

Evidence-Based Spiritual Care: Desirable? Feasible? How Do We Get There?

Spiritual Care Summit 2009 Workshop, Tuesday, February 3, 2009, 2:00-3:30 pm

Description

Is evidence-based spiritual care desirable? Is it feasible? Are there any examples of it? What will it take to make healthcare chaplaincy an evidence-based profession? In this session a panel of leaders in spiritual care research will address the challenges of moving toward evidence-based spiritual care. Each panelist will make a 15 minute presentation. These will be followed by a 10 minute discussion by George Fitchett and 30 minutes of discussion with the audience. Barbara Brumleve, SSND, will be our moderator.

Presentation Outlines

A. Tom St. James O'Connor, ThD, (CAPPE)

1. What is evidence based spiritual care?

It is the judicious use of scientific evidence on spirituality and religion in the spiritual care and therapy of patients/clients. I will present different levels of evidence and discuss the need to critically review available evidence.

2. Is evidence-based spiritual care an oxymoron?

I look at evidence as the result of the search for truth. The job of the chaplain and pastoral counselor is to offer the best service to clients/patients and that means implementing and using the best evidence in spiritual care and therapy. Some believe evidence-based spiritual care is an oxymoron; that scientific research and spiritual care come from two different paradigms and can not meet. I think of it as more of paradox. I will describe Ian Barbour's model of four types of relationships between science and religion.

3. Doing and teaching pastoral research

My journey with evidence based spiritual care and therapy has been mixed. I like it and endorse it knowing that one ought to be searching for good evidence that will help patients/clients. One thing that I have done is to require my CPE students to take a graduate course in research. They are also required to do a literature review on spiritual care and therapy of a population that they work with clinically. Then they are required to put their literature review into a poster and present it at the University, the hospital, a conference and/or to peers. There is huge anxiety over this and some students give up on it but many complete it. Some have won awards from the Society for Pastoral Counselling Research (SPCR) for their posters.

B. Daniel Grossoehme, DMin, BCC, (APC)

1. Feasible and Desirable!

Evidence-based spiritual care is desirable and feasible, but not easy to achieve. The lack of demonstrated outcomes leads other health care team members to ignore religion/spirituality altogether or reduce it to generic psychological mechanisms that any other discipline can handle. As professionals who work in hospitals and medical centers, like St. Paul in Athens, we need to deliver our message in words our health care colleagues understand. Evidence-based spiritual care is also feasible. There are people who are already doing this work. A key issue is that it needs to be done by the "theologian in residence" on the health care delivery team, not just by psychologists or others.

2. What evidence is out there?

Evidence about spiritual care already exists, but the gaps in this research are huge, especially in

pediatrics. Evidence from three different approaches to spiritual intervention will be mentioned.

3. When is good spiritual care more than being present?

Evidence also points to places for possible spiritual intervention that raise questions for traditional approaches to spiritual care. For example, evidence from over 40 studies links 'negative religious coping' with poorer health outcomes. Demonic attribution is a component of negative religious coping, illustrated by a mother who tells me that the Devil caused her adolescent's Sickle Cell disease because of her [the mother's] lack of devotion. Based on the evidence, do I try to intervene and change this mother's attribution? Especially when it may be the normative theology of her church?

4. How do we help chaplaincy become an evidence-based profession?

Transforming spiritual care into an evidence-based profession will require a major change in our culture. This is not a language we speak, and maybe not one that we value. Only a small proportion of clergy/chaplains have science undergraduate majors. Using models for screening for spiritual risk may be helpful, as would explicit spiritual assessments.

C. Michele LeDoux Sakauri, D.Min., (NACC)

1. "All we need is someone who can listen."

Do chaplains in their interactions make a difference, and if so, is there something that chaplains can point to as pivotal in making the difference? These questions were reinforced for me a number of years ago by a comment a physician colleague made when I was changing jobs. "I heard you're leaving; we'll miss you." As I nodded in gratitude, he continued, "but finding someone to take your place shouldn't be difficult — all we need is someone who can listen."

2. Do chaplains make a difference?

In an attempt to identify if and how chaplains make a difference through their interactions, I conducted a study in 2002. My study used three verbatims to examine the role of the chaplain at the bedside. I invited a group of certified chaplains to analyze these three examples of spiritual care. Specifically, I asked the chaplains to use a 5 point scale to rate the patient's spiritual pain at the beginning and end of the interaction. Five types of spiritual pain were identified: despair, estrangement, grief, anxiety, and abandonment. Seventy-two chaplains, certified for an average of 11 years, completed the study packets. The chaplain-respondents reported overwhelmingly that the spiritual care interactions had a positive impact on the patient or family member's spiritual pain. For instance, for the verbatim with the husband of an elderly patient, who was unconscious and actively dying, 94% of the chaplain-respondents identified despair as a significant issue and on average they reported the chaplain's visit had created a shift toward greater hope of 2.4 points on the 5 point scale.

3. Naming what chaplains do at the bedside

When asked what made these shifts toward healing possible, the chaplain-respondents first lifted up the importance of inviting the story of the other. They affirmed that this invitation, coupled with a listening presence that stays engaged to the story, created a space for healing. Second, they described the chaplain's non-judgmental presence as playing an important part in the healing in each scenario. They also identified additional behaviors that gave the chaplains in the verbatims credibility: openness, honesty, and the ability to risk/be vulnerable. This study affirmed the value of the chaplain at the bedside. Through the use of the verbatim as a tool for inquiry, these chaplain-respondents showed they could critique chaplain interactions, assess spiritual pain, and articulate interventional elements that promoted spiritual healing.