

# Chaplaincy Research: Its Value, Its Quality, and Its Future

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**ABSTRACT.** The article is divided into four major sections, the first of which presents and discusses various reasons given by major researchers in the field why chaplains should do research. The second section summarizes findings on the sophistication of research on religion and health published in (a) medical and other healthcare journals, and (b) specialty journals on religion and health, chaplaincy, and pastoral care and counseling. The third section revisits suggestions that have been made by prominent chaplain researchers to increase and improve research by chaplains. The last section offers some suggestions for expanding several lines of current research in the future, including research: (1) to elucidate the nature of spiritual care chaplains provide to different populations, including patients, families and staff; (2) to assess the prevalence and intensity of patients' spiritual needs and the degree to which they are being met; (3) to identify that subset of patients who are spiritually at risk in terms of having high needs and slow religious resources; (4) to identify the biological

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causal mechanisms by which religion influences health; and (5) to measure the effectiveness of chaplain interventions.

**KEYWORDS.** Chaplaincy, pastoral care, research methodology, spiritual care

## INTRODUCTION

Should chaplaincy become more scientific? That was the basic question posed in a 2002 issue of the *Journal of Health Care Chaplaincy*. While several of the contributors to that issue answered with a resounding “Yes” (e.g., Burton, 2002; Fitchett, 2002; Handzo, 2002), many were ambivalent, and others were opposed to chaplaincy becoming scientific. Some, such as McCurdy, were concerned that science was too reductionistic, and that measurement might not capture and might “even distort the very nature of pastoral care itself” (McCurdy, 2002, p. 157).

Is chaplaincy becoming more scientific despite such resistance? A review of all the articles published in the major pastoral counseling journals from 1980–1989 found that only 5.3% of them were quantitative studies (Gartner et al., 1990). Of the articles published in the *Journal of Pastoral Care*—the flagship journal for the various chaplaincy and clinical pastoral care associations in the United States—only 4.7% were quantitative studies. We conducted a similar survey for the years 1990–1999, but we used a more restrictive definition of what to count as an article and we did not report the results for individual journals (Flannelly, Liu, et al., 2003). Therefore, we decided to redo our survey of 1990–1999 for the *Journal of Pastoral Care*, using the identical criteria used by Gartner and his colleagues. Based on new analysis, it appears that the proportion of quantitative studies more than doubled to 11.9% in the 1990s. Another 4.7% were qualitative studies, which would generally be excluded under Gartner et al.’s criteria of what constitutes an empirical study. If we exclude personal reflections from the base count of articles, as Flannelly, Liu et al. (2003) did, the percentage of quantitative studies rises to 18.4%. Their findings suggest that chaplaincy is becoming more scientific.

## ***WHY CHAPLAINS SHOULD DO RESEARCH***

O'Connor (2002) offered four reasons why chaplains should do research. First, since healthcare chaplains function within the culture of evidence-based medicine, chaplaincy, like other healthcare professions, must be evidence-based. Second, since science and religion both seek truth, the two are compatible with one another and share common concerns, including the physical, mental, and emotional health of individuals. Professionals in various disciplines are doing research on these common points of interest in order to integrate spirituality into their theory and practice of health care. It is natural, therefore, that chaplains should do research on these areas of commonality too.

Third, chaplains already do research in their practice to the extent that they utilize clinical evidence from client/patient cases. O'Connor (2002) is certainly correct in stating that case studies constitute one level of research on a continuum of research sophistication (Greenhalgh, 2001; Flannelly et al., 2004). In addition, we agree with him that the case-study method can be a valuable research tool, but more methodologically sophisticated research is needed. There is some evidence that research on chaplaincy and pastoral care is becoming more methodologically sophisticated (Flannelly, Liu et al., 2003), as is research on religion and health, in general (Flannelly et al., 2004; Weaver et al., 2005). We will return to the question of research sophistication later.

O'Connor's fourth reason for chaplains to do research is, essentially, that failing to do so will have profound implications for professional chaplaincy. In his own words: "The focus of chaplaincy in caring for the spiritual, soul needs of the sick has proven its worth" and "other health care disciplines are now seeing its worth" (O'Connor, 2002, p. 190). However, "the other health care disciplines have taken it one step further and have been engaged in doing scientific research on spirituality and health" (O'Connor, 2002, p. 190). This has created a situation in which "investigators in other disciplines have taken over research on spirituality and chaplains are the followers" (O'Connor, 2002, p. 191). Given this situation, "it is easy to imagine in the near future when a nurse who specializes in spirituality will be teaching chaplains on spirituality and health care using the research in the field" (O'Connor, 2002, p. 191). Whether or not that day will come, surveys of the healthcare literature from 1965–2000 show a dramatic increase in research on spirituality, but

there continues to be little research about chaplaincy (Weaver, 2003; Weaver et al., 2006).

The concept of spirituality has long been of interest in nursing (Flannelly et al., 2002; Weaver et al., 2001) and interest in it appears to be increasing in social work as well (Modesto et al., 2006). Although both fields share some common professional goals with chaplaincy, there is a degree of professional competition among the fields. This competitiveness appears to be stronger between social workers and chaplains than nurses and chaplains (Flannelly, Galek, et al., 2005). Indeed, in many ways nurses are the natural allies of chaplains. But, do chaplains want to leave it to nurses to define the spiritual needs of patients (Emblen & Halstead, 1993; Galek et al., 2005; Flannelly et al., 2006) or what constitutes spiritual care (Babler, 1997; Cavendish et al., 2007; Ross, 2006)?

Fitchett (2002) offers three other reasons for integrating research into professional chaplaincy. The first is to strengthen the practice of ministry and improve services to patients. We certainly agree that the major purpose of research in chaplaincy should be to improve the spiritual care provided to patients and families by chaplains and other healthcare professionals. Chaplains should not limit themselves to research on chaplaincy, however, nor should they limit themselves to doing applied research. Chaplains have come to us with research ideas about such diverse topics as the relationship between religion and depression in the elderly (Springer et al., 2003), the extent to which religious beliefs influence death anxiety (Harding et al., 2005), the kinds of psychological problems for which parishioners seek help from clergy (Moran et al., 2005) and secondary traumatic stress among chaplains and other clergy after the September 11th attacks (Roberts et al., 2003; Flannelly, Roberts et al., 2005).

The second reason Fitchett (2002) suggests chaplains do research is to increase awareness of what chaplains contribute to the healthcare team. Just doing research is likely to get the attention of your colleagues and administrators. Publishing research definitely gets their attention and enhances their respect for you and the profession. If the published study catches the eye of a reporter, the findings may reach a much wider audience, increasing the visibility of chaplaincy among the public. The third reason Fitchett gives is to promote interdisciplinary relationships. Collaboration with other healthcare professionals increases a chaplain's opportunities to do research

(especially basic research) and, perhaps, to do better research than a chaplain may have done on his or her own.

Finally, VandeCreek (1992) sees at least three personal and professional benefits to doing research. The prime benefit, according to VandeCreek, is that the process itself acquaints a researcher “with what others are thinking” (VandeCreek, 1992, p. 66), as well as knowing what others are thinking and doing helps improve one’s own pastoral care. The second benefit is that “research work opens unique doors and creates relationships that would otherwise not be possible” (VandeCreek, 1992, p. 67). This is especially true in large hospitals in which other healthcare professionals do research. Chaplains who do research are more likely to be seen as peers by other healthcare researchers, which raises the status of pastoral care. “Third, research stimulates creativity,” which can be “an antidote for the boredom and burnout that accompanies a heavy pastoral care load” (VandeCreek, 1992, p. 67).

### ***THE STATE OF CURRENT RESEARCH***

Before we look at the state of the art in research in chaplaincy and pastoral care, we will give a brief overview of the research on religion and health in general. The following discussion does not address qualitative research. Qualitative research was included in Flannelly et al.’s (2003) analysis of the field to some extent, but the most thorough assessment of qualitative research in chaplaincy is provided by O’Connor et al. (2001).

Flannelly et al. (2004) assessed the sophistication of research on religion and health in four major areas covered in the *Handbook of Religion and Health* (Koenig et al., 2001): anxiety, depression, well-being, and coping with physical disorders. A sample of 283 studies was selected and evaluated on four criteria: (1) the number of questions they used to measure religiosity; (2) their research design; (3) their sampling methodology; and (4) their use of statistical controls. We will review some of their findings.

Much of the early research on the relationship between religion and health could hardly be called research “on religion and health” at all. They primarily were epidemiological studies of various diseases that included some measure of religion for demographic purposes (Levin & Schiller, 1987). It is not surprising, therefore, that Flannelly

et al. (2004) found that studies such as these, in which religion was not a major focus of the study, used less sophisticated measures of religiosity than those that were designed to examine the association between religion and health, specifically.

Levin and Schiller say in their historical analysis of the research up to the mid 1980s: “Although many epidemiologists continue to collect some information about subjects’ religious preference, background, or practice as part of their inquiries, next to nothing has been accomplished in terms of the refinement of concepts or measures (Levin & Schiller, 1987, p. 9–10). However, Flannelly et al.’s (2004) analysis of studies published through the year 2000 found that the number of questions used to measure religion increased over time, suggesting the sophistication of the religious measures that researchers use has increased over the years.

As mentioned earlier, the various types of research methods or designs (case studies, cross-sectional surveys, experiments, etc.) can be thought of as forming a hierarchy. This hierarchy at least partly reflects the degree to which different designs provide the capacity to make causal inferences (Greenhalgh, 2001; Flannelly et al., 2004). Case studies form the lowest rung of the ladder and true experiments form the top rung. Cross-sectional studies, which include most survey research, are located just above case studies in terms of their sophistication. Longitudinal surveys, in which individuals complete the same questionnaire at two or more points in time, are considered more sophisticated because being able to track changes over time is very important for making causal inferences. Flannelly and his colleagues (2004) found that the research designs of studies on religion and health have become more sophisticated over the years, partly because of an increase in the number of longitudinal studies.

Flannelly et al. (2004) did not find any improvement in the sampling procedures used in the field, such as the use of random samples instead of convenience samples; they did find a significant increase in the use of statistical controls, however. Statistical control means that characteristics or attributes (i.e. variables) of a sample of people are measured and analyzed that might not be of interest in and of themselves (such as age, gender, income, education, etc.), but may confound or obscure the relationships that one is interested in studying. For example, if one wanted to look at the relationship between private prayer and health, one would have to control for age of study participants since older people are more likely to be religious and they are more

likely to be ill. One should always try to control for gender, age, other major demographic characteristics, and any factors that are known to be associated with either religiosity or health.

How sophisticated is the research published in chaplaincy and related specialty journals? Flannelly, Liu et al. (2003) tried to answer this question using a number of different criteria. Most (86.7%) of the quantitative studies in their 1990–1999 sample from three journals (*Journal of Pastoral Care*, *Journal of Religion and Health* and *Pastoral Psychology*) were cross-sectional surveys, so the research is relatively unsophisticated, at least by medical standards; cross-sectional surveys are widely used in sociology and other social sciences. However, since very few studies used statistical controls, the research tends to be unsophisticated by the standards of both medicine and the social sciences. Ignoring one study that collected data on over 42,000 chaplain interventions, and another that examined religious themes in over 17,000 articles published in medical journals, the sample size of the survey studies ranged from 4 to over 5,000, with the median being 160 participants. Sample sizes between 100 and 200 participants are common in psychology, but larger samples are needed for surveys when research questions are complicated, and many of the questions one might ask about chaplaincy and pastoral care are inherently complicated, especially in healthcare settings.

Flannelly, Liu et al. (2003) also evaluated the research in the field using a set of criteria that were exactly the same criteria as those used by Gartner et al. (1990). This allowed them to compare the results of the two analyses directly, to see if research in the field was more sophisticated in 1990–1999 compared to 1980–1989. Table 1 makes that comparison. Six measures of research sophistication are shown in the table, which are broken into three categories: internal validity, external validity, and interpretation.

Internal validity is a concept introduced by Campbell (1957), which refers to the degree to which one can be confident about making causal inferences from research conducted in experimental and quasi-experimental settings. Whether or not a study used a control group bears directly on this question. Control groups were very rare in the 1980s and the 1990s because very few studies used experimental or quasi-experimental designs.

The internal validity of a study also rests on the consistency or reliability of the measurements made during an experiment. In the case of mechanical and electronic equipment or instruments, this

TABLE 1. Percentage of Studies Meeting Gartner et al.'s Validity Criteria in the 1980's and the 1990s, According to Gartner et al. (1990) and Flannelly et al. (2003)

Criteria	Gartner et al. (1990) 1980–1989 (%)	Flannelly et al. (2003) 1990–1999 (%)
Internal validity		
Reliability	40	34
Control group	4	12
External validity		
Sampling method	20	63**
Response rate	33	43*
Interpretation		
Hypotheses stated	25	32
Limitations stated	4	58**

Significant differences between the two samples: \*  $p < .05$ ; \*\*  $p < .01$ .  
Adapted from Flannelly, Liu, Oppenheimer, Weaver, & Larson (2003).  
See text for details.

entails their ability to measure something accurately and to do so consistency. The same issues arise with respect to survey instruments or scales. Do they measure what they are supposed to measure reliably and consistently? As used in Table 1, the term reliability simply refers to whether the authors of a study used a survey instrument whose reliability had been previously documented, and whether they reported that documentation in their study. As seen in Table 1, there was no difference in reporting the reliability of the instruments used in the two samples: 1980–1989 versus 1990–1999.

Campbell (1957) also introduced the concept of external validity, which refers to the degree to which one can be confident about generalizing about the general population from the findings of experimental and quasi-experimental research designs. The concept of external validity can also be extended to surveys and other kinds of studies. It mainly hinges on the extent to which the sample under study is representative of the population to which one wants to generalize a study's findings. A random sample is considered to be more likely to be representative of the population from which it is drawn than a convenience sample, although this is not necessarily so. Similarly, the higher the percentage of people who agree to participate in a study when asked to do so (i.e., the response rate), the more

likely it is that the sample is representative. Sample size is also part of external validity, but we were not able to make a direct comparison of sample sized of the studies published in the 1980s and the 1990s.

The measure “sampling method” in the table simply records whether the sampling method was described, not the sophistication of the sampling method used. Likewise, the measure “response rate” simply records whether the response rate was reported, not the quality of the response rate. As seen in Table 1, the reporting of sampling methods and response rates increased significantly between the 1980s and the 1990s. Although these two measures are crude, they indicate the research published in the 1990s was more sophisticated than that published in the 1980s, or at least that there was greater awareness of the standards of sound research in the 1990s. Gartner et al. (1990) and Flannelly, Liu et al. (2003) used another measure of external validity, which did not change over time and is not shown in Table 1. That was the use of repeated measures designs, which was 7% and 8%, respectively, in the 1980s and 1990s.

The last category in Table 1 relates to a researcher’s sophistication in interpreting his or her results. The last two measures in Table 1 (under Interpretation) record whether researchers stated and tested explicit hypotheses and whether they discussed the limitations of the methodology they used. Specifying a hypothesis indicates that the author designed the study with a specific rationale in mind, and that the results can be interpreted in light of the hypothesis being testing. The last measure indicates that the author realizes there are methodological problems or issues in any study and they limit one’s interpretation of findings. Both measures increased over time and the increase in the latter was statistically significant.

A similar comparison of research published in four gerontology journals in the 1980s and 1990s allows us to put some of the Flannelly, Liu et al. (2003) results in a broader context. Three of the journals examined in that study were medical journals and one was a sociology journal. The sophistication of research on religion and health in all four journals improved between 1985–1990 and 1997–2002, in terms of reporting the reliability of instruments, reporting response rates, and specifying hypotheses. The percentages of studies that did so were higher in the gerontology journals, however, than in the journals represented in Table 1. Compared to the journals in Table 1, 64% of the studies published in the four gerontology journals during 1997–2002 reported the reliability of scales they

used, 82% reported response rates, and over 78% tested specific hypotheses.

Our analyses indicate that the research published in pastoral care and related specialty journals is relatively unsophisticated by the standard of other disciplines, but it is improving. While we wish to encourage this trend, we do not suggest that chaplaincy research needs to follow the path taken by other disciplines who are investigating the link between religion and health. The methodology of chaplaincy research still needs to improve, but there is plenty to learn by surveying, interviewing and simply observing patients, families and others in both healthcare and community settings. Indeed, we have noticed that most of the people who suggest that chaplains need to conduct experiments on the effectiveness of chaplain interventions, are not sophisticated about research, they are naïve about it. Studying processes must necessarily precede studying outcomes, particularly when the processes and the outcomes are so complex, and they are linked to many other factors.

### ***SOME SUGGESTIONS FOR INCREASING AND IMPROVING RESEARCH BY CHAPLAINS***

Fitchett (2002) suggests three steps for increasing research in chaplaincy. The first step may be the hardest, to convince chaplains that research is valuable for their practice of ministry. This can be achieved through educating chaplains and CPE students about research, as is done at The HealthCare Chaplaincy. Fitchett and his colleagues (2003) reported that chaplains' negative attitudes about research could be changed even by a one-day research workshop. At the start of the workshop, most of the chaplains who attended felt inadequate and inexperienced or anxious and apprehensive. By the end of the workshop, however, most chaplains felt more positive about research itself; some felt it was possible that they could do research themselves; and others expressed "cautious excitement" about the possibility.

Fitchett's second step is to increase the research literacy of chaplains to the level where they understand the basic elements of research, know where to find relevant high-quality research, and read at least a few relevant studies per year. The third step is for chaplains to do research as part of their regular job description.

VandeCreek (1992) makes several practical suggestions for conducting research. Start small and do not set your sights too high on you first try, “then gradually work into more complicated projects” (VandeCreek, 1992, p. 66). Maybe the second or third project will be worth publishing or presenting at a conference. If you want to try to publish it, submit it to “a journal whose standards match the sophistication of the project” (VandeCreek, 1992, p. 66).

VandeCreek wisely suggests seeking help on a research project from the very start. If you are not familiar with statistics or research design it may be hard to believe, but you can collect quantitative data in a way that makes them impossible to analyze in a meaningful way. If you have not done quantitative research before, make sure you seek help from a statistician or an experienced researcher in advance to plan the design and analyses. If possible, take a college-level research methods course. VandeCreek also suggests finding research-minded peers or working with an experienced researcher, and we totally agree. Flannelly, Weaver, and their colleagues (2003) describe several examples of their collaboration with chaplains who had their own ideas about research topics.

VandeCreek’s (1994) *Research in Pastoral Care and Counseling* is a very useful for beginning researcher in chaplaincy. It walks the reader through the research process and covers both qualitative and quantitative research methods.

### ***SOME SUGGESTIONS FOR FUTURE RESEARCH***

It is not for us to say what kinds of research chaplains should pursue, but there are some current avenues of research that we believe should be continued and expanded in the future. Naturally, we focus on those with which we are most familiar. To start, much more research like the studies reported in this issue of the *Journal of Health Care Chaplaincy* need to be done, from which, among other things, standards of practice might evolve. This research should include studies of the spiritual care provided by chaplains to patients, families, and staff. Such studies should also help to better define spiritual care.

Obviously, chaplains should conduct more research on the relationship between spirituality and health in patients. Most of the current research is done by nurses, physicians and other healthcare professionals. More disturbing, perhaps, the major focus of the

discussion about spirituality in the medical literature is whether physicians should address spirituality with patients. We believe research is needed that will help shift the discussion away from physicians and focus it on patients and their spiritual needs. There is substantial qualitative research on this topic and scales have been developed to assess patients' spiritual needs (Flannelly et al., 2006; Galek et al., 2005; Peterman et al., 2002), but much more research needs to be done with various patient populations (cardiology patients, oncology patients, etc.). This research would not only help us understand the spiritual needs of patients, but show the pervasiveness of patients' spiritual needs. In a market economy, healthcare institutions will not supply services for which they perceive there is little demand. We believe the demand is there, but often goes unnoticed. Beyond that, further research will be necessary to determine the extent to which patients' needs are being met, who is meeting them, and what are the best ways of meeting them.

Fitchett and his colleagues have been doing very valuable research on two related concepts: spiritual risk (1999a, 1999b, 2000) and religious struggle (Fitchett et al., 2004). Religious struggle, which has been found to be associated with poorer health outcomes among patients (Pargament et al., 2001), refers to negative religious coping, such as feeling abandoned or punished by God. Although this sense of abandonment or punishment is relatively low in the general U.S. population (5%) it appears to be higher (9–11%) among the few patient populations in which it has been studied (Fitchett et al., 2004). Spiritual risk is the term Fitchett and his colleagues have used to characterize patients whose religious needs are high but their religious resources are low. Since these patients are less likely to make self-referrals to the pastoral care department (Fitchett et al., 2000), screening tools must be developed to help identify them and their unique needs.

After an extensive review of the literature on religion and health he conducted for the Metanexus Institute, Hufford (2005) noted in his analysis of the field that it was dominated by social scientists and physicians, that it lacked a theological perspective, and that chaplaincy was glaringly absent. The last point echoes the words of VandeCreek (1999) that chaplains have little voice in the growing research field of religion/spirituality and health. For chaplains to have a voice, we think they should try to get involved in basic as well as applied research. In recent years, even neuroscientists have entered

the field, exploring how spirituality is represented in the brain. It would be worthwhile for chaplains to collaborate in this kind of research to give it theological grounding. Evidence that spiritual/religious practices and beliefs affect the brain will go a long way to showing how religion/spirituality can influence health. For example, Flannelly et al. (2007b) have proposed a theoretical model of how religious beliefs and other kinds of beliefs can moderate certain classes of psychiatric symptoms by influencing brain systems involved in assessing threats in the environment. The goal of such theory and research is to identify the biological causal mechanisms by which religion influences health. This research should help to show how chaplains help patients and may point to the best kinds of interventions.

The last avenue of research we would like to discuss concerns measuring the effectiveness of chaplains. No doubt, questions about chaplains' effectiveness will be asked in the future whether or not chaplains choose to ask them. When addressing this issue, chaplaincy as a whole should follow VandeCreek's (1992) advice to new researchers to start small and have limited expectations. There are a myriad of possible approaches to this question, and each chaplain may have his or her perspective about how to pursue it. Flannelly et al. (2007a), for example, have developed a preliminary scale to measure the effectiveness of pastoral care with family members of hospitalized patients. Several other related lines of research are being pursued by our colleagues at The HealthCare Chaplaincy. Some chaplains have adapted items from VandeCreek's (2004) patient satisfaction questionnaire to explore what chaplain activities are correlated with patients' perceptions that their spiritual and/or emotional needs have been met by the chaplain. Other chaplains have adapted items from several sources to create their own scales to measure the quality of their work—one for patients and family members and one for hospital staff. For clinical and methodological reasons, research on chaplain effectiveness probably should concentrate on patients who fall into Fitchett's category of being at-risk – those whose religious needs are high and whose religious resources are low.

The most important things to keep in mind when pursuing this question or any other research question is that there is no one right approach, or one best approach to studying it. Nor is there a way of knowing in advance which avenue of research will have the greatest or most important impact on a field. The clinical research process does not work well when the questions asked and the methods used to

answer them are selected by those outside the field, or directed from the top-down. Clinical research is at its best when the research ideas are generated by those working on the frontlines. Chaplains must decide what questions to ask and how to try to answer them. When doing so, it may be worthwhile to keep in mind that medical journals do not contain studies about the effectiveness of physicians or surgeons; they contain studies about the effectiveness of specific medical treatments and procedures.

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