Screening for Spiritual Struggle

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A growing body of research documents the harmful effects of religious or spiritual struggle among patients with a wide variety of diagnoses. We developed a brief screening protocol for use in identifying patients who may be experiencing religious/spiritual struggle, as well as patients who would like a visit from a chaplain. We describe the results of a pilot study in which non-chaplain healthcare colleagues administered the screening protocol to patients admitted to an acute medical rehabilitation unit. The protocol identified 7% of the patients as possibly experiencing religious/spiritual struggle. Follow up spiritual assessments by the chaplain confirmed religious/spiritual struggle in all but one of these patients and also identified additional cases of religious/spiritual struggled not identified by the protocol. In addition to areas for future research, the authors describe how using a protocol to screen patients for religious/spiritual can make important contributions to spiritual care.

Recently, an older patient with Parkinson's Disease tearfully said to one of our chaplains, "My sister died six months ago. Why did God take her and leave me? I have done everything I'm supposed to do, but this disease. . ." Several years ago another of our chaplains heard these words from a middle age woman with advanced cancer, "Why? Why me? I just can't figure it out. And I get so depressed that I just want to give up on life altogether, you know? And I'm so very angry at God. So angry. I refuse to speak to Him. You know what I mean?" (Massey, Fitchett, & Roberts, 2004).

Painful laments, expressions of religious or spiritual struggle, such as these, are familiar to chaplains. What may be less familiar is a body of research that has developed in recent years documenting the harmful effects of such religious or spiritual struggle. Key features of religious/spiritual struggle, as measured in many of these studies, include feeling angry with God, or abandoned or punished by God (Pargament, 1997; Pargament, Smith, Koenig, & Perez, 1998). This research has caused us to pay special attention to patients such as the two examples quoted above, whose comments indicate they may be experiencing religious/spiritual struggle.

This research includes a study of 96 medical rehabilitation patients, by Fitchett and colleagues, who reported that higher levels of religious struggle were associated with less recovery of independence in activities of daily living (Fitchett, Rybarczyk, DeMarco, & Nicholas, 1999). In a study of 557 hospitalized, medically ill older patients, Koenig and colleagues found that religious struggle was associated with poorer physical health, worse quality of life, and greater depressive symptoms (Koenig, Pargament, & Nielsen, 1998). In a two-year follow-up of this sample, Pargament and colleagues reported that patients with chronic religious struggle had poorer quality of life, greater depression, and increased

disability (Pargament, Koenig, Tarakeshwar, & Hahn, 2004). This team also examined the effects of religious struggle on mortality among these patients. They found that religious struggle was a significant predictor of increased mortality, even after controlling for demographic, physical health, and mental health factors (Pagament, Koenig, Tarakeshwar, & Hahn, 2001). In a recent study, Fitchett and colleagues found that religious struggle was associated with poorer quality of life and greater emotional distress among patients with diabetes, congestive heart failure, or cancer (Fitchett, et al., 2004). Other research, among both patients and community samples, gives further evidence of the adverse emotional effects of religious or spiritual struggle (Ano & Vascolcelles, 2005; Berg, Fonss, Reed & VandeCreek, 1995; Boscaglia, Clarke, Jobling, & Quinn, 2005; Burker, Evon, Sedway, & Egan, 2005; Exline, Yali, & Lobel, 1999; Exline, Yali, & Sanderson, 2000; Manning-Walsh, 2005; McConnell, Pargament, Ellison, & Flannelly, 2006; Rippentrop, Altmeier, Chen, Found, & Keffala, 2005; Sherman, Simonton, Latif, Spohn, & Tricot, 2005; Taylor, Outlaw, Bernardo, & Roy, 1999).

While the negative effects of religion and spiritual struggle are becoming clearer, it is less clear how best to identify patients who may be experiencing it. In an earlier study, we found that the patients most likely to request a visit from a chaplain were those with more religious resources, not those with higher needs (Fitchett, Meyer, & Burton, 2000). In addition to identifying patients who may be experiencing religious or spiritual struggle, it is important for chaplains to be able to identify patients who would like a visit from a chaplain. These patients may be seeking religious/spiritual support at a vulnerable time and they may be dissatisfied with the hospital if that support is not provided. Some of them may also be experiencing religious/spiritual struggle.

At the risk of some over-simplification, we might think of patients as falling into one of three groups. First, are those who might be experiencing religious or spiritual struggle, but who are unlikely to request a chaplain's visit. Second, are those who would like a visit from a chaplain, who may or may not request one, but who would be dissatisfied if they do not receive one. Finally, there may also be a group for whom religion or spirituality (R/S) is not important and who do not wish or expect a visit from a chaplain. It could potentially assist chaplains' productivity, effectiveness, and perhaps departmental satisfaction scores, if a brief method could be developed for accurately determining which patients fell into which of these three groups. Ideally, in order not to add to the workload of pastoral care departments, which rarely have the personnel to assess all newly admitted patients, such a screening or triage process would be implemented by other members of the health care team, who could then make appropriate referrals to the chaplains based on the results of their screening.

This paper reports on our effort to develop and implement such a screening protocol. The general aim of this project was to evaluate the use of a spiritual screening protocol, by non-chaplain health care staff, to identify and refer patients who may need or desire spiritual care services. The specific aims of the project were:

1. to determine the proportion of new admissions for which the health care staff were able to implement the screening protocol,
2. to determine the proportion of screened patients who might be experiencing spiritual struggle,
3. to compare the identification of potential cases of spiritual struggle made on the basis of the screening protocol with the results of a chaplain's spiritual assessment interview, and,
4. to determine the proportion of screened patients who requested spiritual care services.

The project had two additional aims. The first was to identify barriers, if any, to health care staffs= implementation of the spiritual screening protocol. Additionally, we noted that the most frequent complaint about spiritual care from our patient/family satisfaction surveys was that a request had been made for a chaplain to visit, but no one ever came. We assumed use of the protocol might affect patient/family satisfaction with spiritual care by increasing referrals and follow-up of those patients who wished to see a chaplain. Consequently, the final aim of the study was to examine the effect of use of the

protocol on patient/family satisfaction with spiritual care.

Methods

The Screening Protocol

Several assumptions informed the development of the screening protocol. We assumed that people who were experiencing religious or spiritual struggle would not report that in a brief history-taking interview with someone they did not know well or trust. Thus, screening for spiritual struggle would have to be indirect.

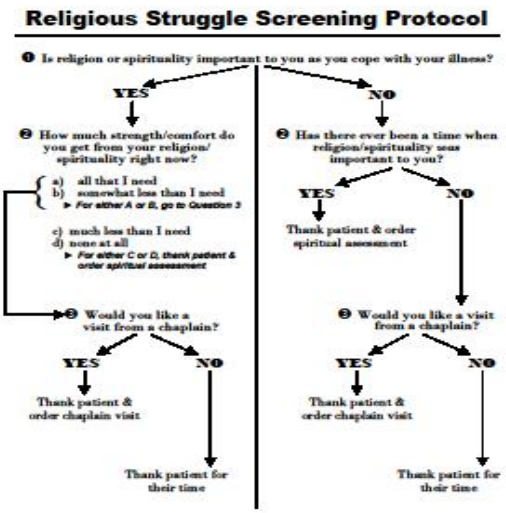

Figure 1

We also assumed that simply asking a patient if religion or spirituality was important might elicit a negative response, "No," that could be misinterpreted as a neutral lack of interest in R/S. Thus, we included a follow-up question for those who reported that R/S was not important, "Was there ever a time when religion/spirituality was important to you?" to identify patients for whom R/S had once been important but who reported it was no longer important. We considered this change a potential red flag for religious/spiritual struggle warranting a more in-depth assessment by a chaplain. We also assumed there could be religious/spiritual struggle among those who reported that R/S was important to them. For those who said R/S was important, we included the follow-up question, "How much strength and comfort would you say that you get from your religion/spirituality right now?" to help identify those who might be getting less strength and comfort from their faith than they felt they needed, another red flag signaling the need for a follow-up chaplain assessment. Finally, we assumed that the protocol questions would have to be simple and brief if busy healthcare colleagues, not trained in spiritual care, would agree to use them routinely.

Figure 1 shows the screening protocol we developed. Based on the patient's responses to these protocol questions, the staff who administered the protocol would take one of three different actions: 1) Screening indicates possible spiritual struggle, refer for in-depth spiritual assessment by chaplain; 2) No indication of spiritual struggle, however, chaplain visit requested, refer for routine spiritual care, which may uncover religious/spiritual struggle; or 3) No indication of religious struggle, no chaplain visit requested, no further action needed.

Protocol Administration

Our pilot study of the use of the screening protocol had three phases, with different health care colleagues administering the protocol in each phase. In Phase I, Patient Care Technicians (PCTs, formerly referred to as nursing aides) performed the screening. Problems with PCT turnover and inconsistency in administering the protocol led to Phase II in which medical residents administered the protocol. The problems with inconsistency in administering the protocol were worse with the residents than with the PCTs. This led to Phase III in which colleagues in the Department of Behavioral Sciences (psychology interns and staff psychologists) agreed to administer the protocol as part of their assessment of all new admissions to the study unit. We provided initial training, and follow-up consultation regarding any questions, to all the staff who administered the protocol. The three phases of the study had different durations, from two to four months.

The protocol was intended to be administered on the day of the patient=s admission. In some cases it was administered on the second day. During Phase I, the PCTs gave unit clerks a sheet indicating the action required. The clerks entered this information into the computer which sent the appropriate orders for chaplain follow up. In Phase II, the protocol was added to the medical residents' computerized physician orders which sent the appropriate orders for chaplain follow-up. During Phase III, the psychology interns and staff kept a centralized log of the results of the screening. The log was checked daily by one of the chaplains who provided the appropriate follow-up.

Where the results of the screening indicated possible spiritual struggle, the unit chaplain (JLR), who is board certified by the Association of Professional Chaplains, made a follow-up visit, usually by the following day, to conduct an in-depth spiritual assessment. This assessment was designed to determine if the patient was experiencing spiritual struggle and, if indicated, to provide follow-up spiritual care that addressed that struggle. The chaplain used his professional judgment to determine the presence of spiritual struggle. Indicators that informed his judgment included the patient=s painful expression of feeling abandoned by God, punished by God, or angry with God.

Study Sample

We tested the screening protocol on an 18 bed acute medical rehabilitation unit at Rush University Medical Center in Chicago. Patients on this unit were admitted for rehabilitation related to amputation, neurological disease, stroke, deconditioning, and orthopedic surgeries, including spine surgery and joint replacements. Lengths of stay varied from a few days to several weeks.

Analysis

We recorded all patients admitted to the study unit during the months in which the protocol was being administered. We recorded the category in which they were placed by the screening protocol. We also recorded the results from any chaplain=s visit, either from follow-up visits where the protocol indicated possible spiritual struggle, or from visits in response to requests for routine spiritual care. Finally, we compared the responses to three questions about emotional and spiritual care from the patient/family satisfaction surveys for the twelve months prior to the study and the thirteen months of the pilot study.

This project was reviewed by the institutional review board of Rush University Medical Center. Because it was a study of a departmental quality improvement project involving minimal risk, it was determined that written informed consent was not required from the patients who were involved.

Results

The main findings from the study are reported in Table 1. From the table it can be seen that the psychology residents were the most consistent in administering the protocol (screened 79% of all new admissions) and the medical residents were the least consistent (screened 22% of all new admissions). In the two phases where there was reasonable consistency in protocol administration, Phases I and III, the protocol questions identified 12 patients, 7% of those actually screened in those two phases, as potentially experiencing spiritual struggle. The chaplain's follow-up assessments confirmed spiritual struggle in 11 of these 12 cases (92%). In both those phases, among those not identified as having potential spiritual struggle, approximately two-thirds of the patients requested a chaplain visit and/or communion.

Table 1. Results from Spiritual Struggle Screening Protocol

		Cases of Spiritual	Cases of Spiritual	Other Spiritual Care Requests	
Screening Administered By	Number (%) of New Admissions Screened	Struggle Identified by Screening	Struggle Confirmed by Chaplain Assessment	Request Chaplain Visit	Request Communion
PCT	78/159 (49%)	4/78 (5%)	4/4 (100%)	51/78 (65%)	22/78 (28%)
Medical Resident	10/46 (22%)	0/10 (0%)	N/A	2/10 (20%)	0

Psychology Staff	85/108 (79%)	8/85 (9%)	7/8 (88%)	52/85 (61%)	8/85 (9%)

PCT = Patient Care Technician

During and after each phase of the study we conducted interviews with the staff who were administering the screening protocol. In those interviews we asked about barriers to administering the protocol. In Phase I, the PCTs reported feeling overwhelmed by other tasks and unable to administer the protocol because of time constraints. From the interviews with them, it appeared the PCTs sometimes misunderstood and failed to correctly follow the protocol. In Phase II, the turnover of the medical residents made consistency in following the protocol very difficult. The resident's heavy work load was a barrier as was their lack of training about the importance of spiritual struggle. In Phase III, we heard reports from the psychology interns and staff that they sometimes diverged from the protocol questions and inferred patient's level of spiritual struggle from other information obtained in their interviews.

Three questions about emotional and spiritual care are included in the Medical Center's patient/family satisfaction survey; 1) "Staff addressed emotional needs," 2) "Staff addressed spiritual needs," 3) "Satisfaction with the Chaplain." Table 2 shows the proportion of patients and families who gave responses of "good" or "very good" to these questions in the twelve month period prior to the pilot study and the thirteen month period after the start of the pilot study. As can be seen from the table, there was little change in satisfaction scores for the questions about emotional needs and about satisfaction with the chaplain. In contrast, there was a 17% increase in the proportion of "good" or "very good" responses for the question about staff addressing spiritual needs, a change that was, statistically, marginally significant (2-sided Fisher=s Exact Test, p = 0.06). An alternative perspective is that there was a notable decrease in the proportion of responses of "very poor," "poor," or "fair" for this survey item, from 21% in the preceding year, to 4% in the thirteen months after the protocol was initiated.

Table 2. Patient/Family Satisfaction Scores Before and During Pilot Study

	Responses of "Good" or "Very Good"*	
Survey Item	Before Pilot Study (Jan 2004-Dec 2005)	During and After Pilot Study (Jan 2006-Jan 2007)
Staff addressed emotional needs	87/100 (87%)	27/29 (93%)
Staff addressed spiritual needs**	56/71 (79%)	25/25 (96%)
Satisfaction with the Chaplain	64/69 (93%)	20/22 (91%)

*The balance of the responses were "Very Poor," "Poor," or "Fair."

**Difference in responses marginally significant (2-sided Fisher's Exact Test, p=0.06).

Discussion

While we had some difficulty finding staff colleagues who could administer the screening protocol

consistently, when it was administered to patients on this medical rehabilitation unit 7% of those screened were identified as having potential spiritual struggle. Follow-up spiritual assessment visits by the unit chaplain confirmed the presence of spiritual struggle in all but one of these cases. In the technical language of screening, the protocol demonstrated a positive predictive value of 92%; the use of the protocol by the staff led to identification of only one false positive case of spiritual struggle.

During Phase II, when it became apparent that there was little consistency in the medical residents= administration of the protocol, the unit chaplain made rounds to newly admitted patients and administered the screening protocol to 36 of 46 new admissions (78%) not screened by the residents. Of the 36 patients screened, based on the protocol, four (11%) were identified as possibly experiencing spiritual struggle. Spiritual assessment interviews with those four patients confirmed they were experiencing spiritual struggle.

Also, in Phase II, during the course of his rounds with other patients on the unit, the chaplain discovered two patients who were experiencing spiritual struggle who had not been identified as such via the use of the protocol, that is, two cases who were false negatives. The chaplain identified other false negative cases, five each in Phases I and III of the study. These were patients who had requested a chaplain visit, and in response to the protocol question had reported they were receiving "somewhat less" strength and comfort than they needed right now from their R/S. When he visited them, the chaplain assessed they were experiencing religious/spiritual struggle that was understated by their choice of the response "somewhat less."

How does the proportion of patients identified by the protocol as potentially experiencing religious/spiritual struggle compare with published reports of the prevalence of religious/spiritual struggle? In our study of 96 medical rehabilitation patients, we found 12% had high levels of religious struggle (Fitchett, et al., 1999). In their study of the 239 older medical patients, Pargament and colleagues reported 26% had at least some positive response to one of seven questions about religious struggle at baseline and two years later (Pargament, et al., 2004). In our study of a mixed group of 238 medical in- and out-patients, we found 15% had moderate or high levels of religious struggle (Fitchett, et al., 2004). Based on these reports, the 7% of medical rehabilitation patients identified in this pilot study, via the protocol, as potentially having spiritual struggle is quite low. This suggests that the protocol is not identifying all the potential cases of spiritual struggle, that it yields a number of false negatives. It is also possible that among medical rehabilitation patients, for example hip or knee joint replacement patients, there are many for whom the outlook is generally positive and the likelihood of spiritual struggle is low.

Our observations about the barriers that created inconsistency in the staffs' administration of our screening protocol were similar to those that have been reported by others, including lack of time, lack of training, discomfort with the topic, and role concerns (Ellis, Vinson, & Ewigman, 1999; Kristeller, Rhodes, Crippe, & Sheets, 2005; Taylor, 2002). Kristeller and colleagues designed a project that provided oncologists with a protocol for inquiring about their patient's spirituality. They found that having a detailed protocol and training, including role-playing, led to high levels of physician comfort in using the protocol. Use of the protocol also did not prolong the patient visit. Better training may have helped overcome some of the barriers to nurses or physicians consistently administering our screening protocol.

We observed a different issue in our conversations with the psychology interns and staff who administered the protocol in Phase III. Being tied to the exact words of the protocol felt limiting to them and they sometimes inferred whether patients were experiencing religious/spiritual struggle based on other comments made during the interview. They also felt it might compromise the patient's trust in them if, in cases where patients described religious or spiritual struggle, they did not get the patient=s permission to make a referral to the chaplain.

Regarding the effects of implementing the screening protocol on patient/family satisfaction, we consider the results presented here to be preliminary. We compared satisfaction scores from the year prior

to the implementation of the protocol with those from the thirteen months beginning with the start of Phase I. However, between Phase I and II, there was a three month gap with no administration of the protocol, and over all three phases, the protocol was administered to only 55% of the newly admitted patients. A more precise evaluation of the impact of the protocol on patient/family satisfaction would compare the satisfaction of those to whom the protocol was administered and those to whom it was not. In light of this, we have reserved comment about the fact that satisfaction scores were higher on only one of the three questions during the year after we began administering the protocol.

Three levels of inquiry about patient's R/S needs and resources have been described: spiritual screening, spiritual history-taking, and spiritual assessment (Massey, et al., 2004). Few acute care hospitals have sufficient chaplaincy staff to implement spiritual history-taking or in-depth spiritual assessment for all newly admitted patients. The two-step model described here with, 1) spiritual screening by non-chaplain staff, followed-up by 2) in-depth spiritual assessment by the chaplain, where indicated by the screening, appears to be a good way to make use of limited chaplaincy personnel. It has also been recommended for nurses (Taylor, 2002).

We wish to note that this is not the first screening protocol developed by chaplains to be published, nor is it the only one to focus on religious/spiritual struggle. A partial list of other models includes articles describing two other screening models (Hodges, 1999; Wakefield, Cox, & Forrest, 1999) that appeared in a Symposium, "Screening for Spiritual Risk" in *Chaplaincy Today*, the Journal of the Association of Professional Chaplains (Volume15, Number 1, 1999). Prior to that, Paul Derrickson described using trained volunteers and beginning pastoral care students to visit newly admitted patients and make referrals where indicated (Derrickson, 1994-1995). Greg Stoddard wrote about training staff to identify patients in spiritual distress (1993). Martin Montonye (1994-1995) described the development of a form nursing staff could use to communicate patients' descriptions of their religious/spiritual needs. George Handzo described a two-level, interdisciplinary model of screening cancer patients for distress, including spiritual distress (1998). What is unique about the present report is the more complete documentation of the results from implementing the protocol.

The 1999 *Chaplaincy Today* Symposium also included an article describing six instruments that could be used to screen for what was then called spiritual risk (Fitchett, 1999B). Among those was Gary Berg=s eight-item Spiritual Injury Scale, first presented as part of his computerized spiritual assessment and used in many VA hospitals (Berg, 1994, 1999). Several other instruments described in that paper, including the Brief RCOPE, developed by Kenneth Pargament and colleagues (1998), the Index of Religiosity (Idler, 1987), and the FACIT-Sp (Peterman, Fitchett, Brady, Hernandez, & Cella, 2002), were developed for research purposes. We think that, although they are sometimes confused (O'Conner, et al., 2005), spiritual screening and spiritual assessment are clinical activities that are distinct from research. In light of the useful screening protocols that have been published, including the present one, we no longer recommend the research instruments described in the 1999 *Chaplaincy Today* Symposium (Fitchett, 1999B) as useful tools for clinical practice.

In addition to those previously mentioned, several limitations of the present study should be kept in mind. Our estimate of those who were screened in each phase of the study does not take into account patients who, because of confusion, dementia, or other conditions, could not be screened. We do not know how many such patients there were in each phase. By not collecting that information we have underestimated the proportion of cognitively-able, newly admitted patients, who were screened.

The chaplain's in-depth spiritual assessment of patients who were identified, by the protocol, as having religious/spiritual struggle permits us to estimate the false positives that come from this screening. But because the chaplain did not visit and assess all the newly admitted patients during each phase, we cannot estimate the proportion of false negatives that might be associated with the protocol. As discussed above, we are sure there are some, that is patients who were experiencing religious/spiritual struggle who

were not identified as such by their responses to the protocol questions. A future study should include both the screening protocol and an in-depth spiritual assessment interview to permit a more thorough evaluation of the protocol. Finally, we are aware that this pilot project only tested the protocol on one medical rehabilitation unit. We have no information on how useful the protocol would be in contexts of greater patient acuity, such as intensive care units, or shorter lengths of stay.

Future research regarding the screening protocol includes, as previously mentioned, comparing it to a chaplain's in-depth spiritual assessment for every patient, as well as testing its usefulness among more diverse groups of patients. In addition, we would like to know more about the staff barriers to administering the protocol, and whether health care colleagues in addition to psychologists could be trained and motivated to administer the protocol consistently. Additionally, we continue to be interested in the many different forms that religious/spiritual struggle might take and in how people cope with it. In the course of this study, experiences with several patients made us especially curious to learn how to identify and assist patients who may be experiencing unacknowledged religious/spiritual struggle.

One colleague suggested that we modify the follow-up question for those who say that R/S is not important to them. The suggestion was to ask "Was there a time before the present illness when religion or spirituality was important to you?" instead of, "Has there ever been a time?" Our colleague felt the change would help keep the focus on religious/spiritual struggle associated with the present illness. Our experience, however, is that some of the struggles we have heard about from our patients were not related to the present illness, and not a small number had their origins in situations that were years old (Bradshaw & Fitchett, 2003). In light of that we feel the present wording of that question works best.

However, in light of this study, we have revised the responses to the question about how much strength and comfort the patient is presently getting from their R/S. A colleague suggested having only three response options for the question would simplify the protocol. Additionally, as discussed earlier, we found a number of patients who had responded, "Somewhat less than I need to this question, whom the chaplain later found to be experiencing religious/spiritual struggle. In the revised version of the protocol we have dropped the response, "Much less than I need," and we now treat responses of either, "Somewhat less than I need," or "None at all" as signs of potential religious/spiritual struggle and indicators of a need for referral to the chaplain for in-depth spiritual assessment.

As we noted at the beginning of this article, there is a growing body of evidence that points to the negative impact of religious/spiritual struggle on quality of life and emotional adjustment to illness. It may also compromise recovery and mortality. In light of this, it is important to be able to quickly identify, and refer for spiritual care, patients who may be experiencing religious/spiritual struggle. The results of this pilot study suggest that our screening protocol is a useful tool for identifying patients who may be experiencing religious/spiritual struggle. It is simple. Staff from other health professions can be taught to implement it. The protocol may miss some patients who are experiencing religious/spiritual struggle, but we only saw one false positive case during the study. In addition, the protocol enables staff to quickly identify patients who wish to receive spiritual care. Consistent referral and spiritual care for those patients may provide them with the spiritual support they desire and insure greater satisfaction with spiritual care services.

In closing, we wish to emphasize three other benefits from using a screening protocol such as the one described here (Fitchett, 1999A). First, using a screening protocol can improve stewardship of the professional chaplain's time. In most departments of spiritual care, there are many pressures on the time of professional chaplains. Chaplains can spend less time in case-finding when health care colleagues use a screening protocol to identify patients who wish to see the chaplain and patients who may need to see the chaplain.

Second, a screening protocol such as this one can be very useful in documenting the need for spiritual care. The protocol can help chaplains document the proportion of patients who request spiritual

care, and the proportion of patients who may need spiritual care. Having information about the proportion of patients in a specific service area who may be experiencing religious/spiritual struggle is like having information about the acuity of R/S needs of those patients. It can provide a rational basis for discussions about the number of staff chaplains that are needed to meet the R/S needs of those patients.

Third, there is strong pressure to provide evidence about the benefits of spiritual care. Because it may be difficult to measure the impact of spiritual care among all patients, chaplains should begin with studies that examine the impact of spiritual care among patients identified as experiencing religious/spiritual struggle. Colleagues in grief counseling faced similar pressure to demonstrate the benefits of their work. It was only when their studies focused on people with evidence of complicated grief that research showed the benefits of their interventions (Parkes, 2001). Similarly, given the evidence of the harmful effects of religious/spiritual struggle, providing spiritual care to patients experiencing religious/spiritual struggle may make a measurable difference in their quality of life, emotional adjustment to illness, and possibly their recovery and survival.

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