The Prevalence of Spiritual Struggle Among Patients with Chronic Illness

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Background: During the last 10 years, there is an increase in the number of studies showing positive associations between spirituality and health. Studies cited that many patients would like spiritual issues embedded into their medical care but not many physicians deal with this elusive domain of well-being. Spiritual screening is a first step towards addressing the spiritual needs of patients.

Objectives: To determine the prevalence of spiritual struggle in chronically ill patients.

Data Collection: This is a descriptive cross-sectional type of study. Using the STATCALC of Epi Info Software for a simple random sampling, we enrolled 80 chronically ill patients from the service wards of the Quirino Memorial Medical Center, aged 19 years old and above, non-pregnant, and claimed to be Christians. Patients' religious disposition was screened using the Religious Struggle Screening Protocol (RUSH Protocol) resulting to 3 actions: 1) referral to chaplain/spiritual counselor for a visit, 2) referral to chaplain/spiritual counselor for spiritual assessment, or 3) No Action. A patient perception feedback was likewise conducted.

Results: Among 80 patients recruited, 100% of the subjects recognized the importance of spirituality in coping with their condition; of which 90% expressed desire to be visited or referred for spiritual support. As to the degree of comfort received from one's religion or spirituality in their journey with illness, 82% receive complete level of comfort, and almost all of them (96%) wished to be visited by a chaplain. The remaining 18% claimed to receive less comfort than needed, and therefore, have the potential for religious/spiritual struggle -- 80% of which, desired to be referred for spiritual assessment. All patients found it helpful to be asked about their spiritual needs during history-taking, with 95% feeling comfortable with the way the spiritual needs were elicited by the researcher using the RUSH Protocol algorithm.

Conclusion: Spiritual issues should be considered as part of the patients' medical care. The RUSH Protocol may be formally integrated in the history taking as an initial step for spiritual assessment to support vulnerable patients with chronic illness.

Keyword: chronic illness, spiritual assessment, medical care

Introduction

Family medicine emphasizes holistic medical care of a person. This includes empathetic consideration of a patient's family, psychological, social, environmental, and cultural situation. Over the past several years, however, there were several suggestions that spirituality is another significant, yet often abandoned and ignored factor in the holistic health of patients,[1] and recently, the relationship between spirituality and medicine has been the focus of considerable interest. World Health Organization has recognized the need of the 4th dimension of health, i.e., the spiritual health to be considered as an important element, with the new proposed definition of health as… "a dynamic state of complete physical, mental, spiritual and social well being, and not merely the absence of disease or infirmity."[2]

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As patients go through lingering illness, their spiritual and religious concerns may be awakened or intensified. Many physicians, however, feel inexperienced and uncomfortable discussing these concerns. Some doctors prefer not to address spiritual issues for fear of imposing religious beliefs, uncertainty of offending patients, lack of knowledge on how to handle it, and lack of time.[3] However, studies suggest that many patients believe spirituality plays an important role in their lives, that there is a positive correlation between a patient's spirituality or religious commitment and health outcomes, and that patients would like physicians to consider these factors in their medical care.[4] In fact, up to 77% of patients would like spiritual issues embedded into their medical care, yet only 10 to 20% of physicians discuss these matters with their patients.[5] These reports became an impetus for more than 80 American medical schools to offer courses on spirituality and teach spiritual history-taking skills.[5]

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.[4] Screening for religious/spiritual struggle is an attempt to identify patients who may potentially be experiencing an inner battle with their faith impacting their coping strategies with illness. It employs a few, simple, non-threatening questions. A positive screen triggers a referral to the chaplain who conducts a more thorough assessment.[7] The next step is spiritual care, which includes the therapeutic aspects of spirituality and medicine to bring presence, compassion, understanding, and active listening to each encounter.[4]

In scientific studies, the commonly used definition of spirituality is by Pargament, defining it as, "the search for the sacred".[8] Spiritual struggle is about the struggle a person experiences when relationships with the sacred are fundamentally challenged or broken during times of great stress and disequilibrium; times when the self is embattled by illness or loss.[9] A study of 96 medical rehabilitation patients by Fitchett, et al. reported that higher levels of religious struggle were associated with less recovery of independence in activities of daily living.[10] In Another study, it was found out that religious struggle was associated with poorer physical health, worse quality of life, and greater depressive symptoms in 557 hospitalized, medically ill older patients.[12] Other research, among both patients and community samples, gives further evidence of the adverse emotional effects of religious or spiritual struggle.[13-15]

The Rush Protocol (Appendix A) was developed to satisfy the need for a method to screen patients for potential religious and spiritual struggle in medical contexts.[16,18] The Rush Protocol has been utilized for research purposes and published reports are already beginning to appear. In one study, the Rush Protocol was incorporated in an electronic self-report of symptoms for use with 187 oncology patients wherein 18% were identified as potentially experiencing religious or spiritual struggle.[19] Another study screened 197 older adults with depression who were referred from primary care practices to an interdisciplinary team intervention for depression.[20] In this sample, 51% screened positive.

The sensitivity of the Rush Protocol was low (42.1%) but the specificity was acceptable (81.3%).[16] A pilot study was done in which non-chaplain healthcare colleagues administered the screening protocol to patients admitted in an acute medical rehabilitation unit. The protocol identified 7% of the patients as possibly experiencing religious/spiritual struggle.[16] Limited body of evidence suggests the Rush Protocol may be useful for screening for religious and spiritual struggle among diverse clinical populations.[16]

This study initiates the screening for spiritual need in the healthcare settings in the Philippines using the Rush Protocol in chronically ill patients, in the hope that health care professionals can help address Filipino patients' spiritual needs, improve efficiency in chaplain referral and consequently, overall patient satisfaction.

Methods

The descriptive cross-sectional study was conducted in a 500-bed tertiary government hospital, of which 427 beds are allocated for service wards. As part of inclusion criteria, participants must be adult, aged 19 years old and above, non-pregnant, and must be chronically ill. Quoting the WHO definition, "Chronic diseases, are not passed from person to person. They are of long duration (3 months or more) and generally slow progression. Patients with the following list of chronic illnesses based on this definition of the WHO and CDC were included as subjects in the study: Arthritis, Asthma, Cancer, Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus Type 2, Heart Disease, Stroke, and chronic pain presenting in duration of 3 months or more. Moreover, only patients who belong to Christian religion or spiritual group whose beliefs are based on the teaching of Jesus (Roman Catholic, Born Again, Methodists or Baptists) were included to avoid variability in subjects.

Through the hospital's information system, the authors were able to get an average of 708 service patients admitted per month excluding pediatric and obstetric services. Forty-nine patients fulfilled the CDC and WHO definition of "chronically-ill", using the ICD Code; 46 out of 49 patients were Christians. STATCALC of Epi Info Software was used to compute the sample size. Based on a previous study by King et al., (2013) and Murphy et al. (2012), the frequency of religious/spiritual struggle in

patients was between 18% - 51%. Based on this assumption, a sample size of 45 patients at a power 99.99% was set. But to account for possible dropouts and improve reliability, sample size was inflated by 80% (81 patients).

Those who refused to consent, with terminal and/or unstable conditions were excluded. A patient who could respond but unable to write, sign or mark a document was asked to may indicate his consent orally in the presence of at least one witness and recorded in writing.

The paper complied with and was approved by the Institutional Review Board of the hospital prior to implementation (Figure 1).

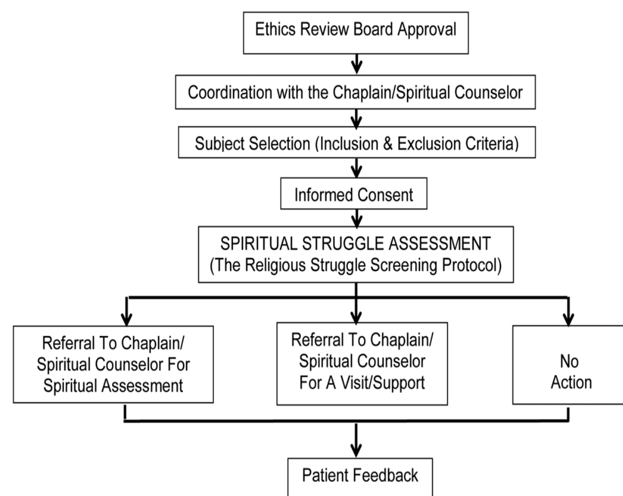

Figure 1. Research study process flow

Participant selection was made in July to August 2018. All identified subjects were asked to sign an informed consent.[1] One subject refused to sign the consent form, thus a total of 80 subjects were screened. Actual screening using the Religious Struggle Screening Protocol translated in Tagalog language (Figure 2) was subsequently employed.

Before the spiritual struggle screening, chaplains and spiritual counselors were informed and coordinated about the spiritual care they will do to patients. The screening for spiritual struggle was through administration of the Religious Struggle Screening Protocol resulting 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) Visit by 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. A feedback questionnaire was conducted by the research assistant who was blinded by the results of the research protocol. The feedback form was answered by the patient prior

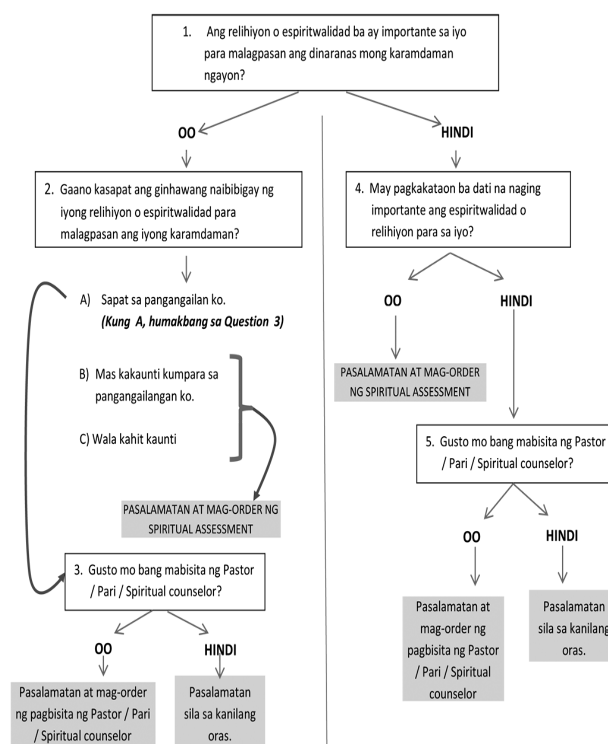

Figure 2. Religious Struggle Screening Protocol (Tagalog version)

to the spiritual care and visit by the chaplain/spiritual counselor to avoid bias.

The patients were screened for red flags. Subjects 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. "Spiritual counselor" is defined as a volunteer non-chaplain personnel, who is part of a Christian-based organization, and had some relevant religious formation or training. According to patient preference, they may take the place of a chaplain in conducting spiritual counseling. Once the subject agrees, an appointment card was handed. Similarly, patients who answered "All I need", and desired a visit to have spiritual support from the chaplain/ spiritual counselor, were subsequently scheduled and given an appointment card. The patient-physician interaction was ended by answering a feedback questionnaire to inquire if they felt any discomfort while being asked about their spirituality and if they were satisfied with the screening process.

Delimitation

Due to the lack of spiritual professionals who can specifically cater the needs of patients belonging to the non-Christian

religion, the study confined its subjects to those upholding Christian faith and those with a chronic trajectory of illness. Additionally, the result or feedback on the spiritual assessment and visit done by the chaplain or spiritual counselor was beyond the scope of this research.

Results

The average age was 57 years old, 2/3 were female, 1/3 male, and 86% were Roman Catholic. Majority of the patients are suffering from Cancer (25%), followed by Diabetes (17.5%) and Stroke (10%) (Table 1).

Among 80 Christian patients battling with chronic illness, 100% believed that spirituality is important in coping with their illness. There were 82% of the subjects (n=66) who reported that they receive all the strength/comfort they need from spirituality as they experience chronic illness, and 96% of which (n=60), desire to be visited by a chaplain/spiritual counselor (Figure 3).

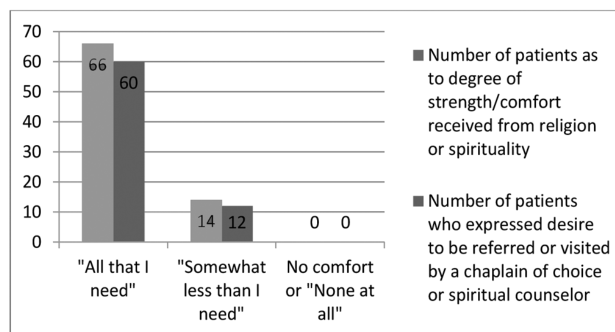

Figure 3. Frequency distribution according to degree of comfort patient receives from their spirituality and desire to be referred for spiritual support.

Eighteen percent of the subjects (n=14) reported that the comfort they receive from their spirituality/religion is "somewhat less than they need"; and were therefore likely to have spiritual/ religious struggle. After patients were informed that they will be referred to a chaplain/ spiritual counselor of choice for assessment, only 80% of these subjects (n=12) desired to be referred for spiritual assessment. No one claimed that they receive no comfort from their spirituality (Figure 3). When combined, 90% of patients with chronic illness desired to be referred for spiritual support.

Among 80 subjects screened for spiritual struggle, 18% were potentially flagged as at risk for religious struggle. Hence, this subset of population was referred for in-depth spiritual assessment by a chaplain/spiritual counselor (Figure 4).

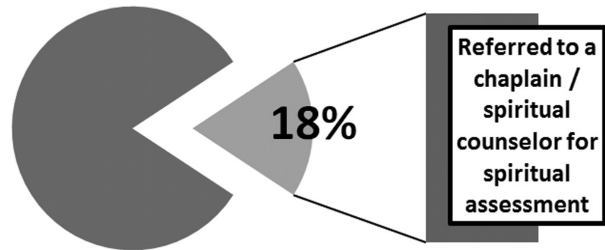

Figure 4. Prevalence of spiritual struggle and their openness for a spiritual assessment by a chaplain or spiritual counselor.

When patient feedback was elicited after conducting the screening, 95% of the subjects said they felt comfortable, and 100% satisfied with the way their spiritual faith was asked by a physician using the RUSH Protocol algorithm (Figure 5). One subject admitted being uncomfortable when being asked about religion / spiritual matters using the said protocol.

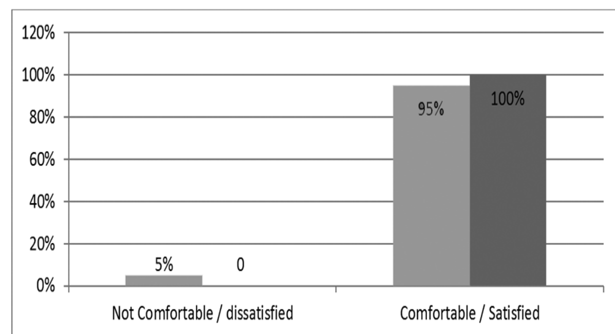

Figure 5. Percentage in terms of presence of discomfort and satisfaction with how the RUSH protocol was administered by the physician.

In summary, all patients in this study recognized the importance of spirituality in coping with their chronic illness and majority of them desire to be visited or referred for spiritual support. Performing this screening was acceptable and considered beneficial by almost all participants, but it would be prudent to be sensitive to individual idiosyncrasies.

Discussion

RUSH protocol algorithm allowed us to employ a few, simple, non-threatening questions to quickly detect patients facing spiritual struggle and subsequently facilitate immediate referral to spiritual professionals as appropriate to their need.

Subjects who answered "spirituality is not important for them", or who are receiving comfort that is "Somewhat less than

Table 1. Demographic profile.

N = 80	Total	As to level of comfort received from Religion/Spirituality			Desired Visit/ Assessment	
		"All that I need"	"Somewhat Less than I need"	"None at all"	Yes	No
Age range						
19-29	4	4 (100%)	-	-	4 (100%)	-
30-39	5	5 (100%)	-	-	5 (100%)	-
40-49	17	11 (65%)	6 (35%)	-	16 (94%)	1 (6%)
50-59	24	21 (87%)	3 (13%)	-	20 (83%)	4 (17%)
60-69	15	12 (80%)	3 (20%)	-	13 (87%)	2 (13%)
70-79	9	8 (89%)	1 (11%)	-	8 (89%)	1 (11%)
80-89	6	5 (83%)	1 (17%)	-	5 (83%)	-
Sex						
Male	28	24 (86%)	4 (14%)	-	25 (89%)	3 (11%)
Female	52	42 (81%)	10 (19%)	-	47 (90%)	5 (10%)
Religion						
Roman Catholic	69 (86%)	57 (83%)	12 (17%)	-	63 (91%)	6 (9%)
Born Again	10 (12.5%)	8 (80%)	2 (20%)	-	8 (80%)	2 (20%)
Baptist	1 (1%)	1 (100%)	-	-	1 (100%)	-
DISEASE						
Cancer	20 (25%)	16 (8%)	4 (28%)	-	19 (95%)	1 (5%)
DM Type 2	14 (17.5%)	12 (86%)	2 (14%)	-	13 (93%)	1 (7%)
CVD Infarct	8 (10%)	7 (88%)	1 (7%)	-	7 (88%)	1 (12%)
Heart Disease	5 (6%)	2 (40%)	3 (21%)	-	4 (80%)	1 (20%)
Hypertension	10 (12.5%)	7 (70%)	3 (21%)	-	10 (100%)	-
CKD	3 (3.7%)	2 (67%)	1 (7%)	-	2 (67%)	1 (33%)
Others (Asthma, Liver disease, SLE, SCI, chronic pain)	20	19 (95%)	1 (7%)	-	18 (90%)	2 (10%)
Total N=80						

I need," or "None at all", are the red flags for potential religious/ spiritual struggle. In a study by Murphy, the prevalence of spiritual struggle in the older age with depression was 51%. Another study by King, which closely resembled this paper, had a similar prevalence rate of 18% with the present study. The difference is that patients were limited to patients who belong to Christ-based religion, and the authors included a variety of chronic illness, not just one.

Factors influencing the prevalence rate may include the stage of grief the patient is experiencing during at the time of interview. For example, those who are under "denial" and "acceptance" stage may have less risk for religious struggle as compared to those who are still under "anger", "bargaining", and "depression" stage. Patient's openness is a paramount factor affecting prevalence as well; thus, striving to gain patient trust and support preceding interview cannot be overemphasized more. Patients must feel that the screener is "serious" in their spiritual abetment so that the patient will contemplate well on the answer; otherwise, patient is susceptible to give a "rightful" answer rather than a sincere one.

All patients claimed that spirituality/religion is important in their ability to cope with long term illnesses; thus, physicians are not offending patients when they mention "God" during conversations that are meant to uplift them. In fact, majority of the patients who consented referral for pastoral care would like to obtain the sacrament of confession, prayer, and/or have an in-depth spiritual assessment, signifying their sturdy desire for spiritual support during this difficult time. Patients who answered they receive "all the strength and comfort they need" from religion/spirituality, yet still expressed the desire to be visited by a chaplain/spiritual counselor may signify a probable underlying struggle that was initially concealed or only partially resolved and/or a continuing need for spiritual nurturance. Thus, patients may not at all appear emotionally and spiritually "distressed" to warrant pastoral care.

Family physicians currently utilize the FICA assessment tool (Appendix C) to assess spiritual needs of patients and incorporate precepts of faith traditions to the treatment plan. While also useful, FICA tool contains open ended questions to elaborate on patient's spiritual background, producing subjective answers, and require longer time to employ. When physicians feel apprehensive using or have time scarcity employing FICA tool, but need a quick measure for spiritual need, the RUSH Protocol Algorithm is the best tool to use. It is imperative however, that spiritual professionals in one's institution are available and have been immediately coordinated with, to avoid giving false hopes to patients that they will be visited.

The authors noted that some patients who answered they receive "somewhat less strength/comfort than they need" from their religion/spirituality refused to be referred to a chaplain/ spiritual counselor. In this instance, the screener or healthcare provider may incorporate FICA assessment tool to take advantage of its open ended questions that could initiate a conversation about spiritual struggle, consequently encouraging patients to seek spiritual counseling.

The advantages of Religious Struggle Screening Protocol (RUSH Protocol) for spiritual need assessment in this study are the following: 1) spirituality is a potentially important component of every patient's physical wellbeing and mental health, 2) its simplicity allows it to be meaningfully used in every follow-up to continuously address ongoing spiritual struggle/s, 3) it respects patient's preference and privacy regarding spiritual beliefs, 4) it makes referrals to chaplains, spiritual directors or community resources as appropriate according to patient's choice. 5) when physicians engage in spiritual discussion, they uncover issues acting as barrier to patient's holistic care.

Conclusion and Recommendation

Results support previous studies suggesting that spiritual issues should be considered as part of the patients' holistic medical care. In the authors' goal to objectively measure patients with potential spiritual struggle and subsequently address patients needing spiritual care, results highlighted the importance of spirituality in coping with chronic illness and the unequivocally high percentage of patients desiring pastoral care and support—yet the spiritual issues remain unaddressed as a vital health concern in the hospital setting.

Results outcry that spiritual issues must be elaborated rather than omitted in conversations with the goal of bringing vulnerable patients into light and prevent crippling complications of chronic illness such as dissatisfaction, hopelessness, depression, familial dysfunction, and suicidal thoughts from arising.

This study took the first step to objectively measure the spiritual need of chronically ill patients by incorporating a brief, unprejudiced spiritual assessment in the patient's history that can be adapted by other health care professionals if they believe there are spiritual issues strongly impacting their patients' treatment outcome. With the largely measured spiritual need and yet lack of resources to address them, the authors recommend family physicians to advance to the next step which is embark and embrace spiritual health advocacies that will raise advertence and foster spiritual care in their respective hospitals.

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