Special Section: Report from a Conference on the State of the Science of Spirituality and Palliative Care Research

State of the Science of Spirituality and Palliative Care Research Part II: Screening, Assessment, and Interventions

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Abstract

The State of the Science in Spirituality and Palliative Care was convened to address the current landscape of research at the intersection of spirituality and palliative care and to identify critical next steps to advance this field of inquiry. Part II of the SOS-SPC report addresses the state of extant research and identifies critical research priorities pertaining to the following questions: 1) How do we assess spirituality? 2) How do we intervene on spirituality in palliative care? And 3) How do we train health professionals to address spirituality in palliative care? Findings from this report point to the need for screening and assessment tools that are rigorously developed, clinically relevant, and adapted to a diversity of clinical and cultural settings. Chaplaincy research is needed to form professional spiritual care provision in a variety of settings, and outcomes assessed to ascertain impact on key patient, family, and clinical staff outcomes. Intervention research requires rigorous conceptualization and assessments. Intervention development must be attentive to clinical feasibility, incorporate perspectives and needs of patients, families, and clinicians, and be targeted to diverse populations with spiritual needs. Finally, spiritual care competencies for various clinical care team members should be refined. Reflecting those competencies, training curricula and evaluation tools should be developed, and the impact of education on patient, family, and clinician outcomes should be systematically assessed. J Pain Symptom Manage 2017;54:441–453. *Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

Key Words

Spirituality, outcomes, assessment, interventions, design

Introduction

As discussed in Part I of the State of the Science of Spirituality in Palliative Care (SOS-SPC), there are notable relationships between spiritual domains and palliative care outcomes among patients and family members. The recommendations outlined in the summary in Part I, highlight the critical methodological challenges together with key gaps in outcomes research. By using definitional and methodological rigor, the field of palliative care can address these

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Table 1
Levels of Clinical Inquiry About Spirituality and Religion

Type of Clinical Inquiry	Clinical Context	Length	Mode	Clinician
Spiritual screening	Initial contact, ongoing reassessment	Brief	Open-ended questions or items with scaled response, goal is to identify patients in need of spiritual care referral	Any clinical care provider
Spiritual history-taking	Initial contact	Brief	Open-ended questions	Clinical medical care provider (e.g., physician, nurse, or chaplain)
Spiritual assessment	Initial contact, ongoing reassessment	Extensive	Conceptual framework guides interview and development of spiritual care plan	Board-certified chaplain or spiritual care professional with equivalent training

gaps and further the understanding of how spirituality, in its multidimensional complexity, relates to palliative care outcomes.

Knowledge regarding how spiritual domains influence outcomes, even if elevated in rigor and depth, is fruitless without research that informs application to the care of seriously ill patients and families. To meaningfully inform how clinicians, clinical teams, and institutions interface with spirituality in the care of patients and families requires addressing key practical questions: 1) How do we assess spirituality? 2) How do we intervene on spirituality? And 3) how do we train healthcare professionals to address spirituality in palliative care. Hence Part II of SOS-SPC addresses the current state of the science, noting key gaps, and makes critical next step recommendations regarding these three domains of inquiry.

How Do We Assess Spirituality?

Spiritual Screening, History-Taking, and Assessment Within Palliative Care. A recent survey of 807 palliative care providers ranked spiritual screening tools as the number one priority for spiritual care research.[1] When reviewing the state of the science, tools can be grouped into three categories of inquiry: 1) *spiritual screening*, 2) *spiritual history taking*, and 3) *spiritual assessment*.[2] Table 1 summarizes each level of spiritual inquiry in terms of context, length, mode of delivery, and the clinician involved.

Spiritual Screening. Spiritual screening evaluates the presence or absence of spiritual needs and/or distress with the goal of identifying those in need of further spiritual assessment and care. Table 2 shows the published models designed specifically for spiritual screening. Given that spiritual screening fits conceptually within the larger umbrella of psychosocial screening, a number of instruments developed for general psychosocial screening include one or more spiritual items (Table 2).[3–9] Likewise, many needs assessment tools contain items assessing spirituality, with tools developed and used largely within cancer patient populations as described in a review by Carlson et al.[10]

There is some evidence to inform the utilization of screening tools in palliative populations. For example, the Rush Spiritual Screening Protocol has been tested among 173 medical rehabilitation patients, among whom 7% tested positive for possible religious or spiritual struggle; 92% were confirmed by chaplain assessment.[11] Steinhauser's "Are you at peace?" single-item assessment tool has been tested among 248 patients with advanced illnesses and found to have significant, positive associations with measures of emotional and spiritual well-being.[12] Mako's "Do you have spiritual pain?" screening tool was tested among 57 advanced cancer patients and found to be significantly related to patient-reported depression.[13] This tool has also been tested among patients ($n = 91$) and family caregivers ($n = 43$) seen at a palliative care outpatient clinic.[14] Among patients, 44% reported spiritual pain, which was associated with lower spiritual well-being. Among caregivers, 58% reported spiritual pain, which was associated with greater anxiety and depression, and worse quality of life (QOL). The Spiritual Injury Scale was examined in 96 medical rehabilitation patients, with higher scores positively associated with depression and negatively associated with QOL on admission and at four month follow-up.[15] Although these tools show promise as screening tools, key gaps include the absence of data providing guidance regarding optimal spiritual screening methods (e.g., content, timing, frequency), and comparison of how screening methods might differ for different settings, trajectories of illness, and religious or cultural contexts.

Spiritual History-Taking. Spiritual history-taking uses a broad set of questions to capture a patient's spiritual characteristics, resources, and needs. It is typically conducted within an initial, comprehensive evaluation by a clinician. Spiritual history taking is based on expert-derived models. The primary models for spiritual history-taking and their descriptions are shown in Table 2, and include Puchalski and Romer's FICA model,[16] Maugans'[17] SPIRIT model, Anandarajah and Hight's[18] HOPE model, and Frick et al.'s[19] SPIR model. The FICA model has undergone testing, with