August 2017 Article of the Month

This month's article selection is highlighted by John Ehman,
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Kestenbaum, A., Shields, M., James, J., Hocker, W., Morgan, S., Karve, S., Rabow, M. W. and Dunn, L. B. "**What impact do chaplains have? A pilot study of Spiritual AIM for advanced cancer patients in outpatient palliative care**." *Journal of Pain & Symptom Management* (July 21, 2017): published online ahead of print by the journal.

[***Editor's Note:*** *Because this article is available ahead of print, no final page numbers can be cited. Quotations noted below are referenced by manuscript [MS] page numbers.*]

SUMMARY and COMMENT: Spiritual AIM (Spiritual Assessment & Intervention Model) is a "brief, chaplain-delivered spiritual care intervention" [MS p. 8] that "was developed through 25 years of clinical practice and supervision" [MS p. 4]. Here, a research team that included three chaplains, four physicians and a Social Worker, sought to evaluate its "feasibility and tolerability" and its "impact on...spiritual well-being, religious and cancers-specific coping, and physical and psychological symptoms" [MS p. 3]. The study not only speaks to the potential value of Spiritual AIM and the important process of empirical testing of a spiritual care model but, along the way, also provides insights into a conceptualization of *fatalism* found in the health care literature.

The model is described succinctly:

> Spiritual AIM posits that every human being, by virtue of being human, has three fundamental or "core" spiritual needs: for meaning and direction (referred to in Spiritual AIM "shorthand" as "Meaning and Direction"); for self-worth and belonging to community ("Self-Worth"); and to love and be loved, often facilitated through seeking reconciliation when relationships are broken ("Reconciliation"). Spiritual AIM asserts that in a crisis -- such as facing one's mortality -- one of three core spiritual needs emerges most strongly, influencing the patient's subjective thoughts and feelings as well as affecting their observable words and behaviors. In Spiritual AIM, the chaplain's pastoral encounter requires diagnosing an individual's primary unmet spiritual need, devising and implementing a plan for addressing this need, and evaluating desired and actual outcomes of the intervention. [MS p. 4]

A full explanation has been published elsewhere [--see Related Items of Interest, §I, below].

The three chaplain co-authors conducted the intervention with 31 advanced cancer patients being treated at an outpatient palliative care service of an urban, academic, comprehensive cancer center. Three 45-60 minute

sessions were audiotaped and transcribed: one followed the patient's completion of baseline measures, and two subsequently were conducted either in person or by phone, two to three weeks apart. "All chaplains met weekly with researchers to promote consistency in assessment and interventions" [MS p. 5]. Participants completed eight self-report measures, including the FACIT-Sp-12, Brief RCOPE, and the Mini-Mental Adjustment to Cancer scale (Mini-MAC) with five subscales: Fatalism, Fighting Spirit, Anxious Preoccupation, Helplessness/Hopelessness, and Cognitive Avoidance --also calculated as two higher-order coping constructs, i.e., Adaptive Coping (Fighting Spirit, Cognitive Avoidance, Fatalism) and Maladaptive Coping (Helplessness/Hopelessness, Anxious Preoccupation) [--see MS p. 6].

Among the results:

> On the FACIT-Sp-12, compared to a large sample of adult cancer survivors, our sample scored approximately one standard deviation below the mean on each subscale at baseline. Post-Spiritual AIM, a significant increase was observed only on the Faith subscale of the FACIT-Sp-12.
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> At baseline, mean scores on the Brief RCOPE Positive and Negative religious coping subscales were lower than previously published norms. Post-Spiritual AIM, there was a trend toward an increase (improvement) in Positive religious coping, while no significant change was seen in Negative religious coping.
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> On the Mini-MAC, we found a significant increase on the Fighting Spirit subscale and a trend toward an increase on the Fatalism subscale. When analyzed in terms of Adaptive or Maladaptive Coping, a significant increase (improvement) was observed in Adaptive Coping from baseline to post-Spiritual AIM. [MS pp. 7-8]

Also, participants were assessed as fairly evenly distributed in terms of the Spiritual AIM categories: 11 with the core spiritual need of Meaning and Direction; 11 with the need of Self-Worth; and 9 with the need of Reconciliation. A table of Examples of Assessments, Interventions and Outcomes for Each Core Spiritual Need in Spiritual AIM [MS p. 19] gives a nice picture of how the intervention was used by the chaplains and received by the patients, with illustrative quotes.

The authors conclude: "This study provides preliminary evidence for feasibility and acceptability of Spiritual AIM..." [MS p. 8] and "suggest[s] that Spiritual AIM may hold promise as a brief, chaplain-led spiritual care intervention for patients with serious or life-limiting illnesses" [MS p. 11]. However, what may be as important for chaplain readers as the findings per se is the authors' perceptively critical discussion of their methodology and the challenge of how to capture change in patients receiving such an intervention. Regarding the FACIT-Sp-12 and the Brief RCOPE (which are two of the most popular instruments in the spirituality & health literature), they admit that "...it is difficult to know whether these measures are the most appropriate or sensitive to any impact of the intervention..." but that "[i]t is possible that the FACIT-Sp-12 and the Brief RCOPE, which both have some parallels to Spiritual AIM, are more sensitive to the kinds of effects that Spiritual AIM is hypothesized to exert" [MS p. 9]. Here they venture into the issue of *conceptualizations* behind measures that -- at least in this reader's opinion -- is too often overlooked in the literature. The Discussion section should be instructive to all chaplains contemplating tests of their own interventions.

Of particular interest to chaplain readers may be the discussion of the finding that there was a trend toward an increase on the Fatalism subscale of the Mini-MAC. The authors note: "Importantly, the 'Fatalism' construct of the Mini-MAC may be conceptualized (or even better, relabeled) as gratitude or active surrender, as reflected by the items comprising the scale (e.g., 'I've put myself in the hands of God;' 'I count my blessings;' 'I've had a good life, what's left is a bonus')" [MS p. 10]. [See also, Related Items of Interest, §IV, below, regarding *fatalism*.] There is a cautionary adage that the use of any measure is as much a window on the measure itself as on the thing being measured, and our article's authors engage the spirit of such a caution here very well. They present their findings as a step in a scientific process that builds on "intriguing" [MS p. 10] results and sets the ground for further study. For any chaplain readers who are new to the research literature and who may become impatient with articles that do not conclude with grand claims, this month's article may implicitly champion the value of carefulness. Our authors state: "The unique work of chaplains deserves both careful elucidation and

close examination" [MS p. 8], and the test of their model of spiritual intervention seems a kind of model itself of research-mindedness for chaplaincy.

One final note: our authors write, "Spiritual AIM is one of the few spiritual assessment models that articulates assessments, interventions, and outcomes, and that has been empirically studied" [MS p. 4], and they indicate two endnotes in relation to that statement. Those two citations are for articles by Stefanie Monod, et al., regarding the Spiritual Distress Assessment Tool, and they are pertinent in this regard only as examples of research testing of an assessment model; there is no direct connection between the Spiritual Distress Assessment Tool and Spiritual AIM.

Special Comments to the Network by Laura Bodin Dunn, MD, Professor of Psychiatry and Behavioral Sciences, Stanford University, Stanford, CA:

> As a psychiatrist who, at the time of the study, was working in a Cancer Center, and as an academic and skeptical researcher, the Spiritual AIM project represented a journey, and frankly, something of a revelation. I went from knowing essentially nothing about what chaplains do, to curious about what chaplains do, to fascinated by what chaplains do, to committed to bringing empirical methods to understanding what chaplains do, to curious again about whether what chaplains do can be characterized using our "traditional" methods, in this case quantitative and qualitative research design and analyses. I came away from the project excited, invigorated, and convinced that chaplains can and do bring unique, crucial and potent skills to the care of patients. I also became passionate about telling people -- especially non-chaplains -- about what chaplains do, how they do it, and why it is so important. This pilot study is the first small step on a long and broad path; hopefully this will stimulate others to take up chaplaincy research and investigate the many questions that remain about the nature and impact of chaplains' work.

Suggestions for Use of the Article for Student Discussion:

This somewhat brief article could be especially useful for students who have had some exposure to the research literature and are at the point of contemplating how research might validate and guide chaplaincy interventions. It best would be paired with (or follow a separate reading and discussion of) Shields, M., Kestenbaum, A. and Dunn, L. B., "Spiritual AIM and the work of the chaplain: a model for assessing spiritual needs and outcomes in relationship," *Palliative & Supportive Care* 13, no. 1 (February 2015): 75-89 [--see Related Items of Interest, §I, below]. The group could focus on the present article's Discussion section, which walks the reader through the authors' thinking about how to interpret the findings. Copies of the FACIT-Sp-12, the Brief RCOPE, and/or the Mini MAC could be useful, so that students can see how the data were derived from specific questions on the measures. [See Related Items of Interest, §II and §III, for sources and for a conceptual break-down of the Brief RCOPE.] The group could also muse specifically about how the concept of *fatalism* might be trickier than at first glance. Additionally, the table of Examples of Assessments, Interventions and Outcomes for each Core Spiritual Need in Spiritual AIM could be discussed as real-world illustrations of the intervention in practice. Does this intervention interest students, and why? Finally, how does the article give insight into the difficulty of capturing the effect of a spiritual intervention?

Related Items of Interest:

I. Spiritual AIM was the subject of a workshop at the Second Caring for the Human Spirit Conference (April 20-22, 2015, Orlando, FL), and a slide presentation by three of our featured article's authors is available online from the HealthCare Chaplaincy Network. For a full explanation of the model, see:

> Shields, M., Kestenbaum, A. and Dunn, L. B. "**Spiritual AIM and the work of the chaplain: a model for assessing spiritual needs and outcomes in relationship**." *Palliative and Supportive Care* 13, no. 1 (February 2015): 75-89. [(Abstract:) OBJECTIVE: Distinguishing the unique contributions and roles of chaplains as members of healthcare teams requires the fundamental step of articulating and critically evaluating conceptual models that guide practice. However, there is a paucity of well-described spiritual assessment models. Even fewer of the extant models prescribe interventions and describe desired outcomes corresponding to spiritual assessments. METHOD: This article describes the development, theoretical underpinnings, and key components of one model, called the Spiritual Assessment and Intervention Model (Spiritual AIM). Three cases are presented that illustrate Spiritual AIM in practice. Spiritual AIM was developed over the past 20 years to address the limitations of existing models. The model evolved based in part on observing how different people respond to a health crisis and what kinds of spiritual needs appear to emerge most prominently during a health crisis. RESULTS: Spiritual AIM provides a conceptual framework for the chaplain to diagnose an individual's primary unmet spiritual need, devise and implement a plan for addressing this need through embodiment/relationship, and articulate and evaluate the desired and actual outcome of the intervention. Spiritual AIM's multidisciplinary theory is consistent with the goals of professional chaplaincy training and practice, which emphasize the integration of theology, recognition of interpersonal dynamics, cultural humility and competence, ethics, and theories of human development. SIGNIFICANCE OF RESULTS: Further conceptual and empirical work is needed to systematically refine, evaluate, and disseminate well-articulated spiritual assessment models such as Spiritual AIM. This foundational work is vital to advancing chaplaincy as a theoretically grounded and empirically rigorous healthcare profession.]

II. The FACIT-Sp and Brief RCOPE are two of the most widely used measures in the spirituality & health research literature. For more about the **FACIT-Sp**, see our October 2015 *Newsletter*, which includes a link to facit.org for versions of the questionnaire. And, for more on the **Brief RCOPE**, see Pargament, K., Feuille, M. and Burdzy, D., "The Brief RCOPE: current psychometric status of a short measure of religious coping," *Religions* 2, no. 1 (2011): 51-76; which is an Open Access article. Also, for a tabular summary of the Brief RCOPE's 14 items, pairing religious coping methods and key religious functions, click HERE.

III. The Mini-MAC was developed in 1994 as a 29-item measure, refined from an original 40-item Mental Adjustment to Cancer scale [i.e.: Watson, M., Law, M., Santos, M., Greer, S., Baruch, J. and Bliss, J., "The Mini-MAC: further development of mental adjustment to cancer scale," *Journal of Psychosocial Oncology* 12, no. 3 (1994): 33-46; and Watson, M., Greer, S., Young, Q., Burgess, C. and Robertson, B. F., "Development of a questionnaire measure of adjustment to cancer: the MAC scale," *Psychological Medicine* 18, no. 1 (1988): 203-209; both of which may be slightly difficult to obtain]. Much of the research on the scale and its use has since been done with Greek, Italian, Chinese, and Portuguese populations; but the measure's 29 items are listed (in English) according to the five subscales in:

> Pereira, F. M. and Santos, C. S. "**Initial validation of the Mini-Mental Adjustment to Cancer (Mini-MAC) Scale: study of Portuguese end-of-life cancer patients**." *European Journal of Oncology Nursing* 18, no. 5 (October 2014): 534-539.
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> > See Table 2 [p. 536] especially for the 5-item Fatalism subscale:

- Since my cancer diagnosis, I now realize how precious life is and I'm making the best of it.
- I've put myself in the hands of God.
- I've had a good life. What's left is a bonus.
- At the moment I take one day at a time.
- I count my blessings

IV. Fatalism: Our featured authors question whether certain items in the Mini-MAC should be label as *fatalism* [--see MS p. 10]. The conceptualization of *fatalism* in measures may indeed deserve some rethinking, especially in the context of spirituality & health research. It's possible that some particular items on instruments meant to detect fatalism may not simply indicate a person's sense of an unchangeable destiny and an attitude of passiveness toward medical treatment. Couldn't a cancer patient who agrees with a statement like, "I've put myself in the hands of God" (from the Mini-MAC), be asserting a basic tenet of faith while still working (and praying) for healing? Moreover, even when patients respond to a situation with fatalism as a form of coping, would it necessarily have to be a form of coping that is dysfunctional to their health? Researchers for a 2013 study of Chinese breast cancer survivors have observed, for instance: "Although past studies suggest that cancer patients used a fatalistic attitude as a mode of coping with cancer that was associated with poor psychosocial adjustment, more recent studies' interpretations indicate that fatalism appears to promote healthy behaviors among survivors" [--see p. 237 of Cheng, et al., cited below]. Chaplains may be in a good position to comprehend the intersection of religion/spirituality, health, and what the literature and various instruments have called "fatalism." The following are just a few articles that speak to the complexity of fatalism as a concept in health care research.

Cheng, H., Sit, J. W., Twinn, S. F., Cheng, K. K. and Thorne, S. "**Coping with breast cancer survivorship in Chinese women: the role of fatalism or fatalistic voluntarism**." *Cancer Nursing* 36, no. 3 (May-June 2013): 236-244. [(Abstract:) BACKGROUND: The existing knowledge on fatalism in the field of cancer has arisen largely from the cancer prevention and screening literature. Little is known about the role of fatalism in cancer survivorship, particularly within Chinese population. OBJECTIVE: This study aimed to explore the role of fatalism in coping with breast cancer survivorship in Chinese women. METHODS: In-depth interviews were conducted on 29 participants selected from those who attended a local cancer self-help organization in China. Interview transcripts were transcribed and analyzed using qualitative content analysis. RESULTS: Although they actively engaged in emotional regulation and self-care management to cope with survivorship, participants believed in fatalism and accepted their inability to change the final outcome of cancer. Such contradictory behavioral and cognitive aspects of coping reported by participants highlighted the role of a complex belief system involving Ming in positively influencing the interpretation of fatalism and the actual coping efforts taken. CONCLUSIONS: Findings suggest that fatalism related to coping in the Chinese context combined 2 elements: fatalistic belief in and acceptance of the way things are as well as the exertion of personal efforts over the situation. As such, it seems more effectively depicted in terms of the emerging concept "fatalistic voluntarism." IMPLICATIONS FOR PRACTICE: When planning intervention for Chinese population, incorporating fatalistic voluntarism as a cognitive belief system in the process of adaptation to survivorship may be more culturally relevant for facilitating their coping behaviors.]

Harandy, T. F., Ghofranipour, F., Montazeri, A., Anoosheh, M., Bazargan, M., Mohammadi, E., Ahmadi, F. and Niknami, S. "**Muslim breast cancer survivor spirituality: coping strategy or health seeking behavior hindrance?**" *Health Care for Women International* 31, no. 1 (January 2010): 88-98. [This Iranian study of 39 breast cancer survivors found that they "strongly attributed their cancer to the will of God" but "at the same time, they reported that they have been actively engaged with their medical treatment and they showed that they are far from passive when

confronting their cancer" [p. 94]. The authors address this apparent consistency in light of cultural contexts and the idea of locus of control.]

Keeley, B., Wright, L. and Condit, C. M. "**Functions of health fatalism: fatalistic talk as face saving, uncertainty management, stress relief and sense making**." *Sociology of Health and Illness* 31, no. 5 (July 2009): 734-747. [(Abstract:) Much research on fatalism assumes that fatalistic statements represent a global outlook that conflicts with belief in the efficacy of health behaviors. Other scholars have suggested a more contextual approach, suggesting that fatalism fulfills personal and social functions. This study analyses 96 in-depth lay interviews in the US, most with low-income members of the general public, about four diseases: heart disease, lung cancer, diabetes and depression. Within these interviews, fatalistic statements always occurred alongside statements endorsing the utility of behaviors for protecting health. This usage pattern suggests that these statements may have useful functions, rather than being simply a repudiation of the utility of health choices. We examine four functions that are suggested by previous researchers or by the participants' comments: stress relief, uncertainty management, sense making and (less strongly) face saving. As these themes indicate, individuals often make fatalistic statements to express an understanding of locally or broadly limiting factors for health efficacy, including genes, spiritual agents, prior behaviours, personality, and other factors.]

Sadati, A. K., Lankarani, K. B., Gharibi, V., Fard, M. E., Ebrahimzadeh, N. and Tahmasebi, S. "**Religion as an empowerment context in the narrative of women with breast cancer**." *Journal of Religion and Health* 54, no. 3 (June 2015): 1068-1079. [This qualitative study out of Iran involved interview with eight breast cancer patients. (From the abstract:) Two main themes discovered in this research were fatalism on the one hand, and the hope and empowerment on the other. Despite the intrinsic conflict between these two concepts, religion, as a specific cultural and epistemological context, reconciles them; in a way, these polar concepts form a unitary structure of meaning and activity. In this structure, semantic coherence and concrete experience leads women with breast cancer to a new meaningful system, which shapes a new path for living well.]

V. Lead author, Allison Kestenbaum (ACPE Certified Educator) noted the Spiritual AIM intervention in a "Reflection on Research" for our Spring-Summer 2013 *Newsletter* (Item #3). For more on Spiritual AIM in the context of chaplains conducting research, see:

Kestenbaum, A., James, J., Morgan, S., Shields, M., Hocker, W., Rabow, M. and Dunn, L. B. "**'Taking your place at the table': an autoethnographic study of chaplains' participation on an interdisciplinary research team**." *BMC Palliative Care* 14 (2015): 20 [electronic journal article designation]. [(Abstract:) BACKGROUND: There are many potential benefits to chaplaincy in transforming into a "research-informed" profession. However little is known or has been documented about the roles of chaplains on research teams and as researchers or about the effects of research engagement on chaplains themselves. This report describes the experience and impact of three chaplains, as well as tensions and challenges that arose, on one particular interdisciplinary team researching a spiritual assessment model in palliative care. Transcripts of our research team meetings, which included the three active chaplain researchers, as well as reflections of all the members of the research team provide the data for this descriptive, qualitative, autoethnographic analysis. METHODS: This autoethnographic project evolved from the parent study, entitled "Spiritual Assessment Intervention Model (AIM) in Outpatient Palliative Care Patients with Advanced Cancer." This project focused on the use of a well-developed model of spiritual care, the Spiritual Assessment and Intervention Model (Spiritual AIM). Transcripts of nine weekly team meetings for the parent study were reviewed. These parent study team meetings were attended by various disciplines and included open dialogue and intensive questions from non-chaplain team members to chaplains about their practices and Spiritual AIM. Individual notes (from reflexive memoing) and other reflections of team members were also reviewed for this report. The primary methodological framework for this paper, autoethnography, was not only used to describe the work

of chaplains as researchers, but also to reflect on the process of researcher identity formation and offer personal insights regarding the challenges accompanying this process. RESULTS: Three major themes emerged from the autoethnographic analytic process: 1) chaplains' unique contributions to the research team; 2) the interplay between the chaplains' active research role and their work identities; and 3) tensions and challenges in being part of an interdisciplinary research team. CONCLUSIONS: Describing the contributions and challenges of one interdisciplinary research team that included chaplains may help inform chaplains about the experience of participating in research. As an autoethnographic study, this work is not meant to offer generalizable results about all chaplains' experiences on research teams. Research teams that are interdisciplinary may mirror the richness and efficacy of clinical interdisciplinary teams. Further work is needed to better characterize both the promise and pitfalls of chaplains' participation on research teams.]
