Spiritual Care

Impact on Patients and Healthcare

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Author's Note: This document was originally written during my 2nd residency at the St. Mark's Pastoral Education Center at St. Mark's Hospital in Salt Lake City, Utah and is published online with the permission of Episcopal Community Services (please contact ECS at St. Mark's for rights).

This work and my time invested is dedicated to Fr. Lincoln Ure and Rev. Nancy Piggot who were supervisors there during my stay. Linc, it has been over a year now, and I still miss you. Linc, I believe it may be God who is blessed to get to be with you now that we no longer get you here. Amen my friend and mentor. May the road rise to meet your feet, the sun fall gently on your face, and the wind be ever at your back. – Rev. John D. Cooper, BCC, July 2017

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The Impact of Spiritual Care - Summary

To understand Spiritual Care, and how it can positively impact patient experience, patient outcomes, and healthcare cost, we need to understand spirituality.

A working definition of spirituality comes from the research of Dr. Delgado-Guay, citing conference proceedings from Dr. Christine Pulchawski. Dr. Delgado-Guay and Dr. Pulchawski define spirituality as a, "way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred." (Delgado-Guay, 2011)

Spiritual care is the professional practice of helping patients explore, understand, and use their spirituality. Concentration camp survivor and psychologist Victor Frankl wrote, "Those who have a 'why' to live, can bear with almost any 'how'."
— Viktor E. Frankl, *Man's Search for Meaning*

Spirituality is not the same as religion – religion is about shared belief, community and practice whereas spirituality is about finding a sense of meaning, purpose and connection. Religion may be a way someone experiences their spirituality; it may help an individual connect to something, find spiritual community and form their personal beliefs, but religion is far from the only source of spirituality, and caring for spirituality in the context of healthcare has more to do with the way an individual finds meaning, connection and purpose than it does with religion.

Spiritual care helps people explore "Why" questions, such as "Why do I have this disease?" or "Why would God do this?" Spirituality can help find meaning and purpose in their own story, helping patients experience connectedness, a sense of purpose, and helping them cope with suffering. Spiritual care is a valuable addition to comprehensive care for a patient.

The practice of spiritual care can be a useful supplement to primary care; sometimes patients struggle to engage in healing, or find obstacles to care planning and decisions that relate to existential or spiritual distress. Spiritual care seeks to address the suffering that can cause distress during healing and decision-making.

Spiritual Care Enhances the Patient Experience

- Patients who get spiritual care are 1.4 to 2.2 times more likely to rate care at the highest levels. (Williams, 2011)
- The majority of patients say spiritual care is important, but only about 9% say any providers ask about it. Patients whose spiritual needs go unmet are much less happy with their care. (Astrow, 2007)
- In the ICU, spiritual care improves satisfaction with both care and decision-making. Studies indicate that exploring spiritual needs, reminiscing and rituals with a clinically trained spiritual care provider in the last 24 hours of life has a large impact on family satisfaction (Wall 2007, Gries 2008, Johnson 2014)

Spiritual Care can Help Patient Outcomes

- Spiritual well-being correlates to and predicts quality of life. (Fisch, 2003)
- Patients see a sacred aspect in loss have less anxiety and depression. (Pargament, 2005)
- Half of advance cancer patients say they have spiritual pain that negatively impacted physical symptoms. (Delguado-Guay, 2011)
- Among seriously ill patients, religious activity and spirituality reduce physical symptoms, disability, psychiatric problems, less depression and drinking. (Koenig, 2002)

Spiritual Care Can Reduce Healthcare Cost

- End of life costs increase by between 2 and 3 times when spiritual needs go unmet. (Balboni, 2011)
- Hospitals who have professional chaplains have fewer ICU deaths and make more effective use of hospice. (Flanelly, 2012)
- Harold Koenig's work shows that spirituality and religiosity reduce hospital stays decrease readmits. (Koenig, 2002)
- Professional chaplains provide spiritual care in compliance with JHACO and legal precedent, reducing risk and potentially costly mistakes (Warnock, 2009)

Spiritual Care Has Other Benefits

- Chaplains have skills that can help other staff face compassion fatigue, PTSD, moral injury, job-related stress, grief work, and ethical concerns
- Engaging in spiritual care helps providers find more meaning and purpose in their work, cope with aspects of futile care, and cope with helplessness (Kociszewski, 2004)
- Some patients who are visited by their own clergy are more likely to want to see a chaplain (Piderman, 2010).
- Patients can be more satisfied with spiritual care from professional providers than their own clergy (Hanson, 2010)

Taking Advantage of Professional Spiritual Care Requires

- Professionally trained chaplains who are either board-certified with APC (Association of Professional Chaplains) or who have completed clinical training
- Clinical training in spiritual care involves over 1600 hours of clinical training at an accredited center as well as several hundred hours of one-on-one supervision and group work
- Board certification requires graduate level education in theology
- APC recommends at least 1 chaplain for each 50 beds; anecdotal evidence suggests that spiritual assessments get done and visitation coverage is better at a 1:30 ratio

This document helps to substantiate these various claims, provide detailed citation for the studies, and summarize their findings.

Impact of Spiritual Care – Review

The practice of spiritual care involves phenomenological, experiential, and therapeutic work with patients around their spiritual identity and practices. Professional providers invite exploration of narrative and spiritual reflection on narrative, in relationship with the patient, providing nurturing listening that makes exploration of spirituality and experience safer and accompanied. Professional spiritual care invites people to explore their own meaning, to make spiritual connections in their lived experience and helps patients find ways to use that meaning and experience for healing.

Evidence shows that spiritual care has an impact on

- Patient Experience
- Patient Outcomes
- Healthcare Costs

Patient experience also has a potential benefit on the financials of healthcare institutions; Medicare payments are increasingly tied to patient experience[1]. In 2013 nearly 1500 hospitals took penalties based on quality ratings, including patient satisfaction.[2]

Throughout the rest of this reference document we will summarize several studies and citations to differing degrees with regards to the impact they show between spiritual care, patient experience, patient outcomes and healthcare costs. Some studies will get more space and attention than others.

Studies Related to Patient Experience

There are several studies that show an impact of spiritual care on patient experience.

- Williams 2011
- Astrow 2007
- Alcorn 2010
- Wall 2007
- Gries 2008
- Johnson 2014

We will review the findings of each of these studies in turn.

[1] http://www.washingtonpost.com/national/patient-ratings-to-affect-medicare-payments-to-hospitals/2011/04/28/AFpecP9E_story.html
[2] http://www.npr.org/blogs/health/2013/11/15/245254951/medicare-penalizes-nearly-1-500-hospitals-for-poor-quality-scores

Williams 2011 Study

Joshua A Williams et al., "Attention to Inpatients' Religious and Spiritual Concerns: Predictors and Association with Patient Satisfaction," *Journal of General Internal Medicine* 26, no. 11 (2011): 1265–71.

Between 2006 and 2009 a research team approached 11,620 patients in the University of Chicago system; of those patients they had responses from 3141 patients. The researchers for Williams study found that patients who got to have a spiritual conversation were between 1.4 and 2.2 times more likely to rate their Hospital, Doctors, Nurses and Team Work at the highest levels of satisfaction on four different measurements of satisfaction. The likelihood of rating care at higher levels increased regardless of whether patients wanted a spiritual conversation or not.

The Williams 2011 study was actually a study examining demographic categories (race, socioeconomic status) and how those categories affected which patients got to have a conversation about spiritual care – the findings demonstrating the impact of those conversations were accidental and secondary to the main purpose of the study.

Table 1-1: Likelihood of Responses from Williams 2011

	Extremely satisfied with doctor's care	Always had confidence and trust in doctors	Coordination & Teamwork among doctors and nurses was excellent	Would rate overall care received at hospital as excellent
Wanted Discussion				
Not Discussed (312)	63% (x1.0)	77%, (x1.0)	55% (x1.0)	59%, (x1.0)
Discussed (570)	71% (x1.4)	84% (x1.7)	72% (x2.2)	69% (1.6)
Did Not Want discussion				
Not Discussed (1298)	63% (x1.0)	78% (x1.0)	57% (x1.0)	60% (x1.0)
Discussed (558)	77% (x1.9)	86% (x1.7)	67% (x1.5)	72% (x1.7)

Table 1-1 shows data from Williams 21001 study. The categories of doctor's care, confidence and trust in their physicians, coordination and teamwork among doctors and nurses, and overall care are shown. Percentages represent the portion of respondents who selected the listed response, and the number in parenthetical shows the likelihood of a respondent giving the listed response in comparison to those who did not have a conversation about spirituality.

Williams 2011 tells us that patients who had a conversation about spirituality with a qualified person were between 1.4 and 2.2 times more likely to pick the listed responses; extremely satisfied with the doctor's care, always had confidence and trust in their doctors, excellent coordination and teamwork and rating the hospital as excellent.

Astrow 2007 Study

A. B. Astrow et al., "Is Failure to Meet Spiritual Needs Associated With Cancer Patients' Perceptions of Quality of Care and Their Satisfaction With Care?," *Journal of Clinical Oncology* 25, no. 36 (December 20, 2007): 5753–57, doi:10.1200/JCO.2007.12.4362.

Astrows' study was taken among outpatients (N=369) who completed a questionnaire at the Saint Vincent's Comprehensive Cancer Center in New York, NY. The surveys included the Quality of End-of-Life Care and Satisfaction with Treatment quality-of-care scale and questions about spiritual and religious beliefs and needs. Two thirds of the respondents said they were "spiritual but not religious" and only 29% said that they attend religious services at least once a week.

Seventy-three percent reported at least one spiritual need; 58% thought it appropriate for physicians to inquire about their spiritual needs. Eighteen percent reported that their spiritual needs were not being met. The authors note that the 82% who say that their needs were met were meeting those needs outside of the healthcare context.

Only 6% of the respondents said that anyone connected to the cancer clinics asked about spirituality with 0.9% of inquiries by physicians. Those patients who reported that their spiritual needs were not being met gave lower ratings of the quality of care (*P*=.009) and reported lower satisfaction with care (*P*=.006).

Table 2-1 Patient Views about Spirituality from Astrow 2007

Question	Responding Yes	Total Responding	Percentage
Appropriate for a doctor to ask about religious beliefs?	177	341	52%
Appropriate for a doctor to inquire about spiritual needs?	196	340	58%
Has staff inquired about spiritual or religious beliefs?	33	350	9%
Has staff inquired about spiritual needs?	2	338	0.6%
Has your physician inquired about spiritual needs?	3	338	0.9%
Are your spiritual needs being met?	250	304	82%

As Table 2-1 indicates while 59% of respondents thought it was appropriate for a physician to ask about their spiritual needs, only 9% responded "Yes" when asked if anyone had asked about their spiritual needs.

Among the spiritual needs cited by patients were: meeting similar patients, relaxation, help with their sadness, help with sharing their feelings, finding spiritual resources, help with their

family, finding meaning in life, finding hope, overcoming fears, talking about the meaning of life, talking about death and dying or finding peace of mind.

Astrow 2007 tells us that most respondents indicated they had spiritual needs, a slight majority thought it appropriate for their clinic to address those needs, and the patients who said their needs were not being met gave lower ratings of overall care.

Alcorn 2010 Study

The Alcorn study involved patients who were enrolled between March 3, 2006 and April 14, 2008. After selection criteria and review, of the 103 patients approached, 75 participated, and 68 completed the entire survey (N=68). Patients were asked, ‘‘Has religion or spirituality been important to your experience with your illness?’’ And could respond “yes” or “no,” those responding ‘‘yes’’ were asked, ‘‘How has religion or spirituality been important to your experience with your illness?’’ Patients were also asked more open-ended questions such as, ‘‘What spiritual issues have you had as you have been dealing with your illness?’’

Findings showed that religious and spiritual concerns were important to most of the patients, most of the respondents (75%) identified two or more of the spiritual themes, and 45% identified three or more themes. During analysis five clear themes emerged, shown in the following table. Younger, more religious and more spiritual respondents identified themes more frequently.

Table 3-1 Spiritual Themes from Alcorn 2010

Theme	N (%)	Representative Quote (Example)
Coping through R/S	39 (74%)	*I don’t know if I will survive this cancer, but without God it is hard to stay sane sometimes.*
R/S Practices	31 (58%)	*I pray a lot. It helps. You find yourself praying an awful lot. Not for myself, but for those you leave behind.*
R/S Beliefs	28 (53%)	*It is God’s will, not my will. My job is to do what I can to stay healthy…*
R/S Transformation	20 (38%)	*Since I have an incurable disease that will shorten my life, it has made me focus on issues of mortality and sharpened my curiosity on religion/spirituality…*
R/S Community	11 (21 %)	*Well, I depend a lot upon my faith community for support. It’s proven incredibly helpful to me.*

The Alcorn study provides evidence that advanced cancer patients find spirituality important, that the majority of them identify spiritual issues and themes in their recovery, and it helps us to identify five common themes of spirituality that patients say are related to cancer recovery.

Wall 2007 Study

Richard J. Wall et al., “Spiritual Care of Families in the Intensive Care Unit*:,” *Critical Care Medicine* 35, no. 4 (April 2007): 1084–90, doi:10.1097/01.CCM.0000259382.36414.06.

The 2007 Wall study used a set of ICU data collected from 10 hospitals with ICU facilities in the greater Seattle area between 2003 and 2005. All patients dying in the ICU, or within 24 hours of discharge from the ICU were eligible for study. Two to three months after hospitalization a follow-up study was sent with additional questions. Satisfaction scores were based on the Family Satisfaction in the ICU (FS-ICU) survey as a valid and reliable instrument that is designed to measure family satisfaction with ICU care.

Multiple regression revealed family members were more satisfied with spiritual care if a pastor or spiritual advisor was involved in the last 24 hrs. of the patient's life (p.007). In addition, there was a strong association between satisfaction with spiritual care and satisfaction with the total ICU experience ($p < .001$). Ratings of spiritual care were not associated with any other demographic or clinical variables.

Family members were more satisfied with their spiritual care if the patient had a do-not resuscitate order at the time of death or if a pastor/spiritual advisor was involved in the last 24 hrs. of life. Satisfaction with spiritual care in the last 24 hours of life persisted after adjusting for patient and family characteristics, EOL care processes, and total satisfaction with the ICU experience. Family member's satisfaction with spiritual care was strongly associated with his or her overall satisfaction with ICU care ($p = .001$). Female family members reported higher satisfaction with spiritual care than male family members ($p = .03$), but there were no other patient or family characteristics significantly associated with higher satisfaction with spiritual care. Overall, the model explained 51% of the variance observed ($R = .712$).

What the Wall 2007 study contributes is evidence that spiritual is correlated to over-all satisfaction with ICU care, and that spiritual care support in the last 24 hours of an ICU patient's life makes a difference to the family.

Gries 2008 Study

Cynthia J. Gries, "Family Member Satisfaction With End-of-Life Decision Making in the ICU," *CHEST Journal* 133, no. 3 (March 1, 2008): 704, doi:10.1378/chest.07-1773.

Dr. Gries 2008 study examined patient and family characteristics and chart the documentation of processes of care that are associated with increased family satisfaction with end-of-life decision making for ICU patients. Data was collected from ICU patients dying in 10 medical centers in the Seattle-Tacoma area from 2003 to 2005. Survey response rate was 41% (442 of 1,074 families responded). Analyses were conducted of 356 families with questionnaire and chart abstraction data.

Measurement on the FS-ICU (see Wall above) was the primary dependent variable for the study, and the subscale score was the mean of all valid responses on 10 relevant items and was transformed to range from 0 to 100, with higher scores indicating more satisfaction.

Findings show that increased family satisfaction (as represented by FS-ICU score) with decision making was associated with the withdrawal of life support, and chart documentation of

physician recommendations to withdraw life support, discussions of patients' wishes, and discussions of families' spiritual needs.

When the patient's wishes were discussed, FS-ICU score was 84.7, when they were not discussed, the FS-ICU score was 75.00. Feeling supported during decision making was associated with the withdrawal of life support, spiritual care involvement, and chart documentation of physician recommendations to withdraw life support, expressions of families' wishes to withdraw life support, and discussions of families' spiritual needs.

The Gries study provides evidence that family satisfaction with decision-making in the ICU is correlated to exploring the patients' wishes and discussions of families' spiritual needs.

Johnson 2014 Study

Jeffrey R. Johnson et al., "The Association of Spiritual Care Providers' Activities With Family Members' Satisfaction With Care After a Death in the ICU*:," *Critical Care Medicine* 42, no. 9 (September 2014): 1991–2000, doi:10.1097/CCM.0000000000000412.

The goal of Johnson's 2014 study was to evaluate the activities spiritual care providers' conduct to support patients and families and whether those activities are associated with family satisfaction with ICU care. Their study was conducted in a three hundred fifty-bed tertiary care teaching hospital with 65 ICU beds. Spiritual care providers and family members of patients who died in the ICU or within 30 hours of transfer from the ICU were eligible for participation.

Spiritual care providers completed a survey about activities, and family members completed validated measures of satisfaction with care and satisfaction with spiritual care. Clustered regression was used to assess the association between activities completed by spiritual care providers and family ratings of care. After selection criteria and response rate the researchers had 244 full responses that were connected to surveys from spiritual care providers.

Spiritual care providers commonly reported activities related to supporting religious and spiritual needs ($\geq$ 90%) and providing support for family feelings (90%). Discussions about the patient's wishes for end-of-life care and a greater number of spiritual care activities performed were both associated with increased overall family satisfaction with ICU care ($p < 0.05$). Discussions about a patient's end-of-life wishes, preparation for a family conference, and total number of activities performed were associated with improved family satisfaction with decision-making in the ICU ($p < 0.05$).

Johnson 2014 tells us that specifically discussing patient's end-of-life wishes improved FS-ICU score and that the more activities a spiritual care provider engaged in with families, the higher their FS-ICU score was after end-of-life.

Studies Related to Patient Outcomes

There are several studies related to patient outcomes

- Fisch 2003
- Delgado-Guay 2011
- Pargament 2005
- Koenig 2002

Fisch 2003

M. J. Fisch, "Assessment of Quality of Life in Outpatients With Advanced Cancer: The Accuracy of Clinician Estimations and the Relevance of Spiritual Well-Being--A Hoosier Oncology Group Study," *Journal of Clinical Oncology* 21, no. 14 (July 15, 2003): 2754–59, doi:10.1200/JCO.2003.06.093.

Fisch and associates in 2003 set out to evaluate the association between quality of life (QOL) measures, QOL impairment as assessed by providers with and without measurements of spiritual well-being. They surveyed 163 patients with advanced cancer. Clinicians rated QOL impairment of their patients and correlation coefficients were used to associates QOL scores through different instruments. Researchers used the FACT-G (Functional Assessment of Chronic Illness Therapy - General Version) and the FACT-SP (Functional Assessment of Chronic Illness Therapy – Spiritual Well Being), both generally accepted instruments, to measure quality of life and spiritual well-being.

Results showed that spiritual well-being was strongly associated with QOL, and higher levels of spiritual well-being was associated with greater accuracy in clinical prediction of impairment.

Fisch 2003 study establishes a correlation does is establish a link between spirituality and quality of life measurements; those patients who have a higher spiritual well-being tend to also experience a higher quality of life while in advance cancer treatment.

Delgado-Guay 2011

In their 2011 Journal of Pain and Symptom Management doctors Marvin Delguado-Guay and Dave Hui published a study of 100 advanced cancer patients at the M.D. Anderson palliative care outpatient clinic in Houston, TX. Patients were assessed using self-rated measurements of symptoms (The Edmonton Symptom Assessment Scale [ESAS] and Hospital Anxiety and Depression Scale), coping (Brief COPE and Brief R-Cope), the value attributed to spirituality/religiosity in coping with cancer (Systems of Belief Inventory-15R), and spiritual quality of life (Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being-Expanded [FACIT-Sp-Ex]).

Table 3-1: Responses to Questions in Delgado-Guay 2011

Questions	Prevalence
Do you consider yourself a spiritual person?	98%

Do you consider yourself a religious person?	98%
Is spirituality/religiosity a source of strength and comfort to you?	100%
Does spirituality/religiosity help you cope with your illness?	99%
Does spirituality/religiosity help your family member/caregiver cope with your illness?	99%
Do you think you are experiencing spiritual pain now and how would you rate your overall spiritual pain?	44%

The vast majority of patients considered themselves spiritual (98%) and religious (98%). Spiritual pain was reported in 40 (44%) of 91 patients. Spiritual pain was significantly associated with lower self-perceived religiosity (7 vs. 10, P ¼ 0.002) and spiritual quality of life (FACIT-Sp-Ex 68 vs. 81, P ¼ 0.001). Patients with spiritual pain reported that it contributed adversely to their physical/emotional symptoms (P < 0.001). There was a trend toward increased depression, anxiety, anorexia, and drowsiness, as measured by the ESAS, among patients with spiritual pain (P < 0.05).

What Delgado-Guay adds to our understanding is that a large quantity of advance cancer patients define themselves as spiritual and/or religious. That many of those people have what they would define as spiritual pain, and that their spiritual pain has an impact on the severity of their physical symptoms.

Pargament 2005

Kenneth I. Pargament et al., "Sacrilege: A Study of Sacred Loss and Desecration and Their Implications for Health and Well-Being in a Community Sample," *Journal for the Scientific Study of Religion* 44, no. 1 (March 1, 2005): 59–78, doi:10.2307/3590519.

In their extensive 2005 study, psychologist Kenneth L. Pargament and the rest of his research team examined the possibility that the way people view loss and suffering impacts their health and well-being. A total of 117 randomly selected adults from a Midwest rural county were selected; the researchers purchased 1000 names from a polling company and called them. A total of 501 people were contacted by phone: 248 (49.5 percent) agreed and 253 (50.5 percent) declined to participate. Of the 248 people who initially agreed to participate, 117 (47 percent) actually returned usable questionnaires. Self-reported religiousness was based on variables from the General Social Survey (NORC 1998), their most traumatic event was chosen from a checklist of traumatic events.

Respondents completed a variety of measurements, including the Sacred Loss and Desecration Scale, a 28-item questionnaire developed for the study by the Spirituality and Psychology Research Team (SPiRiT) at Bowling Green State University. The Impact of Event Scale (IES) to assess intrusive thoughts and avoidant behaviors often associated with anxiety disorders or stress-response syndromes to traumatic events. The 20-item Center for Epidemiological Studies-Depression Scale (CES-D) to measure the level of current depressive symptoms, with an

emphasis on the affective component of depressed mood. Five items adapted from the State-Trait Anger Expression Inventory were used to assess anger associated with the particular negative life event participants described, and five items adapted from the State-Trait Anxiety Inventory were used to assess anxiety associated with this specific negative life event.

Respondents also completed surveys of their physical symptoms, and the number and type of medications. Nineteen questions from the Posttraumatic Growth Inventory (PTGI) to assess positive outcomes from traumatic experiences. Religious coping methods were measured using the 14 items from the Brief RCOPE and 27 additional items from the full RCOPE that assess a wider range of positive and negative religious coping strategies. Note that "Positive" religious coping strategies relate to learning and discover in religious belief, such as "seeking to experience God's love", and "Negative" religious coping relate to more punitive belief systems such as "God is punishing me."

Pargament and his fellow researchers used sanctification theory to articulate the relationship of respondents to their significant negative events. Sanctification theory indicates that we "sanctify" or make spiritual major events in our lives or things that are important to us. Events perceived as sacred losses and violations may elicit both positive and negative religious methods of coping, since these stressful life events are affecting the spiritual dimension. Once we have sanctified an event, it impacts our spiritual reality, and religious methods of coping and framing the event come into play. For the purposes of this study, desecration is associated with more negative religious coping, such as seeing God as abandoning the respondent during the event, and sacred loss is associated with more positive religious coping, such as spiritual meaning and growth, such as experiencing God's love as a result of the loss.

Pearson correlation showed a relationship between Sacred Loss and Desecration and the outcome measurements. Sacred Loss and Desecration were significantly inter-correlated with the trauma impact of the event (IES) and emotional distress. Higher levels of Sacred Loss and Desecration were associated with more intrusion, avoidance, anxiety, and depression. Desecration was also significantly correlated with higher levels of anger. Sacred Loss was also associated with greater stress-related growth and spiritual change.

In hierarchical regression analysis, Sacred Loss and Desecration accounted for a significant portion of the variance in 6 of the 12 criteria. Inspection of the standardized beta weights revealed support for the differential prediction of Sacred Loss and Desecration across the various criterion measures. Sacred Loss was tied to greater internalized emotional distress (i.e., depression) and Desecration was associated with greater externalized distress (i.e., anger). Furthermore, Sacred Loss predicted greater post-traumatic stress symptoms (intrusion and avoidance) and positive change scores (posttraumatic growth and spiritual change), while Desecration predicted greater avoidance-type trauma symptoms and less posttraumatic growth. Interestingly, Desecration also predicted fewer absences from school or work and few doctor visits in the past month.

TABLE 4
HIERARCHIAL REGRESSION ANALYSES

Criterion	Step	R^2	R^2 change	Beta in Step 2	
				Sacred Loss	Desecration
	Hierarchical Regression Models				
Intrusive thoughts	1	0.231	0.231***		
	2	0.355	0.124***	0.335***	0.082
Avoidant behaviors	1	0.257	0.257***		
	2	0.412	0.155***	0.212*	0.297**
State anger	1	0.263	0.263***		
	2	0.333	0.070**	−0.015	0.316**
State anxiety	1	0.205	0.205***		
	2	0.225	0.020	0.071	0.111
State depression	1	0.177	0.177***		
	2	0.245	0.068**	0.265*	0.030
Depression	1	0.208	0.208***		
	2	0.290	0.083**	0.343***	−0.096
Negative health symptoms	1	0.064	0.064		
	2	0.085	0.020	0.176	−0.109
Medication use	1	0.031	0.031		
	2	0.040	0.009	0.107	−0.107
	Multiple Regression Models				
Doctor visits (in past month)	1	0.058	0.058		
	2	0.107	0.049	−0.004	−0.254*
Days absent from school/work (in past month)	1	0.024	0.024		
	2	0.060	0.036	0.104	−0.255*
Posttraumatic growth	1	0.101	0.101**		
	2	0.208	0.107***	0.375***	−0.349**
Spiritual change	1	0.331	0.331***		
	2	0.359	0.028	0.203*	−0.075

*$p \leq 0.05$; **$p \leq 0.01$; ***$p \leq 0.001$.
Step 1: Global religiosity, perpetrator item, and number of objects lost/violated.
Step 2: Sacred loss and desecration.

Figure 1 Pargament 2005 Heirarchical Regression

The Pargament study goes further into regression and covariate analysis between the relationship of sacred loss and desecration to the outcome measurements. This study offers us several important findings. First, a significant number of participants viewed the most significant negative event of the past two years of their lives as a sacred loss and/or desecration. Second, sacred loss and desecration were associated with greater trauma impact and emotional distress. Third, sacred loss and desecration were distinctive, after controlling for other variables, sacred loss remained a strong predictor of depression, intrusive thoughts about the event, greater posttraumatic growth, and positive spiritual outcomes.

What Pargament 2005 shows us is that a sense of desecration and loss can be associated with major events in our lives, and that we can grow to feel that the sanctity (sacred-ness) of our

lives may be violated. When that happens, our sense of desecration and loss is associated with anger, depression, but that it is also related to post-traumatic growth and spiritual discovery. Serious illness and hospitalization can qualify as a major life event.

Koenig 2002

Harold G. Koenig, MD, "Religion, Congestive Heart Failure, and Chronic Pulmonary Disease," *Journal of Religion and Health* 41, no. 3 (October 1, 2002): 263–78, doi:10.2307/27511624.

Using a consecutive sample of 196 patients age 55 or over admitted to Duke University Medical Center with a diagnosis of CHF or CPD, Koenig assessed physical health, social support, mental health, religious activities and attitudes (attendance, prayer and scripture study, intrinsic religiosity) in a 60 to 90 minutes survey involving multiple measurements.

Physical symptoms were measured using the Duke Activity Status Index (DASI) and the Specific Activity Scale (SAS). The DASI is a 12-item self-report questionnaire that measures functional capacity in patients with CHF or CPD and the SAS a 21 item self-report questionnaire that asks about activities of daily living used to calculate metabolic equivalency tasks in patients with heart disease. Physical measurements also included the Guyatt's Chronic Heart Failure and Respiratory Disease Questionnaire, a disease-specific measure that assesses three domains of functioning (dyspnea, fatigue, and emotional function).

Measures of physical illness severity included the Charleson Comorbidity Index (CCI), the Cumulative Illness Rating Scale (CIRS), the American Society of Anesthesiologists (ASA) severity of illness scale, and New York Heart Association Classification (NYHC). Measurements of social and mental health included an 11-item version of the Duke Social Support Index (DSSI) to asses social support network and subjective support. Past psychiatric well-being was measured by five questions, and depression by the Diagnostic Interview Schedule (DIS).

For the 196 who completed the surveys, religious practices were widespread; 98% had a religious affiliation; 48% reported attending religious services weekly or more; 70% reported praying or reading religious scriptures at least daily; and over 85% consistently indicated intrinsic religious beliefs and attitudes. Religious activities and attitudes were inversely related to measures of physical illness severity and functional disability, and were less common among patients with prior psychiatric problems, hospitalizations for depression, drinking problems, and those currently taking psychotropic drugs. Religious activities (especially religious attendance) were associated with greater social support, but were only weakly related to less depression.

The Koenig 2002 study provides evidence that higher levels of religiosity and spirituality correlate with lower levels of depression, anxiety, hospitalizations, drinking issues and drug use.

Studies Related to Healthcare Cost

- Balboni 2011
- Flanelly 2012
- Warnock 2009
- Koenig 2002

Balboni 2011

For this study, 339 advance cancer patients were recruited from September 1, 2002 to August 31, 2007 from 7 outpatient sites. Patients were followed until death. Spiritual care was measured by patients' reports that the health care team supported their religious/spiritual needs. EOL costs in the last week were compared among patients reporting that their spiritual needs were inadequately supported versus those who reported that their needs were well supported.

Medical care costs over the last 7 days of life were estimated and adjusted to reflect costs as of January 1, 2010. ICU costs were based on published estimates (nonventilated ICU care, Day 1 ¼ $4646, Day 2 ¼ $4149, Day 3 or more ¼ $3696/day; and ventilated ICU care, Day 1 ¼ $7061, Day 2 ¼ $5666, Day 3 or more ¼ $4946/day). Student t tests (continuous variables) and chi-square tests (ordinal and dichotomous variables) were used to compare baseline characteristics among those reporting high versus low spiritual support from the health care team. Logistic regression assessed the relation between patient reported spiritual care and receipt of ICU care in the last week of life, receipt of at least 1 week of hospice care, and dying in an ICU. Analyses were adjusted for predictors of EOL care, including race, EOL treatment preferences, EOL discussion, advance care planning, positive religious coping, and religiousness.

Patients reporting that their religious/spiritual needs were inadequately supported by clinic staff were less likely to receive a week or more of hospice (54% vs 72.8%; P ¼ .01) and more likely to die in an intensive care unit (ICU) (5.1% vs 1.0%, P ¼ .03). Among minorities and high religious coping patients, those reporting poorly supported religious/spiritual needs received more ICU care (11.3% vs 1.2%, P ¼ .03 and 13.1% vs 1.6%, P ¼ .02, respectively), received less hospice (43.% vs 75.3% _1 week of hospice, P ¼ .01 and 45.3% vs 73.1%, P ¼ .007, respectively), and had increased ICU deaths (11.2% vs 1.2%, P ¼ .03 and 7.7% vs 0.6%, P ¼ .009, respectively). EOL costs were higher when patients reported that their spiritual needs were inadequately supported ($4947 vs $2833, P ¼ .03), particularly among minorities ($6533 vs $2276, P ¼ .02) and high religious copers ($6344 vs $2431, P ¼ .005).

What the Balboni study provides is evidence that leaving spiritual needs unaddressed can increase the cost of ICU care during end-of-life. This seems synchronistic with findings of other studies related to patient experience and spiritual care on the ICU.

Flanelly 2012

Kevin J Flannelly et al., "A National Study of Chaplaincy Services and End-of-Life Outcomes," *BMC Palliative Care* 11, no. 1 (2012): 10, doi:10.1186/1472-684X-11-10.

The Flanelly study is a large-scale study using the AHA survey database from the American Hospital Association. Data used in this study did not contain any patient-specific metrics; all the data was related to hospital institutions and hospital activities. Combined data from the American Hospital Association's Annual Survey and outcome data from The Dartmouth Atlas of Health Care was analyzed in a cross-sectional study of 3,585 hospitals.

For this study two outcomes were examined: the percent of patients who (1) died in the hospital, and (2) were enrolled in hospice. Ordinary least squares regression was used to measure the association between the provision of chaplaincy services and each of the outcomes, controlling for six factors associated with hospital death rates. Six control variables were used in the analyses: (1) whether the hospital was located in a western state (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon Utah, Washington, and Wyoming); (2) the population density of its catchment area; (3) number of hospital beds; (4) the proportion of Medicaid patients; (5) whether the hospital has a palliative care team; and (6) type of hospital.

Analysis found significantly lower rates of hospital deaths ($\beta = .04$, $p<.05$) and higher rates of hospice enrollment ($\beta = .06$, $p<.001$) for patients cared for in hospitals that provided chaplaincy services compared to hospitals that did not.

Flanelly 2012 shows us with a large data sample that people tend to die less while inpatient in hospitals who have chaplaincy and those hospitals have a higher rate of transfer to hospice.

Warnock 2009

Carla Jean Pease Warnock, "Who Pays for Providing Spiritual Care in Healthcare Settings? The Ethical Dilemma of Taxpayers Funding Holistic Healthcare and the First Amendment Requirement for Separation of Church and State," *Journal of Religion and Health* 48, no. 4 (December 1, 2009): 468–81, doi:10.2307/20685233.

The Warnock 2009 study is primarily a historical review of events at the Veterans Administration related to spiritual care and the ethics of using public funds to pay for health care. Since veteran healthcare services, under the United States Department of Veterans Affairs (VA), are provided with taxpayer funds from local, state, and federal governments, the authors raise ethical questions about how care it to be provided with those funds. The authors examine legal action taken by the Freedom From Religion Foundation, Inc. (FFRF) against the Veterans Administration around the provision of holistic healthcare, including spiritual care.

Recognizing the patient as a whole being, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a prominent non-profit credentialing body, enacted in 2004 the requirement for spiritual assessment of patients as a healthcare team function. "Spiritual

assessment should, at a minimum, determine the patient's denomination, beliefs, and what spiritual practices are important to the patient." The FFRF opposed the use of public funds to establish clinical pastoral education programs and provide spirituality in hospitals, under the claim that spiritual care was promoting religion.

The VA responded by making spiritual care voluntary and centered on the patient. In January 8, 2007, US District Judge John Shabaz, for the Western District of Wisconsin, ruled that the policy change at the Department of Veteran Affairs, integrating religion and "spirituality" into all aspects of medical care, is permissible because it is "voluntary". FFRF will appeal the ruling (FFRF to appeal Veteran Affairs religion ruling 2007). Though this lawsuit failed at the first legal level, the VA and all healthcare institutions should evaluate their spiritual care programs with respect to the First Amendment.

The Warnock 2009 article establishes a difference between "spiritual care" and "religion" and provides us with an extensive review of ethical considerations related to providing spiritual care under the context of separation of church and state.

Koenig 2002

See the above analysis of Koenig 2002 in the previous section on patient outcomes. That analysis also has ramifications for healthcare cost.

Other Studies of Interest

There are several other studies that provide interesting information on spiritual care in a hospital setting.

- Kociszewski, 2004
- Daaleman 2008
- Graves 2002
- Puchalski 2001
- Piderman 2010
- Hanson 2010

Kociszewski, 2004

Cynthia Kociszewski, "Spiritual Care: A Phenomenologic Study of Critical Care Nurses," *Heart & Lung: The Journal of Acute and Critical Care* 33, no. 6 (November 2004): 401–11, doi:10.1016/j.hrtlng.2004.06.004.

The Kociszewski study provides a perspective on spiritual care from nursing. 10 critical care nurses with experience providing spiritual care to critically ill patients or their families participated in an an audiotaped interview.

Six themes emerged: (1) meanings of spirituality, (2) out of tragedy: spiritual awakening, (3) mutual knowing: a bridge to spiritual assessment, (4) the everydayish-ness of spiritual care, (5) prayer and beyond: letting go to the mystical, and (6) spiritual caring: from suffering to blessing.

Critical care nurses' experiences of providing spiritual care emerged as integral and inseparable behaviors imbedded in the everyday nursing care of others. Critical care nurses experienced heightened awareness and responsiveness to patient and family spiritual need during life-threatening situations. Providing spiritual care held significant meaning for these critical care nurses that resulted in professional satisfaction.

Kociszewski 2004 shows that awareness of spiritual care among critical care nurses can have a positive impact on professional satisfaction. The implication is that utilizing spiritual care in collaboration with and support of the nursing profession may help providers cope with the intense requirements of their work.

Daaleman 2008

T. P. Daaleman et al., "An Exploratory Study of Spiritual Care at the End of Life," *The Annals of Family Medicine* 6, no. 5 (September 1, 2008): 406–11, doi:10.1370/afm.883.

The Daaleman study is a qualitative research study of 12 clinicians in an exploratory study of providing spiritual care during end of life that sought to identify primary themes of spiritual care. Being present was a predominant theme, marked by physical proximity and intentionality, or the deliberate ideation and purposeful action of providing care that went beyond medical treatment. Opening eyes was the process by which caregivers became aware of their patient's life course and the individualized experience of their patient's current illness. Participants also described another course of action, which we termed *cocreating*, that was a mutual and fluid activity between patients, family members, and caregivers. Cocreating began with an affirmation of the patient's life experience and led to the generation of a wholistic care plan that focused on maintaining the patient's humanity and dignity. Time was both a facilitator and inhibitor of effective spiritual care.

Daaleman 2008 provides analysis and definitions for practices used in spiritual care as spiritual care appears to hospital clinicians.

Puchalski 2001

Christina M. Puchalski, "The Role of Spirituality in Healthcare," *Proc (Bayl Univ Med Cent)* 14, no. 4 (October 2001): 352–57.

Dr. Christina Puchalski's 2001 article explores how physicians should handle spiritual questions and distress in their patients. Puchalski says that when confronted with spiritual questions, some physicians freeze. Questions such as Why is this happening to me now? What will happen to me after I die? Will my family survive my loss? Will I be missed? Will I be remembered? Is there a God? If so, will he be there for me? Will I have time to finish my life's work?

Puchalski says that in providing spiritual care, physicians can begin with the following:

• Practicing compassionate presence—i.e., being fully present and attentive to their patients and being supportive to them in all of their suffering: physical, emotional, and spiritual

• Listening to patients' fears, hopes, pain, and dreams

• Obtaining a spiritual history

• Being attentive to all dimensions of patients and their families: body, mind, and spirit

• Incorporating spiritual practices as appropriate

• Involving chaplains as members of the interdisciplinary health care team

She also underscores the importance of professional boundaries and in making use of professional chaplains other spiritual leaders for in-depth spiritual counseling. She suggests that physicians not initiate prayer with patients, as this blurs the boundary of physician and clergy. Leading prayer involves specific skills and training that physicians do not have – Puchalski cites sensitivity to multifaith contexts and leading non-tradition specific prayers.

Puchalski 2001 reviews themes found in spiritual care, makes recommendations to physicians about how to offer spiritual care, demonstrates sensitivity to professional boundaries and competencies, and makes clear recommendations for practice.

Piderman 2010

Katherine M. Piderman et al., "Predicting Patients' Expectations of Hospital Chaplains: A Multisite Survey," *Mayo Clinic Proceedings* 85, no. 11 (November 2010): 1002–10, doi:10.4065/mcp.2010.0168.

For this study, through the period of 2006 to 2009, 4500 eligible medical and surgical patients from hospitals in Minnesota, Arizona, and Florida were surveyed by mail to collect demographic information and expectations regarding chaplain visitation. Multivariate logistic regression was used to assess the likelihood of wanting chaplain visitation on the basis of patient demographics and perceived importance of reasons for chaplain visitation.

The strongest predictor of wanting chaplain visitation was denomination vs no indicated religious affiliation (Catholic: odds ratio [OR], 8.11; 95% confidence interval [CI], 4.49-14.64; *P*<.001; evangelical Protestant: OR, 4.95; 95% CI, 2.74-8.91; *P*<.001; mainline Protestant: OR, 4.34; 95% CI, 2.58-7.29; *P*<.001). Being female was a weak predictor (OR, 1.48; 95% CI, 1.05-2.09; *P*=.03), as was site. Among the reasons given by respondents for wanting chaplain visitation, the most important were that chaplains served as reminders of God's care and presence (OR, 4.37; 95% CI, 2.58-7.40; *P*<.001) and that they provided prayer or scripture reading (OR, 2.54; 95% CI, 1.53-4.20; *P*<.001).

The Piderman 2010 study articulates reasons that patients want to see chaplains, for patients chaplains serve as reminders of God's care and that chaplains provide prayer and scripture.

Hanson 2010

Laura C. Hanson et al., "Providers and Types of Spiritual Care during Serious Illness," *Journal of Palliative Medicine* 11, no. 6 (July 2008): 907–14, doi:10.1089/jpm.2008.0008.

The objective of this study was to describe spiritual care received by patients and families during serious illness, and test whether the provider and the type of care is associated with satisfaction with care. A cross-sectional interview with 38 seriously ill patients and 65 family caregivers about spiritual care experiences. The 103 spiritual care recipients identified 237 spiritual care providers; 95 (41%) were family or friends, 38 (17%) were clergy, and 66 (29%) were health care providers.

Two-thirds of spiritual care providers shared the recipient's faith tradition. Recipients identified 21 different types of spiritual care activities. The most common activity was help coping with illness (87%) and the least common intercessory prayer (4%). Half of recipients were very or somewhat satisfied with spiritual care, and half found it very helpful for facilitating inner peace and meaning making. Satisfaction with spiritual care did not differ by provider age, race, gender, role, or frequency of visits. Types of care that helped with understanding or illness coping were associated with greater satisfaction with care.

Hanson 2010 study helps to identify what patients see as spiritual care.

In Conclusion

The content of this document is extensive, and yet still does not provide detailed discussion of each study – a detailed analysis and conversation about the findings of each study would be voluminous to provide for an entire book reviewing research into spiritual care. For more detailed analysis, please refer to the studies themselves.

Key statements provided by this document do not represent a promise of any particular outcome; they are intended to provide material for leadership to consider when contemplating the cost to benefit ratio of professional spiritual care in healthcare.

Questions, comments and requests may be directed to the author, John D. Cooper, through his website at http://www.exploringwisdom.org

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