

Pastoral Interventions and the Influence of Self-Reporting: A Preliminary Analysis

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This article presents the results of 30,700 inpatient visits by chaplains in a healthcare setting over a two-year period. The authors examine the self-report data of chaplains about patients' needs, chaplains' pastoral interventions, and patient outcomes. The article questions the common practice of self-reporting by chaplains and discusses the implication that such self-reporting is more descriptive of chaplains themselves rather than describing the needs of hospitalized patients. Recommendations are made for more qualitative research, such as patient surveys, and anchoring vignettes to supplement quantitative research.

KEYWORDS *chaplain, pastoral care, pastoral interventions, religion, spirituality*

For the past twenty years, the field of pastoral care has been encouraged to develop “objective instruments” that contribute to the clinical intervention literature (McSherry, 1987). One response to this challenge was the development of scales to assess the degree to which hospital patients are satisfied with pastoral care (VandeCreek, 2004) and the degree to which chaplains have met their spiritual and emotional needs (Flannelly, Oettinger, Galek, Braun-Storck, & Kreger, 2009). Related approaches have developed scales to measure patients spiritual needs and the effectiveness of chaplain interventions (Flannelly, Galek, & Flannelly, 2006; Flannelly, Galek, Tannenbaum, & Handzo, 2007; Galek, Flannelly, Vane, & Galek, 2005).

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Another approach has been to develop instruments to assess the institutional roles of chaplains (Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005; Galek, Flannelly, Koenig, & Fogg, 2007).

Other research has relied on chaplains' own reports of their clinical practices. For example, VandeCreek and Lyon (1994/1995) presented the results of a 3-hospital study of 40,000 chaplain visits that recorded the number of chaplain contacts with patients, family members, and staff. Unfortunately, in that study, chaplains only recorded their religious interventions. Using a similar methodology, Handzo and his colleagues (Handzo, Flannelly, Kudler et al., 2008; Handzo, Flannelly, Murphy et al., 2008) recently reported the findings of a 1994–1996 study of 30,000 chaplain visits with patients, families, and staff at hospitals in the New York City area. That study included seven religious and eight non-religious interventions; however, it did not include patient outcomes, and the published reports of the findings do not present chaplains' assessments of patient needs.

To address the need for more quantitative research, the Spiritual and Information Services Department of Baystate Medical Center designed a spiritual assessment system for chaplains to document their pastoral care activities similar to that used by Handzo, Flannelly, Kudler et al. (2008) and Handzo, Flannelly, Murphy et al. (2000). Soon after the chaplains began using the system, noticeable trends began to emerge. For example, some chaplains identified anxiety, despair, and loneliness in a third of their patients while other chaplains never saw these characteristics in their patients. Other chaplains focused on faith related issues in half of their patients while others rarely viewed this as a patient concern. The frequency of certain types of chaplains offering prayer and spiritual support to patients became predictable. In the end, whether or not a patient received prayer or spiritual support seemed to be determined more by the orientation of the chaplain than by patient need.

METHODS

Setting and Sample

These data were collected over a two-year period, from May 2005 thru April 2007 at Baystate Medical Center, a 600-bed acute care facility located in Springfield, Massachusetts. During this two-year sample, the Spiritual Services Department staff consisted of three professional interfaith chaplains: A full-time manager/clinical pastoral education (CPE) supervisor; an interfaith chaplain/CPE supervisor; and two part-time chaplains. In addition, two full-time Roman Catholic priests served on the staff. Other pastoral visitors in the department included CPE students.

Nearly half of the patients (49%) belonged to the Roman Catholic Church, with another 19% belonged to other Christian denominations.

The remaining patients in the sample were non-Christians (3%), Atheists/no religion (3%), or unidentified (26%). Patients whose religion was unidentified were seen in the emergency room where it was difficult to assess this information, or their faith tradition was not identified during admission.

Instrument Development

In the three years prior to this sample, the Spiritual and Information Services staff compiled visitation data and reviewed literature on documentation and assessment tool design (Berg, 1994; Gibbons, Retsas, & Pinikahana, 1999; Fogg, Weaver, Flannelly, & Handzo, 2004). From this analysis, the staff designed an instrument to enable data entry by staff members after pastoral visits with patients and families. Three primary categories of data were defined: patient needs, chaplain interventions, and patient outcomes. Nine specific items were defined within each of these three categories (see Table 1).

TABLE 1 Percentage Distributions of Patient Needs, Chaplain Interventions, and Patient Outcomes Recorded by Chaplains During Visits

Variables	Number of visits	Percent of visits
<i>Identified Patient Needs</i>		
Physical Pain and Suffering	11,370	37.0
Faith Related Issues	7,848	25.6
Anxiety, Despair, Loneliness	5,300	17.3
Anger, Frustration	1,820	5.9
Family Issues	1,572	5.1
Death, Dying	1,551	5.1
Companionship	882	2.9
Sense of Guilt, Shame	347	1.1
<i>Chaplain Interventions</i>		
Prayer, Spiritual Support	10,388	33.8
Empathic Listening, Presence	7,959	25.9
Life Review	6,845	22.3
Encouragement and Empowerment	2,465	8.0
Hope Building, Decision Making	857	2.8
Alternate: Music, Touch, Imagery	651	2.1
Shared Happiness	617	2.0
Crisis Intervention, Conflict	493	1.6
Bereavement Support	424	1.4
<i>Patient Outcomes</i>		
Appreciated Chaplain Visit	10,365	33.8
Expressed Emotion	7,707	25.1
Issues Still Outstanding	6,951	22.6
Faith, Spiritual Growth	2,017	6.6
Anxiety, Fear Reduced	1,260	4.1
Acceptance, Understand Situation	1,017	3.3
Renewed Confidence, Relief	627	2.0
Death	397	1.3
Declined Chaplain Visit	346	1.1

Procedure

Chaplains entered information about each visit into an online database. After recording patient demographic data and referral information, chaplains selected subjects that described their assessment and interventions from three drop-down menus entitled Identified Need, Intervention, and Outcome.

As a means of linking a chaplain's spiritual or religious intervention to the patient's needs, chaplains were encouraged to identify and document the patient's needs including the subsequent pastoral intervention. Chaplains were instructed to make all assessments in dialogue with patients and/or family members. Clinical assignments of staff and students were based on patient acuity and level of professional ability and experience.

At the conclusion of a visit, chaplains were also instructed to identify and document an outcome related to their intervention. Summary data reviews were conducted with the staff and students on a quarterly basis.

RESULTS

During the 24-month study period, 30,700 visits and follow-up visits were recorded with an average of 1,280 visits per month, 295 visits per week, or 42 visits per day. The proportion of the workload derived from the data reveal 41% of the visits were conducted by CPE students, 42% by Catholic priests, and 17% by professional interfaith chaplains.

Needs, Interventions and Outcomes

Table 1 presents the percentage distributions of patient needs, chaplain interventions, and patient outcomes recorded by chaplains during their visits with patients. The needs, interventions, and outcomes are listed in descending order with respect to the relative frequency of visits in which they were recorded.

As seen in the table, the three most frequently identified patient needs by chaplains were Physical Pain and Suffering, "Faith Related Issues," and "Anxiety, Despair and Loneliness." These three needs were recorded in nearly 80% of all chaplain visits. The next three most commonly identified needs were recorded during approximately 16% of visits.

The interventions most often identified by all chaplains was "Prayer and Spiritual Support," followed by "Empathetic Listening, Presence," and "Life Review," which were used during 62% of all visits. "Encouragement and Empowerment" was used relatively infrequently, while the others five interventions were used only rarely.

Three patient outcomes also were observed by chaplains during nearly 62% of visits: "Appreciated Chaplain Visit," "Expressed Emotion," and

TABLE 2 Percentage Distribution of the Four Most Frequent Needs, Chaplain Interventions, and Patient Outcomes Recorded During Visits by Three Types of Chaplains

Variables	CPE	IFC	RCP
<i>Identified Patient Needs</i>			
Physical Pain and Suffering	32.7	26.8	43.9
Faith Related Issues	10.2	2.3	47.5
Anxiety, Despair, Loneliness	29.3	28.6	1.3
Anger, Frustration	6.8	31.7	0.4
<i>Chaplain Interventions</i>			
Prayer, Spiritual Support	34.3	11.3	37.3
Empathic Listening, Presence	47.6	13.1	3.1
Life Review	2.3	33.0	43.6
Encouragement and Empowerment	8.6	9.6	7.1
<i>Patient Outcomes</i>			
Appreciated Chaplain Visit	49.9	19.7	17.8
Expressed Emotion	19.0	32.7	30.7
Issues Still Outstanding	15.6	17.0	31.8
Faith, Spiritual Growth	3.1	6.2	10.7

“Issues Still Outstanding.” The remaining six outcomes were observed during 1.1% to 6.6% of all visits.

Table 2 lists the four most common needs, interventions, and outcomes from Table 1, comparing the relative frequency with which they were recorded by CPE students (CPE), interfaith chaplains (IFC), and Roman Catholic priests (RCP). The table shows the percentage of visits in which each group recorded each need, intervention, and outcome.

Physical Pain and Suffering was one of the most commonly identified patient needs of all three groups of chaplains. Priests, however, were somewhat more likely to identify “Faith Related Issues,” as a patient need, whereas CPE students and interfaith chaplains relatively rarely identified it as a need. On the other hand, CPE students and interfaith chaplains were more likely to identify Anxiety, Despair, and Loneliness as patient needs. Interfaith chaplains were more likely than either other group to identify Anger and Frustration as a patient need. Indeed, this was the most common category of need interfaith chaplains recorded.

As shown in the table, chaplains made various interventions based upon their initial assessment. For example, CPE students employed the interventions of “Empathic Listening, Presence” in nearly half of their patient visits, while interfaith chaplains and priests used this intervention much less often. Priests and interfaith chaplains used “Life Review” most often, although interfaith chaplains used it less often than priests did. “Prayer, Spiritual Support” were the preferred interventions in over a third of the total visits by CPE students and priests.

Looking at the bottom section of Table 2, one sees that CPE students were most likely to report that patients’ “Appreciated Chaplain Visit,” doing so for half of their visits. Interfaith chaplains and priests only reported this

outcome for approximately 20% of their visits, with both groups being more likely to report the patient expressed emotion. At the conclusion of their pastoral visits, close to a quarter of all chaplains reported "Issues Still Outstanding," (see Table 1), with this item being reported by priests roughly twice as often as CPE students or interfaith chaplains in Table 2.

DISCUSSION

From the perspective of chaplains, these data describe what occurs in many pastoral visits. Patients are preoccupied with issues of pain and suffering. Many are anxious and angry, and the role of faith is an important one. Assistance through listening, reflection, and prayer is offered. Many who receive this assistance express emotion and appreciation for the pastoral visit.

What is worthy of attention are the variations in the design and delivery of pastoral care between the three groups of chaplains. The review raises some interesting questions. When a chaplain visits a patient, is the patient receiving pastoral care based on his/her needs? Or, is the visit more a reflection of the chaplain's needs? How can one group of chaplains identify anxiety in nearly a third of the patients they visited, while another group assesses no anxiety? How can some identify faith related issues as the primary problem of nearly half the patients they visit, while others identify faith related issues very rarely? While empathic listening and life review were recorded as common interventions by all three groups, why are patients who received prayer more likely to receive it from some chaplains more than others?

The high numbers of issues related to faith, life review, and prayer reported by priests can reflect their emphasis and understanding of pastoral care through rites and sacraments. This type of pastoral care may also be a result of what the faith group members expect from a priest. The CPE students are often experiencing a high degree of performance anxiety themselves. This may help to explain why students are more likely to identify anxiety in their patients. Students also are in the process of learning the art of empathic listening and sensitive for patients and families to report their pastoral encounter as satisfactory. Interfaith chaplains, on the other hand, may function somewhere in between: sensitive to anger as well as anxiety; facilitate life review as well as listen; and view acceptance through emotional release.

Unfortunately, our online reporting system did not lend sufficient information to determine if the self-reported data is more descriptive of chaplains than indicative of the actual needs of patients. As a management reporting tool, our reporting system is invaluable in demonstrating the activities of chaplains. As a means of generating data capable of withstanding further analysis, our reporting system did not include a means to test the validity of the data entered into the system. Our review of the trends in these data lead

us to conclude that relying on self-reported data, by itself, to measure the effectiveness of clinical interventions is tenuous.

It must be kept in mind, of course, though the current findings are based on a large sample of patients, they reflect the activities and judgments of only a small number of chaplains. Thus, the apparent biases in the reported assessments, interventions, and outcomes may represent individual biases, rather than true differences in clinical practice among interfaith chaplains, priests, and CPE students. Such a small sample of chaplains made it impossible to conduct any meaningful statistical analyses of the data. Nevertheless, it could be useful to conduct cross-tabulations of the three variables to examine, for example, the extent to which specific assessments are associated with specific interventions and specific interventions are associated with specific outcomes. Unfortunately, since the data were only available to us in aggregated form, we were not able to examine those associations.

We have identified three design changes for future data collection and analysis related to chaplains' activities. First, less reliance on chaplain self-reported data is better. In our research, we were reminded what social psychologists have noticed for years: People report what they believe researchers want to see and what reflects positively on their abilities and knowledge. Bandura's (1997) social cognitive theory of self-efficacy regards "people's level of motivation, affective states, and actions are based more on what they believe than on what is objectively true" (p. 2). Empirical evidence supports Bandura's notions that unless people believe their actions can produce the outcomes they have in mind, there is little incentive to pursue them. In other words, how people behave can be better predicted by the beliefs they hold. This last idea may help explain why our chaplains' behaviors varied widely even when they possessed a similar knowledge base and training.

A second design alteration is to counter-balance the effects of self-reporting by including data from the perspective of patients. Self-reporting by patients is one possible way of validating or challenging chaplain assessments and interventions. Unfortunately, many hospital surveys are limited to protect patients from being over-surveyed. By design, patients are asked questions about physicians, nurses, food service, sanitation, and noise levels.

A third design alteration is comparing self-reported data to anchoring vignettes. Of our three considerations, we believe this one holds the most promise. The use of anchoring vignettes as a survey component would be used to consider self-reported responses on an interpersonally comparable scale. Used for many years, and as recently as 2001 by the World Health Organization (WHO), to enable a comparison of data collected between different cultures and countries, WHO included vignettes of sample cases that described the health problems of third parties (Salomon, Tandon, & Murray, 2004). By responding to other people's circumstances, the responses

to the vignettes allowed for capturing individual perceptions without the subjectivity of self-reporting. Adding this data collection strategy to future pastoral care research would allow for an ongoing investigation of an individual's expectation for pastoral care and the adjustment of self-reported data. Anchoring vignettes also may provide a useful instrument for standardizing chaplains' perceptions and expectations in the delivery of pastoral care.

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