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Literature Review - Testing the Efficacy of Chaplaincy Care

Executive Summary

Overall Goal

The overall goal of this document is to provide a thorough critical review of the research on the efficacy of chaplaincy care in acute health care in the United States. Acute care is chosen for study as this is the venue in which the most research has already been done, and from which we can move the field forward. This analysis will also highlight the areas of missing evidence related to conceptual, methodological and outcomes perspectives. The identified gaps in evidence will then provide the outline for a research agenda in this area of spiritual care. The achievement of a robust research process will allow professional chaplaincy to become a research-informed profession and make an increasingly substantive contribution to the quality of health care in the United States.

The Context for Professional Chaplaincy

A professional chaplain is a clergy or a lay person who provides spiritual and religious care to individuals in hospitals, in the military, in prisons and in other organizational or institutional settings. The chaplain may also become a spiritual/religious leader for the institution. In acute health care, board-certification is the standard for professional chaplaincy. The process of chaplains' certification is governed by Common Standards for Certification adopted by the leading professional chaplaincy associations in North America in 2004. These standards require a master's level degree in theology or a related field, endorsement by a religious community, 1600 hours of Clinical Pastoral

Education (CPE) and an in-depth interview by a peer review committee. CPE is a process model of education, predicated on students' individual needs that are compatible with program objectives. (Association for Clinical Pastoral Education (ACPE), website accessed September 11, 2010). The certification standards define the professionalization of chaplains in health care. These standards have yet to be validated against chaplaincy outcomes and performance measures.

Professionalization, in turn, is occurring in a context where patients, as the center of care, are taking a more active role in planning what treatment they receive. There is increasing evidence that patients rely on their spiritual and religious beliefs (Koenig, 1998) and want their religious and spiritual values taken into account in planning their care (Nixon & Narayanasamy, 2010). In response to this demand, national surveys of hospital staff, chaplains, administrators, and program directors illustrate the wide range of roles that chaplains throughout the U.S. perform in their profession (Flannelly, Galek, Bucchino, Handzo & Tannenbaum, 2005; Flannelly, Handzo, Galek, Weaver & Overvold, 2006; Flannelly, Handzo, Weaver & Smith, 2005; Galek, Flannelly, Koenig & Fogg, 2007; Galek et al., 2009).

The acute health care context requires that all services, including chaplaincy, be informed by credible research-based evidence. Professional chaplaincy currently has very little quality research to direct its clinical practice. To guide and improve chaplaincy practice and further integrate spiritual care into health care, clinical investigations specific to the profession are needed to provide a basis for chaplaincy practice. Chaplains, just like all other health care professionals, must develop patient-centered care research. Without this research, spiritual and religious care will continue to be informed only by anecdotes, opinion, and beliefs whose validity remains untested.

Definitions

There is not one operational definition of spirituality that is appropriate for all contexts or research settings. If one definition is even possible, it has not yet become clear what the preferred definition would be. This need not impede definition of spiritual care, however, and research in this area should be guided by a well-crafted definition of spiritual care in order to provide some definitional boundaries and coherence to the developing field. We use the following definition:

Spiritual care refers to interventions made by any care giver that address patients' spiritual needs. Chaplaincy care is specialized spiritual care provided by board certified chaplains.

Literature Review

Spiritual and Religious Needs in Illness- The Case for Spiritual Care

- Religion plays an integral part in the lives of many Americans.
- Patients in acute health care settings have spiritual and religious needs.
- Religion and spirituality are often central to coping with illness and general emotional stress.
- Patients generally want those needs attended to in the treatment process, often by chaplains.
- Spiritual struggle has been found to be common in people who are ill.
- Care that includes the spiritual dimension increases patient and family satisfaction.
- The spiritual needs of many patients in health care institutions are not being met.

What is Chaplaincy in Health Care

A number of published studies and descriptions of what chaplains do and where they practice have been helpful in describing the scope and breadth of chaplaincy practice. Acute care chaplaincy practice includes ministry to patients and their families, hospital administration and staff. Chaplains in acute care often work as a liaison with the religious community, especially when helping the bereaved. Chaplains' ministry uses many interventions including empathic listening, religious rituals and prayer. While there seems to be some homogeneity in the types of ministry engaged in, there also seems to be considerable heterogeneity that is influenced by environmental factors such as the type of hospital or the denomination and training of the chaplain. For example, hospitals can be community hospitals, general hospitals, rehabilitation hospitals or cancer care hospitals. Chaplains vary in terms of their education and professional identity, for instance a chaplain in a hospital can range from being a full-time board certified chaplain, to a volunteer patient visitor, to an individual studying to be a chaplain. Finally, while there is increasing information on *what* chaplains do, there is virtually no evidence for how well they do it and the impact on those with whom they are engaged. With quality being such a central issue in modern health care, the profession of chaplaincy is challenged to provide convincing evidence for its methods and outcomes.

Studies are needed to better understand how patients secure access to a chaplain (e.g. by referral or request). This is important because research shows that not everyone experiencing spiritual struggle receives chaplain attention. Research is needed to look beyond the actual requests for a chaplain as stated (i.e. a request for prayer) and determine the underlying issues that

motivate the requests, for example, existential pain, or the religious, spiritual or social needs of the patient or the person making the request (e.g. social worker, nurse, or physician). Research is also needed to identify how the overall resources of the hospital impact on chaplain referrals. For example, a hospital with a robust chaplaincy department but a weak social work department may generate many more referrals to chaplains for emotional issues than a hospital where the situation is reversed. In some hospitals, chaplains bear primary responsibility in guiding patients about advance directives. In other hospitals, that task falls to patient representatives or social workers. Finally, in many hospitals, the referral pattern to chaplains appears to be related to interests and skills of particular chaplains on the staff.

Chaplaincy Outcomes

The limited available research into chaplaincy effectiveness falls roughly into two general categories-patient satisfaction studies and outcome studies of specific chaplaincy interventions. The patient satisfaction studies are generally stronger methodologically than the outcome studies and tend to show that chaplain visits have a positive effect on overall patient satisfaction. In general, the studies do not give many clear indications of how the patient benefits from the chaplain visits. Whether the same results could have been achieved by visits from professionals from other disciplines or trained volunteers was not subject to scrutiny. The outcome studies are very few in number and most have serious methodological shortcomings. Thus, we have included some research from outside the inpatient acute care setting to better understand the work of chaplains. All the studies that were found, including those here reviewed, are in need of targeted and enhanced replication, and most provide only suggestive findings and conclusions.

Gap Analysis

The review of the literature reveals many significant gaps in the research which would bear future study. Many of these studies would be epidemiologic and descriptive in nature since much of the landscape of chaplaincy care is in need of elaboration. Others have to do with impact and require intervention studies. The major gaps listed below need to be addressed if empirical findings are to guide delivery of spiritual care.

Religious and Spiritual Needs and Resources- Their Role in Coping.

- **The religious and spiritual needs of patients and families in acute care settings who are coping with illness in general.**

- The resources they draw on.
- The spiritual needs associated with specific diseases
 - How the needs change through a disease trajectory and across health care settings including outpatient and long-term care.
 - How these needs relate to coping with illness.
- The spiritual needs associated with specific health care settings including outpatient and long-term care.
- Religious and spiritual struggle, their correlates and outcomes, particularly in relation to coping with illness.

Who Chaplains Are.

- Information about the prevalence of chaplains across settings (e.g. long-term care, mental health, outpatient, assisted living, rehabilitation, hospice etc), and the level of training in each.
- The differences in practice and abilities between Board Certified Chaplains and non board-certified chaplains.
- The extent to which the practice of professional chaplains in acute care conforms to APC Standards of Practice, including the mandate to participate in research.

What Chaplains Do.

- An outline of all the activities/interventions that chaplains do, especially those that they do uniquely, and the prevalence across settings.
- Descriptions of activities/interventions in relation to specific religious and spiritual needs, diseases, and settings.
- An understanding of referral patterns to chaplains.

Desired Outcomes.

- Identification of the desired outcomes of chaplain interventions for patients in acute care, long-term care, palliative care, hospice care, and outpatient settings, considering different patient needs and diseases.
- The desired outcomes of chaplain interventions when helping families.

Efficacy of chaplains: Where, When and How are They Helpful?

- The characteristics, prevalence, benefits and drawbacks of effective chaplaincy service across various settings.
- The chaplain characteristics and interventions generally associated with a good (effective) chaplain.
- The relationship between clearly described presenting needs and interventions.
- The relationship between chaplaincy interventions and the desired outcomes.
- The chaplaincy activities associated with patient satisfaction.

Methodology.

- The developing and testing of measures and methodologies, including case study and other qualitative methods, surveys, and experimental designs, in relationship to their ability to describe and test the questions above.

Conclusion

Health care in the United States is becoming patient-centered, holistic and wellness focused. It increasingly includes care for the patient's social, emotional and spiritual concerns as well as their physical concerns. Patients and families want their religious and spiritual values, beliefs and practices included in their care decisions and processes. However, very often this goal is not achieved. A major reason for this gap is the lack of research-based knowledge about how to deliver desired spiritual care effectively and efficiently. Even where spiritual care is available and provided, even sometimes by routine protocols, there is virtually no research-informed evidence for how that care may contribute predictably to positive health outcomes. Thus, there is currently no way to determine if and how spiritual care contributes value to the health system or to maximize that value. Without apparent value-added, spiritual care will increasingly be left out of the health care equation.

The professional board-certified chaplain is becoming the spiritual care leader on the health care team in charge of helping the team integrate spiritual care into the treatment process. For spiritual care to be most helpful to the patient and family, the chaplain must produce, and be informed by, substantial research evidence that documents effective chaplaincy interventions that promote healing and health, such as by reducing emotional and spiritual distress, improving coping with illness, and improving the quality of life.

Research on the efficacy of chaplaincy care is beginning to grow and is largely confined to the acute care setting. The findings of the few research articles that exist are enticing and suggest potential lines of research that would be fruitful for the small and growing number of research groups that have the skills and interest to pursue studies in this area. Much needs to be done to describe the current state of who chaplains are, where they work, and what they do. The literature review and gap analysis presented here states only the major and most important potential areas to study. Essentially, what is in this paper for the first time is a description of a new and rapidly emerging field. It is also a field which, with the proper evidence base, could be integral to the restructuring of health care in the U.S.

Next Steps

A way to do meaningful research in spiritual care and specifically in chaplaincy care can and must be found so that the spiritual and religious needs of patients and families can be fully integrated into health care through the work of the professional chaplain. It is clear that a much more intentional and focused effort is needed. This effort should have at least two major objectives. First, it ought to catalyze the development of new research capability and competence in this field to provide research capacity in the field over the long term. A network must be established to coordinate the efforts of these research groups. Second, it must follow a targeted, systematically planned research agenda to maximize the progress toward the goal.

The current document lays out this research agenda. By documenting and critiquing the research that has been done to date and naming the gaps in that research from both methodological and results perspectives, an outline is provided for the research agenda for the efficacy of chaplaincy care. Going forward, this research needs to increase in volume, specificity and methodological sophistication. It must recognize the rapidly expanding venues in which U.S. health care is provided and the ways in which the documentation of spiritual needs and resources in electronic medical records and health information exchanges is occurring.

The gap analysis makes clear that there is a great need for descriptive and pilot studies as well as for the development and validation of appropriate measures and interventions. Collection and analysis of case studies is already a part of most chaplains' training and would be appropriate at this point. There also may be existing data bases whose potential could be aggregated to good effect. It would also be possible to identify and describe situations generally regarded as centers of best practice in chaplaincy. The key to evaluating and optimizing chaplaincy efficacy is to document

and study chaplains' contributions to positive health outcomes. Until this goal is reached, spiritual care and chaplaincy care will not be able to evaluate or establish their value.

Research studying chaplaincy care in acute care settings can range in theory across many hospitals and patients with acute or chronic illnesses. Since chaplaincy research has only begun to accumulate, there is a significant danger that research will not proceed in a focused and organized manner. If study questions, methods and outcomes are carefully chosen they will build upon and integrate with other work in the field of spiritual care. One way to support a focused research agenda is to fund research through one or more central consortia, which would set the research agenda, fund studies through a Request for Proposals process, and promote communication and capacity building among the research groups. The consortium would be advised by clinical and research leaders in chaplaincy who would set the basic parameters of the research, monitor its progress, and serve as mentors to new researchers.

Along with situating the research within a consortium, it will also be essential to establish some focus for the research agenda itself in order to produce significant progress in the field. While there is no consensus on what the interventions and outcomes should be for health care chaplaincy, involvement of chaplains in palliative care and end-of-life care is often mentioned and accepted as a major focus of chaplaincy involvement and referral (Galek, et al., 2009; Flannelly, Handzo, Weaver & Smith, 2005; Puchalski & Ferrell, 2010; Weinberger-Litman, Muncie, Flannelly & Flannelly, 2010). Although there is no chaplaincy research specifically focused on outcomes in this area, the one randomized clinical trial that documented the beneficial effects of chaplains' care involved chronically ill patients who today might very well receive treatment from a palliative care team (Iler, Obenshain & Camac, 2001). Another relevant set of studies pertain to Dignity Therapy, a narrative legacy intervention designed for the terminally ill, that has been subjected to rigorous methodological studies that demonstrate positive impact on patient and family well-being (Chochinov 2006). Thus, focusing the research agenda in the area of palliative care and end-of-life care opens the possibility of demonstrating value in an area of care where that value and efficacy are already often assumed and where much current attention is being focused by policy makers and the general public.

Furthermore, this area of health care offers several options for possible relevant outcomes where chaplaincy involvement might prove to have positive health benefits. There are at least three possible outcomes for chaplaincy care that could be investigated as contributors to positive health

outcomes- improved patient and family satisfaction, amelioration of spiritual struggle, and improved alignment of patients' goals with treatments.

It is hoped that this document offers a helpful roadmap for developing research that can guide the full and optimal integration of spiritual care into the health care enterprise. The firm establishment of an evidence-informed professional chaplaincy is the key to this integration.

Testing the Efficacy of Chaplaincy Care

Introduction

Health care is evolving from an exclusive concentration on the physical dimension of illness to a more holistic model which takes into account the psychosocial, and increasingly the spiritual (Meador, 2004; Puchalski and Ferrell, 2010; Sulmasy, 2009). As patients become the center of 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) and want their religious and spiritual values taken into account in planning their treatment (Astrow, Wexler, Texeira, He & Sulmasy, 2007). Coincident with this trend is the emergence of health care chaplaincy as a profession comprised of chaplains who are increasingly ready to be the spiritual care leader on the health care team.

A professional chaplain is a clergy or lay person charged with providing for the spiritual and religious care of individuals in organizational or institutional settings and is often the spiritual/religious leader of the institution itself. National surveys of hospital chaplains illustrate the wide range of roles that chaplains throughout the U.S. perform (Flannelly, Galek, Bucchino, Handzo & Tannenbaum, 2005; Flannelly, Handzo, Galek, Weaver & Overvold, 2006; Flannelly, Handzo, Weaver & Smith, 2005; Galek, Flannelly, Koenig & Fogg, 2007; Galek et al., 2009). Chaplains counsel family members and staff members, conduct community outreach activities with local clergy, and participate in medical and nursing education programs (Feldbush, 2008; Mellon, 2003; VandeCreek & Burton, 2001). Moreover, hospitals are increasingly finding it beneficial to have chaplaincy representation on a number of committees dealing with issues such as ethics, palliative care, and customer service. These changes, in turn, suggest the need for new skills and training that many chaplains do not have. In fact, some question whether chaplains have the skills that qualify them as members of the health care team with charting privileges (Loewy & Loewy, 2007). Countering these concerns, professional chaplains have created qualifications for board certification

of health care chaplains which include graduate-level academic and clinical training and extensive peer review.

There are approximately 10,000 chaplains in North America, who are members of at least one of five major health care chaplaincy associations; Association for Clinical Pastoral Education, Association of Professional Chaplains, Canadian Association for Pastoral Practice and Education, National Association of Catholic Chaplains, and National Association of Jewish Chaplains (VandeCreek & Burton, 2001). Chaplains are theologically trained and accountable to their religious denomination. They are clinically trained to be sensitive to, and respectful of, patient cultural and spiritual needs. They adhere to a code of ethics and operate according to standards of practice.

However, professional chaplaincy is at a crossroads and without quality research to direct clinical practice, professional chaplains will continue to be informed largely by opinion, and anecdote. To guide and improve chaplaincy practice and further integrate spiritual care into health care, research findings specific to the profession are needed to provide an empirical basis for chaplaincy care. The process of moving to a research-informed practice continues in both medicine and psychology (Baker, McFall & Shoham, 2009; Richards & Worthington, 2010), but only minimally in spiritual care. Chaplains are the lead spiritual care professionals on the treatment team (Handzo & Koenig, 2004; Jacobs, 2008). They are the professionals in the hospital “responsible for creating “sacred space”” (Mohrmann, 2008; p.22), and as professionals are held accountable for documenting and improving their contributions (Bay & Ivy, 2006; Berlinger, 2008; DeVries, Berlinger & Cadge, 2008; Gleason, 2004; Mohrmann, 2008; O’Connor & Meakes, 1998). Fulfilling the obligation to practice with the best tools available requires guidance gained through supervised practice that has been informed by experience that in turn has been supported by research. Chaplains must make patient-centered care informed by research a priority to be taken seriously by other health care professionals. Without this research, spiritual and religious issues will continue to be neglected in the care of the patient and family.

In addition to improving care, making chaplaincy a research-informed profession will promote the constructive dialogue about the roles of religion, spirituality and professional chaplains in health-care settings. Conversely, lack of accepted outcomes, methods, and instruments for measuring spiritual care and its effectiveness will inevitably mean that the spiritual domain will not be included in general health care research. This inclusion and integration will generate positive health outcomes for patients and family members and help to improve the overall efficiency, cost effectiveness, and

patient-centeredness of the health care system in the U.S. Research in chaplaincy care will amplify the impact of research findings in spirituality and religion within the general scientific community, and promote more effective spiritual care by clinical staff.

This report is inspired by a landmark report entitled *The potential for efficacy of healthcare chaplaincy and spiritual care provision in the NHS (UK)* (Mowat, 2008). That report proposed to collect and assess the evidence for the efficacy of chaplaincy in the National Health System of the United Kingdom. The current project has the same aim for the U.S. Additionally, it will propose a research agenda to build on current evidence, and begin a process to firmly establish professional chaplains as contributing members of the health care team. Thus, this report will not only describe what is and what has been, but it will lay out a road map for moving professional health care chaplaincy into a future, one that enables professional chaplains to make a much greater contribution to health care in the United States.

The overall goal of this paper is to provide a thorough review of the research on the efficacy of chaplaincy care in acute health care because most research is in acute care. This analysis will also highlight the gaps in this evidence from conceptual, methodological, and outcomes perspectives. The identified gaps will inform the outline of the research agenda in this area of spiritual care so that professional chaplaincy can become a fully research informed profession that makes a substantive contribution to the quality of health care in the United States.

Limitations in Scope

Like Mowat, which limited its scope to research in the U.K., this report will largely limit itself to North American research. The practice of health care chaplaincy in the United States and Canada has only minor differences despite the differences in the health care systems. However, the North American practice is significantly different from Europe and other parts of the world due mainly to the prevalence of well established clinical training programs for chaplains in North America. This difference in training has led to a multifaith model of practice in the U.S., as opposed to a denominational model elsewhere, making comparisons of research findings problematic across countries. A difference in use of titles is also appearing between the U.S. and other parts of the world, with the term “spiritual care provider” or “spiritual care professional” being used outside the U.S. as a synonym for the term “chaplain”. In the U.S., other health care professionals including nurses and social workers also claim “spiritual care provider” as part of their role. Outside the U.S., individuals with no graduate level training and volunteers are often given the same title as individuals

with graduate training and clinical pastoral education (Pesut, Reimer-Kirkham, Sawatzky, Woodland & Peverall, 2010). In addition, there are considerable differences between the U.S. and the U.K. in regard to how religious needs, spiritual needs and spiritual care are defined (Paley, 2008). Training to become a chaplain also differs across countries and in the European Union (Fitchett, King & Vandenheck, 2010; Kofinas, 2006; McManus, 2006).

In addition, the review of the research will be limited to acute care medicine chaplaincy studies. This is the context in which virtually all of the research has been conducted. Citing the very occasional studies outside of this context would make conclusions about the body of research in general more difficult since the issues in other kinds of health care such as long term care and mental health are potentially quite different. Research outside the acute care context will be occasionally cited when the findings fill an important gap or seem generalizable to acute care. Research in other contexts, especially hospice and outpatient settings, is one of the many gaps in the overall research which needs to be addressed going forward.

A review of the extensive literature on the influence of spirituality and religion on health is beyond the scope of this report. For the purposes of this report, the findings of the research reviewed by Koenig, McCullough, and Larson (2001), and others since, that there exists a salutary connection between positive spirituality and religion and positive health outcomes will be accepted. In addition, it is noted that there exists research that has shown that negative spiritual or religious experiences are associated with poorer mental and physical health (Pargament, 1997; Pargament, Koenig, Tarakeshwar & Hahn, 2001, 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, Murphy, Kim, Gibbons, Cameron and Davis (2004) found that people who struggle with an adverse life event and simultaneously struggle with their religious beliefs experience 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).

There are critiques of the research that support the existence of the positive relationship between religion and spirituality and health. The reader is referred to the work of Oman & Thoresen (2002, 2005), Thoresen (2007) and the work of Sloan and Bagiella (Sloan & Bagiella, 2004; Sloan, Bagiella & Powell, 1999). Sloan and his colleagues believe that the research on the connections

between spirituality/religion and health is filled with conceptual and methodological problems. They believe that these problems are so pervasive that any claims for the utility of spirituality and religion in coping with illness are unjustified. They believe there is a real danger that religion, because it is thought to be helpful, will be prescribed by doctors and mental health providers. Notably, Sloan and colleagues are very supportive of having chaplains on the health care team. They simply believe that all that is spiritual and religious ought to be left in the realm of chaplaincy. Thoresen and colleagues (Miller & Thoresen, 2003) have taken a different view of the possibilities of delineating the connections between religion, spirituality and health. They are optimistic that the relationship between spirituality and health has been documented, but that it is complicated, and requires more study. They point out that mediators and moderators are important to study in the examination of the relationships between spirituality and health. Indeed, Powell, Shahabi & Thoresen (2003) reviews the American research literature on the relationship of religion/spirituality and health and concludes that, at the very least, attendance at religious services is related to better health. Both Miller & Thoresen (2003) and Powell, Shahabi & Thoresen (2003) acknowledge that there are few studies on the mechanism for how religion/spirituality acts to enhance health, and even fewer studies that examine actual spiritual/religious interventions with medically ill individuals.

With all of the above in mind, the survey of the major literature documenting chaplaincy interventions was done as follows. Searches were done using Medline, with the word “chaplain” anywhere in the text or title, because “chaplain” or “chaplaincy” were not searchable MeSH terms. “Chaplaincy service” was a searchable term, but this term did not provide an adequate survey of the literature of interest. The Pubmed search was conducted with “Pastoral Care” as a major and “Chaplain” in the text which yielded 151 hits. Also, RSS feeds from Pubmed with the search terms anywhere in the text of newly indexed Pubmed publications were received via email whenever a new publication was added to the search engine. In addition to Pubmed, an identical search was conducted using PsychInfo, PsychArticles, ALTA Religion Database with ALTASerials. Finally, as chaplains often publish in non-indexed journals, such as online journals like *Chaplaincy Today* and *PlainViews*, these and other non-indexed sources were searched for chaplaincy research articles. This searching yielded a handful of articles that documented an actual intervention administered uniquely by a chaplain. These are reviewed below. In addition to specific intervention research conducted by chaplains we surveyed research on, and definitions of, chaplain, spirituality, pastoral care, spiritual care and chaplaincy care in an attempt to bring some clarity to a large and debated arena.

Definition of Spirituality

Over time, the term spirituality has been defined in widely divergent ways. The *Dictionary of Pastoral Care and Counseling* (1990), which has a distinctly Christian perspective, provides several examples of this divergence even among Christian traditions. An Eastern Orthodox Christian perspective sees spirituality as the continual human attempt to live in communion with God in mind, heart, body and soul by seeing clearly and living rightly (Hopko, 1990). A Protestant view shares this vision of spirituality and emphasizes the practice of piety and love of both each other and unbelievers (Hinson, 1990). A Roman Catholic source defines spirituality as one's "distinctive" way of communing with God and growing in faith (Carmody, 1990). Buddhist, Jewish and Muslim viewpoints might highlight additional aspects of spirituality.

In addition to definitions of spirituality that have roots in a particular religious tradition, there are definitions of spirituality that are not tied to a particular tradition. Several widely quoted definitions of spirituality have been proposed in the medical, nursing and psychological research literature (Edwards, Pang, Shiu & Chan, 2010; Koenig, 2009; Pargament, 2007; Puchalski, et al., 2009; Puchalski & Ferrell 2010). The definitions have some commonalities, mainly around finding or making meaning in life, relationships with others, community life, and differentiating spirituality from religion. However, no single definition of spirituality has been widely accepted in the research literature.

Mowat (2008) acknowledges the need for better definitions of spirituality and religion, and reviews the Hollins (2005) opinion piece which states that religion *is* spiritual and leads Mowat (2008) to suggest that to separate religion from spirituality is to end up in a room without doors. However, it is clear that there is not one definition of spirituality that is appropriate for all contexts or research settings. If one definition is even possible, it has not yet become clear what the preferred definition would be. Any research in this area should be guided by a very carefully crafted definition of spirituality, and it is premature in the context of chaplaincy care to insist on a specific definition of spirituality. Nevertheless, some definitional boundaries are needed to provide greater coherence to the developing field.

In this vein, Pargament (1999, Pargament, Mahoney, Exline, Jones, & Shafranske, In press) provides a fruitful set of guiding thoughts about the meaning of spirituality that helps to inform an understanding of chaplaincy care.

1) The sacred lies at the core of spirituality. The term “sacred” is used inclusively here to refer not only to concepts of God and higher powers, but also to other aspects of life that are perceived to be manifestations of the divine or imbued with divine-like qualities, such as transcendence, immanence, boundlessness and ultimacy (Pargament & Mahoney, 2005). Beliefs, practices, virtues, experiences, relationships, motivations, art, nature, war – virtually any part of life, positive or negative- can be endowed with sacred status. By defining the sacred so broadly, it is recognized that spirituality encompasses a wide range of phenomena of interest, both traditional and nontraditional. However, by placing the sacred at the core of spirituality, the distinctiveness of this dimension is highlighted and provides clearer definitional boundaries. After all, without a sacred substance, spirituality would be indistinguishable from other constructs within medicine, nursing, psychology, and social work, such as health, well-being, community, meaning, hope, and authenticity.

2) Spirituality is a dynamic process. It is not a static set of beliefs or practices; rather it changes and evolves over time. In this sense, spirituality can be thought of developmentally. Consciously or unconsciously, people are drawn to spirituality to discover something of sacred value in their lives, sustain a relationship with the sacred, and, at times, transform their relationship with what they hold sacred (Pargament, 2007).

3) Spirituality is in every dimension of life -- in biology, in thought, in emotion, in experience, in motivation, in behavior, in relationships, and in culture. Theoretical and empirical studies make clear that spirituality is a multi-dimensional construct, holding multiple consequences (e.g. Glock, 1962; Idler et al., 2004).

4) Spirituality is multi-valent. Though many spiritual expressions can be linked to positive outcomes, there are all too many cases of individuals who use extremist, destructive means in the pursuit of the most exalted of spiritual ends. From a scientific perspective, defining spirituality as inherently positive is problematic because it confounds processes (i.e. the ways in which an individual is spiritual) with outcomes (i.e. the degree to which an individual experiences spiritual benefits or harm). For this reason, Koenig (2008) calls for definitions and indices of spirituality that are uncontaminated by outcomes. Measures that assess spiritual outcomes (e.g. positive spiritual experiences, felt closeness to God or church) should be clearly labeled as outcome measures.

5) Spirituality unfolds in a larger context. While some choose to express their spirituality apart from organized religious settings, many people prefer to practice their spirituality within the

context of an established religious tradition. Others seek out non-traditional social outlets for their spirituality, such as healing groups, meditation groups, yoga groups, 12-step groups, and most recently online discussion groups. And many people disengage from religious institutions for a period of time only to seek out other like-minded individuals at a later point in time with whom they can share their spiritual interests. In any case, spirituality always expresses itself in a larger social, cultural, and religious milieu.

From this perspective, spirituality and religion have points of commonality and points of difference (see Pargament 1999, Pargament, Mahoney, Exline, Jones, & Shafranske, In press). Both spirituality and religion are dynamic, multi-dimensional, multi-level, and multi-valent processes. And both are concerned about issues of tremendous value and significance. Although they are similar in these respects, spirituality and religion differ in two key dimensions: function and context. In terms of function, religion is directed toward a broader array of significant goals than spirituality. Religion serves the important function of facilitating spirituality itself (indeed, it is the spiritual character of its mission that makes religious institutions so distinctive), but religion serves other functions as well, including those that are psychological, social, and physical. In contrast, spirituality focuses on one particular goal or destination, the sacred, however that might be defined by the individual. With respect to context, religion is more circumscribed than spirituality. Religion is embedded within an established, institutional context; that is, long-standing organizations whose mission is to facilitate members' connection with the sacred (see Hill et al., 2000). In contrast, as noted above, although spirituality can be a vital part of traditional religious life, it can also be embedded in non-traditional contexts.

With this introduction, the remainder of this paper will describe and critique the research to date on the role of chaplaincy in acute health care and the evidence for its efficacy. A major focus will be on detailing the gaps and limitations in this research as a vehicle for outlining the research needs in this field going forward. The evidence presented will show clearly that the great majority of the work in the field falls into the realm of opinion and description. The descriptive work is largely highly focused and has limited generalizability beyond the particular health care setting studied. However, the extant research findings, slim as they are, do suggest some ways forward for future researchers.

Section One- Spiritual/Religious Needs: The Case for Spiritual Care in Health Care

The evidence suggests that religion and spirituality are important to most Americans and religious coping is a major resource that many use to deal with illness. Although research suggests that spiritual needs are common among patients, patients have reported that those needs are often not met.

Religion plays an integral part in the lives of many Americans. According to a Pew Study, 83% of Americans identify with a religious tradition (Pew, 2008). According to a 2008 Gallup Poll, Americans have a high degree of religiosity compared to 27 other developed countries in the world. Sixty five percent of American adults as opposed to only 38% in other countries report that they are personally religious (Crabtree, 2009). Recent figures indicate that weekly or almost weekly church attendance in the U.S. has increased slightly from 42.1% in 2008 to 43.1% in 2010 (Newport, 2010a). Weekly or almost weekly attendance was over 50% in groups identified as Conservative, Republican, Non-Hispanic Black and Black Hispanic, those living in the South, and those aged 65 years or older (Newport, 2010a). People are especially likely to turn to religion in response to stressful life events, including people who may not view themselves as religious (Ano & Vasconcelles, 2005; Baldacchino & Draper, 2001; Pargament, 1997; Pargament & Park, 1997; Park, Cohen & Herb, 1990).

As the concept of “holistic care” has gained widespread acceptance in health care, spiritual care is increasingly being promoted as an essential part of holistic care (CMS Medicare Hospice, 2010; Puchalski et al., 2009; Sulmasy, 2009). One of the places where the evidence for spiritual care as part of holistic care is fairly strong is in the area of spiritual and religious needs. The research is consistent in documenting that patients in acute health care settings do have spiritual and religious needs, that religion and spirituality are often central to their coping, and that they generally want those needs attended to in the treatment process. In one study, 94% of hospitalized patients reported that they felt spiritual needs were as important as physical needs (King & Bushwick, 1994). Fitchett, Meyer and Burton (2000) documented how often people might need spiritual support. They interviewed patients admitted to either a general or surgical medical unit in an urban hospital. Patients were asked what religion they were affiliated with, and if they desired one of three spiritual care services: to talk with a chaplain, to have a chaplain pray with them, or to receive the sacrament of communion. Sixty-eight percent of the patients claimed a religious affiliation and seventy-two percent reported that religion was a source of great strength and comfort to them. Thirty-five percent of the sample requested one or more of the spiritual care services, and those who requested services tended to engage more frequently in religious practices and derive more comfort from

religion overall. These findings suggest that while many people derive great comfort and support from religion they do not always ask for spiritual help in the hospital. Those whose religious resources are helping them at the moment are more likely to seek support than those whose resources are not helping them, and the latter may need spiritual help even more because of their lack of resources (Fitchett, 1999a; Fitchett, Meyer & Burton, 2000).

Chaplains in pediatric hospitals were asked to recall how often parents and children experienced specific spiritual needs (Feudtner, Haney & Dimmers, 2003). The hospitalized children had somewhat different spiritual needs than the parents. More than half of the children had needs around feeling fearful or anxious, and they told chaplains they had difficulties coping with family relationships and also with pain. The needs of parents included anxiety, fearfulness, guilt, coping with their child's pain and grappling with questions related to meaning and purpose of suffering.

In a different survey, chaplains were asked to retrospectively report on how often they encountered spiritual needs in patients. Over 150 chaplains completed an online questionnaire, the Spiritual Needs Survey that identified 28 spiritual needs (Galek, Flannelly, Vane & Galek, 2005). The sample of chaplains that responded represented general hospital chaplains (59%), long-term care chaplains (20%), and chaplains in other settings. In order of most to least frequent, the spiritual needs were: meaning and purpose; love and belonging; hope, peace and gratitude; religion and divine guidance; death concerns and resolution; appreciation of art and beauty, morality and ethics (Flannelly, Galek, Bucchino & Vane, 2006). In general, the spiritual needs of meaning and purpose, and love and belonging were encountered in patients many times a week, whereas needs for appreciation of art and beauty, or morality and ethics were encountered but not as frequently. A considerable weakness of both of these studies is that the needs encountered were based on each chaplain's retrospective perception of needs, which is certainly influenced by the individual chaplain's biases. The retrospective evaluations cannot be assumed to be based on any rigorous clinical assessment or stated patient needs. However, the endorsement of the presence of these spiritual needs highlights the necessity of treating the whole person; mind, spirit, and body, in order to achieve the highest quality of health care.

In addition to spiritual needs, people have religious needs. Religious coping has been documented to be important in coping with 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). Similarly, 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 et al., 2004). Fifty-eight percent of people with cancer engage in religious practices to help them cope with their illness (Alcorn et al., 2010). Another study of family members in waiting rooms found that using religious support, such as prayer and reading the Bible, to cope with surgically related stress was associated with distinct subjective benefits above and beyond those contributed by non-religious sources (VandeCreek, Pargament, Belavich, Cowell & Friedel, 1999).

Mental and physical health may suffer should individuals be unsuccessful in addressing their spiritual and religious needs. Research increasingly indicates the importance and prevalence of spiritual risk and spiritual struggle during times of distress, such as during an illness (Fitchett, 1999a; Fitchett et al., 2004; Hui et al., 2010; Pargament, Murray-Swank, Magyar & Ano, 2005). Patients are at spiritual risk when they have high spiritual needs but have low spiritual resources (Fitchett, 1999a). People with high spiritual risk are likely to experience negative health outcomes should they develop spiritual struggles and negative coping styles. Negative religious coping is associated with increased mortality (Pargament, Koenig, Tarakeshwar & Hahn, 2001) and psychological distress (Fitchett et al., 2004; Rosmarin, Pargament & Flannelly, 2010). There is some evidence that people who remain in a state of religious struggle, using negative religious coping over time, are more likely to develop worse health outcomes compared to those who show positive religious coping after first coping in a negative way (Pargament, Koenig, Tarakeshwar & Hahn, 2004). A spiritual screening will help identify patients who are at high spiritual risk and may be likely to develop negative religious coping. Fitchett and colleagues (1999b; Fitchett & Risk, 2009) suggest methods that chaplains may use to do spiritual screenings for spiritual risk and negative coping. If the results of the screening suggest the patient is at risk, a more thorough spiritual assessment is recommended.

However, even though many hospitalized people would welcome and benefit from competent spiritual care during health crises, and even though religious struggle in these patients predicts poorer health outcomes, the spiritual needs of many patients in health care institutions are not being met. In a survey of advanced cancer patients, 88% felt religion to be at least somewhat important but 47% received little or no support from their faith community and 72% received little or no support for their spiritual needs from the medical establishment (Balboni et al, 2007). Another study documented that 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).

Vance (2001), in a survey of nurses, found that only 25% of patients were given spiritual care. The biggest barriers to care were that nurses felt they did not have enough time or enough education in spiritual matters, or they felt that the spiritual needs of a patient were a private matter. All too often, health care workers do not consider the spiritual needs of their patients to be a priority. Another study found 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).

Chaplains are a spiritual resource for many people. A study of patients in a palliative care unit with end-stage cancer found that 61% of patients were experiencing spiritual pain at the time of being interviewed (Mako, Galek & Poppito, 2006). Roughly 50% of patients indicated that they would like the 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. Most advanced cancer patients (78%) stated that religion/spirituality concerns were important in the illness experience, and younger, more religious or more spiritual patients identified religious and spiritual concerns as important more frequently (Alcorn et al., 2010). Studies of older adults hospitalized for medical problems—the population that chaplains most frequently assist—report that religion is their most important coping mechanism, and that prayer is one of their most common religious activities (Koenig, 1998; Koenig, Pargament & Nielsen, 1998).

What the Reviewed Research Shows.

- **Significant support for patient’s reliance on spirituality and religion and patient’s need and desire for spiritual support, often from a chaplain.**
- **Evidence for the importance and prevalence of spiritual struggle.**
- **Evidence that spiritual needs are often not met.**

Research Gaps.

- **The religious and spiritual needs of patients and families in acute care settings who are coping with illness in general.**
- **The resources they draw on.**
- **The spiritual needs associated with specific diseases**
 - **How the needs change through a disease trajectory and across health care settings including outpatient and long-term care.**

- How these needs relate to coping with illness.
- The spiritual needs associated with specific health care settings including outpatient and long-term care.
- Religious and spiritual struggle, their correlates and outcomes, particularly in relation to coping with illness.

Section Two- What is Chaplaincy in Health Care?

In the last decade, professional health care chaplaincy in North America has made significant strides in formulating the basic structures that mark it as a true “profession”. Standards of Practice, a Code of Ethics, and Standards for Board Certification are all less than ten years old. However, little if any progress has been made on building and testing theories and models for the practice of chaplaincy. This gap may have to do with the fact that most chaplains consider their practice largely a function of their own individuality and thus, not subject to any generalizable theory. It is also essential to note that, while progress with regard to these basic structures has been significant in the recent past, we do not know the proportion of people who work as chaplains who are board certified. There is currently no evidence that being board certified and/or following standards of practice produces more effective chaplaincy care. Thus, there is no regulatory or financial business case for the inclusion of professional chaplains in health care settings.

For this review, it is essential to distinguish “chaplaincy care”, “spiritual care”, and “pastoral care”. These terms are often used interchangeably in the literature leading to confusion. For purposes of clarity, in this review chaplaincy care is care provided by a board certified chaplain or by a student in an accredited clinical pastoral education program (e.g. Association for Clinical Pastoral Education (ACPE)). It is care that is grounded in “initiating, developing and deepening, and bringing to an appropriate close, a mutual and empathic relationship with the patient, family, and/or staff.” (Association of Professional Chaplains (APC), 2010). All such care is provided by an individual who is mindfully aware of sacred matters that arise during the delivery of chaplaincy care.

Sacred matters (Pargament, Mahoney, Exline, Jones, & Shafranski, In Press) are deeper concerns that can arise out of illness and focus attention on the person’s relationship to a larger reality that transcends the moment, is boundless and deals with ultimate issues such as life, death, suffering, beauty and love. The issues are understood through beliefs about God, higher powers,

and other cultural or religious belief systems -areas of knowledge that chaplains are versed in by virtue of their education and experience. Thus, spiritual care will be defined as helping the patient maximize their relationship with that which is sacred in the service of their healing.

The term, pastoral care, has been historically used within the Christian tradition to refer to care provided by clergy. This care is founded in theology and expressly concerned with a cure of a soul (Mills, 1990). Pastoral care is more like an intensive discourse between one or more persons seeking guidance in moral or spiritual concerns from the faith leader (Mills, 1990). Pastoral care is encountered in relationship based on an understood system of shared beliefs, values, and behaviors. The faith leader's care for seekers is worked out within a dialectical relationship "between the person's unique needs, on the one hand, and the established norms of the faith community, as represented by the pastor, on the other" (LaRocca-Pitts, 2006b).

Using these definitions, chaplaincy care is the part of spiritual care practiced by chaplains. Chaplains focus on their awareness of the sacred, listen and observe how the sacred is experienced by the patient. They are then prepared to move from being mindful and present in that awareness into supporting the sacred for the patient in their coping. The chaplain assesses the patient's current spiritual situation and contributes to the understanding of the patient's bio/psycho/social/spiritual/religious health and needs working as part of the interdisciplinary team to ensure the best care for the patient. The chaplain also brings to the team and the organization skills in spiritually, theologically, and culturally competent care, some of which can be modeled and taught to individuals on the team. The chaplain also provides spiritual care to the members of the organization and acts as a leader in patient-centered holistic care.

While some consensus is emerging conceptually with regard to the above definitions, much of the literature uses the terms interchangeably or without clear distinctions. VandeCreek (2010), using "spiritual care" as a synonym for "chaplaincy care", defines spiritual care delivered by chaplains as "professional attention to the subjective spiritual and religious worlds of patients, worlds comprised of perceptions, assumptions, feelings and beliefs concerning the relationship of the sacred to their illness, hospitalization, and recovery or possible death."(p. 4). In an opinion piece, Purdy (2002) defines chaplaincy care as "palliative care that addresses spiritual needs," adding that "Chaplains do not attempt answers for all the questions put to them." (Purdy, 2002; p.140). Chaplains listen to the patient and talk with them about meaning, hell, heaven, God's existence, and the meaning of being human living a limited life (Purdy, 2002).

The definitions above signal a significant shift in the model for delivery of professional health care chaplaincy in the U.S. Traditionally, chaplaincy in acute health care has been delivered by community clergy who minister exclusively to patients of their faith tradition. The major emphasis has been on providing for religious needs and rituals. Thus, care for the spirit has been the exclusive province of the clergy. Further, the chaplain has been focused exclusively on care of the patient and family and not at all on integrated institutional initiatives and communicating with the health care team. The chaplain has operated in a silo which resulted in spiritual/religious care not being integrated into the overall treatment plan.

The advent of bioethics committees, the concern for patient satisfaction, the awareness of the impact of cultural influences, and, finally, the full advent of patient-centered care broadened the general understanding of spiritual care into a realm that all members of the health care team need to participate in. The more widespread availability of clinically trained multifaith chaplains has increasingly allowed the chaplain to be more fully integrated as the spiritual care professional on the health care team rather than simply being the community religious professional. Currently, best practice models of care call for chaplains to be health care team based, rather than denominationally based, and increasingly a referral service for patients with documented spiritual/religious needs as opposed to visitors to anyone who desires a chaplaincy contact (Wintz & Handzo, 2005; Handzo & Wintz, 2006; Handzo 2006; Denley, 2010). 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.

Theory of Chaplaincy

Chaplaincy care has historically not been, in general, theory driven. Where theory is used at all, it is generally borrowed from other professions. Many chaplains resist the idea of theory outright, considering it an infringement on the sanctity of their relationships with their patients. Fitchett (in press) has proposed a system of case analysis for chaplains which could easily and naturally lead inductively to theory in chaplaincy.

Chaplains begin by being present with a patient, so that the chaplain is open to creating new meaning with the one who suffers (Millsbaugh, 2005a). The chaplain, through his or her presence can help restore to the patient the opportunity to feel some control, a sense of power, and a sense of “transcending purpose,” to experience being loved and to express love (Millsbaugh, 2005b). This is important because, as LaRocca-Pitts (2006) eloquently puts it, “the wellspring from which all our

care arises is love.” Being present is often based on the theory of Carl Rogers (Rogers, 1957). To be truly authentic, and have a therapeutic relationship with an individual, four things are required. The first three are: being congruent; being positive and accepting; and being empathic. A fourth characteristic, presence, can arise from those three to enable the therapist to be truly and completely present in the moment with the individual. Geller and Greenberg (2002) studied presence, as suggested to be important for study by Rogers himself in an interview in 2000 (Baldwin, 2000) by asking ten psychotherapists to describe the experience of presence with clients. Their results suggest that there are three domains to be mindful of in therapeutic presence: preparing the situation for experiencing presence; activities that enable the experience of presence; and unconditional positive regard which is the actual experience of presence. Referring to Geller and Greenberg (2002), Chaplain Kit Hall has developed and uses an evaluation form to help her prepare to offer presence to those she visits (Hall, 2010).

Harvey, Brown, Crawford, and Candlin (2008) employed decision analysis to describe the activity that surrounds the preparation for presence, and the depth that happens in the conversation that takes place between the chaplain and patient. During the conversation, the chaplain conveys a polite and attentive stance that allows the patient to self-disclose what is troubling her or what is on her mind. This polite stance is known as linguistic politeness, and it is more complicated than everyday politeness. A chaplain skilled in linguistic politeness knows how to not threaten the conversation partner by speaking inappropriate words. Chaplains converse in a way that allows the patient to speak about great difficulties without losing face.

With the increased emphasis on outcomes in health care, research is needed to determine what kind of outcomes the intervention of “presence” produces. Simply to be passively present at the bedside is no longer enough of a description of this intervention. Greater detail of the practice of presence and a therapeutic result must be documented to happen with some reliability because of that presence.

In addition to theological formation, many chaplains also integrate diverse conceptual frameworks from theories on cognition, personality, and cultural anthropology into their chaplaincy practice. As part of their certification process they must articulate both a theology that guides their spiritual care and “incorporate a working knowledge of psychological and sociological disciplines” as they relate to chaplaincy care. Some theories and theologies that are commonly used are Piagetian, Rogerian, family systems, and field theory, and the theologies of Buber and Tillich. In

another theoretical approach, Gleason (Baldrige & Gleason, 1978; Gleason 1990; 1999) proposes that chaplains provide the best spiritual care to individuals, from a particular faith tradition to none at all, when chaplains understand that patients inhabit one of four different faith “worlds”. Each world of the patient differs from the others based on the complexity of the patient’s faith system. Patients in the first faith world have an uncomplicated view of their faith and take it at face value. They would not even consider questioning their faith so it is not productive to ask this type of patient if their stress is from a crisis of faith. Patients in one of the other faith worlds may question their faith. These patients require a method of chaplaincy care geared toward their particular faith world. Additionally, each patient may move from a simplified view to a more complex view of their faith in the course of a hospitalization. Chaplains must be prepared to work with patients in whichever faith world they happen to inhabit.

Board Certification

The practice of chaplaincy is honed by professional certification requirements and the training they mandate rather than by the different cognitive, personality, and anthropology theories that chaplains draw upon. Especially in North America, board certification has become the standard for professional health care chaplaincy. Board certification became important as clergy recognized the need for a particular experiential education that would prepare theological students to help ill congregants. Common Standards for Certification as a professional chaplain were adopted by the leading professional chaplaincy associations in North America in 2004. These standards require masters level education in theology or a related field, endorsement by a religious community, 1600 hours of Clinical Pastoral Education (CPE) and an appearance before a peer review committee to demonstrate an ability to integrate theological, psychological and sociological theory into chaplaincy care, to function pastorally with others while respecting others’ boundaries, and to work within the common standards of practice, to name just a few competencies. The important commonality in the process of becoming a board certified chaplain is Clinical Pastoral Education (CPE). CPE is “a method of learning ministry by means of pastoral functioning under supervision as developed by ACPE. It is a process model of education, predicated on students’ individual needs that are compatible with program objectives.” (ACPE, 2010).

Clinical pastoral education aims to teach chaplains to become aware of themselves when entering into a relationship with another person, in this case, a patient or family member. Clinical pastoral education seeks to develop the capacity of the chaplain to step back from preconceived notions and plans and see the plan in the other person’s life unfolding, where they are and where

they might be going in their growth. There is explicit training in ethical behavior and experiential training in self reflection, reflective listening, and learning through engaging in reality and with other humans (Holifield, 1983). From the very beginning of the clinical training programs, in the first half of the twentieth century, chaplains have blended clinical technique with theological and psychological theory to optimally meet people where they are in their need.

Despite its long history and wide spread acceptance as the central training model for chaplains, there is limited research on the outcomes of CPE. In a review of 39 studies Derrickson (1990) found that students gain autonomy and self-awareness as a result of participating in CPE. Fitchett and Gray (1994) found that CPE students showed positive change in counseling resources, facilitative relations and non-judgmental acceptance. O'Connor, Healy-Ogden, Meakes, Empey, Edey, Klimek, et al. (2001) found that CPE students reported development in their ministry skills, goals, and personal functioning. Another study at HealthCare Chaplaincy showed that both pastoral skills and emotional intelligence improved over the course of a unit of CPE (Jankowski, Vanderwerker, Murphy, Montonye & Ross, 2008). These improvements were greater for students with no prior CPE experience and for students with fewer years of professional ministry. This research needs to be replicated and more investigation is needed into the role of skills developed in CPE, the use of these skills in chaplaincy delivery, and the impact of these skills on patient outcomes.

Standards of Practice

Along with standards for certification, standards of practice for professional chaplains have developed over the last decade, but first began to solidify in the 1940's. Russell Dicks proposed standards of practice to help hospital administrators understand what to expect from chaplains (Dicks, 1940). These standards reflected both the chaplain's responsibilities to the hospital as well as the mental health of the patients. For instance, chaplains would keep records and work with hospital personnel to develop spiritual care services for patients, and worship was to be interdenominational and not proselytizing (Dicks, 1940). These standards are fundamental and found in standards of practice today. The Association of Professional Chaplains recently issued the first Standards of Practices for chaplains in acute health care which align professional chaplaincy with other health care disciplines (APC, 2010). While these standards do not provide evidence of the efficacy of health care chaplaincy, they do suggest that chaplaincy is becoming more of a profession, that commonalities are emerging in chaplaincy practice, and that best practices are

appearing which could be tested with carefully designed research. Standard 12 of the APC Standards of Practice states that the chaplain “practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.”(APC, 2010).

There are a few examples of endeavors to establish chaplaincy best practice. Pruyser (1976) proposed an example of ministry practice informed by diagnostic classifications. VandeCreek and Lucas (2001) edited a volume devoted to outcome-oriented chaplaincy, a method of focusing chaplaincy practice beyond the core of pastoral presence and relationship to include assessment and measurement of patient outcomes. Research directly investigating the implementation of this approach and its impact of in chaplaincy is greatly needed.

In addition to standards of practice for chaplains, the standards for specific kinds of patient care are increasingly requiring that spiritual care needs be met. Hospital standards set forth in 2003 by The Joint Commission (JC), which accredits most US hospitals, require hospitals to address the spiritual needs of patients (Joint Commission, 2010). The standards for palliative care from the National Quality Forum specify the inclusion of spiritual care in the delivery of palliative care, but do not specifically include chaplaincy (National Quality Forum, 2006). The National Comprehensive Cancer Network (NCCN) guidelines for practice in adult cancer pain specify evaluations of patient spiritual and religious considerations. The guidelines for palliative care mention chaplains as a part of the interdisciplinary team, and the guidelines for distress management require the inclusion of a certified chaplain experienced in psychosocial aspects of cancer (NCCN, 2010). Other practice standards call for the integration of board certified chaplains into the health care team (Puchalski, et al, 2009; Puchalski, Lunsford, Harris & Miller, 2006).

What the Reviewed Research Shows.

- **The definitions of “spiritual care”, “pastoral care”, and “chaplaincy care” are evolving but the terms are not currently used consistently in the literature.**
- **The delivery model for chaplaincy services is evolving from a denominational to a multifaith model, but the efficacy of both models is untested.**
- **While health care chaplaincy has traditionally not been theory driven, it has borrowed from diverse theories and theologies.**

- Professional chaplaincy in acute care has adopted standards of practice and standards for certification.

Research Gaps.

- The differences in practice and abilities between Board Certified Chaplains and non board- certified.
- The extent to which the practice of professional chaplains in acute care conforms to APC Standards of Practice, including the mandate to participate in research.

Descriptions of Where Chaplains Are and What They Do

There are a number of published descriptions of what chaplains do. These descriptions are helpful in describing the scope and breadth of chaplaincy practice including ministry to families, working with the bereaved, use of various interventions, and use of religious rituals and prayer. 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. Further, while it is clear that some chaplains do each of these practices, it is not clear how widespread any of them are. Finally, while there is increasing evidence describing *what* chaplains do, there is virtually no evidence for how well they do it and what results ensue. With quality being such a central issue in modern health care, this is a serious gap in our knowledge.

Where Are There Chaplains?

Chaplaincy services can meet spiritual and religious needs and 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 is the highest percentage found in the 11 years of data available (Cadge, Freese & Christakis, 2008). While this increase in chaplaincy services is promising, it only begins to address the question “Are the spiritual needs of hospitalized patients being met?” This is because the activities that occur in “chaplaincy services” are not clear. The AHA survey, which had a return rate in 2005 of approximately 75% of all the hospitals in the country, did not define chaplaincy services, either in terms of who delivers them or what exactly would be effective chaplaincy services. Thus, a hospital could affirm that they had chaplaincy services if they had lay volunteers coming into the hospital once a month or if they employed a board certified chaplain full-time in a department of chaplaincy care. The chaplaincy

care provided by individuals with such diverse backgrounds could be expected to be quite different in terms of philosophy, theology, and practice. Chaplains were employed in 94% of large hospitals with an average census of 400 patients or more, and of these 71% were board certified chaplains. In smaller hospitals, those with an average patient census of 25 to 100 patients, chaplains were employed in 58% of the hospitals, and 70% of these were board certified. Only 17% of the smallest hospitals employed chaplains (25 patients or fewer). Hospitals in less urban settings relied more on local clergy and lay volunteers (14% in urban vs. 58% in rural areas). (Unpublished data analysis, data from American Hospital Association, 2005).

What the Reviewed Research Shows.

- **Hospitals are required to attend to spiritual needs (Joint Commission Resources, 2010).**
- **Many hospital employ chaplains with the percentage seemingly correlated to the size of the hospital.**

Research Gaps.

- **Information about the prevalence of chaplains across settings (e.g. long-term care, mental health, outpatient, assisted living, rehabilitation, hospice etc) and the level of training in each.**
- **Information about how big chaplaincy departments are (as a ratio to inpatient beds or other means of institutional size), how much chaplaincy departments vary in size, and what factors, such as institution size, owners, location, academic affiliation, religious affiliation, predict that variation.**

What Do Chaplains Do? Theory and Opinion.

Chaplains address patient issues and concerns such as existential questions, spiritual pain and the sacred. They are able to work with religious patients as well as the increasing number of patients without a specific religious identity (Newport, 2010b). Chaplains engage patients and help them reframe their situation to reduce suffering. Chaplains begin with a focus on the patient and the current situation, and assess all factors that could be potentially contributing to stress and suffering. According to a study by Catholic Health Initiatives (2002), chaplains approach persons in a given situation with “focused attention with no agenda” implying that the chaplain is totally focused on the patient. They propose a plan to address the spiritual suffering, help the person immediately, and

then follow-up with a plan to ensure benefits. They write of their experiences with the patient in the patient's chart. This conceptualization again suggests how the role of chaplains is changing. In the past, the chaplain could truly have no agenda because they were not seen as contributing to the general plan of care. As this presumption disappears, chaplains increasingly are seeing themselves and being seen as professionals with a definite agenda- to promote spiritual healing.

To promote spiritual healing, many chaplains conduct a spiritual assessment and create a spiritual care plan which is not to be confused with a spiritual screening. Fitchett and Canada (2010) have helpfully differentiated spiritual screening, spiritual history, and spiritual assessment. Screening is a few simple questions asked by any health care personnel that identify a person in serious spiritual crisis and who needs immediate referral to a chaplain. Spiritual history taking requires more time and more questions to identify specific religious needs and resources of the patient. Spiritual history taking is done by professionals, the clinician in charge of the patient's care or the chaplain as part of patient intake. Finally, a spiritual assessment is done by a professional chaplain who takes considerable time with the patient to understand the patient's spiritual story so that a spiritual care plan can be formulated. The assessment requires the training of the professional chaplains and should only be done by someone with that training.

The chaplain should assess the degree to which the patient may be experiencing issues of purpose and meaning, loss of any of the many aspects of self control, or spiritual pain and suffering (Millspaugh, 2005a). There is currently no research to determine how often chaplains actually do a formal spiritual assessment vs. simply intuit what the patient needs. Nor is there extensive research on the content of assessments. There are a few assessment systems for chaplaincy (Borneman, Ferrell & Puchalski, 2010; Derrickson, 1994/1995; Fitchett, 2002; VandeCreek & Lucas, 2001) but no data on what percentage of chaplains actually use them in the United States so 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 those surveyed knew of available measures and 30% of these chaplains had created their own assessment system (O'Connor et al., 2005). There is no research on the relationships between assessment content, interventions, and outcomes. VandeCreek and Lucas (2001) proposed a system that includes all three, but there does not seem to be any research on whether the components wind up being related in any way. As electronic medical records become universal, it may well be that chaplains will be automatically called upon to assess and help specific patients as part of the hospital protocol which will require specific assessment methods

(LaRocca-Pitts, 2010). Again, this lack of predictability and consistency is likely to be an issue in any research on chaplaincy care.

Interestingly, a new perspective on what chaplaincy care might offer comes from the research of a psychiatrist, Harvey Chochinov, who developed Dignity Therapy (DT; Chochinov, 2006). DT is a psychotherapeutic intervention that creates a generativity document - something “lasting and transcendent of death.”ⁱ DT sessions are taped, transcribed, edited, and returned within one to two days to the patient. In most instances, these transcripts will be left for family or loved ones, and form part of a personal legacy that the patient will have actively participated in creating. A multisite phase 1 trial of DT among end-stage cancer patients, for whom the median time from interview to death was 45 days, showed that 91% reported being satisfied or highly satisfied with the intervention (Chochinov, 2006). Further, 68% reported an increased sense of purpose, and 47% an increased will to live; 81% felt it helped prepare them for death; 81% reported that it had been / would be helpful to their families. The intervention was well tolerated, even in the sickest patients. The sessions averaged 55 minutes (range: 45-75). Notably, protocol burden was not an issue for patients, perhaps because they only spoke to issues important to them. Potentially adverse events, such as revealing a hurtful reality insensitively, occurred but were all sufficiently well managed that none reported negative consequences. Staff responses to the trial have been uniformly, overwhelmingly positive. Practitioners felt it was a viable treatment option, especially in circumstances of existential distress.

A phase 3 trial of DT has been completed (Harvey Chochinov, personal communication). This personal report from Dr. Chochinov indicates that in this 3-arm randomized controlled trial with standard care and a purpose designed control called Client Centered Care, patient experiences were significantly better with DT on all subjective scales as were family bereavement experiences ($p=0.002-0.004$). Differences were not detected on depression, anxiety and grief scales. Randomly selected cases were also captured and are being subjected to qualitative analysis studies; preliminary data indicate high levels of appreciation expressed differently from features captured on available scales. For instance, one woman, hearing from her dying father for the first time that he loved her, expressed its value as priceless. Possible explanations for the dramatically positive personal report and the null findings for psychiatric conditions are several; a prominent possibility is that the intervention is primarily spiritual. If so, possibly DT would be most suitably administered by chaplains. Current studies are evaluating the impact of DT on settledness and peacefulness regarding life-sustaining-care and terminal care decisions.

What Do Chaplains Do? Referrals.

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. Daaleman & Frey (1998) found that 80% of surveyed family physicians referred patients to pastoral care providers or clergy. Most physicians sought help for patients with bereavement issues (76%), terminal illness issues (75%) or marital or family problems (73%). Patient religious or spiritual problems resulted in referrals 64% of the time. A majority of physicians (60%) referred more than 4 times a year. Thirteen percent of respondents never referred to clergy or pastoral care providers. While this study is informative, it does not specifically ask about chaplains, nor is there a way to determine the rate of actual referral. There is some evidence of physicians having a positive attitude in general toward chaplains. Fitchett, Rasinski, Cadge & Curlin (2009) found that 89% of 1,102 physicians in a national survey reported having experience with chaplains, and 90% of these physicians were satisfied or very satisfied with chaplains. This is quite an improvement in attitudes towards chaplains since the 1992 study by Hover, Travis, Koenig, and Bearson that documented that only 46% of physicians in one hospital had any contact with chaplains. In this study, physicians who had no contact with chaplains were more apprehensive about negative impacts the chaplain might have on the patient, such as being "preachy" or "pushy" and not listening to the patients problems.

Flannelly, Handzo, Weaver and Smith (2005) surveyed hospital administrators and asked them how important they felt chaplains were for the following listed activities: End-of-life care; emotional support to patients, family or staff; integrator of spirituality with institutional care; prayer with patient or relatives, provide ethical consultation; liaison with community clergy; be a patient's advocate; perform religious rituals and conduct religious services. The survey was sent to 3,300 Chief Executive Officers of licensed health care institutions and 15% returned the surveys. Chaplains were judged to be important for all of the listed roles with end-of-life care and emotional support being the most highly valued. Hospital administrators with chaplaincy care departments suggested additional roles for chaplains not on the list, such as drug counseling and teaching multicultural sensitivity, community liaison and outreach, crisis counseling and debriefing for staff, grief and bereavement counseling, advanced directives education, participating on a palliative care team, and handling organ and tissue donation requests. Flannelly, Handzo, Galek, Weaver & Overvold (2006) found that hospital directors of pastoral care, nursing, social service and medical services felt that

chaplains were very important in situations that centered around grief and death, prayer, and emotional support.

Galek, Flannelly, Koenig and Fogg (2007) surveyed a national sample of directors of medical, nursing, social services and chaplaincy care departments. The overall return rate for the survey was relatively low, below 30%, for all directors except the directors of chaplaincy care, who had a return rate of 62%. Directors of chaplaincy care felt it was more important than the other directors to refer patients to chaplains. Directors in psychiatric hospitals were less likely to refer to chaplains than other directors. Across all groups the average response was that it was at least “a little bit important” to refer patients to chaplains for meaning, loss and death issues, treatment issues, pain and depression issues, and anxiety and anger issues. These findings suggest that there is a general consensus that chaplains must be doing something to address these needs.

In comparison to the study above, a study of chaplain referrals in an acute care community hospital with 280 beds found that patients were more likely to be referred to chaplains than were family members by 3:1 (Fogg, Weaver, Flannelly & Handzo, 2004). Patients asked to see a chaplain in 13% of the referrals. Staff referred patients to chaplains for many different reasons. Staff asked chaplains to see the patient 16% of the time so the chaplain could provide support or pastoral care, to help with anxiety 18% of the time, and to help with pregnancy loss 9% of the time. Other reasons included crying, depression, and difficult decision. Problematically these reasons for referrals are not clearly exclusive of one another, for instance pregnancy loss is an event that could also involve crying, depression, or anxiety and require the support and pastoral care of a chaplain. Only three kinds of referrals hint at what chaplains might be doing: referrals for pastoral care and support; patient advocacy or assistance; and religious item or ritual. These types of referrals occurred a total of 19% of the time. Patients were more likely to be referred for anxiety, depression and pregnancy loss while family members were seen due to death of patient, bereavement, and support and pastoral care. Again it should be noted that these reasons for referral are not exclusive and can be collapsed, into depression and anxiety for patients and death and bereavement for families.

Vanderwerker et al. (2008) found that nurses and patients referred to chaplains more often than doctors did, and that the nurses referred to chaplains more often for emotional concerns (41% of the time) than spiritual concerns (17% of the time). Emotional issues included anxiety/agitation, pain/depression, grief, and hostility. Spiritual concerns were indicated only if a patient clearly exhibited spiritual distress or requested religious items. It is entirely possible that emotional reasons

for referrals could have been unrecognized spiritual issues, i.e. depression over a life unfulfilled as measured religiously. Reasons for referral are also markedly different depending on whether or not the person was asking for a chaplain. For instance, patients asked for chaplains equally as often for spiritual (31%) as for emotional (30%) reasons, while doctors referred more often for emotional issues (25%) and for medical issues (26%) than for spiritual issues (14%).

Weinberger-Litman, Muncie, Flannelly and Flannelly (2010) studied intent to refer patients or families to chaplains in 133 nurses in one hospital in New York City. Nurses were provided with short statements describing different patient or family situations the nurse might encounter on the job, such as having a family dealing with the death of a patient, the removal of life support from a patient, or emotional discussions with a palliative care patient. Nurses were asked how likely they were to refer to a chaplain to help in each situation. Nurses were moderately or very likely to refer in situations that dealt with death, grief and negative emotions. The nurses were only slightly likely to refer patients who were upset about quality of care or patients who were being non-compliant in taking medications, two situations that can escalate to crisis situations in which chaplains are often called (Johnson, 2010).

Finally, Galek, et al. (2009) found similar results in a sample of referrals twice the size of the Vanderwerker, et al. (2008) study. The most common reason for a referral to a chaplain was that the patient requested a visit. Patients and families most often requested the visit to meet religious needs, including prayer and religious ritual needs. The next most frequently stated needs were related to illness or treatment and end-of-life issues, followed by emotional issues, such as depression, distress or anxiety, and pre-operation needs. When staff referred chaplains to patients, the chaplains most often observed negative affect such as grief, sadness and anxiety. This might be because doctors, nurses, social workers and other staff were more likely to refer a patient to a chaplain for emotional or end-of-life issues. Whereas patients or family members asked for chaplains to visit more often for religious needs or medical issues, and the most common affect reportedly seen by chaplains was gratitude.

These surveys on referrals provide for some general impressions on what is expected from chaplains. Hospital administrators and staff tend to refer patients to chaplains to get them help with emotional issues, end-of-life, and death and dying issues, while patients and families request a chaplain and expect chaplains to help with religious, spiritual, and emotional needs. While this is important initial evidence about what chaplains are hoped or expected to provide, it is not clear what

chaplains actually do or how well they do it. In most of the reports, the reason/s for requesting a chaplain, such as a patient wants prayer, confuses the request with the reason for the request. A prayer request could be due to religious, spiritual or social needs of the patient or the particular perceptions of the person making the request (e.g. nurse or physician). The list of reported situations to which chaplains are referred and, to some extent the interventions they make, can also be significantly affected by factors unrelated to the unique training and contributions of chaplains. Thus, a hospital with a very robust chaplaincy department but a very weak social work department will likely generate many more referrals to chaplains for emotional issues than a hospital where the situation is reversed. In some hospitals, chaplains bear primary responsibility for talking to patients about advance directives. In other hospitals, that task falls to patient advocates or social workers. In many hospitals, the referral pattern to chaplains is significantly related to the interests and skills of the particular chaplains on the staff. This is the case in the study that included referrals for pregnancy loss as cited above (Fogg, Weaver, Flannelly & Handzo, 2004). Finally, the referral categories are often poorly defined and are not standardized across studies.

What Do Chaplains Do?-Activities.

In a series of studies reported from HealthCare Chaplaincy's Spears Research Institute in 2008 and 2009, Handzo, Flannelly and colleagues reported on visitation, referrals and interventions of 40 chaplains and more than 200 chaplaincy students (residency and basic level) at 13 health care institutions in New York City and vicinity (10 hospitals, 2 nursing homes and one rehabilitation center). The data for these studies was obtained through chaplain self-report: chaplains completed a form each time they made a visit to a patient or family member. The form required predetermined information about who they visited, how long they visited and what they did during their visit. In one study, Handzo et al. (2008b) reported that chaplains had longer visits with acute care patients than with others, visited non-acute care patients more frequently, and spent more time with patients when their families were present. Handzo et al, (2008a) found that spiritual assessments occurred 48% of the time on the first visit and 44% of the time on a subsequent visit. Seventeen chaplain activities were listed: general activities were crisis intervention, emotional enabling, ethical consultation/deliberation, life review, patient advocacy, counseling, bereavement, and empathetic listening; spiritual activities were hearing confession or amends, faith affirmation, theological development, performing a religious rite or ritual, providing a religious item, offering a blessing, praying, meditation, and other spiritual support. Spiritual interventions happened approximately 60% of the time alone or along with general interventions approximately 25% of the time. The most

often used spiritual/religious interventions were prayer, blessing, and/or faith affirmation. General interventions occurred alone approximately 11% of the time. Emotional enabling and life review occurred in up to 15% of the visits. Empathic listening occurred most frequently, 72% of the time.

It is important to keep in mind that the data reported in this series of studies consisted of self-reports on a predetermined form by chaplains and chaplain students. Furthermore, the form was filled out by individuals with considerable difference in professional abilities and education. The intervention information does not differentiate between interventions done by board certified chaplains or students. It is possible that the methods used by each group were significantly different in delivery and outcome. There was only a limited glossary to define terms. There was no documented corroboration with patients on the reason for referral or patient needs.

In another study in one oncology hospital, chaplain activity varied depending of diagnosis and circumstances of the visit (Flannelly, Weaver and Handzo, 2003). Scripture reading occurred most often during pre-op visits and faith affirmation and emotional enabling occurred more frequently with family member of patients in respiratory arrest. In addition, type of activity varied depending on the religious tradition of the patient. During pre-op visits, emotional enabling occurred 80% of the time or more and scripture reading and prayer occurred at least 70% of the time. These activities changed in priority somewhat during treatment visits. During treatments Muslims engaged in scripture reading or prayer 91% of the time, but this activity decreased to less than 41% for Catholics, Protestants and Jews. Emotional enabling was the most frequent activity with the chaplain for these latter three groups during treatment.

A major weakness of this study is that the number of chaplains involved was small, (n = 4; a Lutheran minister, an Imam, a rabbi, and a religious sister), so it is not clear whether the differences in activities are due to variations between patient groups or variations between chaplains. For instance, the ministry to Muslim patients was conducted almost entirely by the Imam (Flannelly, Weaver and Handzo, 2003). Also, as with prayer, there was significant variability of each activity across chaplains despite the fact that all were CPE trained. Thus, there is great need for additional research to explore whether these differences will be sustained or were an artifact of the one study.

Montonye and Calderone (2010) examined chaplain reports of their activities in a 600 bed acute care hospital in Massachusetts. In this study, the chaplains included board certified chaplains, chaplaincy students and Roman Catholic priests. The staff reported patient needs, chaplain interventions, and patient outcomes over a two year period for each patient seen. The

reports were limited to drop-down responses on a computer screen for each category. The patient's needs that were recorded by the chaplain were limited to: physical pain and/or suffering; faith issues; anxiety, despair and/or loneliness; anger and/or frustration; family issues; death and/or dying; companionship; sense of guilt and/or shame. The choices of chaplain interventions were limited to: prayer and/or spiritual support; empathic listening and/or presence; life review; encouragement and/or empowerment; hope building and/or decision making; alternative medicine, music, touch and/or imagery; shared happiness; crisis intervention and/or conflict; bereavement support. Chaplains and visitors made determinations of needs in dialogue with those being helped.

In 80% of the visits, the needs of the patients were recorded as physical pain and suffering, having faith related issues or anxiety, or experiencing despair and loneliness. In 82% of the visits the interventions were prayer, spiritual support, empathic listening, presence, or life review. There were some differences in types of interventions engaged in depending on whether the intervention was provided by a CPE student, interfaith chaplain, or Roman Catholic priest. However, patients were assigned to chaplains or priests based on degree of difficulty and chaplain skill sets, so no definitive conclusions about interventions and kind of chaplain can be made.

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 may be the most common intervention that chaplains are expected to engage in, and people who are not familiar with what chaplains have to offer often expect them to offer prayer (Hover, Travis, Koenig & Bearson, 1992). Depending on the type of visit or religious affiliation of the patient, prayer may be the most common intervention (Flannelly, Weaver & Handzo, 2003). Visits before a surgery or at the death of a patient incorporated prayer for most patients, and Muslim and Catholic patients received prayer more often than Protestant or Jewish patients. Professional chaplains have a foundational clinical background that should enable them to anticipate a need for prayer and to ask patients what they would like to pray for. The board certified chaplain has learned how to pray with persons of all faiths, so as to take the patient's needs and shape prayers to best help the particular patient. Even while they are multifaith in theory and practice, there is a respect for that which is authentically possible when being with and praying with persons of faith traditions that are not the chaplain's faith tradition (Taylor, 2000; Zucker, Bradley & Taylor, 2007). In addition to prayer, chaplains, based on their training, develop rituals which are acceptable to people from a variety of spiritual traditions. Rituals bring communal meaning to chaos. For example, chaplains may develop non-religious ritual services for dying patients.

In summary, chaplains report, or are reported by others, that they most frequently engage in spiritual assessments, prayer, religious rituals, emotional enabling and empathic listening/presence with patients. These studies begin to give a picture of what chaplains do, however, they mostly deal with one or a small number of hospitals in roughly the same geographic area, the Midwest to North Atlantic states. Despite the apparently adequate sample sizes, it is still likely that the reported activities were significantly affected by the peculiarities of individual hospitals (rehabilitation hospital vs. cancer care hospital) and even individual chaplains (full-time board certified chaplains, volunteer patient visitors, individuals studying to be a chaplain). It is expected that more research will replicate and expand these findings.

What Do Chaplains Do? Care with Families.

Levine emphasizes that family members are really the patient's primary caregivers (Levine, 1998). As such, they should be intimately involved in treatment decisions. In Levine's opinion, however, they are usually ignored by hospital staff. 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, especially in critical care situations. Chaplains listen to family concerns, instill trust, and provide hospitality, information, and emotional support (Gillman, Gable-Rodriguez, Sutherland & Whitacre, 1996).

Sharp's (1991) study of chaplains in neonatal intensive care units (NICU) in three hospitals documents the frequency of chaplains' interactions with parents and other family members, as well as staff. Only eight percent of families with an infant in the NICU interacted with a chaplain. Eighty-two percent of visits requested by nurses, parents/family or physicians were for decedent care (e.g. comforting parents, baptizing a dying infant). Eighty-three percent of chaplain-initiated visits were for non-decedent care for the support of the parents of an extremely ill child. Chaplains typically interacted with the family for one (73%) or two days (18%). Nurses and physicians reported that, in addition to the above, chaplains helped with the assessment of parental coping, comforted the medical staff, and took part in morally problematic decisions in the NICU.

In a three hospital study, VandeCreek and Lyon (1994/1995) retrospectively examined hospital records over a 61-day period to identify how often chaplains visited patients, family, and staff. Ministry to patients, as counted by first contact visits, accounted for about 19% to 28% of the chaplain visits while ministry to families accounted for 29% to 35% of chaplain visits across hospitals. Although it appears that chaplains saw more family members than patients, the

percentages are somewhat inflated due to counting each family member present during a single patient visit. For example, if there were four family members in the room with a patient when a chaplain visited, the patient was counted once, and family contacts were counted as four. Even though the study also measured the frequency of worship services and sacramental functions, and estimated the time spent in each, it did not identify the extent that patients, family, or staff benefitted from these activities. Neither did the report examine what was done during the visits or identify how often families or patients received follow-up visits.

In one study, chaplains received positive ratings on helpfulness from bereaved family members for the chaplain's assistance over the course of a loved-one's end-of-life care and family care after death. Broccolo and VandeCreek (2004) interviewed 130 next-of-kin, asking two open-ended questions that inquired about what the chaplain did or said, and the degree to which the contact with the chaplain was helpful. The descriptions of what the chaplain did 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.

In surveys, chaplaincy care directors reported that they believe it is very important for chaplains to minister to the needs of family members (Flannelly, Galek, Bucchino & Vane, 2006; Flannelly, Handzo, Weaver & Smith, 2005). These studies found the chaplaincy activities included 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 (Flannelly, Weaver & Handzo, 2003), suggesting that other hospital staff share this perspective as well.

Much of the evidence on ministry to families basically states the obvious (e.g., that chaplains work with families preferentially when the patient has died or the patient is an infant). Again, while we know something about the kinds of situations that chaplains are called to be part of, we continue to know very little about what they do in those situations and what outcomes those interventions produce.

What the Reviewed Research Shows.

- Evidence that other professions consider chaplaincy important, especially in care at the end-of-life.
- Chaplaincy referrals and activities are split between specifically religious activities and general support.
- Evidence that referrals from staff are often for emotional issues.
- Chaplains often work with families, most often around end-of-life and bereavement issues.
- Dignity Therapy may have its primary efficacy in the spiritual realm and may be most suitably administered by chaplains.

A chart of what chaplains do can be found in Appendix One.

Research Gaps.

- A consensus description of key chaplain activities.
- Studies of chaplain activities using these uniform descriptors in representative samples of patients stratified by diagnosis and/or treatment setting.
- An outline of all the activities/interventions that chaplains do including those that they do uniquely and the prevalence across settings.
- Descriptions of activities/interventions in relation to specific religious and spiritual needs, diseases, and settings.
- An understanding of referral patterns to chaplains.

Section Three –Research on Chaplaincy Outcomes

Research into chaplaincy outcomes falls roughly into two general categories - patient satisfaction studies and outcome studies of actual chaplaincy interventions. The patient satisfaction studies are generally stronger methodologically than the outcome studies and tend to show that chaplain visits have a positive effect on overall patient satisfaction. However, in general, they do not give any indication of whether the patient benefits from the visits. It is also not clear whether the same results could not have been achieved by professionals from other disciplines or trained volunteers. The outcome studies are very few in number and most have serious methodological shortcomings. Thus, we have included some research from outside the inpatient acute care setting 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. All studies are in need of targeted and enhanced replication, and most are only suggestive and certainly not conclusive. A table summarizing pertinent studies of patient satisfaction with chaplaincy may be found in Appendix Two, Table 1, and chaplaincy outcome studies can be found in Appendix Two, Table 2.

Patient Satisfaction Studies

Patient satisfaction with the care received in hospital predicts returning to that hospital or referring family and friends to that hospital (Gibbons, Thomas, VandeCreek & Jessen, 1991). Spiritual care is an important facet of overall health care. Daaleman, Williams, Hamilton and Zimmerman (2008), in a study of long term care residents, found most residents received spiritual assistance (87%) in their end-of-life care, and those who received spiritual care 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, Wexler, Texeira, He and Sulmasy (2007) found that patients who did not have their spiritual care needs met were less satisfied with their health care.

It is especially important at the end-of-life, when physical healing is no longer possible, and palliation is the goal, that spiritual and psychological healing be accomplished (Sulmasy, 2002, 2006) and treatment be aligned with the patient's goals (Meier, Casarett, Gunten, Smith & Storey, 2010). Those goals are often influenced by spirituality and religion (Phelps et al., 2009; Balboni et al., 2010). Chaplains are the professionals with special training to offer competent spiritual care.

Parkum (1985) surveyed patients from six hospitals to compare the helpfulness of different nonmedical support services. "Pastoral counselors" were found to be helpful by the most persons (67%) followed by regular volunteers (23%) and social workers (16%). Dr. Larry VandeCreek and his colleagues conducted a number of studies on the spirituality and spiritual needs of inpatients and outpatients using various assessment tools, (VandeCreek, Ayres & Bassham, 1995; VandeCreek, Benes & Nye, 1993; VandeCreek & Smith, 1992) and also did extensive research on patient satisfaction with chaplaincy care (VandeCreek & Connell, 1991; VandeCreek, Thomas, Jessen, Gibbons & Strasser, 1991). VandeCreek and Lyon (1992) developed the Pastoral Care Patient Satisfaction Instrument (PCPSI), a patient satisfaction with chaplains scale that contained 35 items, and then later developed the Patient Satisfaction Instrument for Pastoral Care (PSI) (Vandecreek & Lyon, 1997), a scale with 40 items that 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 competence, communication skills, empathy, attentiveness, and sensitivity. Approximately two thousand former hospital patients or family members who were surveyed returned the mailed questionnaire. Almost all of the respondents agreed that the chaplain possessed spiritual sensitivity, had listened to them, had helped them feel more relaxed, and had comforted them (90% or greater).

Further refinement of the scale produced a revised scale of 23-items, the PSI-C-R scale (VandeCreek, 2004). VandeCreek (2004) examined visits by clergy and chaplains and the frequency of religious service attendance, both in the hospital and before hospitalization, among other variables, in relation to satisfaction. Results indicated that older individuals, those with lower education levels, those who attended church before hospitalization, and those who had shorter stays were more likely to rate satisfaction with chaplaincy care higher than those individuals with more education, those who did not attend church, and those who had longer hospital stays. The chaplain was seen by many as a person with spiritual sensitivity and someone who helped people find ways to cope. Overall satisfaction was correlated with all measures of chaplain activity.

Gibbons, Thomas, VandeCreek and Jessen (1991) examined the satisfaction with chaplain and spiritual services of over 400 patients who had recently left the hospital. Just under half of the former patients had received a visit from 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. About 12% received at least one visit from community clergy, social worker and patient representative. Patients rated chaplains’ visits as being the most important, and having the highest attainment of expectations. It must be noted, however, that ratings of importance and expectations met were on a scale of 1 to 10, and the level of importance for chaplains was 5 and expectations was 6.6. This study also looked at spiritual needs, such as the need for support and counseling for patient and family, the need for prayer, and need for sacraments. Support and counseling needs being met were associated with recommending the hospital to others and selecting the hospital again. Meeting prayer and sacramental needs were not related to recommending the hospital to others. Notable limitations of this study were a 19.5% return rate of the questionnaire, that people who were not visited were included in the analyses, that there was no separation of chaplains from other health care professionals in the providing of support and counseling, and the fact that the patient’s family member instead of the patient may have completed the questionnaire.

VandeCreek and Connell (1991) further examined, using the same dataset as Gibbons et al. (1991), the average level of satisfaction with support, counseling, and prayer. These were all rated around 6 on a scale of 1 to 10, with sacraments for Catholics being rated as 7. There were significant differences between Catholics and Protestants in several of the outcome 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 the support/counseling. As in Gibbons et al. (1991), there is no specification of the activities engaged in by chaplains. There is no comparison of chaplains with social workers, patient representatives or clergy. The authors conclude that patients were satisfied with the services rendered

Flannelly, Oettinger, Galek, Braun-Storck and Kreger (2009) evaluated the impact of chaplaincy services by focusing on the satisfaction with chaplains in a hospital that specialized in orthopedic surgery. Patient satisfaction with the chaplain meeting patients' emotional and spiritual needs was measured, along with satisfaction with chaplain demeanor and specific interventions. Only patients who requested a visit from the chaplain at check-in were visited by a chaplain. Interventions used by chaplains varied across patients and included praying, listening and providing help to overcome fears. Results indicated that 80% of patients felt that their emotional and spiritual needs were met by the chaplain, and over 85% of the patients felt listened to and supported by the chaplain. While there is good evidence now that patients like chaplains and that chaplains have a positive effect on patient satisfaction scores, it is not at all clear what chaplains do, or could do better, that patients find helpful or satisfying. Many of the activities listed in the studies are not clearly defined. In the absence of documented assessments, it is also not clear whether the chaplain's interventions are driven by patient desire or chaplain preference.

Satisfaction with end-of-life care was measured via a telephone interview with family members of decedents (Broccolo & VandeCreek, 2004). Family members were satisfied with chaplains overall, and most agreed the chaplain provided comfort and support, with 49% reporting they received more support than they expected. Chaplain helpfulness on average was rated between very good and excellent. Chaplaincy services were a "pleasant surprise" to many family members who were assisted. This highlighted the fact that many family members did not know what to expect from a chaplain. The majority of those who were helped had a lasting positive impression of the chaplain and the help they received.

In conclusion, studies that have evaluated patient satisfaction with the spiritual care provided by chaplains support the finding that patients are, in general, very satisfied with chaplains. They are more satisfied with chaplains than other members of the health care team providing services. Patients have reported that their spiritual needs were met by the chaplain. Future studies are needed to compare patient satisfaction with the spiritual services offered by board certified chaplains, chaplaincy students, and other professionals.

Outcome Studies

In addition to evaluating and demonstrating patient satisfaction with chaplains' care, research has also examined spiritual care and its benefits to health and well-being. Chaplains have been involved in research both investigating the impact of their ministry on individuals as well as assisting others as part of an interdisciplinary team. There are a few studies worth mentioning in detail in this section.

Outcomes: Interdisciplinary Team Participation.

Chaplains helped deliver spiritual interventions as part of an effort to improve quality of life in advanced cancer patients (Rummans et al., 2006). Patients were randomly enrolled in either a treatment as usual condition or an intervention condition. While in the hospital and undergoing radiation treatments for advanced cancer the intervention patients received at least five and up to eight 90-minute intervention sessions that included physical therapy, cognitive, emotional, social and spiritual interventions, and 10-20 minutes of guided relaxation. Intervention patients also received a 200-page manual with written materials that covered all of the eight manualized sessions. The treatment as usual control group received the same standard of medical care, including meetings with their oncologist and support group resources.

At four weeks follow-up, intervention patients were reporting significantly greater quality of life than patients in the control group. Ratings of spiritual well-being were also significantly higher in the intervention group at four weeks. Notably, the control group decreased in quality of life and spiritual well-being from baseline to week four. By five months follow-up these differences were no longer significant, as the control returned to baseline levels, as did the intervention group. Although the spiritual domain was the domain to show the most improvement it is not possible to document the influence of the chaplain on this process.

In a study of outpatient heart failure, chronic obstructive pulmonary disease (COPD), and cancer palliative care patients who had a life expectancy of one to five years, a chaplain was included in an interdisciplinary team to treat the patients for one year (Rabow, Dibble, Pantilat & McPhee, 2004). The chaplain was part of a comprehensive care team that included three physicians, a social worker, a nurse, a pharmacist, a psychologist, an art therapist, and a volunteer coordinator. The chaplain was responsible for offering spiritual and psychological support. Patients were offered support groups and weekly telephone contacts from medical and pharmacy students. 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 intervention significantly more for intervention patients than for control/treatment as usual patients. Unfortunately, it is impossible in this study to estimate the particular contribution of the chaplain, or any individual professionals involved in patient care, to the overall improvement in patient well-being.

Outcomes: Chaplains Working Alone.

Even though there is much diversity in setting, population served, and activities engaged in, several studies have attempted to measure the impact of chaplaincy on patient and family outcomes. Baker (2000) conducted an intervention study in a church-related continuing care retirement community in an effort to demonstrate the efficacy of pastoral care in treating depression and the negative impacts of changes in life circumstances. He divided the elderly participants into three groups; individuals taking anti-depressant 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. There were no limits on the kinds of pastoral care provided to the adults in the pastoral care group. The pastoral visits lasted about 30 minutes each and continued for 26 weeks. The visits were conducted by four ordained ministers who were serving area congregations, two ministers had a minimum of one unit of clinical pastoral education and two had no clinical training.

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. Group averages did change in expected ways that suggest a positive impact of pastoral visits. Pastoral visits were associated with higher religious and spiritual well-being scores and lower depression scores at post-test. Compared to the control group, the pastoral

visit group had significantly higher religious and spiritual well-being at posttest. However, there were no significant differences between groups at three months follow-up, and in fact, the pastoral visit group had the highest average levels of depression at follow-up compared to the control group. The results of this study should be considered descriptive in nature, due to the nonstandard reporting of group sizes, means, and statistical results, multiple comparisons made using a *t* test which increases the chance of identifying a group difference as significant when it is not, and the examination of subgroups not originally identified before the start of the study. The results of this study are suggestive and in need of replication.

In a study with a well-prescribed intervention protocol, cardiac patients about to undergo coronary artery bypass surgery were provided with a chaplain's care, or not, and mental health outcomes were measured at one and six months post-surgery (Bay, Beckman, Trippi, Gunderman & Terry, 2008). Chaplain care was administered by chaplains in five visits; one pre-operative visit with the patient, one visit to the patient's family during surgery, and three post-operative visits with the patient. Each chaplain followed a protocol for each visit. The first visit focused on pastoral support of the patient's spiritual/psychological needs, the third visit focused on hopes, and the final visit focused on helping the patient through the grief of having limitations and losses due to cardiac disease. The chaplain self-identified as a clergy person to engage "symbolic aspects" of chaplaincy care and engaged in reflective-listening to allow the patients to discuss any concerns they may have.

While there were no significant differences between the groups at the one month follow-up, at the six month follow-up, positive religious coping, as identified by statements on the religious coping measure, the RCOPE (Pargament, Smith, Koenig & Perez, 1998) that reflected seeking God for help, was significantly greater in the intervention group compared to the control group. Also at 6 month follow-up, negative religious coping on the RCOPE as seen in statements that reflected feelings of abandonment and questioning of God, was significantly lower in the intervention group compared to the control group. This is an important finding, given that patients with negative religious coping and struggle are at a higher risk for health complications (Fitchett et al., 2004; Pargament, Koenig, Tarakeshwar & Hahn, 2001; Pargament, Koenig, Tarakeshwar & Hahn, 2004; Rosmarin, Pargament & Flannelly, 2010). However, the meaningfulness of these differences is to be determined, given that the magnitude of these average differences is quite small- on average no more than the equivalent of one point on a scale that can range from a score of 7 to 28. Additionally, there was no significant difference between the intervention group and control group in level of depression over time, likely

due to the fact that the levels of depression of participants in this study were at the low end of the normal range and not in the clinical range. The other mental health outcomes measured- anxiety, hope, and religious problem solving, showed no differences between the intervention group and control group over time or at any point in time. Thus, while the chaplaincy intervention did not have the expected impact on mental health, the same intervention may yield much different results in patients with more compromising illness manifestations, for whom there would be more room for improvement on psychological measures of well-being and distress.

In a study with patients with a more compromising diagnosis the impact of chaplaincy care was more dramatic. Chaplain visits to patients with chronic obstructive pulmonary disease (COPD) in an inpatient setting were studied by Iler, Obenshain and Camac (2001). COPD patients experience anxiety as a common problem, due to symptoms such as difficulty breathing and catching one's breath and a poor long-term prognosis. They are often admitted to the hospital when the disease flares, and they can remain hospitalized for a considerable length of time, and require substantial hospital resources. Patients in this study were approached at admission to the medical/surgical unit of a hospital and asked if they would like to participate in a study conducted by the hospital chaplain. Those that agreed to participate were given the Beck Anxiety Scale both at admission and at discharge. Participants were assigned to one of two groups, patients who received daily chaplain visits during the hospital stay and patients who did not. Chaplain activities were not standardized across patients or visits and lasted approximately 20 minutes. All of the patients were reported to be "open to prayer", and many engaged with the chaplain to gain help with painful emotions, grief and family conflict management. On average, 4.2 visits were made to each patient. At discharge, patients were also asked about their satisfaction with the hospital and whether they would recommend the hospital to others.

Patients who received chaplain visits had significantly lower anxiety, shorter hospital stays, and were more satisfied with the hospital stay than patients who did not receive chaplain visits. While it appears that chaplain visits were responsible for very good outcomes, several limitations to this study should be kept in mind. No causal conclusion can be made regarding chaplaincy care specifically. First, it is not clear what the chaplain did, and second, it is not known if the chaplain's care would be different than the care given by a family member, other person, or other professional. It is not possible to know if the effects are specific to chaplaincy care. That said, this is the one study where we believe that the outcomes presented are defensible methodologically and statistically.

Studies with Misleading Findings.

Other studies exist that are often cited as evidence for the beneficial effects chaplaincy care that prove, upon closer examination, to be documenting no care, or care of another kind. In one study, patients 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. The outcome measures were degree of anxiety, length of stay and other physiological patient measures (Florell, 1973). Patients who received either support condition left the hospital sooner, made fewer calls for help to the nurses' station, and had lower anxiety, respiration, heart rate and lower pain medication needs than the patients who received regular hospital care. There are a number of limitations of this study, including patient assignment to conditions, and most notably the lack of detail on whether the chaplains provided spiritual care or general support and information. It is possible that anyone who gave general support and information could have effected a change, hence the chaplain intervention in the study would not have been unique to chaplaincy care.

In a report by McSherry, Ciulla and Burton (1992) on the importance of quality assurance in chaplaincy practice, three studies are cited and a statement is made that chaplaincy interventions have "shown a statistically significant savings of from 19.6 to 29.9 percent per case". The first study is the Florell (1973) study cited above. While it is true chaplains were involved and provided care, there is no evidence that what the chaplain did was unique to being a chaplain: a social worker or psychologist could also have done what the chaplain did in the intervention. In the second study by McSherry (1987), men who were more religious, as affirmed on a questionnaire, were more likely to leave the hospital sooner. This finding has nothing to do with a chaplain providing care, and it is not clear that the chaplain was involved at all with the patients. In the final reference, McSherry, Kratz, and Nelson (1986), a chaplaincy intervention is credited for saving a hospital upwards of \$400,000 in care costs for a spinal injury patient because the chaplain worked with the patient on issues related to dealing with being paralyzed for life. Again, it is not clear how the chaplain was uniquely responsible for the improvement in the patient's life - he went home able to care for himself with nursing support rather than being hospitalized for the rest of his life. Many people were involved in this particular patient's recovery, and the patient did not personally attribute his improvements to the chaplain. The same might be said of the other two patient stories noted in this report.

These studies highlight the importance of identifying the unique intervention contribution of the chaplain, the measurement of that intervention, and the specific outcomes that can not be expected from the interventions of others on a health care team.

What the Reviewed Research Shows.

- Evidence that patients find chaplain visits helpful and supportive.
- Valued activities include prayer and listening.
- Chaplains included on interdisciplinary teams are associated with improved spiritual well-being in palliative care patients.
- One study found that chaplain visits were related to improved anxiety and depression outcomes, better emotional responding, spiritual needs being met, and another study that shows that chaplain visits are related to shorter stays in the hospital. Whether these changes are directly due to the chaplain's intervention and sustained over time is not known, and research findings suggest that they may not be sustained.

Research Gaps.

- Identification of the desired outcomes of chaplain interventions for patients in acute care, long-term care, and outpatient settings, considering different patient needs and diseases.
- The desired outcomes of chaplain interventions when helping families.
- The characteristics and interventions generally associated with a good (effective) chaplain.
- The relationship between clearly described presenting needs and interventions.
- The relationship between chaplaincy interventions and the desired outcomes.
- The chaplaincy activities associated with patient satisfaction.

Methodology.

- Developing and testing of measures and methodologies including case study and other qualitative methods, surveys, and experimental designs in relationship to their ability to describe and test the questions above.

Research Summary

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 and volunteers. These studies represent the extent of the outcomes research in chaplaincy care in the United States. Most of the cited research consists of evaluations of patient satisfaction with patients' needs being met, and general descriptions of chaplain visits but limited measurement of unique chaplain activities. There is a fairly uniform finding that patients like chaplains. What they like about them is generally unknown, although there are indications that those who have experienced chaplains find them spiritually sensitive and supportive. There are no clear patient outcomes 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 identified the best chaplaincy practices; thereby they do not provide evidence that could be considered evidence-based 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.

Section Four – The Future of Chaplaincy Research

Several recent trends in health care will impact on chaplaincy research going into the future. Firstly, increasing attention at a national level is being paid to palliative care. Secondly, health care is becoming more individualized with electronic medical records that are making possible such innovations as medical homes. Medical homes allow for much of patient care to be provided in the outpatient setting. 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). Thirdly, as noted in the introduction, there has been an increase in the number of Americans who are claiming to be spiritual but not religious, and in those claiming no religious affiliation at all (Newport, 2010b). This trend has been reflected in the research literature where there has been a gradual decline in the number of research 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).

Koenig (2008) notes that many of the 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 sacred (Pargament, Mahoney, Exline, Jones, & Shafranske, in press). Even in the emerging field of palliative care, where spiritual care and

chaplains are universally included in all models and guidelines (National Quality Forum, 2006; Puchalski & Ferrell, 2010), 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 and the lack of professional chaplains on palliative care teams. Thus, unfortunately, it is becoming more likely that palliative care will be proven to be helpful and cost effective without understanding the contribution of spiritual care.

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, Flannely & Liu, 2008). Calls have been made for increased research capacity in chaplains (McSherry, 1987; Fitchett, 2002). VandeCreek challenged chaplaincy to weigh in on the statement “Professional chaplaincy and clinical pastoral education should become more scientific” (VandeCreek, 2002). Fitchett (2002) responded to this challenge and expressed a hope that by 2011 the profession of chaplaincy would become research literate. One of the suggested methods for accomplishing this was to have 1% of the APC membership become active researchers by 2005 (about 30 chaplains) and 2% by 2012 (about 60 chaplains). It is less than a year away from the 2012 deadline, and it is not possible to say how close we are to the goal of having 60 research chaplains in the United States. Certainly, the number of continuing education offerings focusing on research and specifically developed for chaplains has increased, enrollment has been substantial, and there is evidence of their beneficial effects on chaplains’ willingness to become research-literate (Murphy & Fitchett, 2010). Outcome oriented chaplaincy and The Discipline (VandeCreek & Lucas, 2001), a process of systematizing the practice of chaplaincy, has established a method allowing chaplaincy to be understood in the clinical context, and also provides a method to enable outcomes to be established and measured for the first time.

To move the field forward, a rubric of recommended research methods is needed. The health care chaplaincy field needs to develop an evidence base to guide chaplaincy practice. However, a narrow focus on the specific research methods, definitions, or the criteria for what constitutes empirical support for evidence-based treatments for patients seen by chaplains would not be helpful. The American Psychological Association’s (APA, 2005) *Policy Statement on Evidence-Based Practice in Psychology* encourages “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 284). This statement does not necessarily preclude any particular type of research method, but it does imply a deliberate engagement with the best methods available to study the questions at hand. It is important to keep

in mind that different research designs are better suited to address different types of questions (APA, 2006, p. 274). The APA Task Force on Evidence-Based Practice report lists and briefly describes various types of research designs and how they might contribute to evidence-based practice. For example, the method of clinical observation, such as an individual case study, is a good source of intervention innovation and theory creation. The random-controlled trial (RCT), where individuals are randomly assigned to either a treatment or no treatment group to examine the helpfulness of a therapy/intervention, is one method for testing causal influences of change, while the method of natural observation of interventions can inform the chaplain as to the worthiness of interventions and the mechanisms of change in patients in a more natural setting.

It is extremely important to realize that even the most well-designed research study has limitations due to the particular research method used. The gold standard of research methods to demonstrate causality, the random-controlled trial, often has not led to convincing evidence for psychotherapies (Kazdin, 2008). Knowing that an intervention works in general often does not help much when deciding which intervention to use with a specific patient (Kazdin, 2008). There are many difficulties with using RCT investigations of interventions and therapies. Westen, Novotny and Thompson-Brenner (2004) provide a thorough review of the common pitfalls plaguing RCT trials and the situations when RCTs are the most useful. RCTs work the best in situations where a specific person's problem is being treated in a specific way, and the problem is not exacerbated by personality characteristics, family systems influences, or other factors.

To encourage a thoughtful, comprehensive evidence-based approach to health care chaplaincy research some of the major quantitative and qualitative research designs are briefly described and discussed. The various research designs are not described in detail because this has been done in numerous books and articles (e.g., Gall, Gall & Borg, 2007; Cook & Campbell, 1979; Denzin & Lincoln, 2005; Greenberg, 1986; Heppner, Wampold & Kivlighan, 2008; Kazdin, 2003; Kendall & Holmbeck, 1999; Rosenthal & Rosnow, 2007; Shadish, Cook & Campbell, 2002). The purpose here is to briefly describe the defining characteristics of the major designs, their strengths and weaknesses, and the types of research questions regarding health care chaplaincy that they are most suitable for investigating.

Quantitative Research Designs

Summaries of the key characteristics of designs that have the potential for furthering the understanding of health care chaplaincy can be found in Appendix Three, Table 1. These designs

include: survey, correlational, discovery-oriented designs, single-subject, and experimental (including quasi-experimental). Survey designs could be helpful in learning about patients' and chaplains attitudes and beliefs about faith and spirituality, and the roles of faith and spirituality in coping with illness and in health care practice. Survey designs could also help determine what types of chaplaincy interventions are being used, and what interventions patients and chaplains believe are the most helpful. Correlational designs could explore the relationships between the types and severity of illnesses and various chaplaincy interventions. They could also be used to explore whether various types of spiritual practices and chaplaincy interventions are related with positive health care processes and outcomes.

Single-subject, task analysis, and discovery-oriented research designs (Greenberg, 1986, 2007; Kazdin, 1994; Pascual-Leone, Greenberg, Pascual-Leone, 2009) also have great potential for contributing to the advancement of an evidence base for the health care chaplaincy field. The work by Greenberg and colleagues clearly discusses the difficulties inherent in trying to measure and document meaningful change in psychotherapy. One method that is useful for documenting change is discovery-oriented research because it begins not with a hypothesis as much as it begins with an open awareness for observing that which is not expected and a willingness to rigorously document the exploration. An examination of the information collected can lead to an identification of patterns of behavior and the change in patterns that may have occurred at a particular time or after a particular event. Although these designs are more limited in terms of traditional notions of internal and external validity, they are more feasible to carry out in health care settings because they are less intrusive, ethically problematic, costly, and time-consuming. They also are more clinically relevant in that they allow the exploration of research questions that are more meaningful to health care chaplains.

Single-subject designs could prove especially useful for evaluating the effectiveness of interventions used by chaplains in long-term care settings. Chaplains in these settings can use these designs relatively easily to evaluate their own practices. In a single-subject study, the patient serves as his or her own control. By measuring changes in a single patient's symptoms or problems over time, the chaplain can see the impact of their interventions (Kazdin, 2010). If chaplains are willing to invest the relatively small amount of effort needed to administer brief repeated outcome measures to their patients during the course of treatment, they could document the effectiveness of their own work and contribute to the establishment of a large database on the outcomes of health care chaplaincy interventions. Perhaps this will be most feasible if practicing chaplains collaborate

with scholars in academic and research settings. Both chaplains and scholars would benefit from such collaboration, and the database on health care chaplaincy would grow rapidly.

Given that few experimental outcome studies have been conducted in the health care chaplaincy field, there is a need for more of them. Experimental outcome studies are widely regarded as the premier research design, as this design can provide support of a causal relationship between a treatment and an outcome (Kazdin, 2003). Considerable work is put into the design of the research method to control as much of the extraneous influences on outcomes as possible, so that the effect of a treatment on an outcome can be isolated. However, outcome studies using rigorous experimental designs are time-consuming, expensive, and difficult to implement in clinical settings. And even carefully conducted experimental studies have limitations. Most notable of these are; (a) the difficulty of ruling out all possible threats to internal validity, (b) limited external (real life) validity, (c) limited generalizability beyond the specific sample used in the study, and (d) ethical concerns associated with the use of control groups. While experimental outcome designs cannot be viewed as the final or infallible word concerning the efficacy of health care chaplaincy practice, they are valuable for investigating outcome questions such as: Are spiritual approaches and interventions used by health care chaplains effective? Are spiritual approaches and interventions used by chaplains more or less effective than secular ones? What types of changes do they promote? With what types of patients and problems are interventions used by chaplains most effective?

Rapkin and Trickett (2005) introduced the notion of the comprehensive dynamic trial (CDT) as a way of determining the types of interventions that are most beneficial for different clients in specific settings. CDT is based on two fundamental principles. First, an intervention is understood as an “information-dense” activity. Rather than assume that differences among patients, chaplains or service settings are ignorable, CDT captures all such information in order to determine factors that moderate intervention performance. Second, in CDT, intervention implementation fully incorporates principles of continuous quality improvement. In other words, chaplains (and their partners in clinical decision-making, including their patients) receive on-going feedback of information about individual outcomes. Chaplains can use this information to systematically modify their practice, to test ideas about changes that would help to improve outcomes. Data are captured about the kinds of changes chaplains make, and whether these changes ultimately improve outcomes for a given patient (or series of patients). CDT provides data on the nature of patients’ specific problems, their background issues and concerns, the nature of the particular intervention strategies selected, and whether and how well these were administered by the chaplain. These data

can be compared across different chaplains to determine the relative effectiveness of different approaches for different types of patients in a variety of practice settings.

An approach to obtaining the best feedback from the patient begins with an in-depth interview. An example of this approach is seen in the Dynamics of Care interview found in Rapkin, Weiss, Chhabra, Ryniker, Patel et al. (2008). This interview methodology is pertinent to the study of chaplaincy for several reasons. First, it is possible to screen samples of patients to determine the extent to which they are experiencing problems that could benefit from contact with a chaplain, whether or not they are in fact seeking care from chaplains, where else they are turning to for help, and what barriers to help seeking they have encountered. Among individuals receiving help, it is possible to determine the nature and quality of support they receive from chaplains, and the overall benefits that they experience in resolving a particular problem. Note that the dynamics of the care approach provides necessary information about the context and nature of chaplaincy care: for example, a patient who is receiving emotional support from a chaplain, may decide against speaking about death and dying, and not even consider talking with the chaplain about conflicts occurring with his spouse because they are already receiving marital therapy. A dynamics of care assessment is designed to evaluate help-seeking behaviors and patient experiences in care over time as well as assess changes in response to specific interventions.

Another useful lens to view future research in chaplaincy is to include the role of individual's social networks in study design (Rapkin & Dumont, 2000). Membership in certain groups impacts health, for example, religious individuals have better health. The group membership imparts particular personal behaviors that are beneficial to health. The impact of group membership on health and behavior for an individual also depends on the person's role or placement in the group. Knowledge is needed to identify how specific interventions work best for individuals based on placement in their groups and the type of groups to which they belong. Rapkin and Trickett (2005) provide a detailed example of how group processes impact on individuals' responses to a group-administered HIV prevention intervention program, in addition to methods that can help examine the group influences.

Recent developments in public health research and government funding priorities indicate considerable interest in the area of comparative effectiveness and patient-centered outcomes (Chambers & Neumann, 2010). Comparative effectiveness research evaluates several different therapies or treatments for a particular difficulty in relation to specific outcomes to see if one therapy

is more effective than another. This comparison can be done with many of the research methods already mentioned. For example, it is possible to compare patient outcomes associated with different chaplain strategies or settings of care. Recommendations based on comparative effectiveness research are predicated on certain assumptions: relatively large samples of chaplains and patients, resources to implement and monitor standardized intervention approaches, and sophisticated quantitative resources to examine outcomes. Although such research would be quite valuable, it is not the only way to conduct meaningful research on chaplaincy.

Another research approach that has gained considerable interest and support in public health over the past decade is community-based participatory action research (CBPR). In CBPR, local stakeholders partner with academic investigators to address problems of mutual interest. Working together, partners identify problems and questions, select methods to study what is going on, gather data to better define problems, implement intervention strategies and examine results. Methods of CBPR would ensure that research findings would speak to issues of importance to particular chaplains and their patients, and would provide a basis for examining contextual factors that influence the choice of particular strategies and their efficacy in different situations. Schensul (2009) and others have discussed the role of participatory research in understanding local theories regarding change in health and well-being. This kind of inquiry could provide considerable information about the decisions made by different chaplains in different localities in responding to the needs of their patients. Despite the potential lessons that could be learned using CBPR methods to study chaplaincy, this approach in itself does not address the larger concern, to be able to develop scientific principles and guidelines for effective practice of chaplaincy and to document the effectiveness of this care within the healthcare system. Further, CBPR is a potentially time-consuming endeavor for both chaplains and investigators.

Outcomes of chaplaincy care are almost always multidimensional. In addition to improved spiritual well-being, chaplains hope to resolve conflicts between patients, families and treatment teams, connect patients to community sources of support, facilitate use of beneficial treatments and palliative services, and help patients make decisions about long-term care and the type of legacy they hope to leave. Although it is certainly necessary to be concerned about patient burden, it is often possible to take steps that mitigate this problem. Consistent with principles of CBPR, patients should understand why an assessment is required. Ideally, such assessments can be incorporated into provision of care from the chaplain or prompt a referral to another provider. Automated systems for collecting such data and for providing patients with feedback on results is becoming more widely

available. Indeed, such measures can become the basis for establishing a common language about symptoms and needs, to facilitate better communication among patients, chaplains, family members and others on the treatment team.

It is important to emphasize that the array of designs and assessment techniques outlined here are not exhaustive. However, even this limited description of methods demonstrates the potential for very far-reaching and exciting work in this area. Methods described here are explicitly intended to develop an empirical basis for chaplaincy practice from the ground up, by understanding and building upon the activities and experiences of chaplains and their patients. This approach does not in any way preclude the examination of standardized best practices and evidence-based interventions. Rather, it must be understood in the world of chaplaincy, where one size will not usually fit all. Rigorous, systematic, collaborative research on the dynamics of chaplaincy practice would be needed to inform randomized trials of specific interventions, and to determine the characteristics of patients, chaplains and systems of care that must be taken into account.

Qualitative Research Designs

There are numerous overlapping qualitative research designs or strategies and many ways of categorizing them (Denzin & Lincoln, 2005). Five major qualitative research strategies that have considerable potential for contributing to the understanding of health care chaplaincy practice are described in Appendix 3, Table 2: phenomenology, ethnography, grounded theory, biographical, and case study. This discussion is limited to these strategies only because of space limitations, and it is not intended to rule out the possibility that other strategies will prove useful in the study of health care chaplaincy. Quantitative research can be helpful for providing insight into patients' symptoms and behaviors and into chaplaincy processes and outcomes, but it is limited for providing insight into clients' inner, subjective worlds. This is where qualitative designs will contribute the most to increasing understanding of the effects of health care chaplains' interventions. Such studies can help researchers better understand patients' inner worlds, or "lived experience," thereby enabling them to understand and empathize with them more fully.

Phenomenological, ethnographic, grounded theory, biographical, and case study strategies (e.g., Brown, 2010) hold considerable promise for helping researchers gain richer, more in-depth insight into patients' religious and spiritual perceptions, experiences, understandings, feelings, beliefs, values, desires, and practices. These strategies also hold promise for yielding considerable insight into the spiritual nature and processes of coping and healing, as viewed from the

perspectives of patients, families, and chaplains. Biographical and case study strategies also have considerable potential for providing insight into religious and spiritual coping and healing during times of health crises.

Qualitative studies are not easy to do. They are time-consuming, laborious, and challenging to report. However, many of the methods used for data collection in qualitative research are highly similar to the methods used as part of chaplaincy training and practice, such as unstructured interviews, participant observation, audio taped conversations, field (case) notes, and diaries (Denzin & Lincoln, 2005). With some training in qualitative methods and permission from patients, much of what chaplains do could serve as data for qualitative studies. It is hoped that during the next decade many chaplains, perhaps in collaboration with scholars in academic and research positions, will investigate the role of chaplains in health care creatively and rigorously using qualitative methods.

Conclusions

Health care in the United States is becoming patient-centered, holistic and wellness focused. It increasingly includes care for the patient's social, emotional and spiritual concerns as well as their physical concerns. Patients and families want their religious and spiritual values, beliefs and practices included in their care decisions and processes. However, very often this goal is not achieved. A major reason for this gap is the lack of evidence for how to deliver spiritual care effectively and efficiently. Even where spiritual care is officially included in the care provided, there is virtually no research-informed evidence for how to have that care contribute predictably to positive health outcomes. Thus, there is currently no way to determine if and how spiritual care contributes value to the health system or to maximize that value. Without apparent value-added, spiritual care will increasingly be left out of the health care equation.

The professional board-certified chaplain is becoming the spiritual care leader on the health care team in charge of helping the team integrate spiritual care into the treatment process. For spiritual care to be most helpful to the patient and family, the chaplain must produce, and be informed by, substantial research evidence that documents effective chaplaincy interventions that promote healing and health.

Research on the efficacy of chaplaincy care is beginning to grow and is largely confined to the acute care setting. It is in an embryonic state but methodologies, preferred interventions, and desired outcomes have been documented and developed. Potential lines of research are emerging along with a small and growing number of research groups with the skills and interest to pursue studies in this area. Much needs to be done to describe the current state of who chaplains are, where they work, and what they do. The literature review and gap analysis presented here states only the major and most important potential areas to study. Essentially, what is described in this paper for the first time is a new and rapidly emerging field, and it is a field which, with the proper evidence base, could be integral to the restructuring of health care in the U.S.

Appendix One: Major Reasons for Referrals and the Activities of Chaplains

Flannely, Handzo, Weaver and Smith (2005)	Montonye and Calderone (2010)	Handzo et al. (2008a)	Fogg, Weaver, Flannely and Handzo (2004)	Galek et al. (2009)	Galek, Flannely, Koenig and Fogg (2007)	Vanderwerker et al. (2008)	Flannely, Weaver & Handzo (2003)
<p>Advanced directives education</p> <p>Be a patient's advocate</p> <p>Crisis counseling and debriefing for staff</p> <p>Drug counselor</p> <p>End-of-life care</p> <p>Emotional support to patients, family or staff</p> <p>Grief and bereavement counseling</p> <p>Integrator of spirituality with institutional care</p> <p>Handling organ/tissue donation requests</p> <p>Liaison with community clergy</p> <p>Participating on palliative care team</p> <p>Perform religious rituals and conduct religious services</p> <p>Prayer with patient or relatives</p> <p>Provide ethical consultation</p>	<p>Alternative medicine</p> <p>Anger/frustration</p> <p>Anxiety</p> <p>Bereavement/support</p> <p>Companionship</p> <p>Crisis intervention</p> <p>Conflict</p> <p>Death/dying</p> <p>Despair/loneliness</p> <p>Empathic listening/presence</p> <p>Encouragement empowerment</p> <p>Faith issues</p> <p>Family issues</p> <p>Guilt/shame</p> <p>Hope building decision making</p> <p>Life review</p> <p>Physical pain or suffering</p> <p>Prayer/spiritual support</p> <p>Shared happiness</p>	<p>Bereavement and empathic listening</p> <p>Counseling</p> <p>Crisis intervention</p> <p>Emotional enabling</p> <p>Ethical consultation and deliberation</p> <p>Faith affirmation</p> <p>Hearing confession or amends</p> <p>Life review</p> <p>Offering blessing, prayer, meditation</p> <p>Patient advocacy</p> <p>Religious ritual or rite religious item</p> <p>Theological development</p>	<p>Advocacy or assistance</p> <p>Anxiety</p> <p>Death and bereavement</p> <p>Depression</p> <p>Pastoral care and support</p> <p>Pregnancy loss</p> <p>Religious item or ritual</p>	<p>Emotional issues/pain</p> <p>End-of-life issues</p> <p>Illness or treatment</p> <p>Patient request</p> <p>Religious needs such as prayer/ritual</p>	<p>Anxiety and anger</p> <p>Meaning and loss/ death issues</p> <p>Pain and depression</p> <p>Treatment issues</p>	<p>Anxiety agitation</p> <p>Grief</p> <p>Hostility</p> <p>Pain depression</p>	<p>Emotional enabling</p> <p>Faith affirmation</p> <p>Scripture reading</p>

Appendix Two: Summary of Chaplaincy Studies: Patient Satisfaction and Chaplaincy Outcomes

Table 1: Patient Satisfaction Studies

Study	Patients	Setting	Measures	Findings	Limitations	Notable
Broccolo & VandeCreek (2004)	130 family members of deceased patients	Eight facilities, seven hospitals and one nursing home	Phone interview, nine questions, two open-ended about helpfulness of chaplain	74% met the chaplain for the first time at the death of the patient, 99% felt the amount of time the chaplain spent was appropriate, 88% reported the chaplain provided support	50% response rate to request for interview, respondents were from Catholic hospitals only, interviews happened one month after death, unclear the unique support offered by chaplain	An attempt to identify the roles of chaplains at the end of life, future research should further examine the chaplain's roles identified in this study
Flannelly, Oettinger, Galek, Braun-Storck, Kreger (2009)	250 patients, majority female, average age 67 years	150 bed orthopedic hospital in New York City	One-page questionnaire; specifically asking about chaplain services received	80% of patients said chaplain did very well meeting spiritual/religious and emotional needs, chaplain caring, spending time, listening, praying all important	Response bias toward positive ratings, chaplains knew they would be rated, may have enhanced their normal services, orthopedic hospital	Future research should consider expanding item responses on survey from 0-3 to 1-10, continued examination of spiritual/religious needs separate from emotional needs
Gibbons, Thomas, VandeCreek, & Jessen (1991)	484 surveys completed by 290 patients, 130 spouses, 25 children, 22 parents and 7 others; 245 visited by chaplains	Anonymous national survey of discharged hospital patients from mostly upper Midwest zip codes	Satisfaction questionnaire mailed to patient's home, anyone could fill out and return, focused on social work, chaplains and patient advocates	Chaplain visits rated higher in importance than other services, more agreement that chaplains met expectations, if support and counseling needs met then also more satisfaction with hospital	19% return rate, 40% of returns were from family members who rated services higher than patients, 56% patients visited by both clergy and chaplain, care and counseling not clearly exclusively done by chaplain	Possible re-analysis of data excluding family member responses, and/or separate groups of respondents visits from clergy and chaplains, total number of visits of all professions

Appendix Two: Summary of Chaplaincy Studies: Patient Satisfaction and Chaplaincy Outcomes Continued

Table 1: Patient Satisfaction Studies Continued

Study	Patients	Setting	Measures	Findings	Limitations	Notable
Parkum (1985)	432 diabetic and surgery patients	6 hospitals	Interview of hospitalized patients	67% found pastoral counseling service helpful, vs. volunteers (23%) and social worker (16%), expressive help more helpful than instrumental help	Unclear who interviewed patients, satisfaction is equated with helpfulness measured as “yes” or “no”	55% of patients in medical school-affiliated hospitals found pastoral counselors helpful vs. religious hospitals (72%)
VandeCreek (2004)	1,440 discharged patients, mostly Caucasian, majority Protestant, attending church weekly, with extremely serious illness, average age 57 years	14 hospitals of 50 to 500 beds, upper Midwest and Eastern U.S., 8 religiously affiliated, all patients received at least one visit from chaplain while hospitalized	Patient Satisfaction Instrument - Chaplaincy - Revised (PSI - C - R mailed to patient’s home with return envelope	Most patients agree that chaplain helps patient realize God cares, most were comforted by chaplain’s prayers, felt chaplain was professional, most didn’t mind chaplain visit, satisfaction with hospital correlated with satisfaction with chaplain, satisfaction with chaplain services varied depending on hospital	Incomplete data across all questions on the scale, no idea of response/refusal rates, significant differences across hospitals in satisfaction with chaplaincy services, more religious prior to illness more satisfied, no description of chaplains that participated	Some people were “scared” by the chaplain or were made tired by the visit. Not clear why increases in fear or tiredness were also positively related with higher satisfaction scores, not sure who answered the questionnaires
VandeCreek & Connell (1991)	444 surveys completed by Catholic or Protestant insurance claimants; 262 patients, 180 family members, 42 others	Discharged hospital patients from mostly upper Midwest zip codes	American Protestant Health Association Questionnaire mailed to patient’s home	Catholics visited by clergy less frequently than Protestants, Catholics report higher importance to chaplain visit and higher met needs for counseling and support	19% return rate, no uninsured respondents, family members rated services higher than patients, 55% patients visited by both clergy and chaplain, Catholics satisfaction scores higher	Reanalysis of patient only data, expand to other parts of United States, better understand sources of differences in responses of Catholic and Protestant patients

Appendix Two: Summary of Chaplaincy Studies: Patient Satisfaction and Chaplaincy Outcomes Continued

Table 1: Patient Satisfaction Studies Continued

Study	Patients	Setting	Measures	Findings	Limitations	Notable
VandeCreek & Lyon (1997)	2,000 patient or family responses, 86% from U.S. (1448), Canada (508) and New Zealand (44)	Survey mailed to homes of discharged hospital patients who had received at least one visit from a chaplain	Patient Satisfaction Instrument for Pastoral Care (PSI)	Overall satisfaction with chaplaincy services was high; highest for help with personal concerns, coping and prayer, older patients less likely to welcome chaplain, those with few visitors more supported by chaplain, greater satisfaction with hospital experience associated with greater satisfaction with chaplain	Long survey may have eliminated some respondents overwhelmed with coping with disease, 14% of responses were from family members	Rich data source for comparisons of individual statements and various variables related to satisfaction
VandeCreek, Thomas, Jessen, Gibbons & Strasser (1991)	484 surveys completed by 290 patients, 130 spouses, 25 children, 22 parents and 7 others; 245 from those visited by a chaplain	Discharged hospital patients from mostly upper Midwest zip codes	American Protestant Health Association Questionnaire mailed to patient's home	Chaplain visits rated higher in importance than other services, expectations for chaplains more likely to be met, support and counseling needs met more satisfied with hospital	19% return rate, 40% of returns were from family members who rated services higher than patients, 56% respondents visited by clergy and chaplain, care and counseling not clearly exclusively done by chaplain	Possible re-analysis of data excluding family member responses, and/or separate groups of respondents visits from clergy and chaplains, total number of visits of all professions

*These studies are two reports on the same data.

Appendix Two: Summary of Chaplaincy Studies: Patient Satisfaction and Chaplaincy Outcomes

Table 2: Patient Outcome Studies

Study	Patients	Setting	Measures/Interventions	Findings	Limitations	Notable
Baker (2000)	120 persons aged 65 years or older, 94 persons in final data analyses	Church-related continuing care retirement community	Measures: Spiritual Well-being Scale, Self-transcendence Scale, Geriatric Depression Scale, and questions about religiosity, religious practice, social participation, and chaplain interventions. Intervention: Chaplains provided weekly 30± minute pastoral care treatments for half of participants, the other half were in a control group with minimal pastoral care. Study lasted for six months, 3 month follow-up visit for everyone.	Average level of depression decreased in treatment group over 6 months, but was at the highest level of all measurements in the treatment group at the 3 month follow-up. Average level of depression in the control group increased over time	Statistical controls not used to test for change over time across groups, too many statistical tests without accounting for possible chance findings, results were reported without necessary statistics to aid interpretation (<i>N</i> , <i>S.D.</i>), chaplain knew which participants were in treatment group when administering outcome measures, no equivalent treatment comparison group.	Long-term care study, lengthy chaplain visits structured according to resident needs, results suggest need for continued services past end of study

Appendix Two: Summary of Chaplaincy Studies: Patient Satisfaction and Chaplaincy Outcomes Continued

Table 2: Patient Outcome Studies Continued

Study	Patients	Setting	Measures/Interventions	Findings	Limitations	Notable
Bay, Beckman, Trippi, Gunderman & Terry (2008)	170 hospitalized coronary artery bypass graft patients, average age 64 years	Hospital bed and family visits by chaplain at pre- and post-surgery times	Measures: Hospital Anxiety and Depression Scale, Health Hope Index, religious coping brief RCOPE, Religious Problem Solving Scale. Intervention: treatment group received five pre-determined topic chaplain visits, one pre-surgery, one with family, three post-surgery, control group received no chaplain visits. No record of which patients also received visits from parish clergy	Negative religious coping increased in the control group and decreased in the treatment group by the 6 month follow-up. Positive religious coping increased in treatment group and decreased in the control group by the 6 month follow-up.	Manualized approach to intervention may have prevented for spontaneously derived important interventions, one chaplain in one hospital, no equivalent treatment comparison group.	Evidence that chaplain services related to changes in religious coping in coronary patients, replication in other populations warranted
Iler, Obernshain & Camac (2001)	50 chronic obstructive pulmonary disease patients, average age 71 years	Hospital medical/ surgical unit, medium-sized community hospital	Measures: Length of stay in hospital, Beck Anxiety Inventory at admission and discharge. Intervention: chaplains visited treatment group on average 4 times for about 20 minute for prayer or venting of emotions, conflict management	Treatment group stayed for fewer days in the hospital, anxiety scores lower in treatment group at discharge, patients receiving chaplain visits more satisfied with their hospital stay.	Did not identify participants in treatment group who received visits from local clergy, did not compare outcomes for religiously active (40%) vs. not, no delineation of chaplain interventions, no equivalent treatment comparison group	Study showed impact of chaplaincy services in a small, one-person pastoral care department

Appendix Two: Summary of Chaplaincy Studies: Patient Satisfaction and Chaplaincy Outcomes Continued

Table 2: Patient Outcome Studies Continued

Study	Patients	Setting	Measures/Interventions	Findings	Limitations	Notable
Rabow, Dibble, Pantilat & McPhee (2004)	90 heart failure, chronic obstructive pulmonary disease, or terminal cancer outpatients, average age 68 years	One year in clinic with palliative care team with chaplain to provide spiritual and psychological support or clinic without palliative care	Enrollment, 6, 12 months measurement using Rapid Disability Rating Scale, USD Shortness of Breath Scale, Medical Outcomes Study sleep scale, anxiety on Profile of Mood States, Spiritual Well-being Scale, Quality of Life Scale-Cancer Version, Consumer Satisfaction Survey, Advanced Care Planning, medical records, exit interview	Anxiety scores decreased in intervention group, increased in control group; spiritual well-being increased in intervention group, decreased in control group,	Did not identify unique chaplain contribution, did not use equivalent control group,	Number of visits by palliative care team members not measured
Rummans et al. (2006)	103 radiation therapy patients with advanced cancer, average age 59.5 years	Eight, 90 minute structured intervention sessions over 3 weeks led by a psychologist or psychiatrist, accompanied by a nurse, social worker or chaplain, treatment group, care as usual control group	Overall Quality of Life, cognitive, physical, emotional, social and spiritual well-being each measured on an analogue scale 0 to 100, Symptom Distress Scale, Profile of Mood States, Functional Assessment of Chronic Illness Therapy – Spiritual Well-being	Only at week 4 was QOL and Spiritual Well-being higher in intervention group than control group, higher tension/anxiety and confusion/bewilderment on POMS found in control group participants, by five months no significant differences at all between groups.	Did not identify unique chaplain contribution, did not use equivalent control group,	200 page manual given to all intervention participants

Appendix Three: Comparison of Major Quantitative and Qualitative Research Designs or Strategies

Table 1: Quantitative Research Designs

Design or strategy	Defining characteristic	Types of research questions	Type of data	Major advantages	Major limitations
Survey	Participants are asked verbally or in writing to describe their beliefs, attitudes, and practices.	Good for describing chaplains' and patients' attitudes, beliefs, and behaviors (e.g., patients' religious concerns and practices).	Relatively brief, researcher constructed questionnaires	Good for describing the self-reported religious and spiritual characteristics, beliefs, and behaviors of a population.	Relies only on self-report data with all of its potential distortions. Cannot establish causal relationships.
Correlational	The relationship between two or more variables is explored through correlational statistics or causal-comparative methods.	What is the relationship between variables (e.g., what is the relationship between religious crises and various indicators of health outcomes)?	Quantitative patient and outcome measures	Good for exploring associations among religious and health variables when experimental manipulation of variables is not possible.	Cannot establish causal relationships.
Single subject	Study one patient at a time. Take repeated outcome and process measurements over the course of treatment.	Did a specific spiritual (chaplains) intervention work? What components of the chaplain's approach were most effective? What spiritual interventions or processes were associated with what health outcomes?	Quantitative patient, process, and outcome measures and/or ratings from trained judges	High ecological validity. Feasible for chaplains to use in clinical settings. Can demonstrate treatment effects of chaplain interventions and isolate the effects of specific spiritual components of treatment.	Limited external and internal validity unless the design is repeated many times with many patients and chaplains.
Discovery-oriented or change process	Study significant "change" events in chaplaincy treatment and their immediate and long-term impact on processes and health outcomes.	How did an in-session chaplaincy (spiritual) event or intervention affect the immediate (and long-term) processes and outcomes of treatment?	Quantitative and qualitative process and outcome measures or descriptions of patients and chaplains.	Clinically relevant. Good for understanding important spiritual "change events" in health care treatment.	Limited internal and external validity. Exploratory and descriptive in nature.

Appendix Three: Comparison of Major Quantitative and Qualitative Research Designs or Strategies Continued

Table 1: Quantitative Research Designs Continued

Design or strategy	Defining characteristic	Types of research questions	Type of data	Major advantages	Major limitations
Treatment outcome study (experimental)	Treatment conditions and control groups are used in actual treatment situations. Random assignment to either group is preferred whenever possible.	Are chaplain treatment approaches effective? Which chaplain interventions are most effective with what patients and problems?	Quantitative patient and outcome measures and/or ratings from trained judges	Can demonstrate treatment effects and differences between various chaplaincy treatment approaches and between spiritual and secular approaches.	Difficult to conduct in health care settings: expensive, time-consuming, difficult to control all confounding variables, ethical concerns with using control groups.
Comparative Effectiveness	Different treatment interventions are used to address a specific patient difficulty	Given spiritual struggle, which intervention helps reduce the experience of spiritual struggle?	Quantitative patient, process, and outcome measures	Clinically relevant	Difficult to conduct, requires large numbers of participants
Community-Based Participatory Research	Participants work with investigators to identify important issues in need of treatment	Dialysis patients work with investigators to identify important spiritual issues and suggest ways to address them, investigators design responsive interventions	Qualitative, quantitative patient, process and outcome measures	Clinically relevant	Difficult to conduct, requires large numbers of participants willing to be part of research process

Adapted from Richards and Bergin (2005).

Appendix Three: Comparison of Major Quantitative and Qualitative Research Designs or Strategies Continued

Table 2: Qualitative Research Designs

Design or strategy	Defining characteristic	Types of research questions	Type of data	Major advantages	Major limitations
Phenomenology	Studies the meaning of patients' experiences	Meaning questions (e.g., the meaning of clients' spiritual experiences and impact on coping with health problems)	Audio taped or videotaped conversations; written anecdotes of personal experiences	Can give insight into the meaning that patients give to their illness and to spiritually healing experiences in chaplaincy care.	Limited generalizability
Ethnography	Studies patients' values, beliefs, and cultural practices	Descriptive questions about the values, beliefs, practices of cultural group (e.g., patients' spiritual beliefs, values, and practices and their role in coping with illness and medical treatment.)	Unstructured interviews; participant observation; field notes	Can provide rich, detailed description and insight into the religious and spiritual values, beliefs, and practices of patients, chaplains, and health care communities.	Limited generalizability
Grounded theory	Studies patients' experiences over time	Process questions that ask about experiences over time (e.g., how do patients change spiritually during illness and medical and chaplaincy treatment?)	Interviews (audio or video recorded); participant observation; memos, diaries	Can provide rich, detailed description and insight into the emotional, religious and spiritual changes that patients experience during the course of medical and chaplaincy care.	Limited generalizability, amount of change is not quantifiable

Appendix Three : Comparison of Major Quantitative and Qualitative Research Designs or Strategies Continued

Table 2: Qualitative Research Designs Continued

Design or strategy	Defining characteristic	Types of research questions	Type of data	Major advantages	Major limitations
Biographical	Documents the history of a patients' life	What can be learned from this person's life (e.g., about the role of religion and spirituality in the patient's functioning, growth, and healing)?	Letters, journals, memoirs, documents, and interviews	Can provide rich insight into how religious and spiritual beliefs and practices affect emotional functioning, social relationships, and physical and spiritual coping and healing.	May be difficult to establish the factual status of the materials used. Biases of the biographer can distort the trustworthiness of the account.
Case study	Studies a patient or group	What can be learned from the treatment of this patient (e.g., what role did chaplaincy (spiritual) interventions play in his or her healing)?	Clinical observations and recollections, case notes, patient history, patient self-reports, and reports of significant others	Can provide rich insight into patients' religious and spiritual issues, the process and course of treatment, and the perceived effects of specific spiritual chaplaincy interventions.	Limited generalizability. Biases of the therapist can distort the trustworthiness of the report. Outcomes are not objectively measured and documented.

Adapted from Richards and Bergin (2005)

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