October 2012 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Pearce, M. J., Coan, A. D., Herndon, J. E. 2nd, Koenig, H. G. and Abernethy, A. P. "**Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients**." *Supportive Care in Cancer* 20, no. 10 (October 2012): 2269-2276.

SUMMARY and COMMENT: This month's study proceeds out of two basic questions: "Do oncology inpatients receive spiritual care consistent with their needs?" and "When inconsistent, are there deleterious effects on patient outcomes?" [p. 2269, abstract]. The authors name this to be "the first study to provide a snapshot of the relationships between spiritual care needs and patient outcomes among hospitalized advanced cancer patients" and "the first study to examine depression and spiritual care received" [p. 2275].

Data were analyzed from 150 diverse inpatients with advanced cancer at the Duke University Medical Center (Durham, NC), from a total of 268 eligible patients during 2008-2010. Participants were assessed for spiritual well-being (using the FACIT-Sp --see our February 2004 AoM), spiritual needs and care (including original items and eight adapted from the Spiritual Needs Survey by Galek, et al. --see our June 2005 AoM), plus quality of life, depressive symptoms, and satisfaction with care. Some of these assessments were added after the first seven patients were enrolled, making the number for several analyses 143.

Among the findings:

> Eighty-five percent of patients stated that spirituality played a "large to the largest extent possible" role in their overall health and recovery. Thirty-five percent of patients reported that attention to their spirituality and spiritual care would improve their satisfaction with care at Duke University Hospital. Of the 143 patients queried about spiritual needs, 130 (91%) indicated having one or more spiritual needs.... [p. 2272]
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> Two thirds of patients (67%) reported that they had a moderate or greater desire for their medical team to support their spiritual needs and 68% reported that their medical team had provided spiritual care to this extent. The majority of patients (78%) reported that they had a moderate or greater desire for their religious community to support their spiritual needs and 73% reported that their religious community had provided spiritual care to this extent. Almost half (45%) of patients reported that a visit by a hospital chaplain would be helpful to a moderate or greater extent during their hospitalization; 36% reported having received a visit by a chaplain.... [p. 2272]
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> Of the patients that had a moderate or greater desire for the healthcare team to support their spiritual needs, 17% (16 of 95) received less than the care they desired. Of the patients that had

> moderate or greater desire for their religious community to support their spiritual needs, 11% (13 of 117) received less than the care they desired. Of patients that thought it would be helpful to be visited by a chaplain, 40% (27 of 68) had not received such a visit.... [p. 2273]
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> Twenty-eight percent (42 of 150) received less overall spiritual care than desired from one or more sources (i.e., medical team, religious community, or chaplain). [p. 2273]

Perhaps the most significant finding, however, was that "[p]eople who received less spiritual care than they desired were at significantly greater risk of depressive symptoms and lower sense of spiritual well-being, defined as poorer sense of purpose in life, meaning and peace" [p. 2274]. The finding regarding depressive symptoms "has important clinical implications given the established relationship between depression, functional disability, and mortality, particularly among the medical patients" [p. 2275]. Chaplain readers may further be quite interested in a table [p. 2272] showing responses to the eight questions asked about specific spiritual needs. The most frequent positive responses were to the items for "wanted a connection with a higher power" (81%) and "wanted to have someone pray with or for you" (68%).

Curiously, the number of patients who identified having spiritual needs was here unusually high in relation to other studies, and it was also the case that a "substantially greater percent of participants reported receiving spiritual support from their inpatient healthcare team (68%) compared to previous studies" [p. 2274]. The authors speculate on what may lie behind this finding, including the particular circumstances of advanced cancer inpatients and the geographical culture of the sample [--see p. 2274].

This is a concise article that has strong potential to stimulate discussion and further study. The bibliography is modest, perhaps reflecting the "paucity of information" [p. 2270] on the precise subject.

A minor note: see below (Related Items of Interest, §IV) regarding a statement about requirements by the Joint Commission on Accreditation of Healthcare Organizations on p. 2275.

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

This article is short and straightforward enough to appeal to those new to the field while being substantive enough to interest advanced researchers. Students unfamiliar with statistics should be able to read easily around the occasional technical language. The introductory paragraphs [pp. 2269-2270] set up well the context of the study, and the results [pp. 2272ff] are nicely explicated. Students may want first to discuss the significance of an unmet spiritual need. Would there be reasons for meeting such needs that do *not* depend upon clinical outcomes? What does a connection with clinical outcomes add to the consideration of spiritual needs? The needs identified in the article are the result of patients' self-reporting via specific questionnaire items. Might patients have spiritual needs of which they themselves are not aware, which could only be identified through an assessment instrument? Discussion could also focus on the table of responses to the eight spiritual needs items [p. 2272] and whether this suggests anything about students' own attention to needs in the clinical setting. For instance, 57% "wanted to read spiritual or religious material or watch spiritual or religious programs on TV." Do patients at your CPE center have easy access to such material or programming, and if not then what might be the reasons for that? For more advanced students, there could be discussion of methodology for future studies, and the article could lead to an exploration of the FACIT-Sp and Spiritual Needs Survey.

Related Items of Interest:

> **I.** A focus on *unmet* spiritual needs would seem to be implicit in most spiritual assessments to one degree or another. However, a few articles not cited in this month's featured study that may be of

special interest to chaplains are:

Hampton, D. M., Hollis, D. E., Lloyd, D. A., Taylor, J. and McMillan, S. C. "**Spiritual needs of persons with advanced cancer**." *American Journal of Hospice and Palliative Care* 24, no. 1 (February-March 2007): 42-48. [(From the abstract:) … Results showed great variability in spiritual needs. Being with family was the most frequently cited need (80%), and 50% cited prayer as frequently or always a need. The most frequently cited unmet need was attending religious services.]

Hermann, C. P. "**The degree to which spiritual needs of patients near the end of life are met**." *Oncology Nursing Forum* 34, no. 1 (January 2007): 70-78. [This study of 100 hospice patients (both inpatient and outpatient), assessed perception of 17 spiritual needs (with spirituality conceived very broadly) and perception of whether each type of need was met or unmet. Among the findings: 79% said that talking to someone about spiritual issues was a need, and 75% said that this need had been met; 88% said that being with people who shares the same spiritual beliefs was a need, and 74% said that this need had been met; and 85% said that going to religious services was a need, and 30% said that this need had been met. This article uses Hermann's Spiritual Needs Inventory, which is presented in her earlier article, "Development and Testing of the Spiritual Needs Inventory for Patients Near the End of Life," *Oncology Nursing Forum* 33, no. 4 (July 2006): 737-744. The instrument grew out of a most interesting methodology of asking patients first to define what spirituality means to them and then to identify needs in relation to their definition. For earlier work regarding Herman's instrument, see the October 2002 Article-of-the-Month.]

Sharma, R. K., Astrow, A. B., Texeira, K. and Sulmasy, D. P. "**The Spiritual Needs Assessment for Patients (SNAP): development and validation of a comprehensive instrument to assess unmet spiritual needs**." *Journal of Pain and Symptom Management* 44, no. 1 (July 2012): 44-51. [(Abstract:) CONTEXT: Unmet spiritual needs have been associated with decreased patient ratings of quality of care, satisfaction, and quality of life. There is a need for a well-validated, psychometrically sound instrument to describe and measure spiritual needs. OBJECTIVES: To develop a valid and reliable instrument to assess patients' spiritual needs. METHODS: Instrument development was based on a literature review, clinical and pastoral evaluation, and cognitive pretesting (n=15 ambulatory cancer patients). Forty-seven ambulatory cancer patients completed cross-sectional and longitudinal surveys to test instrument validity and reliability. Internal reliability was assessed by Cronbach's alpha, test-retest reliability by Spearman's correlation coefficients, and construct validity by comparing instrument scores to a previously used single-item spiritual needs question. RESULTS: The Spiritual Needs Assessment for Patients (SNAP) comprises a total of 23 items in three domains: psychosocial (n=5), spiritual (n=13), and religious (n=5). Sixty percent of participants were white, 21% black, 13% Hispanic, and 6% Asian or other. Fifty-eight percent were Catholic, 13% Jewish, 11% Protestant, 2% Buddhist, 2% Muslim, and 2% Hindu. Sixty-eight percent described themselves as spiritual but not religious; 15% reported unmet spiritual needs; 19% wanted help meeting their spiritual needs. Cronbach's alpha for the total SNAP was 0.95, and for the subscales was psychosocial=0.74, spiritual=0.93, and religious needs=0.86. Test-retest correlation coefficients were total SNAP=0.69, psychosocial needs=0.51, spiritual needs=0.70, and religious needs=0.65. Participants reporting unmet spiritual needs had significantly higher mean scores on the total SNAP (66.3 vs. 49.4, P=0.03) and on the spiritual needs subscale (39.0 vs. 28.3, P=0.02). CONCLUSION: The results provide preliminary evidence that the SNAP is a valid and reliable instrument for measuring spiritual needs in a diverse patient population.]

II. For a study that looks at the spiritual needs of caregivers instead of patients, see: Buck,, H. G. and McMillan, S. C. "**The unmet spiritual needs of caregivers of patients with advanced cancer**." *Journal of Hospice & Palliative Nursing* 10, no. 2 (March/April 2008): 91-99. The author uses Hermann's Spiritual Needs Inventory (noted above, §I) to assess specific needs of caregivers and matches the general score for unmet spiritual needs with scores from the Center for Epidemiological Studies Depression Scale. Note especially the tables of needs on p. 96. The most frequently indicated unmet spiritual needs were to be with family and to laugh.]

III. One of the articles cited in this month's study is especially noteworthy for its association of met/unmet spiritual needs with health care costs at the end of life: Balboni, T., Balboni, M., Paulk, M. E., Phelps, A., Wright, A., Peteet, J., Block, S., Lathan, C., VanderWeele, T., and Prigerson, H. "**Support of cancer patients' spiritual needs and associations with medical care costs at the end of life**." *Cancer* 117, no. 23 (December 1, 2011): 5383-5391. This article was featured as our June 2011 Article-of-the-Month

IV. This month's article includes the statement that the Joint Commission on Accreditation of Healthcare Organizations' regulations "requir[e] that *all hospitalized patients* receive a spiritual assessment" [p. 2275, italics added]. This assertion is frequently made in the literature, but while the Joint Commission does publish documents that indicate the value of spiritual assessments (e.g., the 2010 monograph, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*), the actual accreditation standards for acute care hospitals only *require* such assessment for inpatients receiving end-of-life care or treatment for behavioral health and substance abuse issues, and in the context of an assessment of factors affecting patient education. For a summary of the 2012 acute care hospital standards mentioning spirituality, religion, beliefs, and cultural diversity, see: www.uphs.upenn.edu/pastoral/resed/JCAHOrefs.pdf (by J. Ehman).

If you have suggestions about the form and/or content of the site, e-mail Chaplain John Ehman (Network Convener) at john.ehman@uphs.upenn.edu .
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