pleasure, fabulous, and life giving.” Two main themes described the leading spiritual care phenomenon. Spiritual care leaders interpret their leadership experience as belonging: Supportive and inclusive environment, Catholic identity, and feeling valued and supported or not, and being transformational: Feeling strategic and an advocate, being supportive, and being resilient.
Table 1

Participants’ demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Faith</th>
<th>Job title</th>
<th>Education</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Female</td>
<td>Presbyterian (ordained minister)</td>
<td>Regional Director of Spiritual Care</td>
<td>Juris Doctor Master of Divinity</td>
<td>Rural and Urban</td>
</tr>
<tr>
<td>P2</td>
<td>Female</td>
<td>Roman Catholic (lay minister)</td>
<td>Director of Spiritual Care for Home Health Services</td>
<td>Master of Divinity</td>
<td>Rural and Urban</td>
</tr>
<tr>
<td>P3</td>
<td>Male</td>
<td>Roman Catholic (ordained minister)</td>
<td>Director of Mission Services</td>
<td>Master of Divinity</td>
<td>Rural and Urban</td>
</tr>
<tr>
<td>P4</td>
<td>Female</td>
<td>Roman Catholic (lay minister)</td>
<td>Regional Director of Spiritual Care and Education</td>
<td>Master of Pastoral Studies</td>
<td>Urban</td>
</tr>
<tr>
<td>P5</td>
<td>Male</td>
<td>Baptist (ordained minister)</td>
<td>Director of Spiritual Care and Education</td>
<td>Master of Divinity ACPE certified educator</td>
<td>Urban</td>
</tr>
<tr>
<td>P6</td>
<td>Female</td>
<td>Roman Catholic (lay minister)</td>
<td>Director of Mission Services</td>
<td>Master of Pastoral Counseling</td>
<td>Urban</td>
</tr>
</tbody>
</table>

Note. All participants except P2 and P3 have 20 plus years of leadership experience. P2 and P3 have less than 10 years.

Presentation of the Findings

Theme 1: Leadership experience as belonging

Subtheme 1: Supportive and inclusive environment

Participants’ identification with the culture of Catholic healthcare was a salient theme of participants’ experience of leading spiritual care in Catholic hospitals. The
spiritual care leaders expressed great appreciation for the holistic care that is offered at Catholic hospitals, that is the attention that is given to the spiritual needs of patients, their families, and the hospital staff. Furthermore, leaders appreciated its supportive environment that allows them to have ongoing development and exercise of their leadership capacities. The majority of the participants began their careers as staff chaplains but, motivated by the encouragement and support of their leaders, transitioned into leadership roles within their organizations. Participants expressed trust in “being seen as leaders” by their own leaders or other people they worked with and ventured into leadership roles without any previous experience or training.

With regards to the departments they lead, participants appreciated that spiritual care is not an add-on aspect in Catholic healthcare. Rather, because of the mission of Catholic healthcare, spiritual care is an integral component of interdisciplinary clinical and organizational teams. As leader P6 said: “You are free to be who you are. You do not have to go through resistance. You can even empower others and help them understand what spiritual care is and how they can support patients.” Holistic attention to the staff’s and patients’ spiritual needs goes beyond solely attending to their religious needs, though when needed these are often included in the support that they receive.

Moreover, spiritual care leaders are included at organizational meetings where important decisions are made. As P4 stated it: “One of the most important things for me is that I am not chasing the administration saying, ‘What about pastoral care? Or how about spiritual care?’ No, I am at the table. I am another colleague, whatever happens, whether we get raises or not. Whatever we talk to dismiss people or not, or eliminate
Leading in Context: The Lived Experiences of Spiritual Care Leaders

Programs, I’m right there in the conversation. I’m not an afterthought.” This is another aspect that reflects the holistic characteristic of Catholic healthcare.

Catholic healthcare’s commitment to its mission and core values speaks to the hearts of participants, as they expressed feeling proud in belonging to it and promoting its mission. This is strongly exhibited by participants who have dual leadership roles for spiritual care and mission. For example, P3 expressed: “Because we are charged with moving the hospital forward in clinical and non-clinical ways... my presence around the table is not just a listening presence, but I really try to ask questions and seek clarification, because that's really important... A chief executive in my previous hospital said to me ‘... I need the mission leader around the table...So my expectation of you is that you are not a silent partner all around the table.’ And that really was transformative for me.” Spiritual care leaders are integrated in the operational teams and empowered to provide their thoughts and comments, something participants found encouraging and affirming of their role within their institutions.

Subtheme 2: Catholic Identity

When placing Catholic healthcare within the context of the Catholic Church ministry, the meaning participants made of their leading experiences differed. Spiritual care leaders who profess the Catholic faith perceived their experiences as a privilege and a responsibility. They perceived their role as one that safeguards their organization in being faithful to its Catholic identity in accordance with Catholic social teaching and the ERDs. P4 for example, grew up, was educated, and worked within the Catholic environment all her life. She described the impact and influence her family, particularly
an aunt and an uncle who were religious and ordained ministers in the Church respectively, had in her upbringing and becoming the person and the leader she is today.

P2 also shared stories of her growing up on her family farm and the role Catholic faith played in her personal and family life. She shared how her parents, informed by their faith, lived a life devoted to service not just to their children but anyone they met, especially those who worked for them. She said: “I really know that home is where [I learned] about servant leadership, caring, and helping someone grow... They really taught me how to love and to care.”

Conversely, leaders that do not profess the Catholic faith perceived their roles as being a steward in which they learn what the Catholic Church guidelines for healthcare are and ask clarifying questions when needed. They are thoughtful and informed leaders that do not hesitate to reach out to their Catholic colleagues when needing help understanding the church guidance. While personally they do not abide to the teachings of the Catholic Church, they look after it and support it as long as they can still do their jobs with integrity. As P1 stated: “I appreciate the ERDs. They are a careful and thoughtful guidelines that reflects Roman Catholic tradition…where I understand myself, as a person of faith, that does not always agree with me. I know those places and circumstances where there might be that sort of tension, but I know how to manage that, and I think I can manage that in a way that keeps integrity both for myself and for the position. If that were to change, I would have to reconsider whether it was still appropriate for me to be a leader [here].”

P5, an ordained Baptist minister who has held leadership positions in Catholic healthcare for most of his professional life said: “When a chapel needs to be blessed, this
is very kind of me, but the leader on record is the priest there, not me the director of spiritual care…yet, I educate, hire, supervise and at times have had to dismiss Catholic priests with whom I cannot share communion, from whom I cannot receive the Eucharist.” However, this exclusion from officiating liturgy and the sacrament of the sick applies to both Protestant and Catholic lay leaders. Catholic leaders as lay leaders in the Church know that this is ordinary, but ordained Protestant leaders saw this is a part of the limitations that they face as Protestant clergy working in Catholic organizations.

These spiritual care leaders clearly expressed knowing that they do not identify themselves as belonging in this broader church context. At times participants spoke about this with humor, as they related stories of being asked to administer sacraments and having to explain they were not ordained Catholic ministers, but also with authenticity and honesty as they spoke of their own religious traditions and their own churches where they worship, find community, and participate in the Eucharist. These participants had a keen awareness of the ambiguities their roles bring.

Subtheme 3: Feeling valued and supported or not

Their success at development, growth, and career advancement was something participants attributed to the mission leaders they reported to. Supportive mission leaders would encourage spiritual care leaders to pursue further education, expand their leadership opportunities, and support their initiatives and strategic plans. Participants valued this support and knew their flourishing depended on it. Participants attended leadership conferences and webinars, as well as leadership formation programs offered in their organizations. P1 said: “I have had opportunities to do some education regarding
leadership, and so some of [my learning] has been theories…other has been practices that I have been exposed to.”

Participants spoke of receiving training in finance so they could learn how to develop and maintain a budget. They also received training in human resources and personnel management where they could learn about hiring for mission fit, conflict management, and accountability. Other training included strategic planning, mission formation, and leadership styles and approaches. Additionally, leaders were included in organizational wide training for leaders regarding patient safety.

Through this support participants were able to expand services such as ambulatory services, train volunteers as pastoral visitors, add additional support groups to the ones that were already being offered, become more integrated in new nurses’ orientation so they learn about spiritual care, and provide stress management programs for employees through their organizations. As a proof of the support they receive from their mission leaders, during the course of this research two of the participants shared that they were promoted to senior leadership positions to provide strategic guidance on spiritual care for their systems, while a third one was given a regional leadership role.

On the other hand, participants felt that their growth was “stifled” or “stagnant” whenever their leaders were not supportive. In these circumstances, participants perceived some jealousy from their reporting leaders which made their work environment toxic. P6 said: “It was a challenge working with that leader, who just had to be the star of everything… And never supported me... I could not get things done. My boss, again, the VP of mission, undermined me. I got hired to build up the department, make it healthy. [But] she was the problem. I went into a toxic environment.” Participants felt
unrecognized and unvalued whenever their leaders stole their ideas, withheld information
from them, and excluded them from participating at important meetings or events.

**Theme 2: Being transformational**

**Subtheme 1: Feeling strategic and an advocate**

Spiritual care leaders had an inner sense of knowing what needed to be done to
advance spiritual care services in their organizations. Their intuition, in some cases,
guided them to leverage relationships with other people in the organization for the
creation of new positions, e.g. to add new positions for spiritual care leadership and/or
chaplaincy in hospitals that lacked such positions, or to expand service coverage in areas
with large patient volumes and chaplaincy needs. In other cases, they were guided to
assess and be aware of both healthcare and organizational changes as well as the
evolution of chaplaincy.

Of the former cases, P1 said: “In 2014, there was energy and desire to create
regional positions...to try to help make things more efficient, standardize practices
between each of the four hospitals, and [to] help cultivate strategic leadership...I offered
my feedback and spiritual care [became] one of the places they found opportunity to
regionalize.” In the later cases, P4 stated: “Spiritual care has changed so much here. I
mean, the chaplain used to be leading with communion, and you took care of your own
unit, and that was it. No. Now we have huddles, and at the huddle the staff decides who
is gonna cover what...The staff has specialties, people have pediatrics, people work in
MICU for continuity of care.” Spiritual care leaders worked on developing best practices
for their department and ensuring their staff completes education, clinical training, and
credentialing. P6 said: “I helped develop them [the chaplains]...they [only] had a unit or
Participants knew that societal and organizational changes due to religious plurality, mergers and an evolving healthcare delivery affect the way spiritual care is practiced, therefore they knew it was necessary to constantly assess and re-assess what were their institutions’ new priorities. P3 recognized this as he acknowledged the changes happening in his system: “Health care is changing in so many different ways. Particularly when we have just formed a partnership with another Catholic healthcare system...We have arrived at a new mission statement...A new circle of values.” P4 said: “You always have to ask: ‘What time is it?’ You have to ask that every day... To make decisions about where are we going to go in the 21st century as population health comes into full place…We cannot do everything. So, what are the things we can do well?” One of these things, they expressed, is their ongoing commitment to hiring chaplains with diverse religious backgrounds that represented that of their changing demographics of their patients.

Moreover, spiritual care leaders knew they need to understand the work of the chaplain, therefore they believed spiritual care leaders needed to be board certified chaplains themselves to fully understand what this role entails. They needed to understand the organization’s policies as well as to know who the other organizational leaders are; they also needed to know the organization’s vision. P2 says: “Number one is understanding the work, number two is understanding the policies. A third one is understanding the leaders of the organization. And four, the biggest thing is what is the
strategic plan of each one of those ministries. What are we as an organization striving to do?"

**Subtheme 2: Being supportive**

Spiritual care leaders understood themselves as leaders that foster growth, development, trust, relationships, and maintain accountability within the departments they lead. For these leaders, it is imperative that they, as leaders, and their chaplains devote themselves to learning and to improving personally and professionally. As such, caring is an essential aspect of their leadership: “I care about all the people who report to me. I care about all people, but I especially take to heart the chaplains that are out in the field, and the work they do and what's being asked of them…I really work on building a relationship with the people who report to me. I want to know who they are, and I want to know how I can care for them, because if I do not know who they are and how I can care for them, I cannot provide them the tools that they need to accomplish their goal and feel satisfied in their work” (P2).

Leaders understood that their role is to encourage, to empower, and to support their chaplains so that they in turn can be better in the work they do. According to P5: “I do not think my job as a leader is to be the best at every aspect of Chaplaincy. I really want to see and I want to foster and develop specific expertise in different chaplains.” For P6, it is about “empowering people. That is the biggest thing. I like to see them grow. I would do coaching, whatever I can.”

This caring is holistic, meaning it is not reduced to job needs but also personal needs: “We have hurting people, really hurting staff, I mean emotionally hurt people, like, priests that have been battered in the other jobs...And then they come here and I can
honestly say that if they left, they have left with some healing. Some sense of, that they were appreciated for who they are, not what they do. That has been very intentional... I care about people. But I do not take care of people. I care for them, but I do not take care of them.” (P4). There is a sense that by taking care of the whole person, employees would feel supported and encouraged which in turn would seem to impact their overall work performance.

Empowering and caring sentiments go hand in hand with keeping chaplains accountable: “My leadership style is one of collaboration, empowerment and accountability... I affirm and encourage the gifts that I see everyone have, and to try to be a leader that encourages people to use those gifts and to discover new ones. But also, my leadership style is one where if I have to have a critical crucial conversation with someone then that will be done, but it will be done in a respectful and clear manner” (P3). Leaders balanced offering encouragement and validation with offering challenging feedback so that their staff learns and grows. Leaders expressed being gracious and acknowledging the hardships of the chaplains’ job. They said that they prayed for them daily and took every opportunity to thank them for their work and commitment.

Leadership was not a top down approach but a collaborative effort in which both spiritual care leaders and chaplains engaged and exchanged information, as leaders facilitated this process: “I think part of facilitative leadership is really engaging and trusting your team and demonstrating that by taking some of their suggestions, if you agree with them...this is what I believe...hopefully I am among the best in our group at this, whatever this thing is called leadership” (P5). Leaders are aware of the limits of their knowledge and expertise and rely and encourage their teams’ ideas and opinions
while leading the department. They emphasized on the need for team cohesion even when facing disagreement, and for collaboration when working on any situation that requires problem solving or decision making.

Subtheme 3: Being resilient

Change and transition were common aspects of the leading experience in this study’s participants. Crises of staffing versus budget, group dynamics and personnel challenges, workload demands, merger and acquisition transitions, and support to their staff during change were among the most prevalent.

For example, with four different sites to manage, P1 struggled to be informed and to provide support accordingly: “I am not as aware as I might be of some of the opportunities that are there. It is a challenge to figure out how to get that information, how to be supportive, and how to sort of know when I need to be there physically, and know when it is that I can be confident that the chaplains, who are there, will be able to take care of what is needed…There are not enough hours in the day to do everything that I would like to do, so it is a challenge some days.” P2 also relied on her staff to overcome this issue, since she supervised 34 chaplains that were assigned across ten different home health facilities.

Participants had difficult conversations with their employees that resulted in either conflict resolution or employee dismissal. Participants acknowledged feeling uncomfortable doing this but, having received conflict management training, they knew it was necessary to have these difficult conversations if they were to have healthy teams. P3 said: “We had a department of high stress, and there were some personality conflicts… I inherited a situation where there were personality conflicts from upper
management towards staff. And I inherited that, and I had to navigate that...I had to engage in the resources for disciplinary procedures... that was a big, big challenge that I had to face, and I could either face it or ignore it...tempting to ignore it, [but] I knew as a leader that I had to address it. We had to really have difficult conversations but, in the end, they were worthwhile conversations.”

Finally, financial crises were among the most significant of crises the participants faced as their hospitals were either merging or being acquired by others. These crises either affected them directly, their staff, or their coworkers, in a significant manner. They spoke about the pain of them witnessing their friends suffer job loss due to organization restructuring. They also spoke of their own grief as they too either faced a job loss or had to say goodbye to long term friendships. P2 said: “An incident that impacted me was that downsizing and elimination of roles within the organization, so that was really significant to me...the downsizing had a great impact on me.” And P4 reflected: “Saying goodbye to some of the people I grew up with…when I came here [when] I was 24 and now I'm 60...there's grief here. There is [a lot of] grief at work.”

Participants were very aware of how their staff was also affected by this change. They knew of the necessity to communicate with their staff, and to communicate often, so that their anxiety would be lessened and they would not despair and lose hope. These times of changes were marked with the participants’ significant learning and growth that helped them to become resilient.

**Analysis and Synthesis of Findings**

The findings of this research indicate that the phenomenon of leading spiritual care in Catholic healthcare is very significant and valuable for these participants. They
reflected on how their experience of this art, of developing and implementing a continuum of spiritual care services in alignment with the organization’s mission, has been transformative and rewarding, and thus provided evidence to answer the main research question satisfactorily.

The first sub-question “what are leaders’ perceived experiences of belonging to their group?” was also answered satisfactorily. This was a crucial part of leaders’ narratives as they passionately shared their stories of feeling supported, supporting their own teams, building them and helping them to develop. Conversely, their experiences of not belonging were strongly marked with disappointment and discontent with their own leaders, and of feeling unappreciated and unvalued.

Overall, participants shared their experiences of leading from their interactions with both their employees and own supervisors, their experience of catholic healthcare, and the significance of spiritual care in the mission of their organizations. Their narratives contain important social aspects that have allowed them to become the leaders they are today, which again points to the significance of the social dimension of leadership in leaders’ experiences.

**Summary**

The study of the phenomenon of leading spiritual care services in Catholic healthcare revealed two main themes in this dissertation. The two themes of belonging and being transformational were crucial aspects of the participants’ leadership experience. Participants significantly valued their work and the opportunity to lead in places where they felt supported and cared for. These leaders also cared for their own employees, supported them, and empowered them. They were aware of the need for
ongoing development and growth and sought opportunities to achieve this. These leaders’ experiences indicated that meaningful and rewarding leadership experiences are possible and achievable. However, most of the participants had undergone experiences of not belonging at some time in their career if not at the present time, and such experiences often cause strong sentiments of discontent with their own leaders of feeling unappreciated and unvalued.
FIVE: CONCLUSIONS AND RECOMMENDATIONS

Introduction

This final chapter will present recommendations for leaders to implement if they desire to achieve a significant leadership experience, similar to the ones the participants in this study experienced. Existing empirical data shows the quality of the employees’ relationships with both their leaders and their organizations as positive contributors to job attitudes such as job satisfaction and perceived organizational support (Wayne, Shore, & Liden, 1997). The emergent empirical evidence derived from this study may expand on this knowledge, and it provides guidance to spiritual care leaders who seek to improve their leadership skills. These two aspects constitute the basic support for the recommendations given below, knowing that social contexts are important aspects of leadership, spiritual care leaders may want to consider a variety of approaches that will help with developing and maintaining meaningful relationships with their own employees.

Purpose of the Study

The purpose of this phenomenological study was to understand the lived experiences of spiritual care leaders in Catholic hospitals and the meanings they create of those experiences. The central phenomenon of this study was leading spiritual care services which was broadly defined as the art of developing and implementing of a continuum of spiritual care services in alignment with the organization’s mission. As an interpretative phenomenological approach, the study held both participants as experts of their own lived experiences of leading and the researcher as the reflexive agent questioning the participants’ understandings as well as the researcher’s own.
Aim of the Study

The aim of this dissertation was to provide emergent empirically derived description of spiritual care leadership in Catholic healthcare. I hope that these results will help other spiritual care leaders reflect on their own experiences, compare them to their own, and learn from the findings described in this study. Particularly, I hope these leaders would contemplate how their leadership would not only depend on their personal qualities and skills but also on their social realities and contexts; this means incorporating their own perceptions of how their leadership derives from their relational and structural dimensions of their work environments. I also hope that credentialing bodies will use this information on the role of social exchanges in the workplace, when devising competencies for the leadership formation, development, and certification of spiritual care leaders.

Proposed Solution

I am proposing a professional seminar to educate spiritual care leaders and the NACC/CHA task force about the necessity for ongoing leadership development for spiritual care leaders in Catholic organizations. The goal of this seminar is to educate this audience about the two factors that appear to influence spiritual care leadership in Catholic healthcare based on this study’s findings: (1) Senior leadership support, and (2) Leadership mentoring, and (3) to propose an additional competence “ongoing engagement in leadership development and mentoring” to the Leadership criteria the task outlined in 2009 (Addendum D). Being spiritual care an essential element of Catholic healthcare mission, it is important to attend to the quality of the working relationship of spiritual care leaders and their mission leaders, and how these mission leaders can help
with building capacity for spiritual care leaders to enact their leadership to promote spiritual care. Likewise, it is important for spiritual care leaders to have access to adequate mentoring that will allow them to transform and grow in self-awareness, teamwork, empowerment and other skills that will ultimately promote their own teams’ development. A conceptual model representing this proposal is offered below in figure 1.

This proposed solution is based on this study’s findings on the importance of leaders’ establishing and maintaining good relationships with their own leaders and as well as with each of their own followers. It is through the quality of their relationships that spiritual care leaders find meaning in their leadership experience, therefore the recommendations offered below point towards the development of leadership soft skills that with aid with improving spiritual care leaders’ self-knowledge, their relationships with their employees and their own supervisors.

Additionally, the term relationships, as shared by participants, encompasses more than personal knowledge. It means assessing and knowing their own and their employees’ weaknesses and strengths, motivations, hopes, desire for growth and knowledge, and tailoring down the support employees need in all those areas to allow them to perform to their greatest potential. The strategies participants shared they use to achieve this, as well as strategies derived from relationship-based approaches of leadership, were considered in the development of the proposed recommendations offered below. Relationship-based leadership theory lies on the premise that a leader and a follower influence one another through a series of interactions, and that when these interactions are favorable they positively influence organizational variables such as
performance, turnover, job satisfaction, organizational commitment, empowerment, among others (Graen & Uhl-Bien, 1995).

**Figure 1.** Conceptual explanation for spiritual care leadership development

**Organizational culture supports valued social exchanges that promote leadership development.**

**Senior leadership support**

Spiritual care leaders’ reporting mission leaders or other reporting supervisors have an essential role in building capacity for spiritual care leaders to exercise their leading abilities. As such, these reporting leaders need to be aware of the resources spiritual care leaders need to perform in their role, as well as how they can affect organizational structures and contexts to either enable or hinder spiritual care leadership. Consequently, they need to create a culture where leadership development is valued and promoted, and to develop strategies for long term sustainability. To the degree these reporting leaders invest on spiritual care leaders’ development, these spiritual care leaders’ performance, perceived job satisfaction and organization commitment can be significantly be improved overtime.
Recommendation one: Relationship with their leaders

Participants in this study attributed the majority of their satisfaction with their leadership role to the support they received from their immediate supervisors. Leaders identified a mutual trust based on reciprocal respect and regard for each other. Based on this, leaders’ relationships with their supervisors can also benefit from frequent meetings and communication, where both leaders and their supervisors shared their individual personality styles, communication needs, and support desired. While leaders cannot control how their individual supervisors would respond to their needs and attempts to improve their relationships, the leaders’ ability to influence their supervisors can lead to a positive engagement and it should be their priority.

Leaders could also attempt to learn about their supervisors’ goals and receive advise on the different ways they could help their supervisors achieve their goals. Emphasizing on the use of their talents would lead to both the leaders’ and their supervisors’ satisfaction as they would both experience a sense of accomplishment. Leaders could also communicate frequently with their supervisors about activities, projects and the likes that are being carried out and the progress or lack of thereof of these. Frequent communication can lead to transparency, generate supervisors’ trust on leaders, and eliminate opportunities for supervisors’ concerns about leaders acting behind their backs.

Leadership Mentoring

Spiritual care leaders need to retained the reflective practice skills they learned during chaplaincy training. Maintaining a practice of action-observation-reflection will allow them to critically examine their leadership behaviors and discover areas in need of
improvement into developing a transformational leadership. Spiritual care leaders may establish mentoring relationships with seasoned leaders that can served both as role models of transformational leadership behaviors and values, but also as sounding boards for spiritual care leaders as they shared their self-reflections and observations of their own leading behaviors.

Mentors can also assist spiritual care leaders with creating a leadership development plan that includes aspects such as leaders’ personal definition of leadership, a self-assessment, values, their vision for their department, goals, among others. This written tool can be an efficient road map for both mentors and leaders as they collaborate in promoting leaders’ development.

**Recommendation two: Leaders know thyselfs**

Leaders need to be competent in the work they perform as well as to know what their limitations are. In terms of competence and skills, they need to be aware of their strengths as well as their weaknesses. Leaders should leverage their strengths to seek support or further growth in areas that they still need development in. For example, one participant mentioned her lack of confidence in dealing with finance in spite of training, but emphasized that her ability to establish friendships with different peers in the organization helped her to seek out support from them who were better in this area. Other participants mentioned furthering their skills by taking advantage of professional development classes that their organizations offered. Leaders’ awareness of their knowledge-needs and their ability to seek out support will contribute to their professional growth.
It is also important that leaders recognize their cognitive preferences and biases. For example, one of the ways leaders can identify their personality and thinking styles is by using tools such as the Myers Briggs Type Indicator and the Clifton Strength Finder. Knowing their level of intra/extraversion, communication and thinking style, and natural talents will help leaders with establishing relationships, particularly when others’ styles are different than theirs. This can also contribute to increasing a leaders’ emotional intelligence, which is known as the ability to understand, manage, and express one’s own feelings and engage with others’ feelings. This aspect also consists of a leaders’ awareness of how they display their personality, their verbal and nonverbal communication, how their emotions are managed, particularly in stressful situations, and how, from all of these, leaders are perceived by others. Through effective understanding of themselves and collaboration/cooperation with others, leaders can serve as role models to others in their organization including their own employees.

Leaders that know themselves can clearly articulate their purpose and, while working at an organization, they can use such charisma to articulate their vision for their departments they lead. They are not victims of deception and arrogance who think they have all of the answers, but they are rather strategic, humble and wise; they know that the best solutions come from a team-approach that garners the collective wisdom of their members. Failing to place adequate attention and intentional efforts to improve in this aspect can effectively sabotage leaders’ chances to earn trust and respectability among their followers and their own leaders, which will in turn affect their ability to establish meaningful relationships.
Recommendation three: Leaders’ relationship with their followers

Frequent meetings with each of their employees will help with them to know about each employee’s personal and professional life and goals; it also provides an opportunity for employees to know their leaders. The goal of these meetings, for the leaders, should be for creating and sustaining relationships. The maintenance of these relationships is done through coaching and mentoring, encouraging and empowering, and attending to each employee individually.

Leaders could consider Maslow’s hierarchy of needs and focus on the interactions with their followers based on their individual needs. For example, in times of change and uncertainty, leaders could be open and available to receive questions and concerns, to create a safe environment for employees to speak honestly, and to show empathy. One of the participants in this study shared a story of a time of downsizing in her organization. During this time, her employees expressed fear of losing their jobs and of a future in the organization. They were grateful that she allowed them a space to vent, showed genuine concern and gave them timely information during the process. Leaders’ awareness of their employees’ needs for safety and security during such times would enhance their relationships and increase trust as employees feel heard, supported, and cared for.

When listening for employees’ self-actualization needs, leaders can provide opportunities for performance challenge by assigning new tasks. This should continue as long as employees accept the challenge and enjoy the satisfaction of the challenge and their feelings of fulfillment. Tasks, assignments, or projects assigned to individuals should not be of a level of difficulty and complexity that is too far beyond their skills or capabilities where extensive training would be needed. Nor should the directions be so
vague and ambiguous, so that individuals fail to understand the context or process in which the job is to be completed. Charging the individual with an assignment that is too difficult to perform may create high levels of stress and anxiety, along with individuals’ perceived potential failure to accomplish the tasks. And, rather than contributing to a sense of job fulfillment and trust in the relationship with their leaders, it may create in individuals sentiments of distrust of their leaders due to their lack of judgment and consideration in placing too high of a responsibility on them.

This process can lead to a conversation with employees about their career advancement goals, and leaders’ better understanding of individuals’ desires for their professional growth in both the present and the future. These leaders could continue to propose challenging tasks and questions about performance improvement that will allow employees’ creativity to blossom. They can accommodate this aspect in accordance to their employees’ engagement in this process and discern how best to guide and manage each employee individually, so that their employees’ furthered development contributes to their employees’ morale and sense of achievement and satisfaction, as well as the overall performance of the organization. Finally, leaders need to display affect, concern, and respect so that their employees may perceive leaders’ genuine interest in them.

Support for the Solution

Participants in this study shared their experience of leading through reflecting on the meaning of their relationships with their organizations, their own leaders and with their followers. They experienced their leadership as a privilege and defined it as knowing the people they work with, acknowledging their dignity, and empowering them so they can use their talents to advance their organizations’ mission. To support the
recommendations outlined above, it is worth considering the social exchange relationships, a series of theoretical frameworks that state that a reciprocity is invoked anytime someone does a favor to another (Kim & Mor Barak, 2015). Scholar Mary Uhl-Bien (2006) referred to these as relationship-based approaches in which a leader and a follower influence one another through a series of interactions. Two types of such social exchanges are the leader-member exchange (LMX), which is the relationship between leader and follower, and the perceived organizational support (POS), which is the relationship between worker and organization (Kim & Mor Barak, 2014).

Since this is a qualitative study, it is beyond of the scope of this dissertation to determine if whether POS and LMX precede or succeed the supportive and transformational behaviors that are part of the leadership experience of this study’s participants. However, what can be said is that the presence, in the participants’ narrative, of those two common themes of being supportive and transformational, suggests that LMX and POS could be at play and responsible for the behaviors and attitudes revealed in this study. In terms of support, when followers perceive their supervisors as caring and friendly, the perceived value of the social exchange is great, and thus the quality of the LMX relationship is equally high (Wayne et al, 1997). This kind of relationship is characterized by leader and member reciprocal respect, trust, support, influence, and loyalty (Deluga, 1994). Likewise, when employees perceive their organizations as supportive and caring, POS is high, and employees display high levels of commitment and effort (Kim & Mor Barak, 2014). Empirical evidence also shows the positive effect of quality social exchanges on other job attitudes such as job satisfaction, job involvement, organizational commitment, ethical climate, employee engagement, and
organizational citizenship behavior (OCB) (Erdogan & Bauer, 2010; Robins & Judge, 2016).

One study demonstrated the multidimensionality of LMX, and it validated the presence of affect, loyalty, contribution and professional respect in high quality LMX (Linden & Maslyn, 1998). Another study showed that LMX, in particular, is strongly related to OCB and task performance (Waismel-Manor, Tziner, Berger, & Dikstein, 2010). The experience of leading of participants in this study seem to show both low and high LMX quality. Leaders that expressed dissatisfaction in their relationship with their supervisors, due to lack of care, respect, and support, eventually left their jobs. Conversely, leaders that expressed satisfaction with their supervisors and their organization, felt supported, received opportunities for career advancement, maintained long tenure and expressed commitment to their organizations. All leaders expressed supporting their own employees, caring for them, and desiring their growth and development.

Additionally, transformational leadership is a “process whereby a person engages with other and creates a connection that raises the level of motivation and morality in both the leader and the follower” (Northouse, 2013). Transformational leaders inspire, meet emotional needs, and intellectually stimulate those they lead (Bass, 1990). Transformational leaders care about their followers’ emotions, values, ethics, standards, and long-term goals, and they desire to understand their follower’s motives, satisfy their needs, and treat them as full human beings (Northouse, 2013).

The four dimensions of transformational leadership (4 I’s) are: (a) inspirational motivation, where leader communicates meaning and challenge, (b) individualized
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

consideration, leaders’ close attention to each member of the team, (c) intellectual stimulation, leaders’ encouragement to their associates in being creative and to grow, and (d) idealized influence, where leaders are role models. The 4 I’s can be applied as transformational leaders share a sense of mission, mentor or coach, spark creativity, and earn trust with their associates. The leading experience of participants in this study seem to display some of these transformational I’s, as they shared an inspiring vision, attended to their individual needs, and encouraged and developed their employees to apply their knowledge and talents through their organizations.

Finally, these transformational behaviors appeared to assist leaders while supporting their teams during difficult times of change and transition. They communicated to their employees any relevant information as soon as they received it and also showed empathy when employees became concerned. Leaders were able to interpret and articulate external environmental factors that interacted with and affected the organization’s financial performance, and to inspire their teams to both become adaptive and see the challenges as opportunities. These results are encouraging given that positive contributions of transformational leadership behaviors to affection and resilience building in followers have already been demonstrated (Sommer, Howell, & Hawlett, 2016).

Implementation of the Proposed Solution

The different factors involved in the implementation of this solution are outlined below:

Factors and Stakeholders Related to the Solution

Spiritual care leaders are the main stakeholders related to this dissertation’s proposed solution. Their growth in self-awareness would shine a light over their
behaviors and actions that need development and those that get in the way of their leadership being effective (Pienaar, 2009). If unchecked, the behaviors that do not contribute to their leadership can become “blind spots” and the cornerstone of inefficiency (Pienaar, 2009).

The chaplains that report to spiritual care leaders, the leaders’ supervisors, and hospital administrators are the other players affected by the proposed solution. To the extent that these parties are committed to engage in a reciprocal relationship with the leaders, the proposed solution is feasible. However, their inability to do so becomes a barrier and it will be discussed below.

- **Potential Barriers and Obstacles to Proposed Solution** – Chaplains and spiritual care leaders’ supervisors can be a barrier to the proposed solution if they do not positively respond to leaders invitation to enhance their relationships. Chaplains may be content with merely meeting the bare responsibilities of their role and decline taking on additional tasks, regardless of how much the added responsibilities will contribute to their growth. In the same way, leaders’ supervisors may not desire a closer relationship with them and may be satisfied with leading in a transactional way. Transactional leaders do not focus on their follower’s needs or growth (Northouse, 2013), therefore this approach to leadership does not support the proposed solution.

- **Financial/Budget Issues Related to Proposed Solution** – Budgetary issues can significantly affect the proposed solution. Healthcare’s competitive market and evolving reimbursement models will always be a threat to spiritual care departments. Confronted with healthcare provision costs and reimbursement
challenges, hospital administrators will tend towards identifying areas where they can afford workforce reduction to minimize labor expense and spiritual care seems to always be one of them (O’Gorman, 2005).

Implications

Practical Implications

This study’s findings point to the potential value of the social dimension of leadership in the phenomenon of leading of spiritual care as it related to senior leadership support and leadership mentoring. While generalizations cannot be made, spiritual care leaders in Catholic healthcare can reflect on their own experiences and compare them to those of the participants in this study. Spiritual care leaders struggling to make meaningful connections with their chaplain employees and with their own supervisors can utilize this study’s proposed solution and recommendations to improve their relationships and overall social exchanges, that consequently will help improving their leadership abilities. Additionally, leaders need to seek out opportunities for ongoing learning and development, particularly in areas that are not taught in chaplaincy training such as finance and human resources, so that their leadership skills and practice can be more balanced.

Competencies for spiritual care leadership. The existing field of competencies for spiritual care leadership identified by the CHA/NACC task force includes organization dynamics. Since organizational dynamics looks at people’s behaviors within their groups, the social exchanges recognized in this study can help leaders in identifying potential behaviors that can help their leadership. This is why the task force defined being competent in organizational dynamics as knowing and being able to
navigate and maneuver within structural, cultural, and power relationships within an organization to achieve desired outcomes falls short. While it includes an understanding of how a system operates in terms of how individuals, groups, and the whole organization interact, it does so from the mission integration perspective without accounting for the social processes that are entailed in these relationships. And, it establishes how the leader must assess how strategic goals are aligned to the organizational mission and how accountability is hardwired to ensure that alignment. It needs to also include the socio-relational aspect of leadership as an aspect of this competence, since as described above, it encompasses the different interactions of leaders through social exchanges that ultimately affect they work they perform. One of the ways to promote this aspect is to check for leaders’ ongoing development and assessing to mentoring as one of the criteria for leaders’ board certification.

Additionally, curricula for healthcare leadership programs need to include social exchange theories that explain the operating social processes that are present in organizations and that shape leadership. Herd, Adams-Pope, Bowers, and Sims (2016) overwhelmingly found that the most reported competences, among the National Center for Healthcare Leadership competences they investigated, were people-related competencies particularly talent development and self-development which is similar to this study’s findings. This suggests there is a general understanding among executive leaders of the value and the role of social exchanges in healthcare leadership.

**Executive leader understanding of spiritual care.** Executive leaders in Catholic healthcare can see this study as a resource to understand spiritual care leadership and the support spiritual care leaders need to perform their jobs. For example, they can
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

look at their current leadership practice and how they support spiritual services. They can increase communication with spiritual care leaders and learn about their priorities and needs. According to the organizational structure, spiritual care leaders typically report to mission integration vice presidents or chief mission integration officers. These senior executives play a very important and decisive role in spiritual care leadership, as they manage the overarching mission budget under which spiritual care departments operate. These mission leaders come from different backgrounds, but usually from business and human resources areas. Some receive some basic theological and spirituality training while being onboarded to these roles, while others pursue two- or three-year graduate degree in mission integration at some Catholic universities. This graduate program was intentionally developed to attend to this specific mission role in Catholic healthcare.

However, as healthcare continues to change and challenge organizations to reduce healthcare costs, and as these mission leaders continue to deal with the perennial “what makes a Catholic hospital Catholic?” question, the tension is warranted. Spiritual care is one of the six Catholic social and pastoral responsibilities these mission leaders attend to as they promote the organization’s Catholic identity. In efforts to promote the other five areas, these leaders may sacrifice investing in spiritual care due to their lack of understanding what it is exactly. Some mission leaders recognized this by admitting their discomfort and inadequacy when trying to convey the value of spirituality and ethics in Catholic healthcare (McCarthy, 2019). Thus, it is argued that a terminal degree in theology is what gives mission leaders the proper formation and education, and thus the ability to speak about “the depth of the social mission of Catholic healthcare” (McCarthy, 2019, pp126). The supportive mission leaders in this study, participants’ study reported
to, were either former priests, religious women, former nurses, or lay leaders with a Ph.D. in Ethics and Moral Theology.

While it may not be possible for every mission executive leader to achieve this high level of education, establishing a deeper working relationship based on trust, respect, and support with their spiritual care leaders may help in developing this greater understanding of the value and depth of the social and pastoral responsibilities of Catholic healthcare. Their mission formation should include a relational dimension, which has already been deemed as essential, as it is what connects mission leaders to all organizational stakeholders and allows them to know stakeholders’ hopes and concerns (Gallagher & Reid, 2015). This relational dimension also allows mission leaders to empower and encourage stakeholders, spiritual care leaders included, to work together solving the complex moral, financial, and social issues that Catholic organizations face every day (Gallagher & Reid, 2015). Finally, as these mission leaders become more invested in supporting spiritual care, they can both support its ongoing integration in healthcare provision and advocate for the different ways in which it contributes to the promotion of the common good and the improvement of the communities Catholic hospitals serve.

**Implications for Future Research**

This study provided empirically derived evidence of the phenomenon of leading spiritual care in Catholic healthcare. While it found that the social dimension of leadership, in terms of relationships, may play an important role in the leadership process, future studies that includes a much larger sample may expand on the importance of meaningful relationships and quality social exchanges in spiritual care leadership.
Qualitative studies such as this one can serve as the foundation for future quantitative designs aimed at developing leadership instruments to determine the specific social behaviors that spiritual care leaders display. Future research may also include the study of this phenomenon in spiritual care leaders in non-Catholic hospitals to determine if the same social aspects are present.

Moreover, executive mission leaders seem to contribute to how this phenomenon as experienced by spiritual care leaders. Therefore, they can have a pivotal role by the way they support spiritual care leaders with commitment to ongoing skill training and professional opportunities that should not be limited to career advance, but that should also include research. As efforts are taken to make spiritual care an evidence-based practice discipline, executive mission leaders can be advocates and promoters by investing on the necessary resources that will allow spiritual care leaders and their staff chaplains to include research as another component of the regular operations. Since participants in this study shared how the financial constraints of healthcare affect them, ongoing research should also focus on how both spiritual care and spiritual care leadership contribute to the promotion of holistic healthcare that is at the core of the mission of Catholic healthcare. The findings may assist leaders in asserting the efficacy of spiritual care in the provision of healthcare, in the promotion of the common good, and in garnering evidence to advocate for workforce protection, when dealing with budgetary crises in this ever-changing healthcare environment.

**Implications for Leadership Theory and Practice**

The social aspects of leadership continue to receive increased attention and ongoing research is still needed to continue to understand the contribution of these
aspects to effective leadership (Linden & Maslyn, 1998; Uhl-Bien, 2006). The reciprocity between leaders and followers continues to need evaluating and additional instruments need to be designed to determine the specific behaviors that affects leadership. For example, the contribution of affect to LMX is so significant that a new theory has been postulated as researchers promote the role of and need for further research on emotions in leadership (Cropanzano, Dasborough, & Weiss, 2017).

Likewise, this study seems to point to meaningful relationships as significant social exchanges that are present in the leader-follower interaction in organizations. This evidence may add to this general knowledge, particularly as it seems these interactions have not been researched yet in Catholic organizations.

Additionally, while contemporary understanding of social exchanges includes interpersonal relationships, and research has primarily focused on three of the identified approaches that emphasize either relationship formation, attributes of relationships, or relationships as social context, it is also suggested that future research focuses on the role of environmental moderators such as constraints, motives, time, and available resources (Mitchell et al., 2012). The findings of this study seem to show how support from their own leaders may contribute to spiritual care leaders’ meaningful leadership experience, while conversely the lack of support negatively affects the leadership experience of spiritual care leaders. This seems to resonate with the existing evidence of constraints impacting quality social exchanges, and the presence of individual motives that determine the value of the social exchanges. Ongoing research may help determine the specific role of these environmental moderators in organizational social exchanges, such as a greater understanding of their role as promoters or hindrances of leadership.
Summary of the Study

This dissertation explored the leadership experiences of spiritual care leaders in Catholic Healthcare, aiming to provide empirically-derived evidence that contributes to the audience’s understanding of spiritual care leadership. The participants were six professionally recognized leaders from two main Catholic healthcare systems in the country.

The phenomenon of leading from these participants’ experiences contained two main themes: leadership experience as belonging and being transformational. These two themes seemed to point to the importance of meaningful relationships in these leaders’ experiences, and thus to the social processes between these leaders and their employees as well as the leaders and their own supervisors. The proposed solution and recommendations stated in this study can help with building a culture that promotes leadership development and inform leaders who are hoping to improve their leadership and work experiences as well as that of their employees.

This study provides a foundation for future research to continue to expand on this topic, to eventually provide evidence of the behaviors spiritual care leaders need to display to facilitate quality social exchanges that result in meaningful relationships. This will contribute to the development of best practices for spiritual care leadership and significantly improve the promotion of the profession of chaplaincy in healthcare.
References


LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS


http://eds.b.ebscohost.com.cuhsl.creighton.edu/ehost/pdfviewer/pdfviewer?vid=1 &sid=0166e82a-e79c-45bd-910c-17a8b2518bb9%40sessionmgr102


Flannelly, K., Oettinger, M., Galek, K., Braun-Storck, A., & Kreger, R. (2009). The correlates of chaplains' effectiveness in meeting the spiritual/religious and emotional needs of patients. *Journal of Pastoral Care & Counseling, 63*, 1-16. Retrieved from:

http://eds.b.ebscohost.com.cuhsl.creighton.edu/ehost/pdfviewer/pdfviewer?vid=1 &sid=7a545f43-f3db-492e-88e4-35e6e3ba5dd3%40pdc-v-sessmgr01


Years: Applying a Multi-Level Multi-Domain Perspective. *Management Department Faculty Publications, 57.* Retrieved from:
http://digitalcommons.unl.edu/managementfacpub/57/?utm_source=digitalcommons.unl.edu%2Fmanagementfacpub%2F57&utm_medium=PDF&utm_campaign=PDFCoverPages


Kim, A. & Mor Barak, M. E. (2015). The mediating roles of leader–member exchange and perceived organizational support in the role stress–turnover intention


leadership, and socioeconomic context effects. *Journal of Business Research, 66*, 2139-2146.


VandeCreek, L. (2000). How has healthcare reform affected professional chaplaincy programs and how are department directors responding? *Journal of Healthcare Chaplaincy* 10, 7-17. doi: 10.1300/J080v10n01_02


Appendix A

Director of Pastoral Care

Sample Job Description — Director of Pastoral Care

Position Title: Director of Pastoral Care

Responsible To: Administrative Representative (Mission Leader most often)

Department: Pastoral Care

I. GENERAL DESCRIPTION

The director of pastoral care is responsible for the development and implementation of a continuum of pastoral services aimed at meeting the goals and objectives of the department. These services are available to all patients/residents/clients, families, and staff. In this pursuit, the director is responsible to administration for the economic and human resources of the pastoral care department.

II. QUALIFICATIONS

A. Education

1. Minimally, a bachelor’s degree is required. Ideally, a graduate degree in a related field is appropriate. 2. The director has experienced formal training within a management or curriculum setting.

B. Training

1. Certification by an appropriate clinical pastoral agency and ongoing advanced training in theology, management, or clinical or pastoral skills 2. Two years of clinical pastoral experience in a healthcare setting 3. Cooperative relationship with persons of varying
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

faith traditions or of no tradition 4. Knowledge of and support for the Ethical and Religious Directives for Catholic Health Facilities 5. Training in public speaking (bilingual where required)

C. Personal Requirements

1. Solid standing within his or her denomination, as evidenced by ecclesiastical endorsement 2. Demonstrable value placed on the importance of working as a team both within and outside the department 3. Good health and socialization skills 4. Ability to be assertive yet flexible 5. Ability to exercise the authority of the position while knowing how to delegate

III. JOB DUTIES

The director is responsible for:

A. Implementing the institution’s mission and philosophy as it relates to the pastoral care department

B. Annually developing the departmental goals and program objectives in discussion with members of the pastoral care team

C. Implementing a continuum of pastoral services for patients/residents/clients and staff

D. Overseeing the staffing, development, evaluation, and education of members of the pastoral care team

E. Maintaining a process of theological reflection

F. Providing the human and fiscal management of the department

G. Attending and participating in department head meetings

H. Ensuring that adequate worship services are available to the patient/resident/client
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

population

I. Hosting area church leaders and, when possible, being involved within the area ministerial council

J. Accepting daily pastoral care responsibilities when required

K. Representing the institution pastorally to the local community, including public speaking and attendance at social gatherings

L. Conducting educational programs regularly for the staff, including programs for the medical staff

M. Establishing a working and reporting relationship with the diocesan office

N. Consulting with administration, especially in the areas of policy formation and changes within pastoral care services

O. Evaluating pastoral personnel (including volunteers) and services

P. Incorporating pastoral care into the ongoing organizational life of the facility

IV. JOB ACCOUNTABILITY

The director is supervised and managed by the administrator or a representative of administration. The director is evaluated annually and is responsible for submitting reports on departmental activities as required. The reporting relationship between the director of pastoral care and his or her administration should be consistent with that of the other departmental directors.

Interview protocol

**Contextualization**

- Tell me how you came to be the spiritual care leader for this department
- Please describe to me your experience of being a leader here
- Tell me about significant events in your leadership
- Probe questions: Who, why or what make these events significant? What did you gain from these experiences?
- What do you perceive are strengths and limitations of your leadership?
- How do you perceive others see or experience you as a leader?
- What do you perceive is your leadership’s impact on others and on the organization?
- Please tell me what you perceive your department’s contributions to the organization are

**Apprehending the phenomenon**

- Describe your approach to leading this department
- Probing question: what informs this approach.
- Tell me about a typical day for you
- Tell me about challenges you have faced while leading this department

**Clarifying the phenomenon**

- Tell me how you go about knowing what the organization needs
- Tell me how you go about knowing what those you seek to influence need
- Tell me how your department responds to the current needs of the organization
What is it like to be a spiritual care leader in a catholic healthcare organization?
Appendix C

Bill of Rights for Research Participants

As a participant in a research study, you have the right:

1. To have enough time to decide whether or not to be in the research study, and to make that decision without any pressure from the people who are conducting the research.

2. To refuse to be in the study at all, or to stop participating at any time after you begin the study.

3. To be told what the study is trying to find out, what will happen to you, and what you will be asked to do if you are in the study.

4. To be told about the reasonably foreseeable risks of being in the study.

5. To be told about the possible benefits of being in the study.

6. To be told whether there are any costs associated with being in the study and whether you will be compensated for participating in the study.

7. To be told who will have access to information collected about you and how your confidentiality will be protected.

8. To be told whom to contact with questions about the research, about research-related injury, and about your rights as a research subject.

9. If the study involves treatment or therapy:
   a. To be told about the other non-research treatment choices you have.
   b. To be told where treatment is available should you have a research-related injury, and who will pay for research-related treatment.
Appendix D

National Association of Catholic Chaplains Spiritual Leadership Competencies for Pastoral Care September 2009

Introduction

The 2007 CHA/NACC Pastoral Care Summit Care Services Task Force produced in fall 2008 the document, Essential Functions/Responsibilities of a Board-Certified Chaplain. These essential functions matched up well with the scope of services that introduced the Standards of Practice for Chaplains in Acute Care Settings identified by the Association of Professional Chaplains (APC) Commission on Quality Services and affirmed by the Spiritual Care Collaborative (http://www.spiritualcarecollaborative.org/standards_of_practice.asp). The Task Force then targeted the need to identify the Spiritual Leadership Competencies, the skills and training required, for a spiritual leader in pastoral care. While a traditional human resource approach would attempt to identify and categorize the skills, knowledge, and abilities required for leaders in pastoral care, the Task Force rather has identified here “fields” of competencies for what is required to be a successful spiritual care leader. This list is not intended to be a comprehensive nor prioritized list. We realize that not all chaplains and those who minister to the spiritual and emotional needs of patients, families, and associates are called to become spiritual leaders of pastoral care. The diversity of gifts is critical to meeting these needs. However, we also believe that many of these gifts for leadership are present in those currently serving in the pastoral care ministry, and we hope this work will help call them forward, encourage the discernment of these gifts, and lead to the further development of the structures and resources to
prepare them for spiritual leadership positions. Therefore, the Task Force aims were to assist: Mission leaders and human resource specialists responsible to hire those for spiritual leadership. Those responsible to develop and provide education and training. Current directors of pastoral care for their own professional development. Spiritual care ministers who are discerning their own professional growth and direction. It also encourages the further collaboration within and among healthcare systems to develop and/or support spiritual leadership opportunities.

I. Leadership: skills and ability to set the goals of a department and inspire/direct the staff to achieve the goals and live out the mission, vision and values of the organization:

1. Model and demonstrate being visionary and inclusive: 1.1. Communicate a compelling and inspired vision or sense of core purpose for Spiritual Care services. 1.2. Demonstrate how Spiritual Care is an integral function of mission. 1.3. Articulate the need for making Spiritual Care more operational, and explore with system leaders ways to do so. 1.4. Position the Spiritual Care department as a resource for Spirituality and Ethics formation. 1.5. Excel in meeting department goals successfully, and constantly and consistently be one of the top performers. 1.6. Exemplify personally and professionally the mission, vision and core values of the organization.

2. Exhibit a collaborative and interdisciplinary management style with other managers of the organization, as well as with the spiritual care team: 2.1. Work with other disciplines across the organization demonstrating an agility in understanding organizational complexities. 2.2. Promote the value of Spiritual Care across the organization as integral to the organization’s mission of healing. 2.3. Exhibit management skills that provide excellence in the provision of spiritual care services for the organization developing a
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

Spiritual care team to meet the needs of a changing healthcare environment. 2.4. Demonstrate a servant leadership style that promotes the development of leadership skills in the members of the Spiritual Care team.

3. Exhibit a strategic agility in adapting Spiritual Care services to the changing needs of the organization in providing a continuum of care: 3.1. Collaborate with Mission Director and/or Supervisor in demonstrating and promoting creative strategies for the delivery of Spiritual Care services. 3.2. Can rethink strategies and adapt to change for the delivery of Spiritual Care services.

II. Finance/Accounting: Knowledge of current principles, practices, and policies to fiscally manage the department. 1. Comprehend, analyze, and monitor balance sheet and income statement of organization particularly as related to Spiritual Care. 2. Build, monitor, and make value-based decisions regarding budget. 3. Situate spiritual care services within the business plan of the institution/organization and the standards of the profession. 4. Demonstrate to the institution and system “value added” and “cost avoidance” benefit of adequate spiritual care/chaplain staffing.

III. Management: Ability to administer a department in collaboration with other departments and administration throughout the organization. 1. Assess department personnel needs. 2. Design a structure for Spiritual Care department. 3. Work with human resources to develop appropriate position descriptions. 4. Hire, develop, and evaluate staff, with appropriate knowledge of labor laws. 5. Determine needs for and purchase equipment and materials. 6. Manage resources and time. 7. Prioritize tasks and balance a multiplicity of demands. 8. Possess working knowledge of and capability with: 8.1. Behavioral-based interviewing. 8.2. Career assessment tools. 8.3. Team development.
8.4. Employee coaching and counseling. 8.5. Group facilitation. 8.6. Conflict resolution
8.7. Succession planning.

IV. Marketing: ability to direct/process the development/management of services and
products from conceptualization through delivery. 1. Collaborate with key partners to
identify Spiritual Care service needs. 2. Identify, assess, select, and develop Spiritual
Care services that meet those needs. 3. Determine cost and price, method for delivery,
and promotion. 4. Promote the value and need of Spiritual Care across the continuum of
care of the organization. 5. Develop, tailor, and provide education and information to
promote Spiritual Care services to potential users of the services and to decision makers.

V. Organizational Dynamics: knowledge of and ability to navigate and maneuver
within the structural, cultural, and power relationships within an organization to achieve
desired outcomes. 1. Understand how the system operates, i.e., how individuals, groups,
and the overall organization interact: 1.1. Understand the business of mission and
stewardship of resources. 1.2. Know and be able to articulate the organization’s strategic
and mission goals, and know how to relate the Spiritual Care department’s goals and
activity to those goals. 1.3. Know where the Spiritual Care department is situated and
how it functions within its organizational environment (branches, divisions, departments),
and how to communicate/problem solve within the communication/reporting channels of
this environment in order to be achieve desired outcomes. 2. Develop and implement
departmental goals that align with organization’s strategic plan. 3. Demonstrate a
personal and departmental accountability. 4. Understand the integral role of Spirituality
to mission, and communicate with system, administration, and mission leaders the
LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

particular and strategic roles of Spiritual Care. 5. Promote the process of ethical decision-making and theological reflection within the department and within the organization.

VI. Professionalism: knowledge, conduct, qualities, and capacity that characterize the profession of chaplain, based on professional and organizational standards and ethics and the best practices of the profession. 1. View self as professional leader within organization, committed to build professional relationships. 2. Possess the characteristic of being a skilled practitioner; an expert in: 2.1. Setting up an office. 2.2. Dressing the part. 2.3. Communication. 2.4. Transitioning. 2.5. Change management. 2.6. Expanding modalities. 2.7. Interaction (within all levels of the organization). 3.Demonstrate confidence in responding to challenges. 4. Promote the professionalism of the chaplain and Spiritual Care department. 5. Build relationships with key partners in organization and within the professional field.

VII. Quality: desired outcome of a mission driven culture that exhibits excellence in going beyond the expectations of those being served. 1. Provide a quality of Spiritual Care services that is evidence-based, outcome-orientated, and consistent with national best practices. 2. Promote quality as integral to the organization’s mission and purpose. 3. Be able to work with colleagues across interdisciplinary lines to create a healing culture of excellence. 4. Demonstrate a quality of work that is mostly error free the first time with little waste of or redone work in areas of: 4.1. Metrics. 4.2. Cost Avoidance. 4.3. Continuous Quality Improvement. 4.4. Planning and Assessing.

VIII. Strategic Planning: Capable of creating the new and different - to be actively involved in setting short term goals while at the same time being future orientated to establish long term goals. 1.Know current and possible future policies, practices, trends,
technology and information affecting business and organization. 2. Use available information and data in developing techniques to seek better performance. 3. Anticipate future consequences and trends accurately. 4. Possess broad knowledge and perspective. 5. Create breakthrough strategies and plans. 6. Utilize available information and data to forecast techniques to seek better performance.

**IX. Technology acumen:** ability to use current and emerging technologies that underlie effective spiritual care management in today’s world. 1. Possess competence in Word, Excel, Access, PowerPoint or their equivalents. 2. Know of system/organization software that, e.g.: 2.1. Monitor customer and personnel development. 2.2. Track productivity. 2.3. Create budgets and financial reports. 3. Think and communicate as an expert in technology does, e.g.: 3.1. Identify problem and key considerations. 3.2. Group data into categories. 4. Be aware of and open to new technologies that can contribute to, and/or impact, spiritual care. 5. Advocate for information and communication technologies that can improve spiritual care, e.g.: 5.1. Templates for tracking Spiritual Care services. 5.2. Hand-held devices (Cook et al., 2017).
DATE: February 16, 2018

TO: Ruth Jandeska

FROM: Creighton University IRB-02 Social Behavioral

PROJECT TITLE: [1198944-1] LEADING IN CONTEXT: THE LIVED EXPERIENCES OF SPIRITUAL CARE LEADERS

SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS

DECISION DATE: February 16, 2018

REVIEW CATEGORY: Exemption category # 2

Thank you for your submission of New Project materials for this project. The following items were reviewed in this submission:

- ApplicationForm-402ApplicationforDeterminationofExemptStatusObservation,Survey, Interview (1).doc (UPDATED: 02/13/2018)

- Creighton-IRBApplicationForm-Creighton-IRBApplicationForm(UPDATED:02/16/2018) • Protocol-RjandeskaInterviewprotocol.docx(UPDATED:02/13/2018)

This project has been determined to be exempt from Federal Policy for Protection of Human Subjects as per 45CFR46.101 (b) 2.

All protocol amendments and changes are to be submitted to the IRB and may not be implemented until approved by the IRB. Please use the modification form when submitting changes.

If you have any questions, please contact Christine Scheuring at 402-280-3364 or christinescheuring@creighton.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Creighton University IRB-02 Social Behavioral's records.