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September 2016 Article of the Month

This month's article selection is highlighted by John Ehman,
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Berning, J. N., Poor, A. D., Buckley, S. M., Patel, K. R., Lederer, D. J., Goldstein, N. E., Brodie, D. and Baldwin, M. R. "A novel picture guide to improve spiritual care and reduce anxiety in mechanically ventilated adults in the Intensive Care Unit." *Annals of the American Thoracic Society* 13, no. 8 (August 2016): 1333-1342.

SUMMARY and COMMENT: Chaplains are often creative problem-solvers, but the lead author of this month's article, Joel Nightingale Berning, a chaplain at NewYork-Presbyterian Hospital (New York, NY), took the step of partnering with other researchers to test empirically a tool that he developed out of his professional training and experience. The article is then both a presentation of a particular strategy for providing pastoral care for patients with a special need and a model for how chaplaincy interventions may benefit from the process of scientific validation. "This study answers calls for more rigorous studies of spiritual and religious interventions, a need to develop a comprehensive approach to assess and meet the spiritual needs of patients, and for research aimed at improving critical illness survivorship" [p. 1340].

At the heart of this inquiry is the use of a laminated 11"x17" [spiritual care communication card](#)* for use specifically in an Intensive Care Unit with mechanically ventilated adults for whom communication is problematic. It consists of "four sections that reflect the domains of a spiritual assessment that would be typically assessed by a chaplain through conversation but instead can be assessed by having the user point to pictures and words to: (1) identify spiritual or religious affiliations; (2) identify a range of feelings; (3) rate spiritual pain; and (4) select a desired religious, spiritual, or nonspiritual intervention that a chaplain can offer" [p. 1334]. It was tested at an urban, tertiary care medical center between March 2014 and July 2015 with a sample of 50 patients (84% of an originally identified ICU population that met criteria). Measures included the proportion of patients able to use the card and the time needed for its use, plus a two-phase approach to assess the *effect* of the intervention:

...[B]ecause we were initially unsure how participants would react to engaging in communication about their emotions and spiritual needs, we first conducted semistructured exploratory interviews with ICU survivors from the first half of study participants (n = 25) to identify the common symptoms picture-guided spiritual care treated. On the basis of our review of these interviews, we then added 100-mm visual analog scales (VASs) to measure anxiety immediately before and after the initial chaplain visit in the second half of study participants (n = 25) and ±100-mm VAS to measure changes in stress and pain attributed to chaplain-led picture-guided spiritual care among those who survived intensive care and were awaiting hospital discharge. [pp. 1336-1337]

Among the results:

Using the communication card for the first time, participants' spiritual affiliation was identified 100% of the time, 47 participants (94%) were able to identify one or more emotion, 45 participants (90%) rated their spiritual pain, and 36 (72%) selected a desired chaplain intervention. It took participants a median (IQR) of 8.5 minutes (5-13) to complete the four sections of the communication card, and it took the chaplain a median (IQR) of 18 (11-25) minutes to both use the card with participants and provide a desired spiritual care intervention. [pp. 1337-1338]

Among the second half of participants (n = 25), in whom anxiety was measured by VAS immediately before and after the initial chaplain-led picture-guided spiritual care, anxiety decreased from a mean (SD) VAS score of 64 (± 29) to 44 (± 28) (mean absolute reduction of 20 points, 95% confidence interval [CI], -33 to -7; P = 0.002; mean relative reduction, 31%; 95% CI, -48% to -15%; P = 0.001). Among 28 ICU survivors who consented to follow-up interviews, 26 (93%) remembered receiving the chaplain's picture-guided spiritual care in the ICU and completed the semistructured interviews. Eighty-one percent reported that they felt more capable of dealing with their hospitalization, 81% felt more at peace, 71% felt more connected with what is sacred, 96% would recommend chaplain-led picture-guided spiritual care to others, and 0% felt worse after receiving spiritual care. [pp. 1338-1339]

On average, ICU survivors who underwent ± 100 -mm VAS testing at follow up (n = 18) reported mean 49-point reduction in stress (95% CI, -72 to -24; P = 0.002) and no significant change in physical pain due to chaplain-led picture-guided spiritual care. [p. 1339]

The present reader was also struck by the fact that "seven participants (14%) used the card to identify a spiritual affiliation that was different from what was listed in the medical record" [p. 1338].

In addition to the quantitative findings, the article provides illustrative quotes from those patients who participated in semistructured exploratory interviews. "Many participants report[ed] decreased anxiety and stress due to being able to communicate using the card, and several describe[d] improved coping having recognized and acknowledged their feelings with the chaplain" [p. 1339] For example:

Made me think for sure. With the numbers. How, for example, disappointed or excited I was.... it made me think. Pretty helpful. Especially the feelings page. Made me think about how I felt about being afraid, disappointed. Made me think about my emotions--which was helpful. A lot of times you get overwhelmed by your feelings, especially when you're sick or in a moment of stress. [p. 1340, Table 3]

Study limits are adequately addressed [pp. 1340-1341] and paired with needs for future research, including the need to "evaluate the psychometrics of the spiritual care communication card and assess whether refinements to the card should be made" [p. 1340], to "consider using more comprehensive and repeated assessments of symptoms, spiritual quality of life, and coping to determine the optimal dose of spiritual care needed to improve well-being" [p. 1341], to test the card by randomized control trials with different patient groups, and to explore especially the effect of chaplain-led picture-guided spiritual care on patients who die and on the satisfaction of their families with their care. Indeed, the card used in this research could be a valuable basis for refining the *idea* of such a visual communication tool, and the study as a whole should help chaplains think generally about the validity of any similar tool they may be using.

The authors state: "To our knowledge, this is the first clinical study to test a structured, integrative, and measureable approach to chaplain care aimed at treating anxiety and stress and improving coping in mechanically ventilated ICU patients" [p. 1340]. The feasibility of the tested intervention they then see as contributing to a "paradigm shift in the role of chaplains in acute care settings" [p. 1341]: "Instead of primarily being consulted just before a patient's death in the ICU, chaplains can now provide interactive spiritual support to mechanically ventilated ICU patients" [p. 1341]. Of course there are hospitals where chaplains already are integrated into the overall care of ICU patients in various ways, but the point is well taken that the model of chaplain-led picture-guided spiritual care presented here could promote a further move "to integrate spiritual care with intensive care and...improve adult patients' well-being both during and after critical illness" [p. 1341].

An [online supplement](#) includes data about specific emotions identified using the communication card, a more extensive selection of illustrative quotes from survivors, and other information that would be of particular interest to research chaplains.

*Note: "©2013 NewYork-Presbyterian Hospital. The owner of the copyright has no objection to reproduction of the work for academic non-commercial purposes, but otherwise reserves all copyright rights whatsoever." [p. 1335]

Special comment to the Network from lead-author [Joel Nightingale Berning](#), staff chaplain at NewYork-Presbyterian Hospital:

For chaplain readers, I hope this study encourages our care for patients on mechanical ventilation. Trach'd and intubated patients have been challenging for many of us, but now I can actually seek out (i.e., screen for) these patients and offer them an intervention that I know has some evidence behind it. That's my favorite kind of spiritual-care research: the particular effects that a particular intervention has on a particular subgroup of patients who tend to be in need.

This was my first experience of doing research. What I brought to our research team was a chaplain's concern for this kind of patient and a tool that helped me minister to them. My medical colleagues brought the expertise in established clinical research methods and taught me how we could use them to study a spiritual intervention. We learned from one another, and the clinical results were revealing to all of us. People who literally could not speak for themselves used the spiritual-care communication board to speak for themselves after all. And, we got to learn what their spiritual needs really were and how responding to them could help their anxiety.

It was a privilege to be work with these patients, their families, Dr. Matthew Baldwin, our co-authors and ICU coworkers, and fellow chaplains, especially Chaplain Seigan Glassing, who illustrated the spiritual-care communication board. I would love to hear any of your responses to the article. Please feel free to contact me at job9122@nyp.org. --JNB

Suggestions for Use of the Article for Student Discussion:

CPE students who have worked with mechanically ventilated patients may want to talk at the outset about their experiences and some of the challenges of communication. Can they identify with the description of difficulties on the top of p. 1334? How have they dealt with these challenges themselves? Did they use or create their own communication cards? How did they assess the value of what they did? What do the students think of the communication card tested in the article [p. 1335]? Are students surprised by any of the study's findings? How do the comments from survivors [Table 3, p. 1340] give insight into the patient experience of receiving pastoral care while on a ventilator. A number of patients used the card to request non-religious interventions [--see p. 1338]; so how salient for students is their role in helping patients have non-religious needs met? Newer students might discuss the place of "proactive spiritual support" [p. 1334] and the idea of being *systematic* in the provision of care. More advanced students, familiar with research, should find much to discuss in the well laid out methodology section and the rich data tables and figures.

Related Items of Interest:

I. In June 2014, Chaplain Joel Nightingale Berning led a workshop, "Chaplaincy with Intubated Patients: 'A Sort of Salvation,'" at the annual conference of the Association for Professional Chaplains in Anaheim, CA. A [handout from that event](#) is available from the author and touches on some of the key points elaborated in our featured article. The footnoted outline of the workshop complements this month's reading.

II. In the same issue of the *Annals of the American Thoracic Society*, [Mary Beth Happ](#), RN, PhD, at Ohio State University offers an editorial: "**The power and importance of accommodation for communication impairment in the Intensive Care Unit**" [vol. 13, no. 8, pp. 1215-1216], in which she comments on our featured study, commending especially how the researchers incorporated a Spanish language version of the communication card. Happ has published important work in the field, and among her articles referenced by Berning, et al., the following may be of particular interest:

Happ, M. B., Garrett, K. L., Tate, J. A., DiVirgilio, D., Houze, M. P. and Demirci, J. R., George, E. and Sereika, S. M. "**Effect of a multi-level intervention on nurse-patient communication in the Intensive Care Unit: results of the SPEACS trial.**" *Heart and Lung* 43, no. 2 (March-April 2014): 89-98. [(Abstract:) OBJECTIVE: To test the impact of two levels of intervention on communication frequency, quality, success, and ease between nurses and intubated intensive care unit (ICU) patients. DESIGN: Quasi-experimental, 3-phase sequential cohort study: (1) usual care, (2) basic communication skills training (BCST) for nurses, (3) additional training in augmentative and alternative communication devices and speech language pathologist consultation (AAC + SLP). Trained observers rated four 3-min video-recordings for each nurse-patient dyad for communication frequency, quality and success. Patients self-rated communication ease. SETTING: Two ICUs in a university-affiliated medical center. PARTICIPANTS: 89 intubated patients awake, responsive and unable to speak and 30 ICU nurses. MAIN RESULTS: Communication frequency (mean number of communication acts within a communication exchange) and positive nurse communication behaviors increased significantly in one ICU only. Percentage of successful communication exchanges about pain were greater for the two intervention groups than the usual care/control group across both ICUs ($p = .03$) with more successful sessions about pain and other symptoms in the AAC + SLP group ($p = .07$). Patients in the AAC + SLP intervention group used significantly more AAC methods ($p = .002$) and rated communication at high difficulty less often ($p < .01$). CONCLUSIONS: This study provides support for the feasibility, utility and efficacy of a multi-level communication skills training, materials and SLP consultation intervention in the ICU.]

Happ, M. B., Garrett, K., Thomas, D. D., Tate, J., George, E., Houze, M., Radtke, J. and Sereika, S. "**Nurse-patient communication interactions in the intensive care unit.**" *American Journal of Critical Care* 20, no. 2 (March 2011): e28-40. [BACKGROUND: The inability to speak during critical illness is a source of distress for patients, yet nurse-patient communication in the intensive care unit has not been systematically studied or measured. OBJECTIVES: To describe communication interactions, methods, and assistive techniques between nurses and nonspeaking critically ill patients in the intensive care unit. METHODS: Descriptive observational study of the nonintervention/usual care cohort from a larger clinical trial of nurse-patient communication in a medical and a cardiothoracic surgical intensive care unit. Videorecorded interactions between 10 randomly selected nurses (5 per unit) and a convenience sample of 30 critically ill adults (15 per unit) who were awake, responsive, and unable to speak because of respiratory tract intubation were rated for frequency, success, quality, communication methods, and assistive communication techniques. Patients self-rated ease of communication. RESULTS: Nurses initiated most (86.2%) of the communication exchanges. Mean rate of completed communication exchange was 2.62 exchanges per minute. The most common positive nurse act was making eye contact with the patient. Although communication exchanges were generally (>70%) successful, more than one-third (37.7%) of communications about pain were unsuccessful. Patients rated 40% of the

communication sessions with nurses as somewhat difficult to extremely difficult. Assistive communication strategies were uncommon, with little to no use of assistive communication materials (e.g., writing supplies, alphabet or word boards). CONCLUSIONS: Study results highlight specific areas for improvement in communication between nurses and nonspeaking patients in the intensive care unit, particularly in communication about pain and in the use of assistive communication strategies and communication materials.]

Tate, J. A., Devito Dabbs, A., Hoffman, L. A., Milbrandt, E. and Happ, M. B. "**Anxiety and agitation in mechanically ventilated patients.**" *Qualitative Health Research* 22, no. 2 (February 2012): 157-173. [(Abstract:) During an ethnography conducted in an intensive care unit (ICU), we found that anxiety and agitation occurred frequently and were important considerations in the care of 30 patients weaning from prolonged mechanical ventilation. We conducted a secondary analysis to (a) describe characteristics of anxiety and agitation experienced by mechanically ventilated patients, (b) explore how clinicians recognized and interpreted anxiety and agitation, and (c) describe strategies and interventions used to manage anxiety and agitation with mechanically ventilated patients. We constructed the Anxiety/Agitation in Mechanical Ventilation Model to illustrate the multidimensional features of symptom recognition and management. Patients' ability to interact with the environment served as a basis for identification and management of anxiety or agitation. Clinicians' attributions about anxiety or agitation, and "knowing the patient," contributed to their assessment of patient responses. Clinicians chose strategies to overcome either the stimulus or the patient's appraisal of risk of the stimulus. This article contributes to the body of knowledge about symptom recognition and management in the ICU by providing a comprehensive model to guide future research and practice.]

III. The bibliography in our featured article provides a number of good leads for further reading. Note especially the following older work:

McBride, J. L., Pilkington, L. and Arthur, G. "**Development of brief pictorial instruments for assessing spirituality in primary care.**" *Journal of Ambulatory Care Management* 21, no. 4 (October 1998): 53-61. [The relationship between spirituality and health is an emerging area of study. However, spirituality assessment instruments with clinical utility for busy healthcare practices are lacking. The article describes research directed at developing and validating brief pictorial measures of spirituality as instruments to measure the relationship between reported spirituality and health. The instruments presented or patterned after the Dartmouth Medical School Primary Care Cooperative (COOP) charts. The charts also provide a nonthreatening way to enhance communication between patients and physicians in this important area.]

IV. For more on the lived experience of prolonged mechanical ventilation, see our [July 2004 Article-of-the-Month](#) (with Related Items of Interest).

Arslanian-Engoren, C. and Scott, L. D. "**The lived experience of survivors of prolonged mechanical ventilation: a phenomenological study**" *Heart and Lung: Journal of Acute and Critical Care* 32, no. 5 (September-October 2003): 328-334. [This small qualitative study identified key themes in interviews with survivors of prolonged mechanical ventilation. (From the abstract:) Although surviving PMV was described as frightening and traumatic, comfort and resolve were derived from family members, religion, prayer, and angelic encounters.]

If you have suggestions about the form and/or content of the site, e-mail Chaplain John Ehman (Network Convener) at john.ehman@uphs.upenn.edu .

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