

# A clinical interview assessing cancer patients' spiritual needs and preferences

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## A clinical interview assessing cancer patients' spiritual needs and preferences

We conducted a phase-I study to test the practicability and usefulness of a short (15–30 min) clinical interview for the assessment of cancer patients' spiritual needs and preferences. Physicians assessed the spirituality of their patients using the semi-structured interview SPIR. The interview focuses on the meaning and effect of spirituality in the patient's life and coping system. Visual Analogue Scales (VAS) and Questionnaires were completed following the interview for rating whether SPIR had been helpful or distressing, and to what extent spirituality seemed important in the patient's life and in coping with cancer disease. Thirty oncological outpatients who all agreed to participate were included. The majority wanted their doctor to be interested in their spiritual orientation. Patients and interviewing physicians evaluated the SPIR interview as helpful (patients mean  $6.76 \pm 2.5$ , physicians  $7.31 \pm 1.9$ , scale from 0 to 10) and non-distressing (patients  $1.29 \pm 2.5$ , physicians  $1.15 \pm 1.3$ , scale from 0 to 10). Following the interview, doctors were able to correctly gauge the importance of spirituality for their patients. Patients who considered the interview as very helpful (VAS > 7) were more often female ( $P = 0.002$ ). There were no differences between patients who evaluated the SPIR as very helpful and those who did not, as far as diagnosis, educational level or belonging to a religious community were concerned. The present study shows that a short clinical assessment of cancer patients' spirituality is well received by both patients and physicians. The SPIR interview may be a helpful tool for addressing the spiritual domain, planning referrals and ultimately strengthening the patient–physician relationship.

**Keywords:** psycho-oncology, spirituality, religion, coping, oncology.

## INTRODUCTION

The constructs of spirituality and religiousness are distinguishable and not identical, albeit overlapping (Zinnbauer *et al.* 1997). There is a growing consensus that spirituality

is the broader construct, encompassing all needs, attitudes, values, convictions, practices that transcend our material and objective world, especially as far as the meaning of life and hope are concerned (NICE 2004). Thus, spirituality may be defined as a combination of religious and existential (non-religious, related to meaning and purpose in life) well-being (Paloutzian & Ellison 1982; Laubmeier *et al.* 2004). Conversely, religiousness is basically a social phenomenon. Religions are defined by the borders of institutional belonging, belief systems, traditions and practical commitments. They can be powerful

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providers of social support, e.g. to cancer patients. Beyond this social and objective aspect, the great religious traditions of humankind have all developed spiritualities. However, a spiritual person may live outwith religious systems with their temples, mosques and churches just as a cancer patient may search for help outside official medicine: 'The field of religion is to spirituality as the field of medicine is to health' (Miller & Thoresen 2003).

The older mainstream research in health psychology was characterized by a strong anti-religion bias, considering religion as unscientific and even pathological. Examples for the development toward a more objective dealing with religious/spiritual themes are the classical Freudian criticism of religion and contemporary psychoanalytic thought (Rizzuto 1979) or Seligman's (1983) rejection of spiritual elements in psychotherapy and, more recently, his leadership in positive psychology (Seligman & Csikzentmihalyi 2000). Contemporary personality psychology accepts spirituality as a 'complex yet identifiable construct that includes but extends beyond religion and religiousness' (MacDonald 2000). It seems important to respect religiousness and spirituality as ambivalent phenomena which do not automatically entail an adequate or a maladaptive coping (Stefanek *et al.* 2005). In the context of oncology, it is crucial to recognize those spiritual orientations which are associated with a good adjustment to the disease.

Psycho-oncological research in spirituality has to face considerable intercultural differences between North America [where most of the previous studies have been published, e.g. (Breitbart *et al.* 2004; Koenig 2004; McGrath 2004; McSherry *et al.* 2004; Murray *et al.* 2004; Puchalski 2004; Ramondetta & Sills 2004; Stefanek *et al.* 2005)], South America (Echeverri *et al.* 2004), Asia (Chiu *et al.* 2000; Morita *et al.* 2000; Ando 2004) and Western Europe, where spiritual coping appears to be a less frequent response to life-threatening medical illness (Zwingmann 2005). Among people who use it, religious coping may nevertheless have positive effects on physical and mental health (Koenig *et al.* 2001). Beliefs in a 'higher power' or 'life after death' are not necessarily specifically Christian. Some of the persons who report those beliefs prefer to talk about spirituality rather than religion (Lambert 2004).

Existing assessments of spirituality can be categorized as qualitative interviews (e.g. Taylor 2003; McGrath 2004; Murray *et al.* 2004) or quantitative measures. The latter may be either functional, e.g. FACIT-Sp-Ex (Functional Assessment of Chronic Illness Therapy – Spiritual Well-Being, Brady *et al.* 1999), SWBS (Spiritual Well-Being Scale; Paloutzian & Ellison 1982), or substantive, e.g. SBI

(Systems of Belief Inventory, Holland *et al.* 1998), INSPIRIT (Index of Core Spiritual Experience, Kass *et al.* 1991). A spiritual well-being module of the EORTC QLQ-C30 (QoL Questionnaire Core 30, European Organization for Research and Treatment of Cancer) is under construction (Vivat *et al.* in press).

The purpose of conducting the present study was to test the practicability and usefulness of a short qualitative clinical interview for the assessment of cancer patients' spiritual needs and preferences in a European context. Three specific research questions were addressed:

- 1 Does a clinical interview aimed at assessing spiritual needs provide clinically relevant data?
- 2 To what extent is this interview perceived as helpful and/or distressing for patients and for the interviewing doctors?
- 3 Can patients who consider the interview as being particularly helpful be distinguished from those who do not, taking into account psychosocial and demographic characteristics?

## METHODS

### Subjects

A total of 30 consecutive patients were approached between January and July 2003, in both a university outpatient centre for psycho-oncology and a large oncological practice. Eligible participants were at least 18 years old. Patients with major psychiatric diseases or who were incapable of reading or writing German were excluded. All patients signed their consent corresponding to the guidelines of the Medical Faculty Research and Ethics Committee, who approved the study. Both interviewers (E.F. and C.R.) are physicians trained in psychodynamical psychotherapy.

### Measures

#### *Semi-structured clinical interview SPIR*

Based on qualitative interview guidelines (Maugans 1996; Bradley *et al.* 2000; Puchalski & Romer 2000; Anandarahaj & Hight 2001; Lee *et al.* 2002; Echeverri *et al.* 2004; Puchalski 2004), we used a semi-structured format consisting of four open-ended questions, each of which may be expanded by a number of subquestions. The interview is structured and named by an acronym (SPIR) which helps the interviewer to touch the different issues of the spiritual domain instead of circumventing what may be difficult to approach:

S: Would you describe yourself – in the broadest sense of the term – as a believing/spiritual/religious person?

P: What is the *place* of spirituality in your life? How important is it in the context of your illness?

I: Are you *integrated* in a spiritual community?

R: What *role* would you like to assign to your doctor, nurse or therapist in the domain of spirituality?

Interviewers received a brief training before working with the SPIR. They were told that some patients may prefer the terms 'religion/religiosity' while others might prefer 'spirituality', and that the terms may have quite different meanings from one subject to the other. They were invited to follow the patient's vocabulary, with its preference and avoidance. A spirituality type 'believing without belonging' may, for instance, reject the religious and church-bound terminology. On the other hand, religiously well-integrated persons may dislike the term 'spirituality' that sounds esoteric to their ears. The complete German text has been previously published (Weber & Frick 2002).

#### Visual Analogue Scales

Following the SPIR, patients and interviewers were invited to rate the perceived helpfulness and distress using horizontal 10-cm Visual Analogue Scales (VAS, from 'not at all' to 'extremely'). Patients were also asked to rate the subjective importance of their spiritual beliefs on a VAS, while interviewers independently rated their perception of the importance of spiritual issues for the patient's life. Patients were asked whether they wished to continue the discussion on spiritual issues with the physician, with a different person (e.g. chaplain) or not at all.

#### Statistical analysis

The primary results of the study are descriptive, while the secondary are inferential. To test for significant differ-

ences, the Chi-square test, the Wilcoxon test and Mann-Whitney's *U*-test were used. Differences were considered to be statistically significant at  $P < 0.05$ . Statistical tests were performed using the *SPSS* computer programme, version 11.5.

## RESULTS

Table 1 shows some of the patients' demographics. All approached patients accepted to take part in the study (response rate, 100%). Some characteristic quotes are shown in Table 2. The average duration of the interview was 12 min (range, 6–19 min).

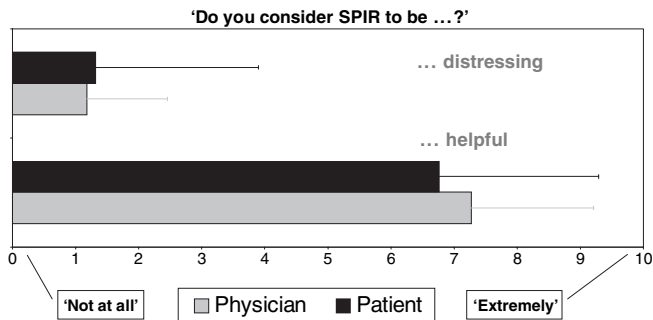
As shown in Table 1, most subjects reported a religious affiliation and were rated as rather spiritual persons by their physician. According to the interviewers' rating following the interview, 25 of the 30 patients considered themselves as spiritual/religious persons (four did not, one was unclear).

**Table 1.** Baseline characteristics of study participants ( $n = 30$ )

	Total
Median age (years) (SD)	53.8 (9.6)
Gender	
Male	19
Female	11
School/education	
Lower secondary school	10
Junior high school	9
Senior high school	3
University	8
Religious affiliation	
None	2
Catholic	22
Protestant	4
Other	2
Therapeutic regimen of cancer disease	
Curative therapy	21
Life-extending therapy	8
Palliative care	1
Setting	
Psycho-oncology outpatient clinic/centre	15
Oncological practice	15

**Table 2.** Examples of responses given by patients during the SPIR interview

S	'I am a believer in a broad sense. Whether it helps, I do not know. If it does not help, that's my bad luck.' 'During the illness I have had spiritual experiences. The Church is not a pillar of strength for me. Rather the faith in the forces of the universe.'
P	'I find strength in my belief. Then I do not feel so alone.' 'God chooses strong people to deal better with the illness.' 'I believe in myself, want to be clear within myself. I am gradually working out what meaning life has.'
I	'Although brought up in a strict religious background, I have nothing to do with institutional church.' 'I don't always believe what is said in the church.' 'As a child I was often at church. Somehow contact with the church has always remained.'
R	'I am glad that somebody is interested in such personal subjects.' 'The doctor should address spirituality only with believers.' 'I prefer that you [the physician] ask me these questions because you are more objective.'



**Figure 1.** Physicians' and patients' ratings following the SPIR interview (Visual Analogue Scales: means of physicians and doctors). There is no statistically significant difference between physicians' and patients' ratings as far as a possible burden/help of the interview ( $P = 0.25$ ) is concerned.

**Table 3.** Can doctors correctly gauge the importance of their patients' spiritual questions after the SPIR? (comparison between patients' and physicians' ratings)

	Means	Min-max	SD	$P$
Patient*	6.3	0.4–10.0	2.8	0.18
Physician†	5.9	0.4–9.6	2.8	

\*Question: Are spiritual questions important for your life?

†Question: Are the beliefs mentioned by the patient important for his/her life?

Both questions were assessed using a Visual Analogue Scale (VAS).

The question 'How should physicians deal with spiritual questions?' was answered as follows: 'not at all' ( $n = 4$ ); 'talk about it' ( $n = 21$ ); 'referral to chaplain' ( $n = 1$ ); other/do not know ( $n = 5$ ). When asked whether and how they wished to continue the dialogue about spirituality, 18 patients wanted to continue with the interviewer, four with another person and nine not at all.

Figure 1 shows that both patients and interviewing physicians consider the SPIR as quite helpful and non-distressing. When patients and physicians independently rate the importance of spiritual issues for the patient (Table 3), no significant difference is found. In a *post hoc* responder analysis, we also tested for differences between those patients who rated the SPIR as being particularly helpful (VAS > 7;  $n = 14$ ) and the other responders (VAS < 7;  $n = 16$ ). High responders were more often women than men ( $P = 0.017$ ). No association could be found with any of the other variables, including education, religious affiliation and setting.

## DISCUSSION

Two major objections have been raised against a scientific and medical study of cancer patients' spirituality: (1) spirituality is immaterial and unempirical, it cannot be an

object of evidence-based research and treatment; and (2) science is incapable of understanding this existential and subjective human orientation, regardless of its relevance to health and patient care. However, it also well recognized that spiritual issues play a major role in the quality of life and coping process of several patients, particularly those facing severe and potentially life-threatening illnesses such as cancer (MacLean *et al.* 2003; Gall *et al.* 2005). Therefore, while respecting the limits of our understanding in this field, both positions cannot and should not hinder physicians from being interested in their patients' spirituality (Miller & Thoresen 2003).

This study evaluates the impact of a qualitative assessment of spirituality using a simple quantitative methodology. The results show that SPIR can be easily administered in clinical care for oncological outpatients. In addition to practical feasibility, SPIR is useful, well accepted (perceived as helpful and non-distressing) and allows physicians not only to gather medically important data about their patients' spirituality but also to know their preferences and needs in this domain. Interestingly, female patients were more likely to find the SPIR helpful than male patients, who appear to be more reserved on the topic of spiritual issues.

Feasibility and practicability of the SPIR depend upon several aspects. Some health professionals, despite recognizing the impact of spirituality for medicine, describe themselves as badly prepared for assessing this area ('I would if I could', Kristeller *et al.* 1999). This uneasiness seems to be more noticeable in doctors than in nurses. It is interesting to note that studies including qualitative methods and content analysis of spirituality-centred interviews have been published more often in nursing journals (McGrath 2001; Taylor 2003) than in medical journals.

Sloan *et al.* (2000) alert physicians untrained in spiritual domains, especially about the danger of coercion and the misconception of faith as an efficient 'drug'. Although the current discussion suggests the inclusion of spirituality in professional health care and research (Brady *et al.* 1999), this critique helps underscore the difference between the spiritual domain and drugs or health outcomes. Other authors have postulated that doctors and other health professionals should receive adequate training for assisting their patients and for interdisciplinary teamwork in the spiritual domain (Puchalski & Larson 1998).

Surveys have shown that the majority of patients want their physicians to ask about spirituality during medical assessments (Ramondetta & Sills 2004). At the same time, Koenig *et al.* (2003) found that up to one-third of patients do not want physicians to discuss spiritual issues with them. They suggest that the physician should initially

explore in a general sense what methods patients use to cope with illness in order to find out whether their spiritual beliefs play a role in their medical decisions. In the United States of America; the Religion and Spirituality in the Medical Encounter Study (RESPECT; MacLean *et al.* 2003) found that two-thirds of patients wanted their physicians to be aware of their religious or spiritual beliefs, and this was correlated with disease severity.

The crisis of religious institutions is more noticeable in Europe than in the America. This crisis has brought about the phenomenon of 'believing without belonging' (Davie *et al.* 2003), where religious beliefs become 'increasingly personal, detached and heterogeneous'. This must be taken into account when spirituality/religiousness is assessed in a European context (Mehnert *et al.* 2003; Gibson *et al.* 2004; Ostermann *et al.* 2004; Zwingmann 2005). Since cultural issues may affect whether and to whom people wish to disclose spiritual issues, the results that we have obtained in a rather homogeneous patient population need to be replicated in different cultural settings.

What can be done to help patients who express spiritual distress or dissatisfaction? Spirituality-centred interventions should be respectful and protective of the patient's autonomy and clearly distinguished from medical prescribing (Sloan *et al.* 2000; Ramondetta & Sills 2004). The assessment of a person's spiritual well-being may itself be an intervention, or may form the early stages of an intervention (White 2000). This has been termed the 'reactivity effect' (Zwingmann 2005). A further step may be the inclusion of values into psychotherapy for oncological patients (Fegg *et al.* in press) or the offering of a specific meaning-centred psychotherapy (Breitbart *et al.* 2004) which is sometimes also called meaning-based or existential psychotherapy (Jung 1934; Yalom 1980).

This study has several limitations, including the small number of patients, the fact that few patients were in an advanced disease stage and the fact that both interviewers are interested in spiritual issues, which may have influenced the patients' responses. Nevertheless, we believe that the results of our study warrant the conclusion that a short clinical assessment of spiritual needs and preferences may provide important data about coping, social support and the patient's search for meaning, and may ultimately help strengthen patient-physician relationship.

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