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Defining and Advocating for Spiritual Care: A Proposal

A vague and persistent uncertainty infects most spiritual care programs funded by health care institutions. Many programs struggle with a sense of being on the margin of the institution, with a sense of being ancillary, secondary and thus extraordinarily vulnerable. It is a sense that the hospital does not really, really need to fund professional spiritual care programs and providers if it does not want too.

Many experience this vulnerability as budgetary concerns. Spiritual care does not charge for its services and thus is dependent on institution funding. This means that job security is persistently subject to senior administrative decision makers who could decide that the institution can not afford professional, institutionally funded spiritual care. That is always a possibility (Ref 1 Lucas, 2001).

Of course, spiritual care programs can influence decision makers in various ways. They can arrange for public relations pressure from community clergy and other community persons on decision makers. Patients and family members can write testimonial letters. Providers can double their efforts to provide exceptional care to very important persons in crucial situations, thus recruiting them as advocates. They can enlist senior physicians and nurses as advocates. They can familiarize themselves with the standards of the Joint Commission on Accreditation of Health Care Organizations (www.jointcommission.org) and be active in their periodic reviews, thus lending visibility to the program. All of these relationships and political efforts can be effective.

Another factor that contributes to the sense of vulnerability is the awareness that advocacy is difficult because spiritual care is hard to define and describe in a comprehensive and specific manner. Spiritual care mean one thing to Christians, something a little different to Jews, and something different still to Moslems. Spiritual care can mean something quite different even to persons within these major religious groups. Catholic spiritual care is somewhat different than that in Protestant traditions. Additionally, what spiritual care means on a maturity nursing unit where most mothers and babies are healthy and happy is different when ministering to cancer patients. Spiritual care takes on a different focus when caring for patients in comparison to family members.

One way to overcome this definitional and advocacy problem is to generalize to a common denominator as, for example, when spiritual care is characterized as "meeting spiritual needs." Inevitably such generalizations lead to amorphous definitions and advocacy that seem less than convincing. These

generalizations lack concrete substance, are not well grounded in a clear theoretical framework, and are likely not convincing to decision makers who question whether to fund a spiritual care program. Authors of one article (**Ref 2** Gibbons, Thomas, VandeCreek, 1991) comment on this movement to the generic when they write, "(J)ob descriptions (of chaplains) are relatively vague when compared to their more technologically-based colleagues. The procedures which effective pastoral care requires in any particular instance often are less specific, enjoy less consensus and generate less easily measurable results than many medical and surgical procedures" (p.117). This presentation is motivated by the conviction that the chaplaincy profession must overcome these definitional and advocacy difficulties.

The published spiritual care literature is of little help. Journals and the websites of pastoral organizations contain little concerning how actually to advocate for spiritual care. A review of The American Theological Library Association data base (ATLA) produced little that is useful. The most extensive effort to define and advocate for professional spiritual care in health care consisted of a White Paper (**REF3** VandeCreek and Burton, 2001) sponsored by five pastoral care organizations. The influence of this effort is uncertain because no follow up evaluations have appeared.

As an organization, the Association of Professional Chaplains (APC) gives significant attention to advocacy when compared to other spiritual care and education organizations. It maintains a Cabinet of Liaisons in which an appointed Association member acts as a liaison to one of eight non-spiritual care organizations with which the Association wants to cultivate relationships. No published information appears to exist as to what these liaisons actually do, but presumably they build relationships within the organization to which they are a liaison. The cabinet has not published materials concerning how to define and advocate for spiritual care.

APC also publishes **Healing Spirit**, a full color magazine published semi-annually and mailed to its members for distribution to decision makers and administrative offices. It seeks "to communicate the many ways professionally trained certified chaplains advance the quality and scope of care in the organizations they serve" (APC Website). It does not, however, provide information concerning how to define and advocate for spiritual care with decision makers.

APC has a Commission on Advocacy consisting of various committees and they produced a document titled, **Becoming an Effective Advocate: A Manual for State Advocacy Chairpersons**. This booklet lays out the guidelines for the appointed Association member in each state who is on call if advocacy problems arise. It, however, does not present arguments for professional spiritual care in health care settings.

The limitations of these efforts suggest the need for additional attention to defining professional spiritual care, advocating for it, and building arguments for why health care institutions should fund it. The need is evident at a practical level. One department head (**Ref. 1** Lucas, 2000) described how repeated changes in administration led to dramatically different stances toward the spiritual

care department and the limits of advocacy efforts. The chairperson of the APC advocacy commission reports that they receive 10-12 requests per year for help in the face of downsizing or elimination of funded spiritual care programs or providers, approximately one per month (personal communication, September 3, 2008). David A. Lichter, the director of the National Association of Catholic Chaplains, recently posted a “reflection on advocacy” on the organization’s website (www.nacc.org/advancing) in which he encourage that organization to create “A more effective, persuasive way to answer the question, ‘How do we know we are doing it?’...in the business environments where chaplains (are) required to learn and embrace professionalization.”

This presentation represents one response to the need for a more grounded definition of spiritual care and a stronger advocacy of it. The presentation adapts results from the recent scientific literature to define spiritual care in a more specific (and hopefully more persuasive) manner and to demonstrate its relevancy in health care institutions as a way to advocate for it. This approach is taken with full awareness that this attention to science is problematic for many chaplains (**Ref 4** VandeCreek, 2002). They are ambivalent, even resistant, to allowing non-ministry, scientific approaches to study and potentially influence spiritual care (**Ref 5** Myers, 1996; **Ref 6** Madison, 1998) although this attention to science has also received some support (**Ref 7** O’Connor, 2002; **Ref 4** VandeCreek, 2002). While exploring this ambivalence is beyond the scope of this presentation, it appears that chaplains suspect that science will remove the traditional religious grounding and uniqueness of ministry, reducing it to some kind of secular service. In turn, decision makers in their critical moments are suspicious that spiritual care wants a place in health care while excusing itself from applicable scientific methods used by the rest of health care. This impasse will be resolved only when all concerned clarify how science can and can not be helpful to spiritual care.

In this presentation I make four theoretical assertions from the literature. After making each assertion, research results are described that support the assertion and potentially demonstrate the relevancy of spiritual care to the institution. The implications for spiritual care are then briefly discussed. For the sake of simplicity, references are regularly made only to “patients” with the understanding that this includes family members, staff, and any others as appropriate.

The four assertions are adapted from the recent work of Dr. Kenneth Pargament and his colleagues. Pargament, a psychologist of religion, published many theoretical articles and empirical studies concerning the religious coping process, but now is giving attention to an exploration of “the sacred” and its role in the lives of individuals and society, creating materials relevant to defining and advocating for spiritual care. The assumption here is that the use of his work will clarify the definition of spiritual care and create a more persuasive advocacy.

Assertion One

Every person is a spiritual being as well as a physical, social, and psychological entity (Ref 8 Pargament, 2008). This includes each patient, each family member, each chaplain, each decision maker. In this statement,

Pargament means to assert that each person consists of at least those four dimensions. Most individuals understand quite precisely what is meant by the physical, social, and psychological dimensions. But, how is spirituality defined? That is a crucial question because advocating for spiritual care is linked to how spirituality is defined.

“Spirituality” does not lack for definitions. Three researchers (Ref 9 Unruh, Versnel and Kerr, 2002) conducted a comprehensive survey of empirical and clinical studies and found 92 definitions. This finding underlines why the definition of spiritual care is ambiguous and advocacy for spiritual care can not be built on such ambiguity. It requires a careful, specific definition of “spiritual,” sufficiently narrow so that it does not include everything that is “meaningful” or that feels “warm and fuzzy” and broad enough to avoid restricting it to an established orthodoxy. Zinnbauer and Pargament (Ref 10 2005) define spirituality as **“a personal or group search for the sacred.”** This definition introduces three key concepts into the discussion, namely “the sacred,” “sanctification,” and “search.” The sacred as the focus of spiritual care is not new. For example, the Discipline for Pastoral Care Giving (Ref 11 VandeCreek and Lucas, 2001) suggests a four-part assessment profile of patients, including their sense of the holy (i.e., sacred), meaning in life, hope, and community.

What does Pargament mean by the sacred? He means what it is traditionally defined to mean. The sacred is that which is set apart, that which is separated from the everyday world because it is special. Some experience the sacred as “deeper”, as the depth of life; other describe it as “higher”, as more transcendent than their usual experience. Persons talk about what is personally sacred in their lives with emotional laden voices, with great care and some hesitation as if treading on holy ground. Talking about what is personally sacred is not easy God talk. Patients perceive that to talk about that which they experience as sacred comes close to the core of their life, perhaps sometimes too close for comfort and yet the sacred is by definition centrally important in their life. The patient’s spirituality is the interaction with and in response to what is sacred in life.

Pargament and Mahoney (Ref 12 2005) suggest two ways in which persons sanctify aspects of their lives. They use the word sanctification here to mean the process of identifying someone or something as set apart as holy, as transcendent, as other than the ordinary. The Judeo-Christian traditions identifies the sacred as God and all that is closely associated with God, such as angels, scriptures, Jesus of Nazareth, rituals and sacraments of worship communities, and sanctuaries as sacred spaces. When patients identify the content of the sacred as God and that associated with God, Pargament calls this “theistic sanctification”, that is, the sacred takes a theistic form.

Here is an example. A patient is diagnosed with a serious cancer. She decides to fight the disease and travels to a distance medical center for further evaluation and treatment. Arriving at the treatment center for her 4 pm appointment after a long day on the road, she is discouraged and exhausted. She sits down next to another woman in the waiting room who begins a conversation with her. How is she feeling? Why has she come to the center?

Does she have cancer also? What kind of cancer is it? They continue to talk. After more conversation, the woman smiles as she says, "You'll be all right. My husband had the same cancer and that was 4 years ago. The doctors treated it and he is doing well. You have to eat right, but you are going to be alright." The patient cries as she quotes her new acquaintance to the chaplain and then she says, "That was a visit from an angel. That's what I say, that lady was my angel." The chaplain says to her, "Hold onto that; that was a sacred experience."

Not all patients, however, engage in this theistic process, professing assumptions and beliefs concerning God. Even if patients profess to "believe in God," their beliefs may lack depth or significant meaning and have little to do with what is really sacred in their lives. These persons engage in "nontheistic sanctification." Because they are spiritual, through perhaps not religious, they imbue aspects of their lives as sacred, describing these aspects with divine qualities such as transcendence, boundlessness, ultimacy, holiness, heavenliness, or blessedness without reference to theism. For example, the poet Wallace Stevens (Ref 13 1990) engages in non-theistic sanctification when he wrote, "After one has abandoned a belief in god, poetry is that essence which takes its place as life's redemption."

Spirituality is a personal or group search for the sacred. One additional word in that definition needs attention. Spirituality entails **the search** for the sacred. The definition (Ref 14 Pargament, Magyar-Russell, Murray-Swank, 2005) uses the word "search" to mean finding the sacred and experiencing spirituality not as a static one time experience, but as a process, always being open to identifying and experiencing the sacred anew. That process never stands still; it's ongoing, always changing and developing.

What are the implications for the funding of spiritual care? Everyone possesses a spiritual dimension. Everyone searches for and establishes something sacred in their life although they may not be able to talk about in those terms. This means that spiritual care is relevant to all patients, not just those who profess a religious faith, who engage in theistic sanctification.

Assertion Two

The spiritual dimension with its attention to the sacred is not reducible to one of the other dimensions (Ref 15 Pargament, 2002). That is, the sacred and spirituality can not be fully explained by conceptualizing them as part of any or all of the other dimensions. Pargament (Ref 15 2002) describes a conversation with a physician after his presentation concerning spirituality. The physician said, "All this talk about spirituality—isn't it just about hormones?" That comment stands in a long tradition that argued that the sacred, spirituality and religion "are nothing but..." Freud (Ref 16 1927/1961) argued that religion was nothing but a recreation of the father figure. Durkheim (Ref 17 1915), a prominent social psychologist who studied religion in primitive cultures in Australia, believed that religion was at root an expression of social needs. Clearly spirituality and religion possess physical, social, and psychological features and can be studied from those perspectives just as physical, social, and psychological phenomena can be studied from the viewpoint of the sacred. Studies from a physical, social and psychological perspective increase our

understanding of the sacred, spirituality and religion, but they can not explain it away. The spiritual dimension has its own independent standing.

The results of at least two publications are relevant here, both of them suggesting that the sacred, spirituality, and religion are independent because they make unique contributions to the coping process. The authors theorized that family members waiting during the CABG surgery of their loved one experienced the need for additional support and the need for an increased sense that the surgery situation was under control. No spiritual care provider called on them while they waited. The authors collected questionnaire data from 150 of these family members concerning their nonreligious support, nonreligious control, religious support, and religious control. The first report (**Ref 18** VandeCreek, Pargament, Belavich, et al., 1999) provided significant statistical evidence that spirituality contributed unique support beyond that obtained by non spiritual sources. That is, spiritual support (e.g., their prayers) increased their coping scores on the questionnaires beyond that attributable to non spiritual means. The second report (**Ref 19** Pargament, Cole, VandeCreek, 1999) concerned control and described similar results. Spiritual methods produced a sense that the surgical situation was in control beyond that achieved by non spiritual methods.

What are the implications for spiritual care and health care decision maker? First, these results suggest that the unique benefits were brought about by the intrapersonal spiritual process itself; no spiritual care was offered. This means that the help afforded by spirituality is not functionally redundant to that obtained from psychological sources. The sacred, spirituality, and religion are unique and make unique contributions. Since patients and family members can use all the coping resources they can find, the more sources of support and control available to them the better they are likely to cope.

Second, this research did not involve a spiritual care visit by a chaplain or a parish clergy. Would the sense of spiritual support and control increase when a clergy, as an official representative of the spiritual community, sits with the family, helping them resource the sacred in their life? This is a worthy hypothesis. The results of these two studies suggest that attention to spirituality is linked to better coping when support and a sense that the medical situation is under control are badly needed. The results suggest to decision makers that spirituality is unique and creates unique benefits.

Assertion Three

“Religiousness is defined as a personal or group search for the sacred that unfolds within a traditional sacred context” (Ref 20 Zinnbauer and Pargament, 2005 p. 35). “Religion,” like spirituality, is another fuzzy term. Within the framework developed here, religion is the traditional expressions of spirituality and must, by definition, consist of a group of believers and have a sufficient history to be regarded as a tradition.

For all the emphasis on spirituality here, religion is important in its own right. 70% of persons in the US describe themselves as “very/somewhat religious” and 56% say they attend religious services at least a few times a year (**Ref 21** Harris Interactive Poll, 2007). It is clear that religion is important in

health care contexts. Three researchers (Ref 22 Koenig, McCullough, and Larson, 2001) surveyed the literature, describing more than 1200 studies and 400 research reviews conducted during the twentieth century concerning the relationship of religion to health care concerns. The studies examined the relationship of religion to mental health (e.g., depression, suicide, anxiety, alcohol and drug use etc), physical health (e.g., heart disease, hypertension, cancer, mortality, disability, and pain), and to the use of health care services.

What are the implications for health care decision makers? Assertions one and two have emphasized the individual, personal spirituality. Assertion three gives attention to the importance of being part of a tradition. Illness and hospitalization are stressful and raise all kinds of personal questions. Their respective traditions help them find answers to their spiritual questions, perhaps for the first time, perhaps in a deeper manner than before, perhaps by being reminded of the familiar words of scripture or a prayer by a spiritual care provider. The funding of spiritual care providers cultivates that link to their religious traditions.

Assertion Four

Spiritual care is defined as giving professional attention to the patient's subjective spiritual world comprised of perceptions, assumptions, feelings and beliefs concerning the sacred. Parkes (Ref 23 1975) called these perceptions, assumptions, feelings, and beliefs, the "assumptive world." Bowlby (Ref 24 1973) described them as constituting "representative or working models" of the individual's experience in the world. Klass (Ref 25 1999) describes them as "world views." Spiritual care gives attention to the patient's subjective assumptive world or world views.

This assertion means that, in contrast to the contemporary practice of medicine, with the possible exception of psychiatry, spiritual care providers deliberately focus on the subjective world of the patient. Further, spiritual care is unique because its concern is the patient's subjective spiritual world where perceptions, assumptions, feelings and beliefs concerning the sacred reign supreme. Patients do not leave this spiritual world behind when they enter the hospital; illness and medical care affect that spiritual world and that spiritual world impacts medical care.

But is there evidence to support the assertion that the sacred and the spiritual care are relevant to medical care in the hospital? A second question must immediately follow: What is the mission of the hospital? Mission statements, while not to be ignored, often consists of high sounding words. Here, however, is the challenge that every hospital faces relative to funding spiritual care: To what extent is a hospital like an auto repair shop, a shop where patients take their bodies to be technologically repaired and then discharged as if there are no subjective or spiritual aspects of the endeavor? No hospital wants to be characterized that way and it can distinguish itself from the repair shop by giving attention to the sacred and spiritual care of patients. Gibbons and Miller (Ref 26 1989) have written,

...(H)ospitals are far more than biological garages where dysfunctional human parts are repaired or replaced. They are rather places where

patients, and their loved ones, come face-to-face with their vulnerability, their finitude, and ultimately their mortality. As such, hospitals are places of anguishing ambiguity. (Patients and family members) journey along a path with hope and healing ranged along one side, while terror and tragedy threaten on the other” (355).

This characterization of the hospital experience suggests that spiritual care is relevant and let's explore the evidence.

Let's start with the circumstantial. “The general hospital is faced increasingly with accommodating (a) sacred mission as it provides life-prolonging and intensive care.... It is, therefore, no accident that general hospitals experienced the introduction of intensive care units and ...chaplains more or less simultaneously” (**Ref 27** Gibbons, Thomas, VandeCreek, et al., 1991). This suggests an important point; medical advances themselves promote attention to the sacred and to spiritual care. The link here between medical advances, the sacred, and the need for spiritual care rest on how medical advances themselves prompt perceptions, assumptions, feelings, and beliefs concerning the sacred and spirituality. More invasive and complicated medical interventions require the patient to trust physicians and the technological machinery of the modern hospital. Patients exhibit that trust to an amazing degree, but they also know that these intervention also put them at risk of more suffering and death no matter how routine the medical interventions have become. And sometimes no interventions are possible, leading to prolonged care with chronic illness the prompt more questions—what is the purpose of my life? Why do I suffer? Why can't I just die? And those are questions in the spiritual care domain. The very technological and medical advances create the need to accommodate to the sacred mission, an accommodating that is expressed in the need for and provision of spiritual care.

Such spiritual questions raised by patients can not usually be answered by asserting what the provider believes to be spiritual truths. Just becoming aware of the questions may well be a sacred experience and this introduces the concept of spiritual struggle. Pargament (**Ref 28** 2005) defines spiritual struggles as “efforts to conserve or transform a spirituality that has been threatened or harmed” (247) and, like the spiritual dimension described in the second assertions, spiritual struggles are not wholly reducible to physical, social, or psychological struggles. Some, in fact, experience these spiritual struggles the “dark night of the soul” (**Ref 29** St John of the Cross, 1534/1990).

What characterizes these spiritual struggles in the hospital? One project (**Ref 30** VandeCreek, 1991) found that the most spiritually needy hospital patients were males, those with less education, and those who attend worship services infrequently. A second study (**Ref 31** VandeCreek and Smith, 1992) explored the sacred experience of meaning making by patients and family members, reporting that family members were significantly more involved in seeking meaning than patients. Another study (**Ref 32** VandeCreek, Nye, and Herth, 1994) found that those hospital patients who struggle the most to be hopeful in the face of their illness were young adults and those with less education. A fourth study (**Ref 33** Fitchett, Murphy, Kim, et al., 2004) examined

the frequency of religious struggles and their correlates among inpatients and outpatients. While half of the sample reported no religious struggle, 15% reported moderate or high levels of struggles. Higher levels of struggles were found among younger patients, CHF patients, those with higher levels of religious coping, those with depressive symptoms, and emotional distress. Those who attended worship most frequently had lower levels of religious struggles. Fitchett (Ref 34 1999a) described and defined the concept of spiritual risk and identified screening resources (Ref 35 1999b).

Spiritual struggles are not altogether bad. They can lead to spiritual growth. A large literature describes post-traumatic growth and that growth is spiritual as well as psychological. One study (Ref 36 Rodrigues, Rodrigues, and Casey, 2000) reported that 42% of patients most of whom were in the hospital said that their illness created a deeper faith. In a recent qualitative research study (Ref 37 VandeCreek and Mottram, in press) that examined the religious life of 10 women who suffered that loss of a loved one by suicide, seven reported that the loss with all its struggles led to spiritual growth in the years following the loss. Here are the words of one mother who lost a young adult to suicide:

I guess I approached things differently (after the suicide) and it helped me find a lot more peace with (the) death. So, I guess I look at that as my spiritual journey as growing a lot from that point on. ...It wasn't immediately, but over the years, I've grown a lot closer to God, and involved Him much more in my life than I did before.

These words are compatible with the large post-traumatic growth literature and suggest that traumatic events can lead to spiritual growth over time.

Spiritual struggles, however, can also lead to spiritual deterioration or become chronic. Some people question whether their illness was "sent by God," that the hospitalization contained a divine message. It is a small step from "sent from God" to "punishment from God." Western culture contains a long history of assuming that suffering, pain, and illness is God's punishment. Hebrew Scriptures recount the first couple's experience of being ejected from the Garden of Eden (Genesis 3:14-19). Why were they removed from Eden? The scripture is clear. It was their punishment for eating of the forbidden tree and with their eviction came suffering, pain, and death. The theme that suffering is punishment for personal or communal sin is carried forward by the Hebrew prophets and by St. Paul in the Christian New Testament. The possibility that personal suffering is personal punishment from God colors the landscape of spiritual struggle.

Study results link spiritual struggles with the Divine to emotional and physical distress. Exline and her colleagues (Ref 38 1999) found that difficulty forgiving God for negative events was linked to greater anxiety, depressed mood, anger, and difficulty forgiving ones self and others. In a second study (Ref 39 Exline et al., 2000), they found that alienation from God was related to increased depression. Pargament and colleagues (Ref 40 2001) found that struggles related to the Divine included feeling punished and/or abandoned by God, anger at God, questioning of God's power, and attributing problems to the devil was associated with less positive feelings, more depression and less spiritual satisfaction.

Longitudinal studies that follow medical patients over a period of time provide the more persuasive evidence that spiritual struggles are relevant to health care settings. The four month recovery period among medical rehabilitation patients was negatively related to anger at God even after removing the influence of depression, social support, independent physical functioning level at admission, and demographics (**Ref 41** Fitchett, Rybarszyk, DeMarco et al., 1999)

Another longitudinal study of medically ill elderly patients (**Ref 42** Pargament et al., 2002) found that struggles with God at the beginning of the study predicted increased depressed mood, decline in physical functioning and quality of life over the following two years after ruling out the influence of a wide variety of other factors. This research (**Ref 43** Pargament, Koenig, Tarakeshwar et al., 2001) also found that struggles with God at the beginning of the study predicted a 22 to 33 % greater risk of dying during those two years of the study. These results suggest that spiritual struggles, particularly those involving negative feelings toward God merit clinical attention because they have mental and physical health implications.

An additional way to determine the importance of spiritual care is to ask patients and family members concerning it. For example, how do patients evaluate their spiritual care? Four reports are important here. One project (**Ref 44** VandeCreek, Thomas, Jessen, Gibbons, and Strasser, 1991; **Ref 45** Gibbons, Thomas, VandeCreek, and Jessen, 1991) asked a sample of patients to compare chaplaincy services to those of social services and patient representatives. The data suggested the following six results: 1) they receive more visits from chaplains, 2) they give more importance to chaplain visits, 3) chaplain visits more fully met their expectations, 4) chaplain visits increase the patient/family likelihood of choosing the hospital again and recommending it to others, 5) patient satisfaction scores evaluating chaplain visits increase with the number of visits, and 6) patient/family member report that chaplain visits become more important with a readmission and during an extended stay.

A recent study (**Ref 46** Piderman, Marek, Jenkins, et al., 2008) examined patient expectations of hospital chaplains. A majority of patients in the study (62.5%) indicated that they wanted to see a chaplain “to be reminded of God’s care and presence;” 83.8% reported that this was “very important” to them.

The third study created patient satisfaction scores with the ministry of chaplains. That project will be described in the second presentation this morning.

How do family members evaluate spiritual care? The death of a loved one in the hospital is often experienced as a sacred time and chaplains often provide spiritual care to bereaved family members. How are their services helpful? One project (**Ref 47** Broccolo and VandeCreek, 2004) telephoned the primary family member after one month, inquiring about the spiritual care offered to them at the time of death. The study generated five results concern how chaplains were helpful: 1) chaplains provided comfort and support, 2) chaplains helped family with details before, during, and after the death, 3) chaplains acted as a surrogate family member until other arrive, 4) the simple availability of chaplains was a

safety net for family members even if contact was limited, and 5) chaplains functioned as a spiritual figure who aided the transition from earth to heaven. How satisfied were these family members with that spiritual care? When given a five point scale (1 = poor; 5 = excellent), the family members created a mean score of 4.37.

Efforts by chaplains themselves to demonstrate scientifically the actual benefits of spiritual care have produced mixed results. One small study (**Ref 48** Iler, Obenshain, and Camac, 2001) provided daily chaplain visits to a randomly selected group of hospital patients and the results suggested significantly lower anxiety, shorter length of stay, and increased patient satisfaction. Another study, (**Ref. 49** Bay, Beckman, Trippi, Gunderman, and Terry, 2008) examined the effects of chaplain visits on anxiety, depression, hope, religious coping, and religious problem solving styles. It found a significant influence only on positive and negative religious coping over time.

What are the implications of these results for the question asked by health care decision makers who ask why they should fund spiritual care? First, they should fund spiritual care because it is intuitively evident that patients carry their spiritual struggles with them into the hospital. Tentative as it is, these research results suggest that spiritual struggles carry measurable negative influences related to the outcome of care offered by the institution. Spiritual care providers are concerned with the perceptions, assumptions, and beliefs of patients from whence these struggles arise.

Second, they should fund spiritual care because without these providers, the resources that respond to these struggles are inadequate. It is clear that most physicians are not trained to engage patients around these issues in a professional manner (**Ref 50** VandeCreek, Grossoehme, Ragsdale, et al., 2007) even though one study (**Ref 51** Ehman, Ott, Short, Ciampa, and Hansen-Flaschen, 1999) reported that 45 % of patients indicated that religious beliefs would influence their medical decisions if they became gravely ill. Yet, only those physicians who are religious themselves tend to provide some attention to spiritual and religious data concerning their patients (**Ref 52** Grossoehme, Ragsdale, McHenry, 2007). Note that collecting spiritual and religious data is different than spiritual care. The first collects information relative to medical decision making; the latter involves engaging patients to help them with their spiritual struggles. In another report (**Ref 53** Kristeller, Zumbrun and Schilling, 1999) only 12 percent or less of oncologists and oncology nurses said they would give attention to the spiritual concerns of patients if 10 minutes remained in the appointment. Attention to spiritual concerns appears to be a low priority.

Given these findings concerning medical and nursing personnel, who does give attention to the sacred and the spiritual struggles of patients if institutionally funded spiritual care providers are not present? Only the parish clergy, but they provide ministry only to their hospitalized parishioners. Two studies (**Ref 54 & 55** VandeCreek and Cooke, 1996; VandeCreek and Gibson, 1997) suggest that the parish clergy make extraordinary efforts to support their parishioners. From the institution's viewpoint, parishioners of local religious congregations—and some not so local—receive at least some attention to their spiritual concerns. It is

common knowledge, however, that parish clergy are overwhelmed with the demands of their congregants and this may limit the time they give to visiting their hospitalized parishioners.

In summary, Pargament (**Ref 56** 2002) wrote,

Religion (and spirituality) deal with matters of great significance. What is the meaning of it all? Is there a larger purpose to our existence? Is there a higher Being? What becomes of us after we die? How should we live our lives? These are matters of 'ultimate concern' (**Ref 57** cf. Tillich, 1951), and even if traditional religious answers to these questions are rejected, the questions themselves remain important."

I have used materials from the social science literature to address definitional and advocacy concerns. While focusing on the work of Pargament concerning "the sacred," I believe that the work of other authors in the social sciences can also be adapted in the same manner.

The results produced here regarding "the sacred" raise at least two questions that merit further attention. First, is the definition of spiritual care (Assertion 4) adequate? Does the definition provide a sufficient focus? Is it too narrow, too broad, too concrete, too ambiguous, too irrelevant to this ministry of spiritual care giving? Is the definition accurate and useful?

Second, is it helpful to use the social science research literature to advocate for spiritual care? Does citing research results create convincing advocacy? Is that advocacy likely more convincing to health care decision makers than existing approaches that involve relationships and political pressure? Discussion of these and additional questions may contribute to a clearer definition of spiritual care and advocacy of it in health care settings.