OPPORTUNITY FOR CATHOLIC HEALTH CARE

The Evidence-Based Spiritual Care Paradigm

GEORGE FITCHETT, DMin, PhD and ALLISON DELANEY, MA, BCC, PT

Around the world, a new evidence-based paradigm is informing the work of health care chaplains. This is a change from the dominant paradigm for spiritual care in the mid-20th century, shaped by the client-centered model of the psychologist Carl Rogers, which focused on empathic presence and active listening.[1] John Gleason, BCC, in 1998 described an emerging paradigm shift at the beginning of the 21st century to spiritual care as a response to individual need. He pointed to the developing models of spiritual assessment as an indicator of the shift. Gleason's observations were astute.

Now that we are well into the 21st century, however, it appears to us that the emerging paradigm for this period is an evidence-based approach to chaplaincy. Indicators of this are the inclusion of standards and competencies about research by the professional chaplaincy organizations. For example, the National Association of Catholic Chaplains requires chaplains to have the competency to "articulate how primary research and research literature inform the profession of chaplaincy and one's spiritual care practice."[2] The Salzburg Statement of the European Network of Health Care Chaplaincy also reflects this paradigm, saying, "The European health care chaplaincy community actively promotes research as an integral part of chaplaincy activity ... All chaplains must develop their ongoing practice in the light of current research."[3] Surveys of chaplains both in the U.S. and around the world suggest strong support for this new evidence-based paradigm.[4, 5]

EVIDENCE-BASED CHAPLAINCY
There are two central reasons why chaplains should embrace a research-informed or evidence-based approach to our work. The first is that research provides a way to evaluate and improve the quality of our care. It helps us to answer the question, "How do we know the care we are providing is the best care that can be offered?"

In the first journal article to use the term "evidence-based pastoral care," Canadian chaplain-researchers Thomas St. James O'Connor and Elizabeth Meakes made the case for evidence-based chaplaincy, writing, "Evidence from research needs to inform our pastoral care. To remove the evidence from pastoral care can create a ministry that is ineffective or possibly even harmful."[6]

Some chaplains are uncomfortable with the idea of evidence-based practice because they believe it requires a simple-minded application of standardized interventions. This is a misconception. Standard definitions of evidence-based practice, such as that of the American Psychological Association, note that it consists of three things: "The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."[7]

The second reason for adopting a research-informed approach to practice is that it helps us

communicate what we do and the benefits associated with our care. This is reflected in the part of the European Network of Health Care Chaplaincy statement that says, "Sharing research findings will also inform healthcare providers and faith communities of the role and importance of chaplaincy and thus promote chaplaincy services."

Chaplains and the services we provide are not widely understood by the public, by the health care colleagues with whom we work, or by the managers who make decisions about health care resources. Research is an important way to describe the spiritual needs of the patients we serve, the care we provide to address those needs, and the outcomes associated with that care. Using research to communicate these things is especially important when we are addressing health care colleagues and decision-makers.

Up until now, the focus of spiritual care research has been the inpatient setting. For example, observing the distress of intubated patients in the ICU led Chaplain Joel Berning and his colleagues at New York-Presbyterian Hospital to develop and test a communication board to facilitate spiritual care.[8] Deborah Marin, MD, and her colleagues at Mount Sinai in New York tracked the satisfaction of 8,978 inpatients using items from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Press Ganey surveys and found that those patients visited by chaplains were more satisfied with their hospital stay compared with those who were not visited by chaplains.[9] The "Hear My Voice" study led by Chaplain Katherine Piderman and her colleagues at the Mayo Clinic in Minnesota has evaluated a promising chaplain-led intervention for patients with neurologic illnesses.[10, 11] In addition to these studies, a robust body of chaplaincy case study research is developing.[12]

CHANGING FOCUS
Although spiritual care and spiritual care research focused on the inpatient context is and will remain important, the focus of health care is changing, and spiritual care must change with it. A comprehensive analysis of the U.S. health care system highlights the shift from inpatient care to the outpatient setting and an increase in chronic disease management with a concurrent increase in unpaid informal caregiving.[13] There is a heightened awareness that, in addition to quality medical services, social determinants of health such as education, income, housing and social support play a very large role in health.[14] A case also has been made that religion and spirituality are among those social determinants, albeit frequently unrecognized.[15]

In the past decade, population health — with its Triple Aim of improving the health of a population, improving the quality of care and outcomes for individuals, and reducing the cost of care — has become the framework for shaping efforts to address the challenges of health care cost, delivery and accessibility. It has given birth to accountable care organizations, risk stratification methods, patient registries, patient-centered medical homes and other models of team-based care. The focus is on helping people to stay well and live to their fullest in the context of chronic illness. This is the new context in which spiritual care must find its place.

While it is clear that population health will be central for the future of health care, it is unclear what spiritual care should look like in the context of population health. Although there is no model

> **While it is clear that population health will be central for the future of health care, it is unclear what spiritual care should look like in the context of population health.**

for spiritual care in this context, one important element to consider is addressing the spiritual needs of people living with chronic illness. For illustrative purposes, we will focus on people living with congestive heart failure, a good example, in part, because it is widely prevalent, with approximately 5.7 million adults in the United States living with that condition.[16]

Congestive heart failure is a major contributor to adult mortality, with 1 in 9 deaths in 2009 including heart failure as a contributing cause,[17] and it costs the nation an estimated $33.7 billion each year, including the cost of health care ser-

vices, medications to treat heart failure, missed days of work and informal caregiving. [18, 19]

A modest body of research has examined religious and spiritual issues associated with living with congestive heart failure. Two findings from that research are important: The first is about religious/spiritual struggle, which often is measured with a scale whose items include, "Wondered whether God had abandoned me" and "Wondered what I did for God to punish me."[20]

RELIGIOUS AND SPIRITUAL STRUGGLE
Three studies have examined religious/spiritual struggle in people with congestive heart failure, and they find a consistent pattern of greater emotional distress, poorer physical functioning, poorer adherence to important health behavior (not smoking, for example) and more hospital days among those with higher scores for religious/spiritual struggle. [21, 22, 23] The second finding focused on feelings of inner peace. In a sample of nearly 200 patients with moderate to severe congestive heart failure, investigators examined the association between responses to an item about inner peace ("I feel deep inner peace or harmony") and five-year survival. In models that adjusted for other factors associated with survival (age, severity of heart failure, depression, health behavior), compared to patients who reported feeling inner peace never, almost never, or on some days, those who reported feeling inner peace on most days or many times a day had a 20 percent increased likelihood of survival. [24]

Further research, including qualitative and case study research, is needed to better understand religious/spiritual struggle and lack of inner peace in patients with congestive heart failure. Meanwhile, we would argue that the existing studies point to several directions for spiritual care for these patients. Specifically, we suggest that protocols developed to screen for patients with potential religious/spiritual struggle[25] be employed in congestive heart failure clinics and that screening also include the measure of inner peace used by Crystal L. Park, PhD, and colleagues.[26] Patients whose responses suggest religious/spiritual struggle or low levels of inner peace could then be referred to a chaplain for more in-depth spiritual assessment and spiritual care as indicated.

The spiritual care offered to these patients should address religious/spiritual struggle and help patients develop inner peace. While one study has shown that chaplaincy care lowered religious/spiritual struggle for cardiac surgery patients,[27] additional research should be used to inform the development and testing of best practices in chaplains' care for these concerns.

In addition to individual spiritual care, group interventions and telechaplaincy should be developed and tested. In light of the existing research, reducing religious/spiritual struggle and increasing inner peace for patients living with congestive heart failure may have the potential to increase their adherence to recommended health behavior, increase their emotional well-being and quality of life, reduce their hospitalizations and increase the likelihood of their survival.

NEED FOR RESOURCES AND LEADERSHIP
This research and associated clinical initiatives will require both leadership and resources. Catholic health care historically has been a strong advocate for spiritual care as a central component of health care. A pastoral letter of the American Catholic bishops published in 1981 by the United States Catholic Conference stated, "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."[28]

However, despite its impressive commitment to spiritual care, Catholic health care has not been at the forefront of developing an evidence-based

> **Catholic health care historically has been a strong advocate for spiritual care as a central component of health care.**

approach to spiritual care. Now there is an opportunity to continue the healing ministry of Jesus in the context of population health to those living with congestive heart failure and other chronic illnesses, which often are disproportionately burdensome to the poor. The Catholic Health Asso-

ciation's commitment to "promote and defend human dignity; attend to the whole person; and care for poor and vulnerable persons"[29] can be fulfilled, in part, by learning from patients, caregivers and communities through research how to better steward our resources to support them. As the largest nonprofit health care provider in the United States — caring for 1 out of every 6 patients each day and with 109 million outpatient visits per year,[30] — Catholic health care is well equipped to lead the development of evidence-based spiritual care beyond the inpatient setting to the outpatient clinics and homes where those suffering from chronic illnesses reside. In our changing health care landscape, now is the time for advancing an evidence-based approach to spiritual care.

GEORGE FITCHETT is a professor and director of research in the Department of Religion, Health and Human Values at Rush University Medical Center in Chicago. He also co-directs the Transforming Chaplaincy project (www.transform chaplaincy.org).

ALLISON DELANEY is a board-certified chaplain and Transforming Chaplaincy Research Fellow. As part of her fellowship, she is completing a master of public health degree at Virginia Commonwealth University, Richmond, Virginia.

NOTES
1. John J. Gleason, "An Emerging Paradigm in Professional Chaplaincy," *Chaplaincy Today* 14, no. 2 (1998): 9-14.
2. National Association of Catholic Chaplains, "Certification Competencies and Procedures." www.nacc.org/certification/nacc-certification-competencies-and-procedures/.
3. European Network of Healthcare Chaplaincy, "The European Network of Healthcare Chaplaincy Statement — Healthcare Chaplaincy in the Midst of Transition." http://enhcc.eu/2014_salzburg_statement.pdf.
4. George Fitchett et al., "Evidence-Based Chaplaincy Care: Attitudes and Practices in Diverse Healthcare Chaplain Samples," *Journal of Health Care Chaplaincy* 20, no. 4 (2014): 144-60.
5. Austyn Snowden et al., "International Study of Chaplains' Attitudes about Research," *Journal of Health Care Chaplaincy* 23, no. 1 (2017): 34-43.
6. Thomas St. James O'Connor and Elizabeth Meakes,

"Hope in the Midst of Challenge: Evidence-Based Pastoral Care," *Journal of Pastoral Care* 52, no. 4 (1998): 359-67.
7. APA Presidential Task Force on Evidence-Based Practice, "Evidence-Based Practice in Psychology," *American Psychologist* 61, no. 4 (2006): 271-85.
8. Joel N. Berning, et al., "A Novel Picture Guide to Improve Spiritual Care and Reduce Anxiety in Mechanically Ventilated Adults in the Intensive Care Unit," *Annals of the American Thoracic Society* 13, no. 8 (2016): 1333-42.
9. Deborah B. Marin et al., "Relationship between Chaplain Visits and Patient Satisfaction," *Journal of Health Care Chaplaincy* 21, no. 1 (2015): 14-24.
10. Katherine M. Piderman et al., "The Feasibility and Educational Value of 'Hear My Voice,' a Chaplain-Led Spiritual Life Review Process for Patients with Brain Cancers and Progressive Neurologic Conditions," *Journal of Cancer Education* 30, no. 2 (2015): 209-12.
11. Katherine M. Piderman et al., "I'm Still Me: Inspiration and Instruction from Individuals with Brain Cancer," *Journal of Health Care Chaplaincy* 23, no. 1 (2017): 15-33.
12. George Fitchett and Steve Nolan, eds., *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy* (London: Jessica Kingsley Publishers, 2015).
13. Thomas Rice et al., eds., "United States of America: Health System Review," *Health Systems in Transition* 15, no. 3 (2013): 1-431. www.euro.who.int/__data/assets/pdf_file/0019/215155/HiT-United-States-of-America.pdf.
14. Bruce G. Link and Jo Phelan, "Social Conditions as Fundamental Causes of Disease," *Journal of Health and Social Behavior* 35 (1995): 80-94.
15. Ellen L. Idler, "Religion: The Invisible Social Determinant," in *Religion as a Social Determinant of Public Health*, ed. Ellen L. Idler (New York: Oxford University Press, 2014) 1-23.
16. Dariush Mozzafarian et al., "Heart Disease and Stroke Statistics — 2016 Update: A Report from the American Heart Association," *Circulation* 133 (2015): e38-e360.
17. Dariush Mozzafarian et al., "Heart Disease and Stroke Statistics — 2016 Update."
18. Paul A. Heidenreich et al., "Forecasting the Future of Cardiovascular Disease in the United States: A Policy Statement from the American Heart Association," *Circulation* 123, no. 8 (2011): 933-44.
19. Heesoo Joo et al., "Cost of Informal Caregiving for Patients with Heart Failure," *American Heart Journal* 169, no. 1 (2015): 142-48.
20. Kenneth I. Pargament et al., "Patterns of Positive

and Negative Religious Coping with Major Life Stressors," *Journal for the Scientific Study of Religion* 37, no. 4 (1998): 710-24.

21. George Fitchett et al., "Religious Struggle: Prevalence, Correlates and Mental Health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients," *International Journal of Psychiatry in Medicine* 34, no. 2 (2004): 179-96.

22. Crystal L. Park et al., "Religiousness and Treatment Adherence in Congestive Heart Failure Patients," *Journal of Religion, Spirituality & Aging* 20, no. 4 (2008): 249-66.

23. Crystal L. Park, Jennifer H. Wortmann and Donald Edmondson, "Religious Struggle as a Predictor of Subsequent Mental and Physical Well-Being in Advanced Heart Failure Patients," *Journal of Behavioral Medicine* 34, no. 6 (2011): 426-36.

24. Crystal L. Park et al., "Spiritual Peace Predicts 5-year Mortality in Congestive Heart Failure Patients," *Health Psychology* 35, no. 3 (2016): 203-10.

25. Stephen D.W. King et al., "Determining Best Methods to Screen for Religious/Spiritual Distress," *Supportive Care in Cancer* 25, no. 2 (2017): 471-79.

26. Crystal L. Park et al., "Spiritual Peace Predicts."

27. Paul S. Bay et al., "The Effect of Pastoral Care Services on Anxiety, Depression, Hope, Religious Coping, and Religious Problem-Solving Styles: A Randomized Controlled Study," *Journal of Religion and Health* 47, no. 1 (2008): 57-69.

28. United States Catholic Conference, "Health and Healthcare: A Pastoral Letter of the American Catholic Bishops," Nov. 19, 1981.

29. Catholic Health Association of the United States, "Catholic Identity Overview." www.chausa.org/catholicidentity/overview.

30. Catholic Health Association of the United States, "2018: U.S. Catholic Health Care." www.chausa.org/docs/default-source/default-document-library/cha_2018_miniprofile7aa087f4dff26ff58685ff00005b1bf3.pdf?sfvrsn=2.

QUESTIONS FOR DISCUSSION

Authors George Fitchett and Allison DeLaney endorse an evidence-based approach to pastoral care. They argue that research is one of the best ways to describe the spiritual needs of patients, the care chaplains provide to address those needs and the outcomes related to that care.

- Research, charting and assessment are necessary elements of an evidence-based approach. How willing and how able is your ministry to invest the time and resources in pursuing an evidence-based approach? How is this related to patient and employee satisfaction?

- Improving the quality of pastoral care in the context of population health is particularly important to Fitchett and DeLaney. How does their example of congestive heart failure as a major chronic disease make the case for how evidence-based pastoral care could contribute to improved outcomes?

- The authors suggest that religion/spirituality could be considered a social determinant of health. Do you agree? Discuss how spiritual care focused on reducing religious/spiritual struggles and developing inner peace in patients fits into a population health framework.

HEALTH PROGRESS ®