March 2016 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Park, C. L., Aldwin, C. M., Choun, S., George, L., Suresh, D. P. and Bliss, D. "**Spiritual peace predicts 5-year mortality in congestive heart failure patients**." *Health Psychology* 35, no. 3 (March 2016): 203-310.

SUMMARY and COMMENT: Our article this month begins by noting that "[r]esearch linking religiousness to physical health, including mortality, has been accumulating for decades" but "[m]ost of the research examining the religiousness-mortality link has focused on attendance at worship services" [p. 203]. In contrast, the present study "focused specifically on the spiritual component of deep peacefulness, which has been shown to be critically important to individuals with serious and life-limiting illnesses," using a sample of patients with congestive heart failure (CHF), a disease for which "[s]urprisingly few studies have examined psychosocial factors and mortality outcomes" [p. 204]. "CHF is among the most prevalent chronic diseases in the United States, ...the only cardiovascular disorder that is increasing in both incidence and prevalence, [and] ...one of the most expensive chronic diseases in the United States" [p. 204].

A sample of 191 CHF patients from a multicardiologist practice in greater Cincinnati, OH, and Northern Kentucky were recruited and assessed in 2007, and mortality data were collected between 2011 and mid-2013. Spiritual peace was assessed by a single item from the Fetzer Multidimensional Measure of Religiousness and Spirituality: "I feel deep inner peace or harmony," rated on a 6-point Likert scale ranging from *never or almost never* to *many times a day* [--see Related Items of Interest, §I, below]. Our authors understand the idea of peacefulness here in terms of "the affective aspects of spiritual-wellbeing..., a 'state of tranquility or serenity' [and] a subjective sense that may refer to feeling at peace with God or to a nonreligious sense of tranquility" [p. 204]. They additionally explain, "Peacefulness may reflect a sense of resolution regarding interpersonal conflicts, acceptance of one's illness, a lack of struggle, and a sense of comfort and meaningful connection" [p. 204]. Other variables assessed were: service attendance, social support, depressive symptoms, adherence to healthy lifestyles, alcohol consumption, smoking status, 14 specific health conditions, and CHF functional capacity.

At 5-year follow-up, 61 participants (31.94%) had died. Among the findings from the data:

> ...[T]he religious (attendance) and spirituality (peace) variables were, in general, related to better health and health behaviors. Both were inversely associated with depressive symptoms and positively with better adherence to healthy lifestyle recommendations. ...However, religious attendance was unrelated to either survival or mortality in this study. ...Spiritual peace was significantly associated with decreased risk of mortality, by 20%.... Figure 1 [below] plots the survival curves for individuals with high and low levels of spiritual peace, controlling for all of the

other variables in the model. For illustrative purposes, we dichotomized spiritual peace (1 = never or almost never to some days; 2 = most days to many times a day). Very few of those with high levels (i.e., feeling inner peace and harmony most days to many times a day) had died by the end of the study period, compared with about 25% of those with low levels of spiritual peace. [p. 207]

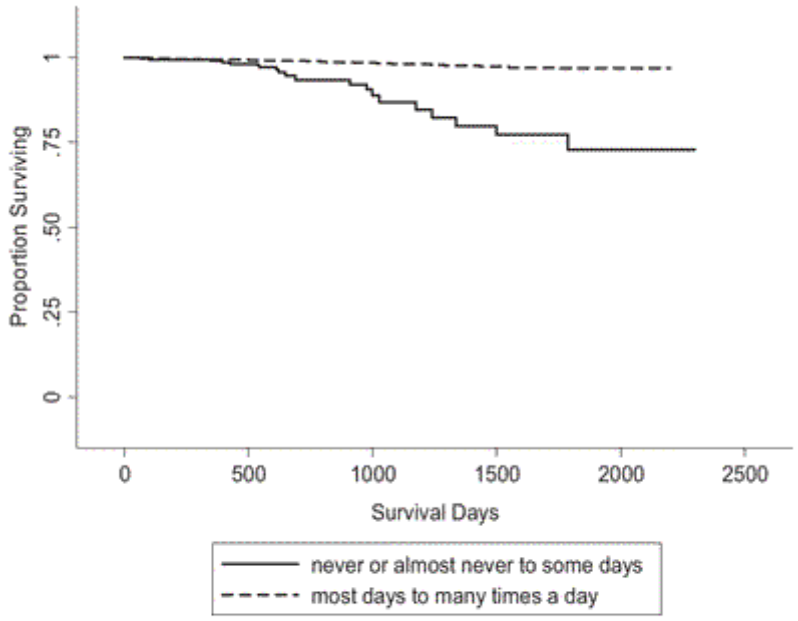

Fig. 1: Impact of spiritual peace on survival, controlling for demographics, health, and adherence to health behaviors.

[p. 208]

The authors acknowledge that their "sample size was relatively small in terms of studies that examine mortality" [p. 208], but they hope for future research not only to expand the sample size but involve a "broader range of health statuses" [p. 209]. They also invite further research that would explore spirituality in this context more experientially and as a multi-dimensional concept. The use of a one-item measure of spirituality that focuses on peace and harmony may have presented some limitation, but this reader appreciated the methodology of using a single question about peace as a spiritual assessment. It complements other research from 2006 by Karen E. Steinhauser, et al., "'Are you at peace?': one item to probe spiritual concerns at the end of life" [--see Items of Related Interest, §II, below]. This speaks to a larger issue of whether such a single measure about peace may feasibly balance the dual healthcare workflow needs of simplicity and effectiveness in assessing something as complex as spirituality.

Special comment to the Network from our article's lead author Crystal L. Park, PhD, Professor, Clinical Psychology, University of Connecticut:

> In general, I am a strong advocate of measuring religiousness and spirituality multidimensionally, because religious beliefs, motives, personal and public rituals and internal experiences may all be important and may have different effects on different aspects of well-being. And yet, there are situations in which this sort of complexity is not feasible. In this study, we focused on one aspect of religiousness and spirituality, but one that we had good theoretical reasons to suspect would prove important in predicting patients' health status over time. Even so, we were somewhat surprised that these effects on mortality held even when we statistically controlled for many confounds, including baseline objective health status and health behaviors. I am eager to see what future research focusing on spiritual peace will

demonstrate in terms of survival as well as learning more about how we can help patients to find more inner peace and harmony. --*Crystal Park, 3/12/16*

Suggestions for the Use of the Article for Student Discussion:

This is a clearly laid out article that should open up discussion about the medical significance of a sense of personal peace. What do students think of a question about peace as a key for spiritual assessment? Might a patient be doing well spiritually and *not* say that they "feel deep inner peace or harmony"? Conversely, might there be circumstances in which a patient is in spiritual distress but yet not indicate it by that question? Even if chaplains didn't adopt an explicit question about peace in their pastoral practice, might they want to keep especially mindful of it during pastoral conversation? If chaplains had as a specific pastoral goal to address patients lack of a sense of peace and harmony, how would that affect their thinking about interventions? Also, have students thought before about how something like spiritual peace may actually affect patient mortality? What do students make of the idea, drawn from other researchers, that "*religiousness* may be more important in resisting disease than in helping people already diagnosed and in treatment" [p. 208, italics added]? For students with more advanced knowledge of research, the Statistical Analysis section [pp. 205-206], plus two rich data tables [pp. 206 and 207], should be interesting. The identification of variables and the choice of measures for those variables could spark further discussion: e.g., the use of service attendance to measure religiosity.

Related Items of Interest:

I. The question about "deep inner peace or harmony" (as well as one about service attendance) was taken from the *Brief Multidimensional Measure of Religiousness and Spirituality*, part of the "Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research" published in 1999/2003 from the Fetzer Institute and a working group of the National Institute on Aging. This is a good source for chaplain researchers, and the original report states that it "may be used and reprinted without special permission." Regarding the item on "deep inner peace or harmony," see pp. 13, 16, 85, and 91 of the report (though "inner peace" specifically is also addressed on pp. 4, 92, 94, and 95; and "inner harmony" is qualified as "at peace with myself" on p. 27).

II. The previous research that used a single-item about *peace* for spiritual assessment, cited in our featured article, is:

> Steinhauser, K. E., Voils, C. I., Clipp, E. C., Bosworth, H. B., Christakis, N. A. and Tulsky, J. A. "**'Are you at peace?': one item to probe spiritual concerns at the end of life**." *Archives of Internal Medicine* 166, no. 1 (January 9, 2006): 101-105. [(Abstract:) Physicians may question their role in probing patients' spiritual distress and the practicality of addressing such issues in the time-limited clinical encounter. Yet, patients' spirituality often influences treatment choices during a course of serious illness. A practical, evidence-based approach to discussing spiritual concerns in a scope suitable to a physician-patient relationship may improve the quality of the clinical encounter. METHODS: Analysis of the construct of being "at peace" using a sample of patients with advanced cancer, congestive heart failure, or chronic obstructive pulmonary disease. Descriptive statistics were used to compare response distributions among patient subgroups. Construct validity of the concept of being "at peace" was evaluated by examining Spearman rank correlations between the item and existing spirituality and quality-of-life subscales. RESULTS: Variation in patient responses was not explained by demographic categories or diagnosis, indicating

broad applicability across patients. Construct validity showed that feeling at peace was strongly correlated with emotional and spiritual well-being. It was equally correlated with faith and purpose subscales, indicating applicability to traditional and nontraditional definitions of spirituality. CONCLUSIONS: Asking patients about the extent to which they are at peace offers a brief gateway to assessing spiritual concerns. Although these issues may be heightened at the end of life, research suggests they influence medical decision making throughout a lifetime of care.]

The article was our February 2006 Article-of-the-Month. The article itself is available online through Vanderbilt Medical Center.

Note: The single item "Are you at peace?" measure from the Steinhauser, et al., article was recently used in a study by the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Care Nurses Association, which found assessment in that area exceptionally low. See: Kamal, A. H., Bull, J., Ritchie, C. S., Kutner, J. S., Hanson, L. C., Friedman, F., Taylor, D. H. Jr., for the AAHPM Research Committee Writing Group, "**Adherence to *Measuring What Matters* measures using point-of-care data collection across diverse clinical settings**." *Journal of Pain and Symptom Management* 51, no. 3 (March 2016): 497-503.

III. In addition to the resources cited in our featured article's bibliography, see the following recent articles on heart failure and spirituality *in general* (--note that two are co-authored by Crystal L. Park):

Mills, P. J., Redwine, L., Wilson, K., Pung, M. A., Chinh, K., Greenberg, B. H., Lunde, O., Maisel, A., Raisinghani, A., Wood, A. and Chopra, D. "**The Role of Gratitude in Spiritual Well-Being in Asymptomatic Heart Failure Patients**." *Spirituality in Clinical Practice* 2, no. 1 (March 2015): 5-17. [(Abstract:) Spirituality and gratitude are associated with well-being. Few if any studies have examined the role of gratitude in heart failure (HF) patients or whether it is a mechanism through which spirituality may exert its beneficial effects on physical and mental health in this clinical population. This study examined associations between gratitude, spiritual well-being, sleep, mood, fatigue, cardiac-specific self-efficacy, and inflammation in 186 men and women with Stage B asymptomatic HF (age 66.5 years +/- 10). In correlational analysis, gratitude was associated with better sleep ($r = -.25$, $p < .01$), less depressed mood ($r = -.41$, $p < .01$), less fatigue ($r = -.46$, $p < .01$), and better self-efficacy to maintain cardiac function ($r = .42$, $p < .01$). Patients expressing more gratitude also had lower levels of inflammatory biomarkers ($r = -.17$, $p < .05$). We further explored relationships among these variables by examining a putative pathway to determine whether spirituality exerts its beneficial effects through gratitude. We found that gratitude fully mediated the relationship between spiritual well-being and sleep quality ($z = -2.35$, $SE = .03$, $p = .02$) and also the relationship between spiritual well-being and depressed mood ($z = -4.00$, $SE = .075$, $p < .001$). Gratitude also partially mediated the relationships between spiritual well-being and fatigue ($z = -3.85$, $SE = .18$, $p < .001$) and between spiritual well-being and self-efficacy ($z = 2.91$, $SE = .04$, $p = .003$). In sum, we report that gratitude and spiritual well-being are related to better mood and sleep, less fatigue, and more self-efficacy, and that gratitude fully or partially mediates the beneficial effects of spiritual well-being on these endpoints. Efforts to increase gratitude may be a treatment for improving well-being in HF patients' lives and be of potential clinical value.]

Mills, P. J., Wilson, K., Iqbal, N., Iqbal, F., Alvarez, M., Pung, M. A., Wachmann, K., Rutledge, T., Maglione, J., Zisook, S., Dimsdale, J. E., Lunde, O., Greenberg, B. H., Maisel, A., Raisinghani, A., Natarajan, L., Jain, S., Hufford, D. J. and Redwine, L. "**Depressive symptoms and spiritual wellbeing in asymptomatic heart failure patients**." *Journal of Behavioral Medicine* 38, no. 3 (June 2015): 407-415. [(Abstract:) Depression adversely predicts prognosis in individuals with symptomatic heart failure. In some clinical populations, spiritual wellness is considered to be a protective factor against depressive symptoms. This study examined associations among depressive symptoms, spiritual wellbeing, sleep, fatigue, functional capacity, and inflammatory biomarkers in 132 men and women with asymptomatic stage B heart failure (age 66.5 years +/- 10.5). Approximately 32 % of the patients scored >10 on the Beck Depression Inventory, indicating

potentially clinically relevant depressive symptoms. Multiple regression analysis predicting fewer depressive symptoms included the following significant variables: a lower inflammatory score comprised of disease-relevant biomarkers ($p < 0.02$), less fatigue ($p < 0.001$), better sleep ($p < 0.04$), and more spiritual wellbeing ($p < 0.01$) (overall model $F = 26.6$, $p < 0.001$, adjusted R square = 0.629). Further analyses indicated that the meaning ($p < 0.01$) and peace ($p < 0.01$) subscales, but not the faith ($p = 0.332$) subscale, of spiritual wellbeing were independently associated with fewer depressive symptoms. Interventions aimed at increasing spiritual wellbeing in patients lives, and specifically meaning and peace, may be a potential treatment target for depressive symptoms asymptomatic heart failure.]

Park, C. L., Lim, H., Newlon, M., Suresh, D. P. and Bliss, D. E. "**Dimensions of religiousness and spirituality as predictors of well-being in advanced chronic heart failure patients**." *Journal of Religion and Health* 53, no. 2 (April 2014): 579-590. [(Abstract:) We examined relationships between seven dimensions of religion/spirituality (RS) (forgiveness, daily spiritual experiences, belief in afterlife, religious identity, religious support, public practices, and positive RS coping) and three dimensions of well-being (physical, mental, and existential) in a sample of 111 patients with advanced chronic heart failure. Participants completed questionnaires at baseline and 3 months later. Results showed that fairly high levels of RS were reported on all seven dimensions. Furthermore, RS dimensions were differentially related to well-being. No aspect of RS was related to physical well-being, and only a few aspects were related to mental well-being. Forgiveness was related to less subsequent depression, while belief in afterlife was related to poorer mental health. All aspects of RS were related to at least one aspect of existential well-being. In particularly, daily spiritual experiences were linked with higher existential well-being and predicted less subsequent spiritual strain. These results are consistent with the view that in advanced disease, RS may not affect physical well-being but may have potent influences on other aspects of well-being, particularly existential aspects.]

Ross, L. and Austin, J. "**Spiritual needs and spiritual support preferences of people with end-stage heart failure and their carers: implications for nurse managers**." *Journal of Nursing Management* 23, no. 1 (Jan 2015): 87-95 . [(Abstract:) BACKGROUND: Spiritual care is an important element of holistic care but has received little attention within palliative care in end-stage heart failure. AIMS: To identify the spiritual needs and spiritual support preferences of end-stage heart failure patients/carers and to develop spiritual support guidelines locally. METHOD: Semi-structured interviews (totalling 47) at 3-monthly intervals up to 1 year with 16 end-stage heart failure patients/carers. Focus group/consultation with stakeholders. RESULTS: Participants were struggling with spiritual/existential concerns alongside the physical and emotional challenges of their illness. These related to: love/belonging; hope; coping; meaning/purpose; faith/belief; and the future. As a patient's condition deteriorated, the emphasis shifted from 'fighting' the illness to making the most of the time left. Spiritual concerns could have been addressed by: having someone to talk to; supporting carers; and staff showing sensitivity/taking care to foster hope. A spiritual support home visiting service would be valued. CONCLUSIONS: Our sample experienced significant spiritual needs and would have welcomed spiritual care within the palliative care package. IMPLICATIONS FOR NURSING MANAGEMENT: Nurse managers could play a key role in developing this service and in leading further research to evaluate the provision of such a service in terms of its value to patients and other benefits including improved quality of life, spiritual wellbeing, reduced loneliness/isolation and a possible reduction in hospital admissions.]

Sacco, S. J., Park, C. L., Suresh, D. P. and Bliss, D. "**Living with heart failure: psychosocial resources, meaning, gratitude and well-being**." *Heart and Lung* 43, no. 3 (May-June 2014): 213-218 . [(Abstract:) OBJECTIVES: The present study explored the experiences of people living with advanced heart failure (HF) to determine the extent to which (1) psychosocial resources relevant to HF patients were qualitatively reported, and (2) to determine the extent to which psychosocial resources were correlates of subsequent well-being as assessed by validated quantitative measures. BACKGROUND: HF is a serious life-limiting illness that involves impaired heart functionality.

Patients commonly face severe physical fatigue and frequently endure disabling depression. Individuals with HF often report the use of social support and religion/spirituality (R/S) as helpful, but little work has systematically linked their reliance on these resources and well-being. METHODS: 111 participants completed four open-ended questions to assess aspects of living with HF. Open-ended questions were coded to identify psychosocial resources: positive meaning, gratitude, R/S, social support, and medical resources. Data were collected once and then again 3 months later. Participants also completed measures of well-being, including religious meaning, life meaning, satisfaction with life, depressive symptoms, death anxiety, and health-related quality of life. Bivariate correlations were used to relate psychosocial resources and well-being. RESULTS: Patients reported many psychosocial resources, particularly positive meaning, R/S, social support, and medical resources. Positive meaning and R/S were inversely linked with depressive symptoms. R/S was also related to less death anxiety, while social support was related to higher anxiety about death three months later. CONCLUSIONS: Findings advance our understanding of the struggles HF patients experience and the roles of psychosocial resources such as meaning and gratitude in alleviating these struggles. Results may help explain how resources like R/S and social support may influence well-being.]

Strada, E. A., Homel, P., Tennstedt, S., Billings, J. A., and Portenoy, R. K. "**Spiritual well-being in patients with advanced heart and lung disease**." *Palliative and Supportive Care* 11, no. 3 (June 2013): 205-213. [(Abstract:) OBJECTIVE: The purpose of this study was to evaluate levels of spiritual well-being over time in populations with advanced congestive heart failure (CHF) or chronic obstructive lung disease (COPD). METHOD: In a prospective, longitudinal study, patients with CHF or COPD (each n = 103) were interviewed at baseline and every 3 months for up to 30 months. At each interview, patients completed: the basic faith subscale of the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp) questionnaire, the Memorial Symptom Assessment Scale (MSAS), the Rand Mental Health Inventory (MHI), the Multidimensional Index of Life Quality (MILQ), the Sickness Impact Profile (SIP), and the Short Portable Mental Health Questionnaire (SPMSQ). RESULT: The mean age was 65 years, 59% were male, 78% were Caucasian, 50% were married, 29% lived alone, and there was no significant cognitive impairment. Baseline median FACIT-Sp score was 10.0 on a scale of 0-16. FACIT-Sp scores did not change over time and multivariate longitudinal analysis revealed higher scores for black patients and lower scores for those with more symptom distress on the MSAS-Global Distress Index (GDI) (both p = 0.02). On a separate multivariate longitudinal analysis, MILQ scores were positively associated with the FACIT-Sp and the MHI, and negatively associated with the MSAS-GDI and the SIP (all p-values < 0.001). SIGNIFICANCE OF RESULTS: In advanced CHF and COPD, spiritual well-being remains stable over time, it varies by race and symptom distress, and contributes to quality of life, in combination with symptom distress, mental health and physical functioning.]

Tadwalkar, R., Udeoji, D. U., Weiner, R. J., Avestruz, F. L., LaChance, D., Phan, A., Nguyen, D., Bharadwaj, P. and Schwarz, E. R. "**The beneficial role of spiritual counseling in heart failure patients**." *Journal of Religion & Health* 53, no. 5 (October 2014): 1575-1585. [(Abstract:) To ascertain the beneficial role of spiritual counseling in patients with chronic heart failure. This is a pilot study evaluating the effects of adjunct spiritual counseling on quality of life (QoL) outcomes in patients with heart failure. Patients were assigned to "religious" or "non-religious" counseling services based strictly on their personal preferences and subsequently administered standardized QoL questionnaires. A member of the chaplaincy or in-house volunteer organization visited the patient either daily or once every 2 days throughout the duration of their hospitalization. All patients completed questionnaires at baseline, at 2 weeks, and at 3 months. Each of the questionnaires was totaled, with higher scores representing positive response, except for one survey measure where lower scores represent improvement (QIDS-SR16). Twenty-three patients (n = 23, age 57 +/- 11, 11 (48 %) male, 12 (52 %) female, mean duration of hospital stay 20 +/- 15 days) completed the study. Total mean scores were assessed on admission, at 2 weeks and at 3 months. For all patients in the study, the mean QIDS-SR16 scores were 8.5 (n = 23, SD = 3.3) versus 6.3 (n

= 18, SD = 3.5) versus 7.3 (n = 7, SD = 2.6). Mean FACIT-Sp-Ex (version 4) scores were 71.1 (n = 23, SD = 15.1) versus 74.7 (n = 18, SD = 20.9) versus 81.4 (n = 7, SD = 8.8). The mean MSAS scores were 2.0 (n = 21, SD = 0.6) versus 1.8 (n = 15, SD = 0.7) versus 2.5 (n = 4, SD = 0.7). Mean QoL Enjoyment and Satisfaction scores were 47.2 % (n = 23, SD = 15.0 %) versus 53.6 % (n = 18, SD = 16.4 %) versus 72.42 % (n = 7, SD = 22 %). The addition of spiritual counseling to standard medical management for patients with chronic heart failure patients appears to have a positive impact on QoL.]

White, M. L. and Schim, S. M. "**Development of a spiritual self-care practice scale**." *Journal of Nursing Measurement* 21, no. 3 (2013): 450-462. [(Abstract:) BACKGROUND AND PURPOSE: Development of a valid, reliable instrument to measure spiritual self-care practices of patients with heart failure. METHODS: African American patients (N = 142) with heart failure participated in the study. Spiritual advisors from several religious groups reviewed the Spiritual Self-Care Practices Scale (SSCPS) for content validity. Construct validity was determined using a principal components factor analysis. Reliability was established using Cronbach's alpha coefficients. RESULTS: Religious advisors provided suggestions to improve content validity. Four factors consistent with spiritual practices (personal spiritual practices, spiritual practices, physical spiritual practices, and interpersonal spiritual practices) emerged from the factor analysis. The alpha coefficient was moderate at 0.64. CONCLUSIONS: Results indicated the SSCPS was reliable and valid for measuring spiritual self-care practices among African Americans with heart failure. Additional testing is needed to confirm results in other patient groups with chronic illnesses.]
