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The Chaplain Family Project: Development, Feasibility, and Acceptability of an Intervention to Improve Spiritual Care of Family Surrogates

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In the Intensive Care Unit (ICU), family members experience psychological and spiritual distress as they cope with fear, grief, and medical decisions for patients. The study team developed and pilot tested a semistructured chaplain intervention that included proactive contact and spiritual assessment, interventions, and documentation. An interdisciplinary team developed the intervention, the Spiritual Care Assessment and Intervention (SCAI) Framework. Three chaplains delivered the intervention to surrogates in two ICUs. There were 25 of 73 eligible patient/surrogate dyads enrolled. Surrogates had a mean age of 57.6, were 84% female and 32% African American. The majority (84%) were Protestant. All received at least one chaplain visit and 19 received three visits. All agreed they felt supported by the chaplains, and qualitative comments showed spiritual and emotional support were valued. A semistructured spiritual care intervention for ICU surrogates is feasible and acceptable. Future work is needed to demonstrate the intervention improves outcomes for surrogates and patients.

KEYWORDS *Chaplain; proxy decision making, surrogate, spiritual distress, intensive care, spiritual care*

In the hospital, many seriously ill adult patients and a majority of intensive care unit (ICU) patients face major medical decisions at a time when they are unable to make them due to coma, delirium, or dementia (Raymont et al., 2004; Torke et al., 2014). In such cases, family members usually serve as surrogate decision makers for the patient. Surrogates often rely on their own religious or spiritual beliefs as they cope with their family member's illness and make medical decisions (Geros-Willfond, Ivy, Montz,

Bohan, & Torke, 2016). Prior research has found that in spite of its importance, spiritual concerns are rarely addressed with ICU family members and some ICU surrogates do not receive the spiritual support they desire (Geros-Willfond et al., 2016). To address this concern, the study team developed a semistructured approach for providing spiritual care to the family surrogates of ICU patients. The purpose of the pilot study was to assess the feasibility and acceptability of this approach with ICU surrogates.

LITERATURE REVIEW

Surrogates report they highly value spiritual support from hospital staff, and there is evidence that ICU families who receive spiritual care are more satisfied with the total ICU experience (Braun, Beyth, Ford, & McCullough, 2008; Elliott, Gessert, & Peden-McAlpine, 2007; Geros-Willfond et al., 2016). Prior qualitative research has identified spiritual themes important to family members, such as the value of life, religious coping, and the support of a religious community (Braun et al., 2008; Elliott et al., 2007). Other studies have identified faith as one important factor in surrogate decision making (Boyd et al., 2010; Zier et al., 2008). For example, one study of family members of multiple faiths from several European countries found that those who identified as religious were more likely to want aggressive care at the end of life than those who identified as "affiliated" with their faith (Bulow et al., 2012). Another found that over 50% of the public believes divine intervention could save a family member from a major trauma even when physicians have determined care is futile (Jacobs, Burns, & Bennett Jacobs, 2008).

In spite of this evidence, spiritual concerns of family members may be unaddressed in crucial conversations such as ICU family meetings (Ernecoff, Curlin, Buddadhumaruk, & White, 2015). More general research on surrogate/clinician communication has found that because clinician work flow often involves coming to the bedside to visit patients at irregular times, family members may miss important opportunities to receive information and support (Torke, Alexander, Lantos, & Siegler, 2007). The same dynamic may occur with chaplain visits, resulting in an unmet need for spiritual support. Although there is a minimal amount of data regarding the effect of spiritual care on surrogates, data from studies of patients have found that support of patients' spiritual needs is associated with important outcomes, including satisfaction (Flannelly, Oettinger, Galek, Braun-Storck, & Kreger, 2009; Marin et al., 2015), cost (Balboni et al., 2011), and preferences for end of life care (Balboni et al., 2013). Sharma

et al. (2016) recently found that interventions specific to chaplain practice, such as prayer and exploration of meaning, are associated with increased patient satisfaction.

Supporting families of seriously ill patients is important because there is evidence family members of a person facing serious illness have high distress, including high levels of depression, anxiety, and posttraumatic stress (Wendler & Rid, 2011). The patient's illness may also raise questions about faith, values, and meaning that are frequently important to family members as well as patients (Geros-Willfond et al., 2016).

Although good spiritual care has the potential to improve spiritual well-being for family members, there is little research evidence for this. A few studies have examined the effect of chaplain interventions on patient outcomes and found effects on anxiety (Iler, Obenshain, & Camac, 2001), heart rate (Kurita et al., 2011), well-being (Kevern & Hill, 2015), and religious coping (Bay, Beckman, Trippi, Gunderman, & Terry, 2008). One study examined the effect of a telephone support intervention on caregiver outcomes in the outpatient setting and found qualitative evidence the intervention was helpful but no change in quantitative results (Steinhauser, Voils, Bosworth, & Tulsky, 2015). In summary, a review of the literature did not identify any spiritual care interventions for family members of seriously ill, hospitalized patients. The present manuscript describes the development and pilot testing of a framework for spiritual assessment and care that is appropriate for the clinical care and research. The framework is designed to be delivered by chaplains to the family members of seriously ill patients.

Development of the Intervention

The design team included chaplains, physicians, health system leaders, and research staff. The team met weekly through the design process to discuss core elements of chaplain practice and to design the intervention. The team defined spiritual assessment as an advanced skill performed in the medical setting by a chaplain. This is in contrast with spiritual screening or spiritual history, which can be performed by other clinicians or laypeople (LaRocca-Pitts, 2012; Larocca-Pitts, 2008). While all of these tasks are important to patients and families, spiritual assessment and the ability to respond with high quality spiritual care requires advanced training provided through clinical pastoral education. The intervention was developed and delivered based on professional standards in chaplaincy, which include establishing pastoral relationships with sensitivity, openness and respect, honoring diversity and differences in spiritual practices, and working collaboratively with other clinicians.

The team relied on a recent international consensus conference definition of spirituality:

> Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationships to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices. (Puchalski, Vitillo, Hull, & Reller, 2014)

Because serious illness in a family member often brings out concerns about faith or meaning, this chaplain intervention was designed to support family members from a wide variety of religious and spiritual beliefs.

One challenge of spiritual care interventions is the need to balance individual responsiveness and flexibility with the structure of a reproducible intervention. The fields of psychology, nursing, and medicine have developed methods for delivering structured, reproducible therapeutic interventions in randomized trials that are based on one-on-one communication, such as cognitive behavioral therapy (Holmes, 2002), behavioral change interventions (Michie & Abraham, 2004; Michie, Fixsen, Grimshaw, & Eccles, 2009; Webb, Joseph, Yardley, & Michie, 2010), and caregiver support for aging related illnesses (Callahan et al., 2006). To be reproducible, an intervention must be structured and carefully documented so the study can be replicated by other scientists or implemented by other clinicians (Bellg et al., 2004). The desire for scientific rigor thus pushes the field of chaplaincy in the direction of greater structure. This is in tension with certain core aspects of chaplain practice, including deep responsiveness to the spiritual needs of each unique individual (Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014). Being responsive to a patient's concerns seems to require that chaplains "avoid an agenda in their encounters with patients" (Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014). Some chaplains have expressed concern that prescribed questions may in fact interfere with good spiritual care (Lewis, 2002). The team sought to balance the need for greater structure with the flexibility of authentic responsiveness by designing a semistructured approach to spiritual care, described in the next section.

Spiritual care assessment and intervention (SCAI) framework

The assessment and intervention framework has the following core components: (a) Proactive contact with surrogate decision makers in person or by phone to schedule times to meet; (b) A semi-structured spiritual assessment; (c) Delivery of spiritual care; and (d) Documentation of each

interaction in a comprehensive electronic note. Each component is described in the following sections.

Scheduled Proactive Contact

To address the concern that chaplains may not reach many family members who could benefit from spiritual care, the intervention included scheduled proactive contact. Chaplains contacted family members by phone or at the bedside. Spiritual care could be delivered at that time or at a separate, mutually acceptable time. If in-person visits were not feasible, the chaplain delivered spiritual care by phone. There were three visit types: (a) *Initial visits* to conduct a comprehensive spiritual assessment of strengths and distress using the four dimensions in the framework and to address these concerns through specific spiritual care interventions; (b) *follow-up visits* to address spiritual distress and strengths identified in previous visits or to identify new concerns as the patient's illness unfolds and the surrogate continues to cope with that illness in the context of his or her own life; and (c) *bereavement visits* if the patient died during the hospital stay.

Spiritual Assessment

A literature review identified five published chaplain assessment methods (Appendix 1). (Fisher, Francis, & Johnson, 2000; Fitchett, 2002; M. LaRocca-Pitts, 2012; Monod et al., 2010; Pruyser, 1990; Shields, Kestenbaum, & Dunn, 2015) Similar to the multiple definitions of spirituality, these frameworks had a great deal of overlap with respect to the dimensions of spirituality addressed. During weekly meetings, the team sought to identify the smallest number of dimensions of spirituality that was conceptually complete (Appendix 1).

The Meaning and Purpose dimension focuses on the person's understanding of life events, including the family member's illness and possible death. The Relationship dimension includes the person's sense of connection to others, including community, family, and friends. In the setting of a hospital admission, it also considered relationships with clinicians, such as physicians and the chaplain. The Transcendence and Peace dimension addresses the feeling of connectedness to something greater than oneself, such as the experience of the divine, God, the sacred, or a higher power, the ability to be spiritually centered, and practices and rituals that promote a sense of peace or connection. Finally, the Self-Worth Dimension focuses on one's own sense of self, including feeling loved, self-awareness and understanding, and sense of place in the world.

Assessment Structure

A review of the literature revealed existing assessments differed as to whether they included specific questions addressing the core elements of spirituality. Some models used the framework to organize the material that arises in the chaplain's unstructured encounter and did not include any guidance on language used with the surrogate (Fitchett, 2002; Shields et al., 2015). Others, such as the Spiritual Distress Assessment Tool (Monod et al., 2010), developed a set of core questions for each dimension and a related, structured approach to analysis. In balancing the goals of the chaplain's individual responsiveness with reproducibility of the intervention, the SCAI framework contains core questions for each dimension of spirituality. These questions were chosen from the literature or written by the research team. The question, "What is the most powerful or important thing in your life?" was developed by Fitchett et al. (2014). The question, "Are you at peace?" has been validated by Steinhauser et al. (2006).

Intervention

The SCAI framework was designed to explicitly connect the spiritual assessment tool to spiritual care. One published model by Shields et al. (2015), the Spiritual Assessment and Intervention Model (AIM), also explicitly linked assessment to intervention. This model asked the chaplain to identify a primary spiritual need from the three dimensions of their model and to address that need by taking on a particular role in relationship to the patient, which they described as "embodiment" of the role. This model focused on helping the patient through the nature of the relationship of the chaplain to the patient (Shields et al., 2015). In contrast, the SCAI framework assumes surrogates may have needs in more than one dimension and more than one need can be addressed in a given visit.

The chaplain then addresses spiritual distress and strengths in each dimension. Other fields such as medical communication (Curtis & White, 2008) and family therapy (Rolland, 1990) have also developed strength-based approaches to intervention. Within spiritual care, Spidell (2014) has advocated for acknowledging and supporting strengths as a foundation of resilience.

Based on the literature describing chaplain practice, the SCAI framework provides a list of specific spiritual interventions, such as prayer, reading scripture, and active listening (Flannelly, Weaver, & Handzo, 2004; Handzo et al., 2008; Massey et al., 2015). Also incorporated were interventions based on the experience of the IU Health chaplains on our team.

The chaplain was asked to tailor interventions based on each individual's spiritual needs.

Chaplain Observed Effects of Spiritual Care

The team developed a list of potential effects that spiritual care may have on the surrogate. Chaplains were asked to indicate any that they observed over the course of each visit. There was also the opportunity to list other effects in a text field for each dimension.

Chaplain Documentation

In addition to entering a standard chaplain note in the electronic medical record (EMR), the chaplain also documented the visit in a study form using Research Electronic Data Capture (REDCap) a secure, customizable, online database designed for human subjects' research. The REDCap data entry form was customized to match the SCAI framework. Chaplains could also record comments about their use of the intervention, overall impressions of the surrogate, and any important social or familial dynamics that were encountered.

IMPLEMENTATION

Setting and Participants

The current pilot project was designed to assess the feasibility and acceptability of the SCAI framework with 25 surrogate decision makers in two ICUs at a Midwest tertiary referral center. We selected this setting because the majority of patients were critically ill and at increased risk of death compared to a general hospital population, and high surrogate distress has been well-documented (Azoulay et al., 2005).

Eligible patients were adults 18 and older admitted to a medical or cardiovascular ICU with severely impaired mental status, defined as coma, sedation, or documentation of advanced Alzheimer's disease, such that a surrogate must make all decisions. Patients were excluded if they were not followed by the medical or cardiovascular ICU Team (i.e., were in the unit due to overflow), were imminently dying (in order to avoid spending the last minutes or hours of the patient's life involved in study enrollment) or were expected to be transferred out of the ICU within 24 hours of admission. Eligible surrogates were aged 18 years and older who were the patient's legally authorized decision maker under Indiana law, a health care representative (HCR) as documented in the hospital patient record, or a first degree relative noted to be involved in decision making for the

patient (determined via social work notes and/or the unit chaplain). Surrogates were excluded if they could not be reached within 3 days of ICU admission or were unable to complete study instruments in English in either written or oral form. Both patient and surrogate had to meet eligibility criteria to be enrolled.

A research assistant (RA) identified eligible patients daily Monday through Friday using the EMR. For each eligible patient, a member of the research team contacted the unit chaplain or viewed the medical record to identify the surrogate most involved in decision making. The RA then contacted the surrogate decision maker in person or by phone to describe the study and obtain informed consent for the patient's and surrogate's participation.

Intervention Delivery

The intervention was delivered by board eligible or board certified chaplains. Our institution hires board eligible permanent staff chaplains with the expectation that they will become board certified within two years of the hire date. Board eligible chaplains have completed at least four units of Association of Clinical Pastoral Education accredited Clinical Pastoral Education, but still need to demonstrate 31 professional chaplaincy competencies in written essays and by meeting a regional or national certification committee, as well as accruing 2,000 clinical hours of work experience. This study included board eligible chaplains because they are commonly practicing in hospitals across the country prior to board certification.

After enrollment, the chaplain contacted the surrogate decision maker either at the bedside or by phone. Phone attempts were made up to three times daily for three days. Efforts were made to arrange a time to meet with the surrogate within 24 hours of enrollment whenever possible. The chaplain attempted to meet the surrogate in person, but if this was not possible due to the surrogate's unique circumstances, the chaplain met with the surrogate by phone. The chaplain attempted to schedule meetings with the surrogate every two to three days (or daily if the chaplain believed this would be beneficial to the surrogate), for a total of at least two additional follow-up visits, and then determined the need for additional follow-up visits based on individual needs.

In the initial visit, the chaplain assessed the four SCAI framework dimensions by asking at least one question in each dimension. Chaplains could ask additional questions as they deemed appropriate and could also explore the surrogate's concerns in an open ended fashion. Subsequent visits addressed at least one dimension. Chaplains then provided

interventions such as prayer and active listening that they determined would benefit the surrogate.

Data Collection

RAs collected demographic data from the surrogate via telephone survey at enrollment. At 6–8 weeks after hospital discharge, RAs administered multiple choice questions about the spiritual care experience and semi-structured, audio-recorded interviews with the surrogate decision makers to elicit qualitative feedback about their experiences. Chart reviews were conducted by RAs to obtain clinical characteristics and hospital outcomes.

Data Analysis

Qualitative comments about chaplain care and the Chaplain Family Project were transcribed verbatim. A thematic analysis was conducted using principles of grounded theory (Lindlof & Taylor, 2002; Strauss & Corbin, 1998). Five investigators independently read all responses and identified important concepts, or codes. The primary investigator grouped codes into broader themes and these were reviewed, revised, and approved by all coders. Chaplain documentation of the characteristics of the visits was obtained using a separate REDCap database designed to match the SCAI framework.

RESULTS

Enrollment and Participants

There were 76 patients screened and 73 were found to be eligible. Of these, 23 of their surrogates refused, 25 could not be reached within the eligibility window, and 25 were enrolled. The mean age of enrolled patients was 62.28 (*SD* 16.27), 32% were African American, and 48% were female (Appendix 2). Sixteen (64.0%) were incapacitated due to intubation with sedation and 5 (20.0%) had diagnoses of altered mental status or dementia. The median length of ICU stay was 12 days (range 3–77 days). Eight of the 25 patients died in the hospital and seven had a comfort plan in place (DNR with a primary goal of comfort care).

Of family surrogates, the mean age was 57.60 (*SD* 13.31) and 84% were female. The majority of surrogates were Protestant (84%), 44% reported attending religious services weekly or more, and 84% reported nonorganizational religious activity such as prayer twice a week or more. The enrollment interview was delivered to 25 surrogates. The 6–8 week

follow-up interview was delivered to 20 surrogates. The other five could not be reached within the 6–8 week window.

Chaplain Visit Characteristics

All surrogates received at least one visit from the study chaplain, with 19 patients receiving the planned initial plus two follow-up visits (Table 1). In one case, the patient died before the study chaplain visit and the surrogate received a bereavement visit. Of the eight patients who died, seven of the surrogates received at least one bereavement call. There were a total of 80 visits for the 25 surrogates. Visits were conducted by phone

TABLE 1. Chaplain Family Project Chaplain Visits

Number of participants with each visit type	Frequency	%
Initial visits[a]	24	30.4
One follow-up	22	27.8
Two follow-up visits	19	24.1
Three or more follow-up visits	14	17.8
Bereavement calls		
None	17	68.0
One	5	20.0
Two	2	8.0
Three	1	4.0
Location of visits (any visit)[b]		
Patient room	11	13.8
Waiting room	8	10.0
Quiet room	26	32.5
Other hospital location	3	3.8
Phone	32	40.0
Initial visit dimensions addressed[b]		
Meaning and Purpose	24	100.0
Relationships	23	95.8
Transcendence	23	95.8
Self-worth	23	95.8
Follow up visits dimensions addressed[b]		
Meaning and Purpose	33	73.3
Relationships	32	71.1
Transcendence	33	73.3
Self-worth	34	75.6
Bereavement calls dimensions addressed[b]		
Meaning and Purpose	6	54.5
Relationships	10	90.9
Transcendence	7	63.6
Self-worth	5	45.5
Visit Duration		
Initial visit duration (med, r)	40 (3–130)	
Overall follow-up visit duration (nonbereavement) (med, r)	30 (10–135)	
Overall bereavement visits (med, r)	25 (3–75)	

[a]One patient died prior to the first visit; therefore, the initial visit was a bereavement phone call.
[b]Data is presented by visit; therefore, many participants have more than one ($n = 80$).

40.0% of the time and the rest occurred in the hospital. In initial visits, all four dimensions were addressed over 90% of the time. In follow up visits, each dimension was addressed over 70% of the time. Of the initial visits, the median duration was 40 minutes (range 3–130 minutes). The shortest visit involved a surrogate who came to the hospital but abruptly ended the visit to attend to a family obligation. The longest two visits were over 120 minutes and were related to acute distress from the patients' severe illness. The median duration of follow-up visits was 30 minutes (range 10–135 minutes) and 25 minutes for bereavement visits (range 3–75).

Implementation of the SCAI Framework

Each question developed for the SCAI framework was used. The question used least was "How do your values and beliefs help you make decisions?" (7.5% of visits) and the most common question was "How are you taking care of yourself right now? (36.3% of visits) (Table 2).

Interventions and Chaplain-Observed Effects of Spiritual Care

Of interventions listed in the framework, all were used except Ritual and Sacrament (Table 3). The most common interventions were Active Listening (87.5%), Emotional Support (81.3%), Non-Anxious Attending (73.8%), and Prayer (57.5%) (Table 4).

Effects of spiritual care were listed by spiritual dimension (Table 5). Overall, the most frequent was "demonstrates awareness of need for self-care" (48.3%), a need that may be particularly important for family members of seriously ill patients. For the Meaning and Purpose dimension, the most frequent was "reaches a clear understanding of how values and beliefs help or hinder coping" (31.1%).

Surrogate Evaluation

Surrogates rated the project very highly (Table 4) with all indicating they felt supported by the chaplains and would recommend them to other family members. Audiotaped comments reflected the myriad ways the chaplains supported family members. Two themes addressed interventions specific to spiritual care, prayer, and exploring faith. As one participant described:

> I looked forward to him coming and having prayer with me and the sitting and talking to me and having prayer with (patient). Ya know, I could just feel the spirit … I think that really help me through hard times. I mean, I know it did. It was just a comfort for him to be there.

TABLE 2. Use of Questions for Any Visit

Question	Frequency	%
I. Meaning and Purpose		
What are your sources of strength?	25	31.3
What helps you understand what is going on now?	18	22.5
Are you struggling with any decisions right now?	19	23.8
When life is hard, what do you depend on to keep going?	15	18.8
What happens when you feel helpless	9	11.3
What does it mean for you to be here?	9	11.3
What is the most powerful or important thing in your life?	8	10.0
How do your values and beliefs help you make decisions?	6	7.5
None	3	3.8
II. Relationships		
Who are you able to rely on?	25	31.3
Do you have any religious, spiritual or communal support?	19	23.8
Who is there for you at a time like this one? How are they important?	19	23.8
How are you connected to others during this health crisis?	18	22.5
Are you experiencing any changes in how you are connected to others?	16	20.0
How important is your relationship with God/ higher power?	16	20.0
How are you feeling connected to them?	15	18.8
None	0	0
III. Transcendence and Peace		
Can I pray for you? How shall I pray for you?	28	35.0
Are you at peace?	24	30.0
Is there anything you have faith in?	19	23.8
Is there any moment when you can relax?	15	18.8
How do you experience peace?	15	18.8
Do you have any sense of a higher power or God	12	15.0
None	0	0
IV. Self-worth		
How are you taking care of yourself right now?	29	36.3
What is weighing on you right now?	21	26.3
How do you feel about yourself right now?	16	20.0
When was the last time you got some sleep or had a meal?	15	18.8
What stresses are you experiencing?	14	17.5
Are there times when you feel like you have to choose someone else over yourself?	10	12.5
None	0	0

Note. Data is presented by visit; therefore, many participants have more than one ($n = 80$). Questions are listed in decreasing order of frequency.

As this quote also reflects, other themes were related to emotional support, relationship building, and presence. Another participant stated:

> Well, the best experience would just be that they were there and showed that they cared … and showed that they were thinking about us … That's what I would say is the best experience, knowing that somebody was there at the hospital, and that they, that you guys cared.

TABLE 3. Frequency of Interventions

Interventions	Frequency	%
Active Listening	70	87.5
Emotional Support	65	81.3
Non-Anxious attending	59	73.8
Prayer	46	57.5
Spiritual Counseling	44	55.0
Naming behaviors that are beneficial or healthy	36	45.0
Normalization	22	27.5
Explores behaviors that may be self -defeating or harmful	20	25.0
Life Review	13	16.3
Reading the bible or other sacred text	8	10.0
Bereavement Support	7	8.8
Faith affirmation	4	5.0
Referral to member(s) of the interdisciplinary team	2	2.5
Advance Care Planning	1	1.3
Confession/amends	1	1.3
Crisis/Trauma Care	1	1.3
Provision of Religious/Spiritual Resources	1	1.3
Referral to other clergy/spiritual support	1	1.3
None	1	1.3
Ritual or sacrament	0	0

Note. Data is presented by visit, so many participants have more than one ($n = 80$). Interventions are listed in decreasing order of frequency.

Two themes addressed the proactive aspect of the Chaplain Family Project, specifically Proactive Contact and Timing. Participants appreciated the presence of the chaplain, the frequency of visits, and the sense that the chaplain was available when needed:

> The best experience was the fact that the chaplain offered the service. I don't ever remember having that any place else.

Participants described the effect of the intervention, with most reporting a sense of "lifting burden," "comfort," or "peace."

When asked what could be improved about the Chaplain Family Project, 19 respondents said "nothing." Most comments related to wanting greater availability of the chaplain or requesting the intervention be available to more family members. There were two criticisms of the study, one person commented the initial explanation of the study was burdensome and another commented the study surveys were intrusive.

DISCUSSION

This pilot study of a spiritual care intervention delivered by chaplains to surrogate decision makers demonstrated that proactive contact led to all

TABLE 4. Chaplain Family Project Experience (frequency [%])

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
1. The chaplains supported me during (patient's) hospital stay.	13 (65.0)	7 (35.0)	0	0	0
2. I would recommend the chaplains to other families.	16 (80.0)	4 (20.0)	0	0	0
3. The chaplains contacted me too often.	0	0	1 (5.0)	10 (50.0)	8 (40.0)
4. The chaplains took up too much of my time.	0	0	1 (5.0)	11 (55.0)	8 (40.0)
5. The chaplains provided spiritual support to me.	13 (65.0)	6 (30.0)	1 (5.0)	0	0
6. The chaplains provided emotional support to me.	13 (65.0)	6 (30.0)	1 (5.0)	0	0

surrogates receiving at least one encounter and most receiving the three planned visits. The chaplains' ability to provide multiple spiritual care visits to families was greatly assisted by the use of phone visits, which made up 40% of overall study visits. The majority of visits also included the required elements of the SCAI framework. This suggests that such an undertaking is feasible in the ICU setting.

The second goal was to determine if the approach was acceptable to family members. We found it was generally well received, as indicated by both survey responses and qualitative comments. Surrogates appreciated the proactive contact as well as the spiritual support. Consistent with professional chaplaincy standards, surrogates with a variety of religious perspectives felt highly supported by the chaplain.

Development of the SCAI framework involved close collaboration between researchers and chaplains and frequent communication between the unit and study chaplains. The interdisciplinary team included spiritual care and chaplaincy leadership, chaplain researchers, physicians, and research staff. The development process included both review of existing literature regarding structured spiritual assessment, as well as reflection by the chaplains on the most essential elements of their practice. In this study, three chaplains implemented the intervention and found it to be complementary to their traditional chaplain practice. One chaplain observed that some of the questions were similar to ones she already used in her practice. The major drawback observed by the chaplains was the length of the electronic documentation for the study. In future work, we

TABLE 5. Chaplain Observed Effects of Spiritual Care

Outcome	Frequency	%[a]
I. Meaning and Purpose		
Reaches greater clarity about the meaning and purpose of life	32	31.1
Reaches a clear understanding of how values and beliefs help or hinder coping	26	25.2
Reaches decisions about medical care or other concerns that reflect personal values	21	20.4
None	12	11.7
Reflection or acceptance of loss and grief	8	7.8
Identifies spiritual strengths or resources	4	3.9
Other	0	0
II. Relationships		
Reports a greater sense of community	43	51.8
Recognizes impact of his or her behavior on others	20	24.1
Expresses or intends to express remorse and/or forgiveness	9	10.8
Acknowledges lack of support or loneliness	3	3.6
Develops intention to affirm others	2	2.4
Recognizes value of his or her role as a family member	2	2.4
Other	2	2.4
None	2	2.4
III. Transcendence and Peace		
Feels a connection to the divine	37	35.9
Expresses a greater sense of peace or acceptance	31	30.1
Increases practices that foster connection with the divine or a sense of inner peace	29	28.2
None	5	4.9
Other	1	1.0
IV. Self-worth		
Demonstrates awareness of need for self-care	43	48.3
Balances self-care with care and concern for others	30	33.7
None	6	6.7
Expresses awareness of self-worth	4	4.5
Articulates stress on self	4	4.5
Expresses awareness of God's love/divine love	1	1.1
Other	1	1.1

Note. Data is presented by visit ($n = 80$ visits). Many participants have more than one visit and many have more than one effect per visit. Those that were prespecified in the SCAI Framework are in italics. Those listed at "Other" were reviewed and coded by investigators. These codes are in bold. Effects are listed in decreasing order of frequency.
[a]percentage of responses within each domain.

will refine the documentation so the SCAI framework could be feasibly incorporated into routine chaplaincy practice.

Chaplains who participated in the project reflected that the SCAI framework assisted them in making sure important dimensions of spirituality were addressed during each visit. The chaplains felt the framework was open-ended enough that they could be uniquely responsive to the concerns of each family member. Each question in the assessment was

selected for at least one visit but none were used over 40% of the time suggesting that the choice of questions varied by visit.

The SCAI framework was intended to be a useful tool to complement the practice of highly trained and skilled chaplains. The director of Spiritual Care and Chaplaincy Services specifically selected chaplains for the project who demonstrated these skills. Chaplains were asked to recognize opportunities to explore the four dimensions of the SCAI framework as they arose in response to both the questions included in the guide and spontaneously from the surrogate. The chaplains demonstrated the capacity for reflection on patient and family spirituality in their practice, and were able to assess each person's spirituality in the context of the current illness crisis. Specific skills included active listening, hearing emotions behind the words, providing accurate empathy, recognizing when one's own issues arose, recognizing the theological implications of the person's concerns, and making connections between theology and spiritual care interventions.

Chaplain leaders have recently called for additional research into the provision of spiritual care, including assessment of outcomes and the development of interventions that can be studied using rigorous methods (Fitchett et al., 2014; Handzo et al., 2014; Jankowski, Handzo, & Flannelly, 2011). An important aspect of such studies is ensuring the intervention is reproducible, which requires structure and careful documentation. Standards have been published for assessing whether interventions are delivered according to plan, known as fidelity to protocol (Bellg et al., 2004). In developing the SCAI framework, we sought to balance the open, responsive approach that is core to the practice of spiritual care with an intervention that was structured enough to be reproduced in future studies with a high degree of fidelity.

To facilitate future assessment of fidelity to study protocol and replicability, we identified core dimensions of spirituality and specific questions. This is in contrast to other spiritual care frameworks or assessment tools, which have identified core dimensions but not specified question wording (Fitchett, 2002; Shields et al., 2015). Similar to AIM, our framework also provides guidance for intervention and documentation of both the process and outcomes of spiritual care (Shields et al., 2015). We hope future research will test whether this approach can be delivered with high fidelity to protocol by using methods of direct observation of the visits and whether or not the intervention has an effect on important outcomes such as surrogate well-being or decision making for the patient.

The major limitation of this pilot project was our inability to assess the effect of the intervention on important quantitative outcomes for the patient or surrogate. Because important outcomes such as spiritual well-

being, anxiety, or depression are likely to vary over the patient's hospital and posthospital course, our pre/post assessments could not determine if the chaplain visits reduced distress. Also, because of the high illness severity and intensive care setting, future research is needed using a control group to assess important outcomes. We also note the study was not large enough to identify whether certain surrogates were most likely to benefit from the approach. This intervention was implemented by only three chaplains. Other chaplains may have selected different questions and interventions in their practice of spiritual care. Further work is needed to assess the use of the framework by a larger group of chaplains and to determine whether it could be successfully implemented by other chaplains in other settings. Finally, relying on chaplains who are board-eligible but not yet certified to deliver the intervention may raise concerns regarding whether the chaplains had the skills and knowledge to provide spiritual care in the present study.

In conclusion, a spiritual care intervention directed at family members of critically ill patients in the ICU is feasible and acceptable to family members. Future interventions are needed to demonstrate that this approach can lead to improvements in outcomes for ICU family members.

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APPENDIX 1. Review of Spiritual Dimensions in Published Spiritual Care Frameworks and the Spiritual Care Assessment and Intervention (SCAI) Framework

Pruyser (1990)	Spiritual needs Model/ Spiritual distress assessment tool (Monod et al., 2010)		Spiritual AIM (Shields et al., 2015)	FACT (LaRocca-Pitts, 2012)	7X7 model (Fitchett, 2002)	SH4DI (Fisher et al., 2000)	SCAI framework
	Dimension	Need					
Faith	Meaning	Need for Life Balance	Meaning and Direction	**F**aith (includes meaning and purpose)	Belief and meaning	Personal Domain: Meaning Purpose and Values; Self-Awareness, Self-Esteem and Identity	Meaning and Purpose
Providence							
Communion		Need for Connection	Learn to Love Others (God)		Community	Communal domain	Relationships
Awareness of the Holy	Transcendence					Transcendental Domain	Transcendence and peace
Repentance							
Sense of Vocation	Values	Need for values acknowledgment/need to maintain control			Vocation and Obligation		
	Psycho-social Identity	Need to maintain identity	Self-worth and Belonging to Community				Self-worth, Identity,
					Experience and Emotions		
					Courage and Growth		
				Active in your Faith Community, Support and Presence	Rituals and Practice		
				Coping/comfort			
				Treatment plan			
					Authority and Guidance		
Grace or Gratefulness							

Abbreviations: AIM = Assessment and Intervention Model; FACT = Faith, Active, Coping Treatment Plan; SD4HI = Spiritual Health in 4 Domains Index.

APPENDIX 2. Demographic and Hospital Characteristics of Participants ($n = 25$ patient/surrogate dyads)

Characteristic	Patients	Surrogates
Age, mean (*SD*)	62.28 (16.27)	57.60 (13.31)
Education, mean (*SD*)	12.68 (2.36)	14.12 (2.39)
Sex: Female	12 (48.0)	21 (84.0)
Race		
African American/Black	8 (32.0)	8 (32.0)
White	17 (68.0)	16 (64.0)
Other	0	1 (4.0)
Hispanic	1 (4.0)	1 (4.0)
Married/Opposite sex partner	15 (60.0)	17 (68.0)
Income Category		
≤$24,999		6 (26.1)
$25,000–$74,999		14 (60.9)
≥$75,000		3 (13.0)
Relationship to Patient		
Spouse or Equivalent		11 (44.0)
Son/Daughter		6 (24.0)
Other		8 (32.0)
Duke: Organization Religious Activity		
Never to a few times/month		14 (56.0)
Once/week or more		11 (44.0)
Duke: Nonorganizational religious activity		
Rarely/Never to a Few times/month		4 (16.0)
Once/week or more		21 (84.0)
Duke: Intrinsic religiosity, mean (SD)		12.48 (3.08)
Religion		
None	2 (8.0)	0
Protestant	20 (80.0)	21 (84.0)
Liberal	1 (5.0)	1 (4.8)
Moderate	3 (15.0)	2 (9.6)
Conservative	0	2 (9.6)
Other[a]	16 (80.0)	16 (76.2)
Catholic	2 (8.0)	3 (12.0)
Other[b]	1 (4.0)	1 (4.0)
Hospitalization characteristics		
Total length of stay (median, range)	15 (3–78)	
ICU length of stay (med, r)	12 (3–77)	
In hospital death	8 (32.0)	
Reason for Hospitalization		
Altered Mental Status	2 (8.0)	
Respiratory Failure	6 (24.0)	
Heart disease	6 (24.0)	
Transplant	3 (12.0)	
Vascular disease	2 (8.0)	
Other	6 (24.0)	

SD = standard deviation;
[a]Other for Patients included 7 nondenominational, 8 "Baptist," 1 "Christian Church"; for surrogates 8 "Nondenominational," 8 "Baptist."
[b]Other is "agnostic."