Effectiveness of Spiritual Intervention on Religious Struggle among COVID-19 Patients

Angelo Christopher M. Aguinaldo, MD and Ma. Teresa Tricia Guison-Bautista, MD

Background: Spiritual struggle is a state of distress a person experiences when relationships with the sacred are fundamentally challenged or broken. Its presence has been associated with increased morbidity and mortality. During the COVID-19 pandemic, attempts to address the whole being of patients, including spiritual well-being, were explored to improve outcomes of care.
Objective: The study determined the prevalence of spiritual struggle among COVID-19 related cases and assessed the effectiveness of a formulated spiritual regimen versus the standard pastoral care.
Methods: This is a randomized, triple-blind, controlled trial. COVID-19 patients tagged as having religious struggle were randomized into two equal groups (chaplain-led spiritual intervention and self-driven standard pastoral care). The Religious Struggle Screening Scale (RSSS) was measured at baseline and 4 weeks after the intervention in both groups.
Results: Prevalence of spiritual struggle among COVID-19 patients was 67%. Baseline patient demographics were similar for both groups. The overall RSSS slightly decreased throughout the 4-week duration for both groups. In addition, the six dimensions of the RSSS, namely: divine, demonic, interpersonal, moral, ultimate meaning and doubt were noted to have slightly improved. However, the differences in the two groups were not significant.
Conclusion: There is no difference in the effect on religious struggle of a formulated spiritual regimen and standard care given to COVID-19 patients.

Key words: religious/spiritual struggle, spiritual regimen/intervention

Introduction

Family physicians provide comprehensive primary care needs for patients and their families, including consideration of various social, economic, and cultural factors affecting health and disease. The effect of differences in cultural knowledge and identity, including religion on health outcomes at multiple levels may also play a vital role.[1] Literature suggests a strong relationship between spirituality and art of healing. Furthermore, spirituality is a complex and multidimensional part of the human experience which has cognitive, experiential and behavior aspects.[2]

The present pandemic emergence taught humanity a lesson. The high infectivity rate and uncertainties of the illness resulted to high level of fear, depression and anxiety. There is an inevitable need for a person's spirituality to be stirred and/or amplified.[3] Social isolation is an experience that produces negative impact on one's emotional well-being. Such patients require higher levels of support during time of seclusion and withdrawal from their family and community. An individual on isolation can cause internal struggles, as these are part of life. Spiritual struggles are among the deepest of all conflicts. Higher levels of religious struggle were associated with less recovery of independence in activities of daily living.[4] Patients who were angry at God did not show much improvement in their rehabilitation as patients who found comfort and strength in their faith.

Physician-related barrier was hesitancy broaching the subject of spirituality that includes lack of time, difficulty identifying patients open to discuss spirituality, and a belief that addressing spiritual concerns is not a physician's responsibility.[5] In a study, patients admitted to hospitals agree that spiritual health is equally important as physical health. Respondents believed that doctors

Department of Family and Community Medicine, Quirino Memorial Medical Center, Quezon City

should consider their patients' spiritual needs as part of their medical care and they want their physician to discuss their religious beliefs more.[6] Moreover, when spiritual care needs of hospitalized patients were not provided, they were at an increased risk of developing anxiety and depression.[7]

A spiritual screening tool, as part of a clinical encounter, is the first step in incorporating this perspective into medical practice to subsequently address their spiritual needs.[8] Screening for religious struggle is an attempt to identify patients who may potentially be experiencing an inner battle with their faith affecting their coping mechanisms with their illness. A positive screen triggers a referral to the chaplain who conducts a more thorough assessment.[9] The next step is spiritual care, which includes meaningful conversations on spirituality and the standard care, which require the physician to have compassion, understanding, and the art of active listening.[7] The RUSH Protocol was developed to satisfy the need for a method to screen patients for potential religious and spiritual struggle in medical contexts.[10]

This study determined the effectiveness of a formulated spiritual regimen to reduce spiritual struggle among COVID-19 related cases in a tertiary hospital.

In the light of holistic care and management, the results of this study will identify the need to apply routine screening for religious struggle and possibly implement a spiritual intervention to patients with COVID-19 illness spectrum.

Methods

Design

This is a randomized, triple-blind, controlled trial.

Participants

Patients were 19 years old and above, diagnosed as any of the COVID-19 related spectrum (suspect, probable or confirmed) who either sought teleconsultation and/or were admitted to the ward or isolation facility of Quirino Memorial Medical Center from January 10, 2022 to February 8, 2022. Only those who voluntarily signed the Informed Consent Form were included in the study. Excluded were minors, pregnant, COVID-19 critical cases, and with co-existing terminal illness.

Sample Size

Based on the average monthly census of the wards_(N=80), the computed sample size was 67 participants using Yamane formula with margin of error 0.05.

Randomization

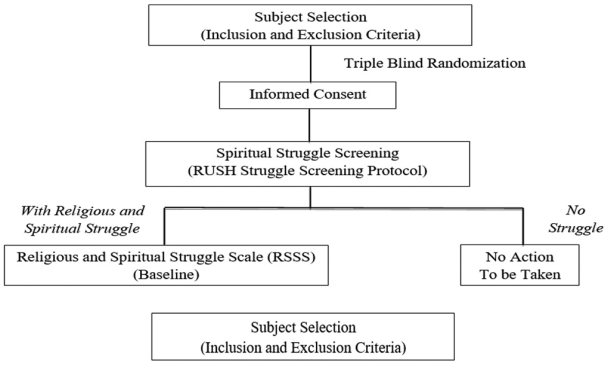
Eligible participants were randomly assigned at a 1:1 ratio to the treatment and control arms. The researchers were blinded to this process, and the allocation sequence was concealed throughout the trial.

Study Variables

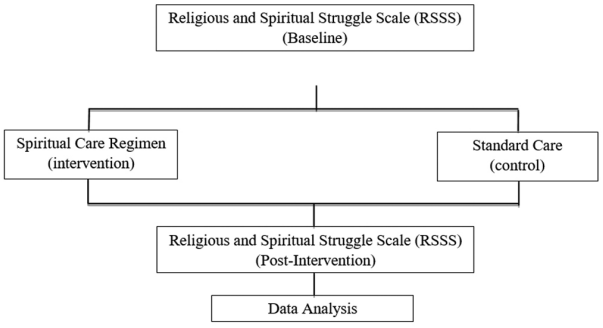
1. Demographics of respondents in terms of age, gender and religion.
2. Frequency of respondents who considered religion or spirituality as important in coping with illness.
3. Respondents' degree of comfort/strength received from their religion/spirituality.
4. Prevalence of spiritual struggle among respondents.
5. Level of religious struggle before and after the spiritual intervention and standard care.

Procedures

Part 1: From subject selection to spiritual struggle screening.



Part 2: From identification of those with spiritual struggle to spiritual intervention.

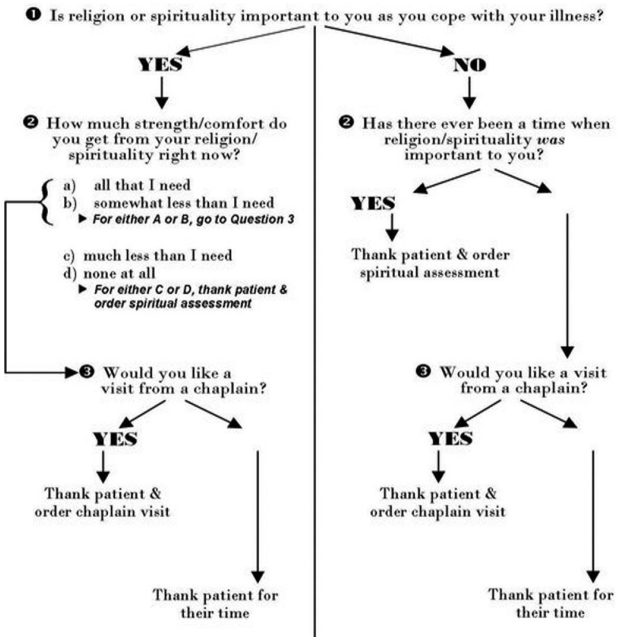


Data Collection

Gathering and collection of data were performed by a trained nurse who was blinded to the treatment assignment. Baseline data were obtained upon transfer to the COVID-19 ward. Data monitoring and validation were conducted by the resident-on-duty who was likewise blinded.

Tools and Questionnaires

1. Demographics
2. Religious Struggle Screening Protocol(RUSH Protocol)



The Rush Protocol from Rush University Medical Center in Chicago is the most researched and validated spiritual screening tool. The RUSH protocol results to 3 actions: 1) Referral to a chaplain/spiritual counselor for further spiritual assessment for those who experience incomplete level of comfort from spirituality, 2) referral to a chaplain for support for those who claim they receive complete level of comfort from spirituality, or 3) No Action. The need for spiritual support and care as they cope with illness was determined. Those who answered, "spirituality is not important for them, and who are receiving comfort that is 'Somewhat less than I need,' or 'None at all', were red flags for potential religious/ spiritual struggle. They were probed if they would like to have a visit from the chaplain of choice/spiritual counselor for an in-depth spiritual assessment or visit. Similarly, patients who answered, "All I need", and desired a visit to have spiritual support from the chaplain/spiritual counselor, were subsequently set an appointment.

Religious and Spiritual Struggle Scale

There are no right or wrong answers in this 26-item measures using a 10-point scale. A score of "0" means not at all/not applicable, "1" means slight degree up to "10" extreme degree. It consists of six domains of R/S struggle: divine (negative emotion centered on beliefs about God or a perceived relationship with God), demonic (concern that the devil or evil spirits are attacking an individual or causing negative events), interpersonal (concern about negative experiences with religious people or institutions; interpersonal conflict around religious issues), moral (wrestling with attempts to follow moral principles; worry or guilt about perceived offenses by the self), doubt (feeling troubled by doubts or questions about one's r/s beliefs), and ultimate meaning (concern about not perceiving deep meaning in one's life).

Spiritual Regimen / Intervention

A trained Chaplain formulated and carried out the spiritual regimen /intervention using the respondent's preferred platform (Facebook messenger/Viber/Google meet/Zoom/WhatsApp). It consisted of three (3) individual sessions centered around a specific theme and lasted for an average of 30 minutes

1. First session - participant's feelings about God's presence in his/ her life (e.g. abandonment, anger, neglect, etc)
2. Second session - participant's spiritual connection with God
3. Third session – targeted feelings of acceptance and surrender

Standard of Care (Control)

Standard of care consisted of services as requested by the patient such as anointing of the sick, call to prayer, gospel reading, litany of Christ the healer, remembrance, prayer of praise. For non-Christians, an equivalent anointing of the sick and customized pastoral care were rendered.

Ethical Considerations

All subjects were provided with informed consent form. A dialogue with the patient expounded on the purpose of the study, potential benefits and possible negative effects. The study was conducted in accordance with the protocol, consistent with the ethical principles such as the Declaration of Helsinki and the National Guidelines for Biomedical/Behavioral Research of the National Ethics Committee (NEC) of the Philippines. Participants were informed about refusal and withdrawal at any point during the study. All information gathered were kept confidential in accordance with the Data Privacy Law. The investigators made themselves available for any questions or clarifications raised. Respondents were not given remunerations but were rendered appropriate medical attention, treatment and spiritual support. The study was reviewed and approved by the QMMC Ethics Committee for review and approval.

Data Analysis

Percentage and frequency distribution were used for the categorical data. Independent t test was used to compare the two groups. The level of significance was set at p values <0.05. Statistical analysis was done using Medcalc statistical software.

Results

A total of 113 patients were screened using the RUSH protocol. Only 76 respondents were eligible and were enrolled to the study from January 10, 2022 to February 8, 2022. Thirty-eight patients were equally allocated to the intervention and control arms. In between the first and second week, 3 patients from treatment group and 6 from the control group dropped out as they clinically deteriorated.

Patient Demographics

There were no differences between the 2 groups in terms of the participants' demographics except that there were more females in the intervention group and more males in the control group.

COVID-19 Severity Profile

Comparison between intervention and control group. Higher percentage was mild (42.11%) followed by asymptomatic (34.21%), moderate (15.79%) and severe (7.89%) in intervention group. On the other hand, mild (42.11%), moderate (34.21%), asymptomatic (15.79%) and severe(7.89%). P value showed no significant difference (0.6127).

Importance of Religion or Spirituality (R/S) in Coping with Illness

A higher percentage (46%) believed that religion or spirituality is not important in coping with illness, followed by respondents who do not have any idea (38.05%).

Degree of Comfort/Strength Received from their Religion/ Spirituality

Half of the respondents claimed that they receive less comfort/ strength from their religion/spirituality than what they need", followed by "all that I need" (32.74%) and "no comfort or none at all"(17.70%). The prevalence of spiritual struggle was 67.26%.

Intervention Group

Respondents had no significant changes in their scores using the religious spiritual struggle scale (RSSS). However, the overall RSSS score slightly decreased from 3.21 to 3.19 after intervention, which was reflected across all domains: divine (4.25 to 4.22) demonic (2.11 to 2.08), interpersonal (2.43 to 2.42), moral (3.24 to 3.21), ultimate meaning (3.78 to 3.73) and doubt (3.43 to 3.42).

Standard of Care

The respondents from the control group also had stable RSSS scores. Closer look, the overall RSSS scale showed slight reduction from 3.44 to 3.35, and in 5 out of 6 domains such as divine (5.14 to 5.01),

Table 1. Respondents' demographics.

	Intervention (n=35)		Control (n=32)		p value
	n	%	n	%	
Age					
19 to 59	29	82.9	27	84.4	0.8679
≥60	6	17.1	5	15.6	
Gender					
Male	14	40.0	20	62.5	0.0678
Female	21	60.0	12	37.5	
Major Religion					
Christian	9	25.7	9	28.1	0.8904
Catholic Church	15	42.9	15	46.9	
Iglesia ni Cristo	3	8.6	2	6.3	
Islam	2	5.7	2	6.3	
Seventh-day adventist	5	14.3	2	6.3	
Jehovah's Witnesses	1	2.9	2	6.3	

Table 2. COVID-19 severity profile between intervention and control group.

	Intervention		Control		P value
	n=38	%	n=38	%	
Asymptomatic	**13**	**34.21**	**9**	**23.68**	**0.6127**
Mild	**16**	**42.11**	**15**	**39.47**	
Moderate	**6**	**15.79**	**10**	**26.32**	
Severe	**3**	**7.89**	**4**	**10.53**	

interpersonal (2.70 to 2.61), moral (3.37 to 3.26), ultimate meaning (3.78 to 3.67) and doubt (3.52 to 3.41).

Comparison between Spiritual intervention Group and Control Group

The degree of change before and after intervention was compared with control group. There was no significant difference between the two groups. This was also true in terms of demonic, interpersonal, moral, ultimate meaning and doubt dimensions.

Discussion

Spirituality has been an indicator of good health rationalizing the attempts to include a spiritual component to health assessment.[11] Hence, it may be appropriate to include spirituality in discussions related to providing whole person health care. Religious/Spiritual struggle (R/S) is a state of challenge during times of great stress and disequilibrium; times when the self is embattled by illness or loss.[12] Spiritual/Religious struggle was associated with poorer physical health, worse quality of life, depressive symptoms in 557 hospitalized, medically ill older patients[13] and significant predictor of mortality. Surprisingly, the study demonstrated a high 67% prevalence of R/S struggle compared to several studies where it usually ranged from 10 to 63%.[14] The unpredictability of catastrophic consequences of the pandemic times was postulated as the possible reason to the relative increase in prevalence of spiritual struggle.[15] In addition, the uncertain atmosphere related to COVID-19 may aggravate struggles and may result to ill-defined directions for proper coping.

To begin with, majority of the cohort of subjects in this study, did not consider R/S as an important aspect when coping with illness, on top of a number of lukewarm disposition ("no idea") towards it. The

Table 3. RSSS scores before and after the spiritual intervention.

	n	1st		2nd		p value
		Mean	SD	Mean	SD	
Divine	35	4.25	1.93	4.22	1.94	0.2113 ns
Demonic	35	2.11	0.53	2.08	0.53	0.3256 ns
Interpersonal	35	2.43	0.99	2.42	1.00	0.1608 ns
Moral	35	3.24	0.96	3.21	1.00	0.3256 ns
Ultimate Meaning	35	3.78	0.99	3.73	1.03	0.2313 ns
Doubt	35	3.43	0.94	3.42	0.98	0.8454 ns
Overall score	35	3.21	0.85	3.19	0.88	0.2776 ns

Table 4. RSSS scores of control group from baseline to end of study.

	n	1st		2nd		p value
		Mean	SD	Mean	SD	
Divine	32	5.14	0.99	5.01	1.00	0.1317 ns
Demonic	32	1.91	0.56	1.91	0.56	0.7869 ns
Interpersonal	32	2.70	0.97	2.61	0.96	0.1428 ns
Moral	32	3.37	0.99	3.26	0.98	0.1023 ns
Ultimate Meaning	32	3.78	1.09	3.67	1.06	0.1518 ns
Doubt	32	3.52	1.01	3.41	0.98	0.1297 ns
Total	32	3.44	0.73	3.35	0.73	0.1120 ns

Table 5. Comparison between intervention and control groups.

	Intervention			Control				
	n	Mean Difference	SD	n	Mean Difference	SD	Difference	p value
Divine	35	0.03	0.11	32	0.13	0.45	-0.10	0.2278 ns
Demonic	35	0.03	0.14	32	0.01	0.17	0.02	0.6847 ns
Interpersonal	35	0.01	0.05	32	0.10	0.34	-0.09	0.1963 ns
Moral	35	0.03	0.18	32	0.11	0.36	-0.08	0.2885 ns
Ultimate Meaning	35	0.04	0.19	32	0.11	0.41	-0.07	0.3965 ns
Doubt	35	0.01	0.23	32	0.10	0.36	-0.09	0.2282 ns
Total	35	0.02	0.12	32	0.10	0.31	-0.08	0.2524 ns

lack of value placed on R/S in the medical context at baseline could affect the final turn out of the study variables. This could also explain why it is highly probable to observe seemingly status quo findings even with the implemented spiritual intervention. While the RUSH protocol is the most validated screening method, newer studies recommend to utilize more than two screening tools to define those with R/S struggle. In one study, the sensitivity of RUSH protocol was only 42%, while the specificity was at 81%.[10] It is likely that those with R/S struggle were not well captured. Furthermore, the screener, in this case a trained nurse, could also be affected by the other competing demands of work and may have performed the screening process in less favorable circumstances.

The spiritual regimen employed in this study was conceptualized by the volunteer chaplain based on a contemporary pastoral care framework. It was developed into a professional person-centered holistic care approach, recognizing pastoral/spiritual care interventions such as assessments, support, counselling, guidance, education, and rituals to assist with the spiritual, religious, or existential need(s) of a patient. While there is a conceptual framework for the spiritual regimen, one aspect to look at is the efficacy and appropriateness of the formulated spiritual intervention, in terms of who, what, when, where and how of the process. It is possible that the spiritual care provider may not meet the expectations of the participant, the R/S themes discussed during sessions may not be relevant to the participant at that moment, the timeliness of the actual sessions in relation to the illness trajectory could be off, the apparent impersonal online mode of delivery and the overall acceptability of the intervention may negatively impact the way it was perceived by the participants.

Technology can only ever be an instrument; the skills and professional art of the pastoral care/healthcare chaplain remain key to the provision of exquisite and professional pastoral care, and arguably more so in a virtual sense without the benefit of physical presence. Pastoral relatedness, empathic care, and deep listening require more intention from the chaplain without the ability to be physically present. Potential factors influencing the outcome of the deployment of the RUSH protocol and/or spiritual regimen were: 1) patients who were experiencing religious or spiritual struggle, for example feeling angry with the Divine, may not be comfortable disclosing this information in the context of an initial assessment with an unfamiliar health professional/ spiritual care provider; 2) cultural adaptability of the RUSH protocol in the Philippine setting focusing on clarity and relevance to the sensibilities of local people; 3) the relatively short duration of the study where timeliness of intervention at the height of medical distress could change the perceived level of struggle, as a longer study period would strengthen the conclusion.[16] 4) The assurance of protection brought by the COVID-19 vaccination could somewhat allay anxiety and fears.

The understanding of the process of resolution of spiritual struggle is dependent on the individual person's definition of resolution (as the definition may determine when the individual felt they had resolved their struggles, the importance of resolution, etc.) There is not as of yet a constructed definition of spiritual resolution, and so this can be largely relative. Aside from the growing evidence of the harmful effects of spiritual struggle, another concern raised by Fitchet,et al. 2000 was that patients with higher spiritual needs were less likely to request a chaplain.[17] Chaplains are usually limited in health care institutions, especially those with multi-religion milieu and tend to respond only to identified needs; thus, predisposing persons with greater spiritual needs or spiritual struggle to go unidentified and unassisted.[10] This lack may negatively affect the healthcare institutions' patient satisfaction as shown in a study by Marin, et al., revealing that chaplain visits increased the willingness of patients to recommend the hospital, that patients visited by chaplains were also more likely to endorse that staff who met their spiritual needs and their emotional needs, and that patients visited by a chaplain were more satisfied in chaplains' integration into the healthcare team, improving patients' satisfaction with their hospital stay.[18]

Conclusion

With the degree of change in the Religious Spiritual Struggle Scale before and after spiritual intervention turning out to be not significant, it can be implied that the employed intervention was not effective in reducing religious and spiritual struggle for the duration of the study. What proved promising was the improved overall and dimensional scores in RSSS in terms of demonic, interpersonal, moral, ultimate meaning and doubt, among those who struggled in the intervention group than in the control group.

Recommendation

Lengthening the duration of the study may be helpful in seeing the true picture of the outcome variables. Incorporating qualitative data may also provide depth and breadth of the recognized R/S struggles. Despite the lack of effectiveness of spiritual intervention shown in this study, the many supporting studies suggesting that spiritual issues should be considered as part of the patients' holistic medical care would be sufficient evidence to integrate R/S struggle screening and management. The study took the first step to objectively measure the spiritual needs of patients by incorporating a brief, unprejudiced spiritual assessment in the patient's history that can be adapted by other health care professionals especially when spiritual issues strongly impact their patients' treatment outcome.

References

1. Kirmayer LJ. Rethinking cultural competence. Transcult Psychiatr 2012; Apr;49(2):149-64. doi: 10.1177/1363461512444673.
2. Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. Am Fam Phys 2001 Jan 1;63(1):81-9.
3. Sahoo S, Mehra A, Suri V, Malhotra P, Yaddanapudi LN, Dutt Puri G, Grover S. Lived experiences of the corona survivors (patients admitted in COVID wards): A narrative real-life documented summaries of internalized guilt, shame, stigma, anger. Asian J Psychiatr 2020 Oct;53:102187. doi: 10.1016/j.ajp.2020.102187. Epub 2020 May 30.
4. Fitchett G, Rybarczyk BD, DeMarco GA & Nicholas JJ. The role of religion in medical rehabilitation outcomes: A longitudinal study. Rehab Psychol 1999; 44(4): 333–53. doi: 10.1037/0090-5550.44.4.333 Corpus ID: 144375829

5. Saguil A, Phelps K. The spiritual assessment. Am Fam Physic 2012 Sep 15; 86(6):546-50.
6. Pearce MJ, Coan AD, Herndon JE 2nd, Koenig HG, Abernethy AP. Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. Support Care Cancer 2012 Oct;20(10):2269-76. doi: 10.1007/s00520-011-1335-1. Epub 2011 Nov 29.
7. Anandarajah G and Hight E. [Brown University School of Medicine, Providence, RI]. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. Am Fam Phys 2001; 63(1): 81-9.
8. Fitchett G, Murphy P, King SDW. Examining the validity of the rush protocol to screen for religious/spiritual struggle. J Health Care Chaplain 2017 Jul-Sep;23(3):98-112. doi: 10.1080/08854726.2017.1294861. Epub 2017 Apr 3.
9. Akbari M, Hossaini SM. The relationship of spiritual health with quality of life, mental health, and burnout: The mediating role of emotional regulation. Iran J Psychiatr 2018 Jan;13(1):22-31.
10. Fitchett G, Risk JL. Screening for spiritual struggle. J Pastoral Care Counsel 2009 Spring-Summer;63(1-2):4-1-12.
10. Koenig HG. Is Religion Good for Your Health?: The Effects of Religion on Physical and Mental Health (1st ed.). Routledge. 1997. https://doi.org/10.4324/9781315869964
11. Larson JS. The World Health Organization's definition of health: Social versus spiritual health. Soc Indic Res 1996; 38: 181–92. https://doi.org/10.1007/BF00300458
12. Risk J. 2008, April. Spiritual Struggle. Retrieved from URL http://www.healthministriesnetwork.net/Health_and_Wellness/Spiritual/Spiritual_Struggle.pdf
13. Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: a two-year longitudinal study. J Health Psychol 2004 Nov;9(6):713-30. doi: 10.1177/1359105304045366.
14. Roze des Ordons AL, Sinuff T, Stelfox HT, Kondejewski J, Sinclair S. Spiritual distress within inpatient settings- A scoping review of patients' and families' experiences. J Pain Symptom Manage 2018 Jul;56(1):122-145. doi: 10.1016/j.jpainsymman.2018.03.009. Epub 2018 Mar 14.
15. Koffman J, Gross J, Etkind SN, Selman L. Uncertainty and COVID-19: how are we to respond? J R Soc Med 2020 Jun;113(6): 211-6. doi: 10.1177/0141076820930665.
16. Temple M & Kerlin AM. A qualitative exploration of strategic trauma and abuse recovery: A spiritually integrated treatment to address trauma. J Psychol Theol 2022; 0(0). https://doi.org/10.1177/00916471221077248
17. Fitchett G, Meyer PM, Burton LA. Spiritual care in the hospital: who requests it? Who needs it? J Pastoral Care 2000 Summer;54(2):173-86. doi: 10.1177/002234090005400207.
18. Marin DB, Sharma V, Sosunov E, Egorova N, Goldstein R, Handzo GF. Relationship between chaplain visits and patient satisfaction. J Health Care Chaplain 2015;21(1):14-24. doi: 10.1080/08854726.2014.981417.