January 2007 Article of the Month

This month's article selection is by Chaplain John Ehman,
University of Pennsylvania Medical Center-Penn Presbyterian, Philadelphia PA.

Carey, L. B., Newell, C. J. and Rumbold, B. "**Pain control and chaplaincy in Australia**." *Journal of Pain and Symptom Management* 32, no. 6 (December 2006): 589-601.

SUMMARY: This study addresses two questions: "1) Are chaplains involved in assisting with issues regarding pain control? and 2) If chaplains are involved in pain control issues, what is the nature of that involvement?" [p. 593]. The sample is of Australian chaplains, but the research questions are pertinent in general, and the methodology and findings here are valuable for further investigation beyond the Australian context.

The data were collected as part of a larger study [--see Carey, Rumbold, Newell and Aroni in Related Items of Interest, below] during June 1997 to July 2000, from 327 chaplains who returned a mailed survey (response rate of 79.7%) and 100 who participated in taped "in-depth, semi-structured" interviews that "lasted, in most cases, approximately 2 hours" [p. 594]. While this data may be now a bit dated, the combined quantitative-qualitative design provides for a rich assessment of a function of chaplains that has received little attention.

The survey found that "approximately 85% of chaplains believed that 'it was part of the work of a chaplain to help patients and their families cope with physical pain,'" and "57.5% indicated that they had actually been involved...with assisting patients and/or their families with regard to pain control issues"--the latter figure constituted by a positive response of 66% of staff chaplains but only 39.4% of volunteer chaplains [p. 594]. A total of 36.7% of chaplains reported that they had assisted *clinical staff* with patient pain control issues, but this was also much more likely to be the case with staff chaplains than with volunteer chaplains (i.e., 43.5% to 22.9%).

Findings from the qualitative arm of the study--in which 65% of the interviewees "provided in-depth information regarding their experiences with 'pain control' issues" [p. 594]--are largely summed up in the Discussion section:

> Informant data from chaplains revealed considerably unique and important information about the nature of chaplaincy involvement with regard to pain control. At the assessment level, it was possible to identify a common chaplaincy strategy of initially discerning or helping clinical staff to validate the nature of a patient's pain, particularly with regard to nonclinical issues that may be causing or exacerbating the intensity of pain. At the ministry level, the most recurrent theme was that of chaplains providing advocacy, either on behalf of patients, their families, or nurses, concerning inadequate or inappropriate pain control. With regard to their counseling and education role, chaplains sought to help improve patients/families understanding of pain control, so as to empower them to make informed choices. Chaplains also provided counseling or education to

> clinical staff concerning nonmedical strategies or about palliative care to help alleviate patient suffering.
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> One particular pastoral intervention identified by this research but often overlooked in the literature is that of pastoral ritual and worship. Often regarded as a purely "religious" activity at the end of life, the creativity of the chaplains interviewed went well beyond the use of standard liturgical rites of passage. The qualitative data collected revealed that a variety of religious and nonreligious practices were used by chaplains to help patients, families, and clinical staff to endure prolonged periods of patients' physical and nonphysical pain. [p. 596]

One intriguing aspect of the study is the use of what the authors refer to as the "World Health Organization 'Pastoral Intervention' codings (WHO-PI)" [p. 594] in their thematic analysis of the interviews. These codes sort pastoral interventions into four categories: "Pastoral Assessment," "Pastoral Ministry," "Pastoral Counseling or Education," and "Pastoral Ritual or Worship." They are described in a table on p. 595. [NOTE (added 2/2/07 and revised 7/23/10):] The source for these "World Health Organization Pastoral Intervention" codes has been difficult for this reader to track down, as there seems to be no US library holding for the edition of the *International Classification of Diseases* that the authors list in their bibliography (or are in the bibliographies of other articles by Carey, with different co-authors --see Related Items of Interest, below). However, after a good deal of investigation, the source appears to be an *expansion* of the World Health Organization's "International Statistical Classification of Diseases and Related Health Problems" by the National Centre for Classification in Health (NCCH) in Australia, and the pastoral intervention codes in question are in the third volume of a five volume set published by the Faculty of Health Sciences at the University of Sydney and collectively called the ICD-10-AM (i.e., the 10th revision of the Australian Modification of the International Classification of Diseases) --this third volume being specifically titled the *Tabular List of Procedures ICD-10-AM: Australian Classification of Health Interventions (ACHI)*. See sample pages of this third volume from the 2002 third edition of the ICD-10-AM, especially page 281 showing the code for Pastoral Ritual/Worship. It was the 2002 edition that added codes for pastoral care interventions after "the NCCH received a request from the Australian College of Chaplains to include intervention codes on pastoral care for the Third Edition of ICD-10-AM" [--see p. 67 of the NCCH's *ICD-10-AM Third Edition Education*]. In light of this information, the full bibliographic form for the source would seem to be:

> National Centre for Classification in Health. *Tabular List of Procedures ICD-10-AM: Australian Classification of Health Interventions (ACHI)*. Vol. 3 of *The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM)*. Third edition. Sydney: University of Sydney, 2002.

And, as for the pastoral codes themselves, this reader has wondered whether the "WHO-PI" might better be referred to as the "ACHI-PI." However, in a personal communication with the Research Network, Dr. Carey has stated that he believes that the WHO holds the copyright on the material. Definitive clarification is being sought.

The codes can be found in volume 3 of the 2002 third edition on p. 268 (Pastoral Assessment), p. 278 (Pastoral Counseling or Education), p. 281 (Pastoral Ritual/Worship), and p. 296 (Pastoral Ministry), along with a further code on p. 297 for Allied Health Intervention, Pastoral Care. The codes have since continued to be part of the ACHI, in the 2004 fourth edition and the 2006 fifth edition.

The article concludes by lining out a number of questions for future research suggested by the findings:

> "Why do nurses go to chaplains about the practice of doctors?," "Why does it seem to fall to the chaplains to be patient advocates?," "Why are chaplains, who are medical lay people, educating patients and families about pain control?," "Is this the best or safest practice or is it because chaplains are simply filling a void left by other disciples that actually require additional training?" […and] "Should chaplains, who are already part of a system committed to holistic health care, be

more involved in the continuing education of clinical staff?" and "If chaplains are to be more involved, what strategies should be in place to more effectively integrate chaplaincy?" [p. 600]

COMMENT: Speaking from my own professional experience as a chaplain, I regularly receive referrals regarding pain management issues, from nurses, physicians, families, and patients themselves, and I sit on my hospital's Pain Management Committee; so the involvement of chaplains in pain management seems to me to be ripe for research, and the present work by Carey, et al. lays a good foundation for further study. Also, as an aside, I believe that American chaplains would be well served to follow the pastoral care research developments underway in Australia, as illustrated by the present article (and by the fact that one of the institutions with which the authors are connected, La Trobe University, Victoria, offers an innovative degree in degree in Pastoral Care taught from within a health science faculty). This month's article looks at the practical roles of hospital chaplains, with implications beyond the Australian context. The role-based themes of the qualitative data, described on pp. 595-598, show the rich and varied skill set that chaplains bring to an interdisciplinary care team. As pain management becomes an increasing focus in health care (e.g., the recent push in the United States for pain to be monitored as a "fifth vital sign"), the involvement of chaplains in patients' issues of physical pain may become more and more a subject of clinical discussion. Descriptive studies, like the one at hand, need to be replicated and tied especially to questions of how chaplaincy interventions may be clinically effective in reducing patients' needs for pain medication or actually relieving pain when standard pharmacotherapies become ineffective.

Suggestions for the Use of the Article for Discussion in CPE:

The article should be quite readable for CPE students in general, though the brief description of Data Collection on p. 593 may be mystifying to those new to research. The findings are clearly presented, and the use of quotes from the interviews is engaging. There is a longer-than-normal introductory section that establishes the basis for the research, and students may appreciate this background information. Since the study indicates that volunteer chaplains are less involved with pain issues than are staff chaplains, discussion of the article might best occur after students have "settled in" for a few months and begun to assume a staff-like role, and this might be a fine article for a combined staff and student group. The most obvious course for discussion would follow the major themes from the qualitative data, to see how students' experiences may be represented in--or deviate from--the findings. How do students see their role in relation to physical pain management, and how do their theologies affect their perspective on this? Patients in pain can be personally difficult to encounter, so students may want to think not only about what they *could* do for patients but how they may resist the pastoral encounter because of the circumstances. The authors emphasize the importance of "the capacity of chaplains to assist patients and their families to reassess negative or putative theological assumptions" [p. 599] about pain, and this might be a highly productive topic as students grapple with the tension between a desire to follow patients' leads and a desire to challenge "unhealthy" ideas and behaviors.

Related Items of Interest:

Carey, L., Cobb, M. and Equeall, D. "**From 'pastoral contacts' to 'pastoral interventions'**." *Scottish Journal of Healthcare Chaplaincy* 8, no. 2 (October 2005): 14-20. [This article reports research describing chaplaincy activities at two hospitals in the United Kingdom. Its significance for further reading in light of our Article-of-the-Month is that the authors offer a little background to the "World Health Organization Pastoral Intervention codings" (pp. 15-16) *--but see the note about the source for these codings in the Summary section, above*.]

Carey, L. B., Rumbold, B., Newell, C. J. and Aroni, R. "**Bioethocal issues and health care chaplaincy in Australia**." *Scottish Journal of Healthcare Chaplaincy* 9, no. 1 (May 2006): 23-30. [This is a report of the larger study with which our Article-of-the-Month is connected.]

Mako, C., Galek, K. and Poppito, S. R. "**Spiritual pain among patients with advanced cancer in palliative care**." *Journal of Palliative Medicine* 9, no. 5 (October 2006): 1106-1113. [The authors note other research indicating that "spiritual pain often manifests itself in physical...symptoms" (p. 1107), but in their study of 57 patients with advanced cancer in a palliative care hospital, "Neither the presence of spiritual pain, nor its intensity were significantly correlated with either physical pain or perceived seriousness of illness" (p. 1109). Nevertheless, they affirm that for some, "the sense of spiritual pain is inextricably linked with the physical," and "one person indicated that he could not tell the difference between physical and spiritual pain," while others "described their spiritual pain in bodily terms" (p. 1110).]

Snedeker, A. A., Yowler, C. J. and Fratianne, R. B. "**The impact of guided imagery on pain and anxiety levels of burn patients**." *Journal of Burn Care and Research* 27, no. 2, Supplement (March 2006): S151. [This is a brief report of a poster presentation at the 2006 annual meeting of the American Burn Association, describing ongoing research at the MetroHealth Medical Center/Case Western Reserve University, Cleveland, OH, where Fr. Art Snedeker has led an intervention to help burn patients manage pain and anxiety. The abstract is as follows: "Introduction: Guided imagery uses various relaxation techniques, such as rhythmic breathing and visualization of a relaxing and pleasurable experience, to minimize the anxiety of a stressful situation. We have used guided imagery for 5 years as an adjunctive therapy in the control of pain and anxiety associated with inpatient burn care. A prospective study was completed to determine the efficacy of this technique in our patients. Methods: During his initial visits, our burn chaplain would introduce the concept of visual imagery to inpatients in our burn center. If patients requested instruction in the technique, prospective data was collected. Using the Likert Visual Analogue Scale, data were collected on pain and anxiety levels before and after each guided imagery session. These sessions were usually held immediately prior to wound care and dressing changes. All data was obtained within 5 minutes of starting and finishing the session. Results: Significant decreases were noted in anxiety levels with the use of guided imagery. On the 1-10 scale of the Likert Scale, mean anxiety levels decreased from 6.8 to 3.3 (p_0.05) while pain levels decreased from 5.7 to 3.9 (NS). Conclusions: Guided imagery is a useful adjunct in control of the anxiety that accompanies inpatient burn care. Future studies need to determine how long the effect lasts and the optimal timing and number of sessions required for optimal anxiety relief."]

Strang, P., Strang, S., Hultborn, R. and Arner, S. "**Existential pain--an entity, a provocation, or a challenge?**" *Journal of Pain & Symptom Management* 27, no. 3 (March 2004): 241-250. [This research from Sweden--a June 2004 Article of the Month--found that 32% of the study's sample of physicians held that "existential suffering can be expressed as physical pain." The authors conclude that "'existential pain' is mostly used as a metaphor for suffering, but also is seen as a clinically important factor that may reinforce existing physical pain or even be the primary cause of pain...." (--from the abstract)]

[ADDED 11/7/07]: Wachholtz, A. B., Pearce, M. J. and Koenig, H. "**Exploring the relationship between spirituality, coping, and pain**." *Journal of Behavioral Medicine* 30, no. 4 (August 2007): 311-318. [(Abstract:) There is growing recognition that persistent pain is a complex and multidimensional experience stemming from the interrelationship among biological, psychological, social, and spiritual factors. Chronic pain patients use a number of cognitive and behavioral strategies to cope with their pain, including religious/spiritual forms of coping, such as prayer, and seeking spiritual support to manage their pain. This article will explore the relationship between the experience of pain and religion/spirituality with the aim of understanding not only why some people rely on their faith to cope with pain, but also how religion/spirituality may impact the experience of pain and help or hinder the coping process. We will also identify future research priorities that may provide fruitful research in illuminating the relationship between religion/spirituality and pain. (References: 52)]

FOR MORE ON SPIRITUALITY & PHYSICAL PAIN, see also the December 2005 Article of the Month page. And for the related topic of *SPIRITUAL/EXISTENTIAL* PAIN, see the June 2004 Article of the Month page.
