A Preliminary Proposal for a Scale to Measure the Effectiveness of Pastoral Care with Family Members of Hospitalized Patients

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The authors conducted an electronic search of the Medline database for articles measuring family satisfaction. Content analysis was then performed on the relevant studies to determine the types of themes included in scales measuring family satisfaction in healthcare settings. The authors used these themes to develop a scale for measuring the effectiveness of pastoral care with family members. A convenience sample of chaplains that was asked to judge the usefulness of each of the scale items, rated them all, on average, to be “somewhat useful” to “very useful” for evaluating chaplains’ effectiveness. The value of the scale is discussed in terms of its being a more outcome-oriented measure of effectiveness compared to typical family satisfaction instruments.

Research on patients’ satisfaction with their medical treatment dates back to the late 1960’s. But the significance of patient satisfaction really came to the forefront with the institution of quality assurance programs in hospitals. Such programs were the outgrowth of the consumer movement of the 1970’s and 1980’s in which people demanded greater accountability from all service providers. A wide variety of scales have been developed since the 1970’s to measure satisfaction with healthcare in various kinds of settings, including dental care, hospice care, orthopedic care, and psychiatric services.

Dr. Larry VandeCreek and his colleagues conducted a number of studies on the spiritual needs of patients using various assessment tools, and also did extensive research on patient satisfaction with pastoral care. VandeCreek and Lyon published a patient satisfaction scale in 1997 that contained 40 items which reflected 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 includes items about the chaplain’s com-

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petence, communication skills, empathy, attentiveness, and sensitivity. Further research produced a revised 23-item scale that focused on the first two aspects of ministry.15

The concept of family satisfaction with healthcare services has not been as widely studied but it has gained more attention in recent years. Research indicates that chaplains spend a significant amount of time working with family members, providing emotional support and helping them to deal with difficult decisions.16,17 VandeCreek also did research on the needs and concerns of the family members of hospitalized patients,18,19 but he did not try to develop a comprehensive scale like he did for patients.

National surveys have found that pastoral care directors believe it is very important for chaplains to minister to the needs of family members.20,21 These studies found this ministry to include praying with patient’s relatives, grief and bereavement counseling, helping family members deal with difficult decisions, and generally providing emotional support to families. The chaplains in these studies rate such types of activities as being more important than performing religious rituals or services. Administrators who were surveyed shared the same perspective as chaplains about the importance of providing emotional support to family members. Related research shows that over 40% of referrals to chaplains at one hospital were for the relatives and friends of patients,22 suggesting that other hospital staff share this perspective as well.

Levine emphasizes that family members are really the patient’s primary caregivers.23 As such, they should be intimately involved in treatment decisions. In Levine’s opinion, however, they are usually ignored by hospital staff.24 Chaplains can and often do play a valuable role in bridging this gap. Indeed, Gillman and his colleagues see chaplains as a vital link between family members and the treatment team, by listening to their concerns, instilling trust, and providing hospitality, information, and emotional support.25

A qualitative study by Broccolo and VandeCreek is particularly relevant.26 The study asked the next-of-kin of patients who died in the hospital about the pastoral care chaplains provided to family members. Family members saw chaplains as family members themselves, who comforted and supported them, and showed their concern for them in various ways. These findings further demonstrate the importance of chaplains’ ministry to family members, and highlight some of the things that family members found helpful. The findings also suggest that it would be useful to be able to quantify the types of chaplain interventions and related behaviors that are helpful to family members. Since, to our knowledge, there are no published scales for measuring the effectiveness of pastoral care with family members, we attempted to develop such a scale.

The present article examines the nature of family satisfaction measures used to evaluate healthcare professionals, services, and facilities. It then attempts to apply these findings to develop a scale which the authors believe may be useful for measuring the effectiveness of pastoral care with family members. The authors were particularly interested in developing a scale that was more outcome or effectiveness oriented than typical satisfaction instruments.

**Literature Search**

An electronic search was conducted on the National Library of Medicine’s electronic database Medline. The search looked for English language jour-
nal articles with the words “family satisfaction” in the title. The search identified 41 articles on “family satisfaction” dating back to 1986. Then, we retrieved and read the abstracts of each article. Seventeen of the articles seemed to be relevant in that they apparently measured satisfaction or needs in family members of patients in hospitals, hospices, or nursing facilities. Thus, we obtained copies of seventeen articles.

Thirteen of these proved to be studies that employed some quantitative measure of family satisfaction. One of two articles that studied nursing homes was excluded because it addressed a variety of themes not addressed in the other studies (e.g., food, costs, institutional setting/environment) which were outside the scope of the present paper. The remaining twelve studies were coded with respect to (1) the type of care that was assessed, (2) professional discipline which was being evaluated, if any, and (3) the major themes that were measured. 27,28,30,31,32,33,34,55,56,57,38

Findings
Most of the studies looked at family satisfaction with specific types of care, including intensive care units (3 studies), critical care units (2 studies), end-of-life care (2 studies) and pediatric care (2 studies). Three of the studies did not mention staff members by professional discipline, whereas six specifically focused on nurses and physicians. Some of these studies asked questions about other staff, such as social workers or other treatment team members, but they asked fewer questions about them. Two studies mentioned chaplains, but contained no specific questions about them, although these same two studies asked family members if they were satisfied with the spiritual support they received from staff.

Most of the scales contained between 8 and 30 Likert-type items, which were typically adapted from previous research on either patient or family satisfaction. Four of the studies provided extensive information about the methodology used for developing and testing their scales.

Table 1 presents the number and percentage of studies that examined family satisfaction with different themes related to staff behavior. Several studies also measured family satisfaction with the patient care, per se, and such things as visiting hours, safety and security, etc., but we did not code these aspects of satisfaction. Respect for the patient was an over-arching dimension or construct, although we do not address this below since we are focusing on staff’s interactions with family members. Clearly, respect was also a central component of many of the measures of family satisfaction although only one study ever used this term.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of Studies</th>
<th>Percent of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>10</td>
<td>83.3</td>
</tr>
<tr>
<td>Caring and Concern</td>
<td>10</td>
<td>83.3</td>
</tr>
<tr>
<td>Competence</td>
<td>8</td>
<td>66.7</td>
</tr>
<tr>
<td>Information</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td>Decision-making</td>
<td>6</td>
<td>58.3</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>6</td>
<td>50.0</td>
</tr>
</tbody>
</table>
The themes listed in the table are not mutually exclusive and survey items sometimes tapped more than one theme. The specificity, or details, of items varied considerably.

The three themes that family members were most frequently asked about were the degree to which they felt staff conveyed caring and concern for them, staff's communication with them, and their satisfaction with the competency of the staff. Some surveys specifically asked if staff were competent, but most asked questions about their knowledge, skills and particular kinds of staff activities that implied competence. Likewise, some items simply touched on communication or discussions between family and staff, while many dealt with different aspects of the information staff provided to family members. These included the willingness of staff to provide information, the clarity, adequacy and usefulness of that information, as well as the timeliness of information. Three studies included items about the honesty of communication with or the information provided by staff.

Decision-making was another important issue raised in seven of the studies. All seven asked a single question about family members' satisfaction with the degree to which they were involved in plans and/or decisions affecting the patient.

Satisfaction with the availability and responsiveness of staff were the next most common kinds of issues, being raised in half of the studies. The question of staff availability was rather straightforward, while responsiveness encompassed responding to concerns, requests and queries to some extent.

Five studies explicitly asked if staff were helpful, including two studies that measured responsiveness in separate items. Another five studies measured coordination among staff members, including referrals among disciplines.

Four studies asked family about their satisfaction with the emotional support they received from staff, with two of the four studies asking about encouragement and hope from staff. Three studies inquired about family satisfaction with the staff's sensitivity to their needs and spiritual support from staff. All of these studies only contained a single measure of these concepts.

**Proposed Pastoral Care Scale**

We believe the foregoing analysis provides a sound basis for developing a scale to measure the effectiveness of pastoral care with family members. Are these themes applicable to measuring pastoral care? By and large we think they are, since many of the themes can also be found in VandeCreek's scales of patient satisfaction with pastoral care. But some of the themes should be emphasized more than others. Accordingly, we devised a scale by adapting some of the items reported in these studies and the VandeCreek scales.
scales that put these themes into an effectiveness rather than a satisfaction format. Before presenting the proposed items, however, we should say a few words about our reasons for using an effectiveness rather than a satisfaction format.

There are several problems with patient/family satisfaction scales. Like all self-report instruments they are subjective. Consequently, the question arises whether there is a way to reduce this subjective element. Public health scales try to do this by providing very specific response categories, and typically attempt to measure behaviors instead of attitudes. But here, it would appear, we are interested in attitudes. Or are we? We will return to this question later in this article.

Another problem with satisfaction scales is that satisfaction and dissatisfaction with a service are influenced not only by the quality of service provided, but by one’s expectations. Thus, one client might be “very dissatisfied” by the same level or quality of service with which another client might be “very satisfied,” depending on their expectations. Likewise, a score of “satisfied” from two clients may mean different things depending on their expectations even though they appear to be the same.

A third problem has to do with the nature of Likert scales in general, and satisfaction scales in particular, which are anchored not at their endpoints but at their center. Regardless of how many points a scale contains, or whether a mid-point response category is provided, responses vary around a central point. This mid-point represents neutrality, in which the respondent is neither satisfied nor dissatisfied. Often this mid-point is labeled “unsure” or “undecided.” In essence, a satisfaction scale is like a seesaw with uncertainly as its fulcrum.

Because the mid-point is a neutral position on the scale people may tend to use it even when they are truly undecided or the item is not applicable. Our response categories are designed to avoid such interpretative problems.

We believe much of the uncertainty about the meaning of satisfaction can be eliminated by asking questions in a way that taps the degree of effectiveness instead of satisfaction, per se. Hence, one might ask how effective the chaplain was at providing some aspect of pastoral care rather than how satisfied the family was with it. In doing so, one must establish a meaningful starting point for the scale. We believe this starting point or anchor should be “not at all” effective. One could argue that expectations would still influence clients’ responses, but surely this influence would not be as large as in the case of measuring satisfaction. Indeed, research has shown that the anchoring points of response choices strongly influence responding, which is why one should be very careful in selecting them.

Table 2 presents a list of items for the proposed scale and their response categories. Unlike other disciplines, most of the work of chaplains involves communication with patients and families, so it would not be surprising if the entire scale captured a major communication theme. Nevertheless, items 1 and 2 are specifically intended to measure the general communication theme we observed in family satisfaction studies. Item 3 is intended to capture the caring and concern theme as well as communication, whereas item 4 is intended to provide a seminal measure of the importance of the broader concept of respect, which we mentioned earlier. Some of these items also reflect themes addressed in VandeCreek’s patient satisfaction scales.
TABLE 2. Proposed Items for Measuring the Effectiveness of Pastoral Care with Family Members

To what degree did the chaplain:

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at All</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Very Much</th>
<th>Not Certain</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen to your concerns</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Respect your opinions and beliefs</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Communicate caring for you and your family</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Treat you with dignity and respect</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Provide you with valuable information</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Help you get information you wanted</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Help you deal with difficult decisions</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Respond to your needs or concerns</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Spend the right amount of time with you</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Help you deal with other staff</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Help find someone who could help you</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Give you hope or encouragement</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Help you overcome your fears/concerns</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Help you tap your inner strength and resources</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Help you cope with your sense of loss</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Seem sensitive to your needs or concerns</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Help you find meaning in your situation</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Take the time to pray with you</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Meet your other religious or spiritual needs</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Respect your cultural needs</td>
<td>0.0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Items 6 through 11 are designed to measure themes of information, decision-making, responsiveness, availability, and coordination. The items relating to decision-making are adapted from VandeCreek’s scales to reflect the chaplain’s role in this process in relation to family members. There can also be an ethical component to decision-making situations that may be captured in part by item 2. The term “helpful” is used in several items because we believe helpfulness it is an over-riding concept that is probably synonymous with effectiveness.

Items 12 through 15 primarily provide measures of emotional support, although item 14 certainly would seem to measure religious/spiritual support, as well. Item 16 specifically taps the sensitivity theme we observed in other studies, while items 17 through 19 were adapted from VandeCreek’s revised patient satisfaction scale. Item 20 was not part of any of the themes we observed in the literature, but it was included because it represents an important aspect of chaplains’ work and is consistent with the over-riding concept of respect that is evident in most of the items.

Note that the response categories include “not certain” and “not applicable.” This was done to make it explicit why individuals do not respond to particular items. Otherwise, individuals might skip items and we would not know why.

**Chaplains’ Impressions of the Scale**

To find out what chaplains thought about the scale we sent it to a convenience sample of chaplains for whom we had e-mail addresses. The chaplains were asked to rate how valuable they thought each of the 20 items are for evaluating pastoral care with family members. A 5-point rating scale was used: 1 = Not valuable at all, 2 = Not very valuable, 3 = Unsure, 4 = Fairly valuable, and 5 = Very valuable. Table 3 presents the mean and median ratings for the 20 items and their standard deviations.

<table>
<thead>
<tr>
<th>Item</th>
<th>Median</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Listen to your concerns</td>
<td>5</td>
<td>4.8</td>
<td>0.5</td>
</tr>
<tr>
<td>2. Respect your opinions and beliefs</td>
<td>5</td>
<td>4.8</td>
<td>0.4</td>
</tr>
<tr>
<td>3. Communicate caring for you and your family</td>
<td>5</td>
<td>4.8</td>
<td>0.7</td>
</tr>
<tr>
<td>4. Treat you with dignity and respect</td>
<td>5</td>
<td>4.9</td>
<td>0.3</td>
</tr>
<tr>
<td>5. Provide you with valuable information</td>
<td>5</td>
<td>4.0</td>
<td>1.1</td>
</tr>
<tr>
<td>6. Help you get information you wanted</td>
<td>4</td>
<td>4.1</td>
<td>0.9</td>
</tr>
<tr>
<td>7. Help you deal with difficult decisions</td>
<td>5</td>
<td>4.8</td>
<td>0.5</td>
</tr>
<tr>
<td>8. Respond to your needs or concerns</td>
<td>5</td>
<td>4.6</td>
<td>0.9</td>
</tr>
<tr>
<td>9. Spend the right amount of time with you</td>
<td>5</td>
<td>4.1</td>
<td>1.1</td>
</tr>
<tr>
<td>10. Help you deal with other staff</td>
<td>4</td>
<td>4.0</td>
<td>1.0</td>
</tr>
<tr>
<td>11. Help find someone who could help you</td>
<td>5</td>
<td>4.2</td>
<td>1.0</td>
</tr>
<tr>
<td>12. Give you hope or encouragement</td>
<td>5</td>
<td>4.4</td>
<td>1.1</td>
</tr>
<tr>
<td>13. Help you overcome your fears/concerns</td>
<td>5</td>
<td>4.3</td>
<td>1.0</td>
</tr>
<tr>
<td>14. Help you tap your inner strength and resources</td>
<td>5</td>
<td>4.5</td>
<td>1.1</td>
</tr>
<tr>
<td>15. Help you cope with your sense of loss</td>
<td>5</td>
<td>4.8</td>
<td>0.5</td>
</tr>
<tr>
<td>16. Seem sensitive to your needs or concerns</td>
<td>5</td>
<td>4.7</td>
<td>0.7</td>
</tr>
<tr>
<td>17. Help you find meaning in your situation</td>
<td>5</td>
<td>4.5</td>
<td>1.0</td>
</tr>
<tr>
<td>18. Take the time to pray with you</td>
<td>5</td>
<td>4.7</td>
<td>0.5</td>
</tr>
<tr>
<td>19. Meet your other religious or spiritual needs</td>
<td>5</td>
<td>4.6</td>
<td>0.5</td>
</tr>
<tr>
<td>20. Respect your cultural needs</td>
<td>5</td>
<td>4.7</td>
<td>0.5</td>
</tr>
</tbody>
</table>
On average, the 40 chaplains rated all the items as being at least fairly valuable. The items rated the lowest were those related to providing information (items 5 and 6), those involving other team members (items 10 and 11), and one that asked about the amount of time chaplains spend with family members (item 9). One chaplain suggested we replace the word “right” with “adequate” in item 9. A number of other wording changes were suggested, such as: “help you find hope” instead of “give you hope” in item 12; and “help you address” instead of “help you overcome” in item 13.

Some chaplains suggested combining some of the items, and others offered additional items. Examples included: “Did the chaplain seem to understand your situation?” “Would you want the chaplain to visit you again?,” and “Would you recommend the chaplain to another patient?” Other items, which were suggested to measure overall effectiveness, included: “Was the chaplain effective in working with you?” and “Did the chaplain’s interventions help you?”

Discussion

The present article reviews the nature of family satisfaction scales in various healthcare settings and applies these findings to try to develop a scale that might be useful for measuring pastoral care with the family members of hospitalized patients. A number of measurement and interpretation issues with satisfaction scales lead the authors to propose a scale that tries to capture the effectiveness of pastoral care from the family’s perspective rather than satisfaction per se.

Our literature search was not exhaustive since we restricted our search to articles that included the words “family satisfaction” in their title. But it was very informative in that it identified thirteen major themes relating to staff behavior which are presumed to affect family satisfaction with healthcare.

Though the proposed scale contains at least one item designed to tap each of these themes, it employs several items to capture the key elements of pastoral care, including the emotional and spiritual support of family members. The themes themselves are unlikely to reflect the underlying dimensions of family needs. They could represent a single dimension of respect and dignity, or could represent multiple dimensions such as information seeking and emotional and spiritual support. Testing of the scale is needed to see how well it measures the needs of families and to better enable us to understand how these needs can be met.

The feedback from chaplains was very valuable. Some chaplains recommended wording changes that we intend to incorporate, and it may be worthwhile to have one or more global measures of effectiveness as some chaplains suggested. Although some chaplains also suggested that we combine items, we believe the scale should be tested more extensively before combining or eliminating items. We hope to test it with family members in the near future.

Endnotes

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19. Gerard T. Broccolo and Larry VandeCreek, “How are Health Care Chaplains


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45. Ibid.
52. VandeCreek, 2004, op. cit.

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