

Testing the Efficacy of Chaplaincy Care

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The current article reviews the research conducted in the United States on the clinical practice of chaplains with patients and family members, referrals to chaplains, patient satisfaction with chaplaincy services, and the limited literature on the efficacy of chaplain interventions. It also discusses the methodological limitations of studies conducted on these topics and makes suggestions for improving future chaplaincy research. The authors conclude that past studies have not adequately defined chaplain interventions, nor sufficiently documented the clinical practice of chaplains, and that more and better designed studies are needed to test the efficacy of chaplaincy interventions. The authors recommend that chaplains generate research-based definitions of spirituality, spiritual care, and chaplaincy practice; and that more research be conducted to describe the unique contributions of chaplains to spiritual care, identify best chaplaincy practices to optimize patient and family health outcomes, and test the efficacy of chaplaincy care.

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INTRODUCTION

Health care in the United States is evolving from an exclusive concentration on the physical dimension of illness to a more holistic model (Meador, 2004; Puchalski and Ferrell, 2010; Sulmasy, 2009). This holistic model is patient-centered and takes into account patients' psychosocial and spiritual needs (CMS Medicare Hospice, 2010; Puchalski et al., 2009; Sulmasy).

As patients become the center of health care and take a more active role in planning what treatment they receive, there is increasing evidence that they rely on their spiritual and religious beliefs to help them cope (Koenig, 1998). They want their religious and spiritual values taken into account when planning their treatment (Astrow, Wexler, Texeira, He, & Sulmasy, 2007).

Chaplains are the primary spiritual care professionals on the healthcare team (Handzo & Koenig, 2004; Jacobs, 2008). They are the professionals in the hospital that create "sacred space" (Mohrmann, 2008, p. 22), and, as professionals, they are held accountable for documenting and improving their contributions to care (Bay & Ivy, 2006; Berlinger, 2008; DeVries, Berlinger, & Cadge, 2008; Gleason, 2004; Mohrmann; O'Connor & Meakes, 1998).

To guide and improve chaplaincy practice and further integrate spiritual care into health care, research findings that provide an empirical basis for best practices in chaplaincy care are needed. The process of moving to a research-informed practice continues in both medicine and psychology (T. B. Baker, McFall, & Shoham, 2009; Richards & Worthington, 2010), but relatively little research has been conducted on chaplaincy. Without research that focuses on the unique contributions of chaplains in spiritual care, it is likely that spiritual and religious issues will continue to be neglected in the care of patients and family members.

Spiritual Coping

Spiritual and religious coping, such as ritual and prayer, are important to many individuals to find strength and support when facing physical illness and distress. For example, spiritual coping and prayer were found helpful when experiencing general emotional stress (Ano and Vasconcelles, 2005), mental illness (Tepper, Rogers, Coleman, & Malony, 2001), and medical illness (Koenig, Larson, & Larson, 2001), particularly cancer (Boscaglia, Clarke, Jobling, & Quinn, 2005; Fitchett et al., 2004; Sherman & Simonton, 2007; Tarakeshwar et al., 2006; Kristeller, Sheets, Johnson, & Frank, 2011).

A national survey of American adults found that 58% pray at least once a day or more often (Pew, 2008), and 35% of people pray about their health

concerns (McCaffrey, Eisenberg, Legedza, Davis, & Phillips, 2004). Fifty-eight percent of people with cancer engage in religious practices to help them cope with their illness (Alcorn et al., 2010). Prayer and spiritual coping can also be important for family members of hospitalized patients. In one study, family members in waiting rooms used prayer and other religious activities to cope with stress during a loved-one's surgery (VandeCreek, Pargament, Belavich, Cowell, & Friedel, 1999). The family members benefitted from their religious coping practices above and beyond the benefits gained from non-religious forms of support.

Studies of older adults hospitalized for medical problems report that religion is the most important coping mechanism, and that prayer is one of the most common religious activities (Koenig, 1998; Koenig, Pargament, & Nielsen, 1998). Fitchett, Meyer, and Burton (2000) reported that 68% of hospitalized patients had a religious affiliation, and 72% reported that religion was a source of great strength and comfort to them.

Spiritual Needs

In addition to documenting that patients and families use religious and spiritual support during health crises, research has documented these spiritual and religious needs in acute care settings (VandeCreek, Benes, & Nye, 1993; VandeCreek & Smith, 1992). Achieving spiritual and psychological healing is particularly important at the end-of-life, when physical healing is no longer possible, and palliation is the goal (Sulmasy, 2002, 2006), and when treatment should be aligned with the patient's goals (Meier, Casarett, von Gunten, Smith, & Storey, 2010). Those goals are often influenced by spirituality and religion (Phelps et al., 2009; Balboni et al., 2010).

One study of hospitalized patients reported that 94% felt that their spiritual needs were as important as their physical needs (King & Bushwick, 1994). In another study, 84% of advanced cancer patients felt religion to be at least somewhat important (Balboni et al., 2007). In another study of advanced cancer patients, 78% stated that religion/spirituality concerns were important in dealing with their illness (Alcorn et al., 2010). Patients who were more religious or more spiritual tended to identify religious and spiritual concerns as being important. Roughly half of the patients in a palliative care unit with end-stage cancer would like a chaplain to provide a sense of "presence," listen to them, visit with them, or accompany them on their journey. The more religious cancer patients also desired religious interventions from the hospital chaplain more frequently (Mako, Galek, & Poppito, 2006).

Spiritual Struggle

Mental and physical health can suffer should individuals be unsuccessful in addressing their spiritual and religious needs. Research has indicated the

importance and prevalence of spiritual risk and spiritual struggle during times of distress, such as during an illness (Fitchett, 1999; Fitchett et al., 2004; Hui et al., 2010; Pargament, Murray-Swank, Magyar, & Ano, 2005). Fitchett defines spiritual risk as having high spiritual needs but having low spiritual resources (Fitchett, 1999). Patients with high spiritual risk are likely to experience negative health outcomes should they develop negative coping or spiritual struggles.

Negative religious coping and spiritual struggles are associated with increased mortality (Pargament, Koenig, Tarakeshwar, & Hahn, 2001) and psychological distress (Fitchett et al., 2004; Rosmarin, Pargament, & Flannelly, 2010; Winkelman et al., 2011). There is some evidence that people who remain in a state of spiritual struggle over time, for example, questioning God's care for them, are more likely to develop worse health outcomes compared to those who show positive spiritual coping and those who began in struggle but developed positive spiritual coping (Pargament, Koenig, Tarakeshwar, & Hahn, 2004). In a landmark study, Fitchett, Rybarczyk, DeMarco, and Nicholas (1999) found that people undergoing rehabilitation in a medical facility who were both religious and angry with God were much slower to recover than other patients. Fitchett et al. (2004) found that adverse life events and simultaneous struggle with religious beliefs is associated with greater levels of depression and emotional distress. Ai and colleagues have also found strong evidence for a link between spiritual struggle and poor health outcomes (Ai, Pargament, Appel, & Kronfol, 2010; Ai, Pargament, Kronfol, Tice, & Appel, 2010).

Are Patients' Spiritual Needs Being Addressed?

Despite the evidence that spiritual struggles are associated with poorer health outcomes, the spiritual needs of many patients in health care institutions are not being met. Forty-seven percent of advanced cancer patients said they received little or no support from their faith community and 72% said they received little or no support for their spiritual needs from the medical establishment (Balboni et al., 2007). Only 42% of hospitalized psychiatric and medical/surgical patients could identify an individual to whom they could turn with spiritual concerns (Sivan, Fitchett, & Burton, 1996). A nursing study by Vance (2001) found that only 25% of patients were given spiritual care. The biggest barriers to nurses delivering spiritual care were that they felt they did not have enough time, they felt they did not have enough education in spiritual matters, or they felt that the spiritual needs of a patient were a private matter (Vance). Other research has reported that physicians—the central figures in treatment decisions—are less likely than all other hospital disciplines to believe it important to refer patients to chaplains (Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005).

WHERE CHAPLAINS ARE AND WHAT THEY DO

There is no question that people have spiritual needs and that spiritual care is an important component of health care, and chaplains are the professionals who are trained to meet those needs. In a large survey of pediatric palliative care programs chaplains were the typical providers of spiritual care (Fitchett et al., 2011). The increasing number of clinically-trained multifaith chaplains has allowed the chaplain to be more fully integrated as the spiritual care professional on the healthcare team, moving beyond the role of a community religious professional brought in to the hospital for a ritual. Best practice models of care currently call for chaplains to be (1) based on healthcare teams, rather than be denominationally based, and (2) be a part of referral services for patients with documented spiritual/religious needs, rather than making visits only to those who ask for a chaplain (Fitchett et al., 2000; Handzo, 2006; Denley, 2010; Handzo & Wintz, 2006; Wintz & Handzo, 2005). While this new model is gaining wide acceptance and provides better congruence with the processes by which health care is currently provided, its efficacy and outcomes remain untested.

Studies with descriptions of where chaplains work and what chaplains do illustrate the scope and breadth of chaplaincy practice, which includes ministry to families, working with the bereaved, and the use of various interventions, religious rituals, and prayer with patients and families. However, many of these studies are restricted to a few hospitals (e.g., New York Chaplaincy Study) or particular practice settings like oncology or neonatology.

Where Are Chaplains?

Chaplaincy services are provided at approximately 68% of all hospitals in the United States of America (American Hospital Association (AHA), 2005). This is an increase from 2003 when 59% reported chaplaincy services, and it is the highest percentage recorded since data on chaplaincy were first collected by the AHA in 1980 (Cadge, Freese, & Christakis, 2008). A national survey of pastoral care departments found that chaplains were employed in 94% of large hospitals (average census of 400 patients or more), whereas 31% of smaller hospitals (25 to 100 patients) employed chaplains (Flannelly, Handzo, & Weaver, 2004). The percentage of employed chaplains who were also board certified was the same in both cases (71%). Only 23% of the smallest hospitals (25 patients or fewer) employed chaplains, and only 67% of chaplains were board certified. Hospitals in less urban settings relied more on local clergy and lay volunteers (14% in urban vs. 58% in rural areas). Thus, board certified chaplains guided by common standards of practice are more likely to be in large, urban hospitals, while small or rural hospitals are more likely to have a variety of individuals offering spiritual care from a variety of philosophies, theologies, and practice.

What Do Chaplains Do?

Chaplains address patient issues and concerns with the sacred, existential questions, and spiritual pain. They are able to work with religious patients as well as the increasing number of patients without a specific religious identity (Newport, 2010). Chaplains begin with a focus on the patient and the current situation, and they assess all factors that could be contributing to stress and suffering. However, there is little research on chaplaincy practice, such as the methods for conducting spiritual assessments and interventions. One source of information on chaplaincy practice is to look to the reasons that hospital staff refer patients to chaplains.

REFERRALS TO CHAPLAINS

In an acute care setting, referrals of patients to chaplains, pastoral care providers, or clergy may be initiated by physicians, nurses, and other hospital staff, as well as by the patients or the patient's family members. Although Flannelly, Handzo, Galek, Weaver, and Overvold (2006) found that physicians believed it was less important to refer patients to chaplains than did nurses or social workers, the physicians believed it was important to make referrals for some types of issues. Fitchett, Rasinski, Cadge, and Curlin (2009) support the finding that physicians have a positive attitude in general toward chaplains. The national survey of 1,102 physicians found that 89% had experience with chaplains, and that 90% of those with experience were satisfied or very satisfied with chaplains. This appears to be quite an improvement in attitudes toward chaplains since a 1992 study by Hover, Travis, Koenig, and Bearson, in which only 46% of physicians in one hospital said they had any contact with chaplains. Of interest in this older study was that physicians who had no contact with chaplains were apprehensive about the negative impact a chaplain might have on patients, such as being "preachy."

Studies by The Spears Research Institute of HealthCare Chaplaincy have examined the attitudes of hospital staff and administrators about the roles of, and referrals to, chaplains. Flannelly, Handzo, Weaver, and Smith (2005), for example, surveyed 3,300 hospital administrators about the importance of eleven kinds of chaplain activities. The administrators that responded (15%), felt all of the chaplain activities were important, especially the provision of end-of-life care and emotional support for patients and families. Directors of pastoral care, nursing, social service, and medical services felt that it was very important for chaplains to pray with, and provide emotional and grief support, to patients and family members (Flannelly et al., 2006). A complementary study by Galek, Flannelly, Koenig, and Fogg (2007) found that the directors felt it was most important to refer patients to chaplains for issues relating to meaning, loss, and death. The results of a survey of nurses at a New York City hospital are consistent with those already

mentioned (Weinberger-Litman, Muncie, Flannelly, & Flannelly, 2010). Nurses reported they were most likely to refer to chaplains in cases of end-of-life decision making, grief, and the general need for emotional support.

Two large studies of hospitals in the New York City area have documented actual referral rates to chaplains. Vanderwerker et al. (2008) found that nurses referred patients to chaplains far more often than did other staff, and that the main reason for all staff referrals was emotional issues, including anxiety/agitation, pain/depression, grief, and hostility. Spiritual concerns were indicated only if a patient clearly exhibited spiritual distress or requested religious items. Over a 7-year period at a community hospital, the most common reasons for referrals to a chaplain were loss (including pregnancy loss) and emotional issues, including anxiety, crying, depression, and loneliness.

A large, 2-year study by Galek et al. (2009) highlights a contrast in referral reasons. Patients and families most often requested a chaplain visit to meet religious needs (e.g., prayer and religious rituals) while staff were far more likely to refer patients to chaplains for emotional or end-of-life issues. When patients or family members requested the chaplain visit, the patients exhibited positive affect (i.e., gratitude, happiness, hopefulness, etc.), whereas staff referrals were associated with negative patient affect (i.e., anxiety, depression, grief, sadness, etc.).

These studies of referrals suggest that patients and family members ask for chaplains when they are less emotionally or spiritually distraught. Hospital administrators and staff tend to refer patients to chaplains when there are emotional issues, end-of-life, and death and dying issues. Patients and families expect chaplains to help with religious, spiritual, and emotional needs, while staff seek a chaplain's help more often for emotional support for the patient.

CHAPLAINS' ACTIVITIES: CARE OF PATIENTS

It is important to have a method to identify spiritual and religious needs so as to improve patient and family care. Fitchett and Canada (2010) have three defined activities that comprise a method to identify spiritual and religious needs: spiritual screening, spiritual history, and spiritual assessment. Screening involves a few simple questions that can be asked by any health care personnel. A spiritual screening can help identify patients who are at high spiritual risk and may be likely to develop spiritual struggles. Methods for spiritual screenings for spiritual struggles and spiritual risk are provided by Fitchett (1999) and Fitchett and Risk (2009). If the results of the screening suggest the patient is at risk, a more thorough spiritual history taking is recommended. Taking a patient's spiritual history requires more questions and takes time to identify the specific religious needs and resources of the patient (e.g., Borneman, Ferrell, & Puchalski, 2010). A spiritual history is

done by healthcare professionals, the clinician in charge of the patient's care, or the chaplain as part of patient intake.

A spiritual assessment is done by a professional chaplain who takes considerably more time with the patient to understand the patient's spiritual story in order to formulate a spiritual care plan. The spiritual assessment should determine the degree to which the patient may be experiencing issues with purpose and meaning, loss of self control, or spiritual pain and suffering (Millspaugh, 2005). There are a few assessment systems for chaplaincy (Derrickson, 1994/1995; Fitchett, 2002a; VandeCreek & Lucas, 2001). VandeCreek and Lucas (2001) proposed a system that includes assessment content, interventions, and outcomes, but there is little research on the relationship among these components of care (Montonye & Calderone, 2010). In reality, the content of an assessment protocol for any given chaplain is likely to be idiosyncratic. A study of Canadian chaplains found that only 20% of chaplains surveyed knew of assessment tools, and 30% of these chaplains had created their own assessment system (O'Connor et al., 2005). In other research, chaplains conducted spiritual assessments during less than half of their patient visits (Handzo et al., 2008a).

A series of papers by HealthCare Chaplaincy's researchers reported on the visits and interventions of 40 chaplains and more than 200 students taking clinical pastoral education (CPE) at 13 health care institutions in New York City and vicinity (Flannelly, Weaver, & Handzo, 2003; Handzo, 2008a, 2008b). Spiritual assessments were made during 48% of initial visits and 44% of subsequent visits Handzo et al. (2008a). Even though it appears that a majority of chaplains do not use an assessment system, they may be increasingly called to use one. As electronic medical records become universal, chaplains will be called upon to assess and document specific interventions that address specific patient needs and outcomes, and this will require using documented assessment methods (LaRocca-Pitts, 2010).

Spiritual interventions were performed during approximately 60% of all visits, by themselves or in conjunction with general interventions (Handzo et al., 2008a). The most frequently used spiritual interventions were prayers, blessings, and faith affirmation. The most common general interventions were empathic listening, life review, and emotional help to express feelings. Chaplains had longer visits with acute care patients than with non-acute care patients, and spent more time with patients when their families were present (Handzo et al., 2008b).

Patients expect chaplains to remind them of God's caring presence, and many patients also expect traditional religious activities (Piderman et al., 2008; Piderman et al., 2010). Prayer is one of the most common interventions that chaplains are expected to engage in, and people who are not familiar with chaplains often expect them to offer prayer (Hover et al., 1992). Prayer also is one of the most common interventions that chaplains perform, depending on the patient's immediate situation and religious affiliation

(Flannelly, Weaver, & Handzo, 2003; Handzo et al., 2008a). Chaplains pray with patients prior to surgery more than they do with patients in other situations, and they pray with Muslim and Catholic patients more often than they do with Jewish patients.

Professional chaplains have a foundational clinical background that enables them to anticipate a need for prayer and to ask patients what they would like to pray for. Board certified chaplains have learned how to pray with persons of all faiths; they incorporate the patient's needs and shape prayers to best help the particular patient. They are multifaith in theory and practice, and there is a respect for that which is authentically possible when being with and praying with persons of faith traditions that are, or are not, the chaplain's faith tradition (Silton, Asekoff, Taylor, & Silton, 2010; Taylor, 2005; Zucker, Bradley, & Taylor, 2007).

Montonye and Calderone (2010) examined chaplain reports of their activities in a 600-bed acute care hospital in Massachusetts. The chaplains included board certified interfaith chaplains, chaplaincy students, and Roman Catholic priests. Patient needs, chaplain interventions, and patient outcomes were recorded over a two-year period. The needs of the patients were recorded as physical pain and suffering, having faith related issues or anxiety, or experiencing despair and loneliness in 80% of the visits. In 82% of the visits the interventions were prayer, spiritual support, empathic listening, presence, or life review. There were major differences in types of interventions depending on whether the intervention was delivered by a clinical pastoral education student, interfaith chaplain, or Roman Catholic priest: however, patients were assigned to students, chaplains, or priests based on degree of patient difficulty and chaplain skill sets.

In summary, when working with hospital patients, chaplains frequently performed spiritual interventions such as prayer much of the time, and conducted spiritual assessments some of the time. They also used more general interventions, including emotional support and empathic listening/presence with patients. It is not clear how specific interventions were chosen, what the best practices in spiritual care were for which patients, or if the care activities were unique to chaplaincy. Most of these studies deal with one, or a small number, of hospitals in the Midwest and North Atlantic states, and many were conducted by a single research institute, all of which might limit the conclusions about chaplain activities to these geographic areas.

CHAPLAINS' ACTIVITIES: CARE OF FAMILIES

In one study, over 40% of referrals to chaplains at one hospital were for the relatives and friends of patients (Flannelly, Weaver, & Handzo, 2003). In another study, VandeCreek and Lyon (1994/1995) examined hospital records at three hospitals over a 2-month period to identify how often chaplains visited patients, family, and staff. Family contacts accounted for 29% to

35% of chaplain visits across hospitals. Family contacts were somewhat inflated in this study, however, because each family member present during a visit was counted separately as a visit. For example, four family visits were recorded if there were four family members in the room when a chaplain visited.

Chaplains are a vital link between family members and the treatment team, especially in critical care situations (Gillman, Gable-Rodriguez, Sutherland, & Whitacre, 1996). Chaplains listen to family concerns, instill trust, and provide hospitality, information, and emotional support. Levine (1998) emphasizes that family members are really the patient's primary caregivers, and as such, they should be intimately involved in treatment decisions. In Levine's opinion, however, they are usually ignored by hospital staff. This is unfortunate, because as VandeCreek and Smith (1992) found, family members of a hospitalized patient were more involved in spiritual issues, such as a search for meaning in life, than patients or persons in the community.

A study by Sharp (1991) found that chaplains attending to families with an infant in neonatal intensive care units (NICU) typically interacted with the family for one (73%) or two days (18%). Most chaplain-initiated visits were to support the parents of an extremely ill child, while most requests for chaplain visits by nurses, parents/family, and physicians were for decedent care (e.g., comforting parents, baptizing a dying infant).

In a study of bereaved family members, family members were asked to describe the contact they had with chaplain before and after their loved-one's death, and whether they found it helpful (Broccolo & VandeCreek, 2004). Chaplain activities were viewed as helpful, and fell into five categories: providing comfort and support, assisting with the details of death, being a temporary family member, making meaningful contact, and being a spiritual doula for the deceased to make the transition from this life to the afterlife.

According to research by Flannelly, Galek, Bucchino, and Vane (2006) and Flannelly, Handzo, Weaver, and Smith (2005), hospital administrators and directors believe it is very important for chaplains to minister to the needs of family members. Chaplaincy activities reported included praying with patients' relatives, grief and bereavement counseling, helping family members deal with difficult decisions, and generally providing emotional support to families. Fitchett et al. (2011) interviewed directors of pediatric palliative care programs and chaplains and found considerable variability in chaplain activities. Chaplains addressed spiritual suffering, provided rituals, and improved palliative care team-family communication.

As the aforementioned research indicates, chaplains are called by hospital staff, patients, and family members to provide support to patients and families. Chaplains provide spiritual, religious, and emotional support. They can become temporary family members when a death has occurred. They are less likely to conduct a formal spiritual assessment, and if they do, they are just as likely to create their own as follow an assessment plan protocol. What is not

known is which chaplain activities best help whom in which situations to effect the best outcomes. Next, this review turns to studies that measured the impact of chaplaincy care upon patients or families.

PATIENT SATISFACTION AND INTERVENTION STUDIES

Research into chaplaincy care outcomes falls roughly into two general categories: 1) studies of patient satisfaction with chaplaincy care and 2) studies of actual chaplaincy interventions and their relation to health outcomes. The patient satisfaction studies are generally stronger methodologically than the intervention studies and tend to show that chaplain visits have a positive effect on overall patient satisfaction. The health outcome studies are very few in number and most have serious methodological shortcomings. Some research from outside the inpatient acute care setting is reviewed to obtain a broader horizon of chaplaincy research. In terms of levels of evidence, the research literature does not offer well-established findings to date. While findings are suggestive, all studies are in need of targeted and enhanced replication.

Patient Satisfaction Studies

Patient satisfaction with the spiritual care received in a hospital predicts patient satisfaction with care overall and predicts the patient returning to that hospital or referring family and friends to that hospital (Gibbons, Thomas, VandeCreek, & Jessen, 1991). Daaleman, Williams, Hamilton, and Zimmerman (2008) reported that 87% of long-term care residents received spiritual assistance in their end-of-life care, and those who did were perceived by family members to have had better overall care. Families rated the facilities more positively when spiritual care needs were met. In another study, Astrow et al. (2007) found that patients who did not have their spiritual care needs met were less satisfied with their health care.

Gibbons et al. (1991) examined patient satisfaction with chaplain and spiritual services of over 400 patients who had recently left the hospital. About half had been visited by a chaplain, and half of these had also been visited by clergy. About a third received a visit from a social worker, and a third from a patient representative. Patients rated chaplains' visits as being the most important, and having the highest attainment of expectations. The need for support and counseling was positively related to the likelihood that the patient would recommend the hospital to others and select the hospital again themselves.

VandeCreek and Connell (1991) examined the average level of satisfaction with support, counseling, and prayer, using the same dataset as Gibbons et al. (1991). There were significant differences between Catholic and

Protestant patients on some of the measures. Catholics received significantly more visits by a chaplain, and gave higher ratings to the importance of a chaplain visit, the need for sacraments, and support/counseling. In another study, the overall rating of the importance of chaplains was equivalent across Catholic, Jewish, and Protestant patients (VandeCreek, Thomas, Jessen, Gibbons, & Strasser, 1991). In both of these studies, as in Gibbons et al., there was no specification of the activities engaged in by chaplains, nor was there comparison of the activities of chaplains with social workers, patient representatives, or clergy.

A study on patient satisfaction with care in six hospitals compared the helpfulness of different non-medical support services (Parkum, 1985). "Pastoral counselors" were found to be helpful by the most patients (67%), followed by regular volunteers (23%), and social workers (16%). VandeCreek and Lyon (1992, 1997) developed two patient satisfaction scales, the second of which evaluated four domains of chaplain ministry: (a) "supportive ministry" which provides comfort and reassurance; (b) a ministry that "helps patients cope;" (c) "acceptance of the chaplain's ministry" which reflects negative attitudes about chaplains; and (d) "ministry to the patient's private concerns," that covers chaplain's competence, communication skills, empathy, attentiveness, and sensitivity. Of the approximately two thousand former hospital patients and family members surveyed by VandeCreek and Lyon (1997), almost all of the respondents agreed that the chaplain had comforted them, possessed spiritual sensitivity, had listened to their concerns, and had helped them feel more relaxed, thereby improving their health care.

Patient satisfaction with visits by clergy and chaplains indicated that satisfaction appeared to be influenced by a number of factors, including the patient's age, education, and level of church attendance, and hospital length of stay (VandeCreek, 2004); however, overall satisfaction was correlated with all measures of chaplain activity. In a study of bereaved family members, chaplain helpfulness was rated between very good and excellent (Broccolo & VandeCreek, 2004).

Flannelly, Oettinger, Galek, Braun-Storck, and Kreger (2009) evaluated satisfaction with chaplains in a hospital that specialized in orthopedic surgery. Patients were asked about their satisfaction with chaplain demeanor and actions, such as the chaplain seeming to care for the patient and sitting down when talking with the patient, praying with the patient, listening to the patient, and providing help to tap inner resources. The results indicated that 80% of patients with spiritual/religious or emotional needs felt that their needs were met by the chaplain. The activities associated with satisfaction of spiritual/religious needs being met were the chaplain making the patient comfortable, praying with the patient, and helping them tap their inner strength and resources.

In conclusion, studies that have evaluated patient satisfaction with chaplaincy care have found that patients, in general: (1) were very satisfied with

chaplains, and (2) believed that chaplains have met their emotional and spiritual needs, thereby improving their health care. Patients were more satisfied with chaplains than other members of the health care team providing services. However, with the exception of the Flannelly et al. (2009) study, it is not clear what chaplains did or what patients found most helpful or satisfying. Nor is it clear if, or how, chaplain activities and patient satisfaction impact on patient health outcomes.

Intervention Studies

Chaplains have been involved in research investigating the impact of their ministry on patient health, both when acting alone and when assisting other professionals as part of an interdisciplinary team.

INTERDISCIPLINARY TEAM PARTICIPATION

Chaplains were part of a team that delivered spiritual interventions to improve quality of life in advanced cancer patients (Rummans et al., 2006). Hospital patients undergoing radiation therapy were randomly enrolled in either an intervention condition or a treatment-as-usual control condition. Patients in the intervention condition received physical therapy, cognitive, emotional, social, and spiritual interventions, and guided relaxation across eight sessions. They also received a 200-page manual with written materials that covered all of the eight manualized sessions.

At a four-week followup, intervention patients reported a significantly greater quality of life than patients in the treatment-as-usual group. Ratings of spiritual well-being were also significantly higher in the intervention group at four weeks, whereas quality of life and spiritual well-being of the control group decreased from baseline to four weeks. Although the spiritual domain showed the most improvement in patients in the intervention group, it is not possible to know what the crucial part of the intervention was that was responsible for the improvement or who delivered it. Furthermore, no significant differences were found between groups at a 5-months followup on the measures of interest, indicating no lasting effect of the intervention.

In another study, a chaplain was part of an interdisciplinary team treating outpatients with heart failure, chronic obstructive pulmonary disease (COPD), and palliative care cancer patients who had a life expectancy of one to five years (Rabow, Dibble, Pantilat, & McPhee, 2004). The chaplain was responsible for providing spiritual and psychological support. Patients' physical functioning and psychosocial and spiritual well-being were assessed at entry, after 6 months, and after one year in the program. Spiritual well-being increased, and anxiety decreased, over the course of the study significantly more for intervention patients than for treatment-as-usual

patients. Unfortunately, it is impossible to estimate the contribution of the chaplain to the team or to the overall improvement in patient well-being.

CHAPLAINS WORKING ALONE

In a retirement community, ordained ministers, some with chaplaincy training, delivered a pastoral intervention treating depression and the negative impacts of changes in life circumstances (Baker, 2000). The elderly participants were divided into three groups; individuals taking antidepressant medication, individuals at-risk for depression and individuals selected after a weekly religious service. Each of these three groups was again divided into two groups; those receiving weekly pastoral visits and those not receiving weekly pastoral visits. The pastoral visits lasted about 30 minutes each and continued for 26 weeks. Religiosity, religious practice, spiritual well-being, self-transcendence, depression, and social participation were all measured before the pastoral visits began, after six months of visits, and three months after visits ceased. Compared to the control group, the pastoral visit group had significantly higher religious and spiritual well-being at post-test.

In another study, the effectiveness of chaplaincy care for 50 inpatients with chronic obstructive pulmonary disease (COPD) was studied by Iler, Obenshain, and Camac (2001). Participants were randomly assigned to one of two groups, an intervention group where patients received daily hospital visits from a chaplain who self-identified as a clergy person, and a group of patients who did not receive chaplain visits. On average, patients in the intervention condition received four chaplain visits of approximately 20 minutes each. Interventions were not standardized across visits. Patients in the chaplain intervention group had significantly lower anxiety, shorter hospital stays, and were more satisfied with the hospital stay than patients who were in the control group.

Bay, Beckman, Trippi, Gunderman, and Terry (2008) conducted a much larger study, with a well-prescribed intervention protocol, with over 200 patients who were about to undergo coronary artery bypass surgery. Patients were randomly assigned to experimental (chaplain's care) and control conditions, and mental health outcomes were measured at one and six months post-surgery (Bay et al.). Chaplain care was administered by chaplains in five visits; one pre-operative visit with the patient, one visit to the patient's family during bypass surgery, and three post-operative visits with the patient. Each chaplain visit followed a protocol.

There were no significant differences between the two groups at the one-month followup. At the six-month followup, the intervention group exhibited significantly higher positive and significantly lower negative religious coping, as measured by the RCOPE (Pargament, Smith, Koenig, & Perez, 1998). The latter is a particularly important finding, given that patients

with negative religious coping and struggle are at a higher risk for health complications (Fitchett et al., 2004; Pargament et al., 2001, 2004; Rosmarin et al., 2010).

In summary, the meaningfulness of the differences found in Bay et al. (2008) study is yet to be determined, because the magnitude of the difference in means between the groups was small. Moreover, no significant group reductions in depression or anxiety were found. The findings of the Iler et al. (2001) study are difficult to interpret given there was no standardized intervention, and it is not clear what would have been unique to chaplaincy care. The findings of the Baker (2000) study must be qualified by the fact that there were no significant differences between groups at three months followup, and, in fact, the pastoral visiting group had the highest mean levels of depression at followup compared to the control group. These studies are a promising beginning in documenting chaplaincy care and its impact on health outcomes, yet much research remains to be conducted.

STUDIES REPORTED IN MISLEADING WAYS

Other studies exist that are often cited as evidence for the beneficial effects of chaplaincy, which, upon closer examination do not provide such evidence. In one study, patients who were about to undergo orthopedic surgery were provided regular hospital care, emotionally supportive care by a chaplain, or emotionally supportive care and information about the treatment by a chaplain, (Florell, 1973). Patients who received either supportive condition left the hospital sooner, made fewer calls for help to the nurses' station, and had lower anxiety, respiration, heart rate, and medical needs than the patients who received regular hospital care. It is not clear in this study that chaplains delivered an intervention unique to chaplaincy care. It is possible that anyone who gave general support and information could have effected the changes seen.

McSherry, Ciulla, and Burton (1992) cite three studies that supposedly demonstrate the effectiveness of chaplaincy care. The first study is the Florell (1973) study. The second is a study by McSherry (1987a) in which men who were more religious, according to a questionnaire, were more likely to leave the hospital sooner. Being more religious has nothing to do with chaplaincy care, and it is not clear that the chaplain was involved with the patients at all. The third study, by McSherry, Kratz, and Nelson (1986), credits a chaplaincy intervention for saving a hospital upward of \$400,000 in care costs for a patient with a spinal injury. The claim is based on the fact that a chaplain worked with the patient on issues related to coping with being paralyzed for life. It is not clear, however, that the chaplain was uniquely responsible for the improvement in the patient's life. Many people were involved in this particular patient's recovery, and the patient did not personally attribute his improvements to the chaplain.

RESEARCH SUMMARY

The studies reviewed here represent the extent of the patient outcomes research in chaplaincy care in the United States. Most of the cited research consists of self-report evaluations of patient satisfaction, with patients' needs being met, and general descriptions of chaplain visits with limited measurement of unique chaplain activities. Although the research is limited, the findings are fairly uniform in showing that patients are satisfied with chaplaincy care. What patients like about chaplains is generally unknown, although there are indications that those who have experienced chaplains find them spiritually sensitive and supportive. There are no clear patient-outcome studies that document the efficacy of the unique aspects of chaplaincy care, as opposed to spiritual care provided by an interdisciplinary team. The methods of the studies have not compared chaplaincy practices; therefore they do not provide evidence that could be considered evidence-based best practice, as called for by O'Connor and Meakes (1998). The amount and type of outcomes research conducted so far has not yielded well-established findings in any area. None of the studies that look at referrals or activities reach a high level of evidence for the efficacy of chaplaincy. Most of the studies equated chaplaincy students with board certified chaplains or volunteers.

THE FUTURE OF CHAPLAINCY RESEARCH

Several recent trends in health care will impact, both positively and negatively on chaplaincy research going into the future. First, increasing attention at a national level is being paid to palliative care. Fortunately, clergy and chaplains have been found to be more involved in palliative care research than they were in other medical research (Flannelly, Weaver, Smith, & Oppenheimer, 2003), and it can be anticipated that there will be more research directly involving spiritual care and chaplaincy care. Second, health care is becoming more individualized with electronic medical records. The electronic medical records are making possible such innovations as "medical homes," in which most of a patient's care is provided in an outpatient setting. This will require electronic documentation of patient interventions, a practice which will increasingly include documentation of spiritual interventions and patient outcomes. Third, as noted in the introduction, there has been an increase in the number of Americans who claim they are spiritual but not religious and those who claim they have no religious affiliation at all (Newport, 2010). This trend has been reflected to some degree in the health care literature, where there has been a gradual decrease in the number of articles on pastoral care and an increase in the number of research articles on the more generic term 'spiritual care' (Harding, Flannelly, Galek, & Tannenbaum, 2008). Professional chaplains have been trained to help

people with faith and with no faith; it will become increasingly important to have professional board certified chaplains on staff who will document the spiritual care practice necessary for these groups of individuals.

These trends require a concerted response from chaplaincy going forward. Measures of spirituality, spiritual risk, and spiritual struggle must be identified, validated, and used consistently. Koenig (2008) noted that many measures of spirituality are confounded with concepts such as emotional health, positive feelings, and existential well-being. Spirituality measures are often stripped of what makes them a measure of the concept of sacred (Pargament, Mahoney, Exline, Jones, & Shafranske, in press). A definition of spiritual care is greatly needed (VandeCreek, 2010). Even in the emerging field of palliative care, where spiritual care and chaplaincy are universally included in all models and guidelines (National Quality Forum, 2006; Puchalski & Ferrell, 2010), palliative care research has not generally included spiritual care and chaplaincy in the models. This exclusion is due at least in part to the unavailability of proven measures to test the effects of spiritual care as well as the lack of professional chaplains on palliative care teams. These barriers must be overcome so that the effects of spiritual care and chaplaincy care will be documented.

Chaplains should be the generators of research-based definitions of spirituality, spiritual care, and chaplaincy practice; definitions that can lead to establishing the efficacy of chaplaincy methods (Weaver, Flannelly, & Liu, 2008). Calls have been made for increased research capacity in chaplaincy (McSherry, 1987b; Fitchett, 2002b, 2011). VandeCreek challenged chaplaincy to weigh in on the statement "Professional chaplaincy and clinical pastoral education should become more scientific" (VandeCreek, 2002). Almost 10 years prior to this current publication, Fitchett (2002b) responded to this challenge and expressed a hope that by 2011 the profession of chaplaincy would be research literate. He suggested that 1% of the APC membership should become active researchers by 2005 (about 30 chaplains) and 2% by 2012 (about 60 chaplains). The 2012 deadline is upon us, and it is not possible to say how close we are to the goal of having 60 research chaplains in the United States. The number of continuing education offerings focusing on research and specifically developed for chaplains has certainly increased, enrollment has been substantial, and there is evidence of this education's beneficial effects on chaplains' willingness to become research-literate (Murphy & Fitchett, 2010).

To move the field forward, a rubric of recommended research methods is needed. Outcome oriented chaplaincy and The Discipline (VandeCreek & Lucas, 2001), a process of systematizing the practice of chaplaincy, is a method to enable outcomes to be established and measured and can allow chaplaincy to be understood in the clinical context. The health care chaplaincy field needs to develop an evidence base to guide chaplaincy practice. The field might benefit from the similar perspective offered by the American

Psychological Association (APA, 2005) in its' *Policy Statement on Evidence-Based Practice in Psychology*, which encourages "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 284). This statement implies a deliberate engagement with the best methods available to study the questions at hand. As to the type of research to engage, it is important to keep in mind that different research designs are better suited to address different types of questions and populations (APA, 2006, p. 274; Fitchett, 2011). The case study is one research design that lends itself to chaplaincy (Fitchett, 2011; Cooper, 2011).

In conclusion, research to date supports the importance of spiritual and religious needs of patients and their families, and that patients, family of patients, and hospital staff recognize the need for chaplaincy and are satisfied with chaplaincy care. However, research to date is inconclusive on what chaplains do that is unique to chaplaincy practice, how what they do relates directly to patient health outcomes, and which practices are best for which kinds of patients in what patient settings. More research is needed to describe the unique contributions of chaplains to spiritual care and identify best chaplaincy practices to optimize patient and family health outcomes.

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