

Original Article

Cite this article: White KB, Murphy PE, Jeuland J, Fitchett G (2019). Distress and self-care among chaplains working in palliative care. *Palliative and Supportive Care*, 1–8. <https://doi.org/10.1017/S1478951518001062>

Received: 25 September 2018

Revised: 23 October 2018

Accepted: 29 November 2018

Keywords:

Chaplain; Palliative care; Distress; Self-care

Author for correspondence:

Kelsey B. White, University of Louisville, 6800 Chimney Hill Road, Crestwood, KY 40014.
E-mail: kelsey.white@louisville.edu

Distress and self-care among chaplains working in palliative care

Kelsey B. White, M.Div., M.Sc.¹, Patricia E. Murphy, Ph.D.², Jane Jeuland, M.Div.³ and George Fitchett, Ph.D.²

¹University of Louisville, Louisville, KY; ²Rush University Medical Center, Chicago, IL and ³Yale New Haven Hospital, New Haven, CT

Abstract

Background. The prevalence of burnout and distress among palliative care professionals has received much attention since research suggests it negatively impacts the quality of care. Although limited, research suggests low levels of burnout or distress among healthcare chaplains; however, there has been no research among chaplains working in specific clinical contexts, including palliative care.

Objective. This study explored the distress, self-care, and debriefing practices of chaplains working in palliative care.

Method. Exploratory, cross-sectional survey of professional chaplains. Electronic surveys were sent to members of four professional chaplaincy organizations between February and April 2015. Primary measures of interest included Professional Distress, Distress from Theodicy, Informal Self-care, Formal Self-care, and debriefing practices.

Result. More than 60% of chaplains working in palliative care reported feeling worn out in the past 3 months because of their work as a helper; at least 33% practice Informal Self-care weekly. Bivariate analysis suggested significant associations between Informal Self-care and both Professional Distress and Distress from Theodicy. Multivariate analysis also identified that distress decreased as Informal and Formal Self-care increased.

Significance of results. Chaplains working in palliative care appear moderately distressed, possibly more so than chaplains working in other clinical areas. These chaplains also use debriefing, with non-chaplain palliative colleagues, to process clinical experiences. Further research is needed about the role of religious or spiritual beliefs and practices in protecting against stress associated with care for people at the end of life.

Introduction

The increase in the number and type of palliative care (PC) programs suggests an expanding demand for PC clinicians (Dumanovsky et al., 2016). Accompanying this has been an expanded exploration of the effect of PC on its providers (Back et al., 2016; Kamal et al., 2016; Kavalieratos et al., 2017). Research suggests that 60% of PC clinicians report burnout and stress (Kamal et al., 2016; Whitebird et al., 2013). Healthcare providers have acknowledged the harmful effects of burnout on clinical care (Prins et al., 2009; Tei et al., 2014; West et al., 2006; Williams et al., 2007) and the importance of self-care strategies (Back et al., 2016; Harrison et al., 2017). PC chaplains collaborate within a multidisciplinary environment and often create deep relationships with patients and families (Massey et al., 2015), putting them at risk for increased distress. The potential for decreased empathy within patient-clinician encounters as a result of an imbalance between stress and coping strategies may specifically concern professional PC chaplains. Existing research suggests potentially low levels of distress among chaplains (Flannelly et al., 2005; Oliver et al., 2018; Taylor et al., 2006; Yan & Beder, 2013) and potentially a wider range of coping strategies employed by chaplains compared with nurses (Ekedahl & Wengstrom, 2008); however, researchers have not specifically examined the distress levels of chaplains in PC or their self-care practices.

PC researchers continue to add to the literature on burnout. Younger age, working >50 hours per week, and fewer institutional colleagues predicted higher burnout rates among PC professionals (Kamal et al., 2016; Pereira et al., 2011). Emotional exhaustion and depersonalization appear worse among non-physician PC clinicians (Kamal et al., 2016). These variations in distress among clinical professionals could result from organizational level differences or from discipline-specific operational or self-care strategies (Back et al., 2016; Kavalieratos et al., 2017; Sinsky et al., 2013). As researchers identify proactive strategies to increase resilience (Back et al., 2016; Harrison et al., 2017; Jonas & Bogetz, 2016), clinicians have also identified the importance of addressing emotions and integrating experiences associated with existential and spiritual suffering (Boston & Mount, 2006). PC clinicians with greater self-care

and self-awareness seem to have lower levels of burnout, especially among those with frequent exposure to death (Sansó et al., 2015).

Facilitating closure and providing care at the time of death are prominent activities for chaplains working in acute and PC care (Massey et al., 2015). Learning self-awareness and self-care are core components of chaplains' education (Jankowski et al., 2008). As with other PC clinicians, predictors for distress among chaplains included less clinical integration, increased time providing trauma care, years in current position, and perceived institutional support (Galek et al., 2011; Taylor et al., 2006; Yan & Beder, 2013). One small study suggested that chaplains who provide ritual care at the graveside may also experience greater stress than those who do not (Carter et al., 2013). Limited research suggests nurses use functional coping strategies, whereas chaplains shift between professional and religious coping strategies (Ekedahl & Wengstrom, 2008).

The present study was designed to provide an initial report of distress and self-care among chaplains working in PC. The study had three specific aims: (1) to describe the spiritual and work-related distress levels of chaplains who work at least part-time in PC; (2) to describe these chaplains' self-care activities and the extent to which they debriefed clinical experiences with colleagues; and (3) to examine personal and work-related factors that might be associated with the chaplains' distress and self-care activities.

Methods

Participants and procedures

Some of the study methods have been previously described (Jeuland et al., 2017). Invitations to participate in the online survey (via Survey Monkey) were sent to members of four major associations of professional chaplains in the United States: Association of Professional Chaplains; National Association of Catholic Chaplains; National Association of Veterans Affairs Chaplains; and Neshama: the National Association of Jewish Chaplains. The survey was open between February and April 2015. Inclusion criteria were employment in a hospital and spending 15% or more of professional time in PC, including clinical, teaching, and administrative activities. This study was approved by the Yale University Human Investigation Committee and the Rush University Institutional Review Board.

This report describes findings from 322 chaplains of the 531 valid responses received. Of the 209 cases that were omitted, 149 worked less than full-time (the majority of whom worked half-time or less), 30 were respondents who reported minimal or no clinical activity, and 30 were cases that were missing information for the dependent variables (distress, self-care, and debriefing).

Survey development

The survey measures were created by the investigators using published descriptions of chaplain activities (Handzo et al., 2008) and professional expertise. For the present study, the main measures were items related to distress, self-care, and debriefing. Covariates used included factors that might be associated with distress and self-care, including chaplains' personal and professional background, healthcare setting, PC team integration, case-load, chaplaincy activities, and death exposure (Table 1).

Study measures

Distress

The study included five items that assessed distress associated with working as a chaplain in PC (Table 2). The items were scored from 1 (strongly disagree) to 5 (strongly agree). For the five items together, Cronbach's alpha was low (.646); dropping two of the items ("Had existential questions such as, why does God allow the people I serve to suffer?"; "Had times in which I completely lost my faith") increased the alpha for the remaining three items to .696. The sum of the responses to these three items constituted our Professional Distress scale (items 3–5 in Table 2). We retained the other two items as important additional single-item measures of distress. Item 1, "Had existential questions such as, why does God allow the people I serve to suffer?" is related to the theological issue known as theodicy (attempts to integrate beliefs with experiences of suffering in the world) and is labeled Distress from Theodicy here.

Self-care

We created two measures of self-care (Table 2): Informal Self-care (seven items) and Formal Self-care (three items). The Informal Self-care items were scored from 1 (never or less than monthly) to 4 (daily) and an Informal Self-care score was created by summing the item scores (Cronbach's alpha = 0.645). The Formal Self-care items were scored as 0 (missing, not available, never or less than monthly) or 1 (monthly or more).

Debriefing

The study included five items in which the participants reported the frequency of debriefing difficult cases with different chaplaincy and non-chaplaincy colleagues (Table 2). Each item was scored from 0 to 3 (0 = never, less than once a month, not available, or missing; 1 = once a month or more; 2 = once a week or more; 3 = daily). A sum of each of the five items created a debriefing score.

Covariates

Variables that follow include (1) items that were used to describe the study sample and (2) measures of the chaplains' personal and professional background and work setting to examine their possible association with distress and self-care.

Chaplain personal and professional background

For descriptive purposes, chaplains' personal and professional background and work setting included: gender, self-reported race, religious affiliation, and highest degree. The study included a question about years of experience as a board-certified chaplain. We used this item to create a measure of years of experience working as a chaplain. Where the response for years working as a board-certified chaplain was missing and the respondent reported not being board-certified (59 cases), we assigned one year of experience as a chaplain. Other measures of professional background included reports of any training in PC beyond initial chaplaincy training. Type of hospital where employed was coded in five categories and role in PC coded in four categories (Table 1). Chaplain age was not included in the survey.

Other work-related measures

Previous PC research has identified that the amount of clinical time predicts increased levels of burnout (Kamal et al., 2016;

Table 1. Chaplain characteristics

Group	Variable	Item	Frequency (%)
Personal background	Gender (<i>n</i> = 312)	Female	137 (43.9)
		Male	175 (56.1)
	Race (<i>n</i> = 294)	White	262 (89.1)
		Black	17 (5.8)
		Asian-American	9 (3.1)
		Hispanic	6 (2.0)
	Religious affiliation (<i>n</i> = 315)	Protestant	226 (71.7)
		Catholic	76 (24.1)
		Other	13 (4.1)
Professional background	Highest degree (<i>n</i> = 316)	Bachelor's	5 (1.6)
		Master's	257 (81.3)
		Doctoral	54 (17.1)
	Board-certified chaplain (<i>n</i> = 315)	Yes	254 (80.6)
Healthcare setting	Type of hospital	No	61 (19.4)
Palliative care team integration	Years' experience as chaplain (<i>n</i> = 322)	Median (IQR)	5 (1–13)
		Actual range	(0–40)
	Additional PC training (<i>n</i> = 312)	Yes	219 (70.2)
Palliative care team integration	Time in palliative care	No	93 (29.8)
Healthcare setting	Type of hospital	General	168 (52.2)
		Academic	75 (23.3)
		Specialty	44 (13.7)
		VA	20 (6.2)
		Other	15 (4.7)
Palliative care team integration	Time in palliative care	Occasionally	147 (45.7)
		HT or often	119 (37.0)
		Frequently/always	56 (17.4)
	Role with palliative care	Unit chaplain	119 (37)
Palliative care team integration	Role with palliative care	Dedicated PC PT	129 (40.1)
		Dedicated PC FT	47 (14.6)
		Other	27 (8.4)
	Multiple chaplains on PC team? (<i>n</i> = 319)	Yes	183 (57.4)
Caseload	Multiple chaplains on PC team? (<i>n</i> = 319)	No	136 (42.6)
	Patients seen per day (<i>n</i> = 260)	Median (IQR)	5 (3–6)
Caseload	Patients seen per day (<i>n</i> = 260)	Actual range	(1–30)
	Required to see all new patients? (<i>n</i> = 315)	Never/rarely	138 (43.8)
Caseload	Required to see all new patients? (<i>n</i> = 315)	Occasionally	40 (12.7)
		HT	30 (9.5)
		Often	33 (10.5)
		Frequently/always	74 (23.5)
	How much PC time is spent in clinical care?	Occasionally	112 (34.8)
Caseload	How much PC time is spent in clinical care?	HT	72 (22.4)
		Often	85 (26.4)
		Frequently/always	53 (16.5)
	Types of patients (<i>n</i> = 321)	Adult only	255 (79.4)
Chaplain activities	Types of patients (<i>n</i> = 321)	Any pediatric	66 (20.6)
	Chaplaincraft (<i>n</i> = 307)	Median (IQR)	19 (16–22)
Chaplain activities	Chaplaincraft (<i>n</i> = 307)	Actual range	(5–25)
	Involvement in goals of care (<i>n</i> = 312)	<i>M</i> (<i>SD</i>)	15.3 (4.5)
Chaplain activities	Involvement in goals of care (<i>n</i> = 312)	Actual range	(5–25)
	Ritual support (<i>n</i> = 320)	<i>M</i> (<i>SD</i>)	9.7 (2.9)
Chaplain activities	Ritual support (<i>n</i> = 320)	Actual range	(3–15)
	Address spiritual or existential distress (<i>n</i> = 304)	Median (IQR)	19 (15–24)
Death exposure	Address spiritual or existential distress (<i>n</i> = 304)	Actual range	(8–40)
	Deaths per month (<i>n</i> = 288)	Median (IQR)	10.0 (5–20)
Death exposure	Deaths per month (<i>n</i> = 288)	Actual range	(0–110)
	Patients remembered (<i>n</i> = 298)	Median (IQR)	4.0 (2–6)
Death exposure	Patients remembered (<i>n</i> = 298)	Actual range	(0–45)

Unless specified, *n* = 322.

FT, full-time; HT, half-time; IQR, interquartile range; PT, part-time; VA, Veterans Administration.

Table 2. Frequencies of distress, self-care, and debriefing among PC chaplains

Distress	Thinking over the past three months, to what extent do you agree with the following?	Strongly disagree <i>N</i> (%)	Disagree <i>N</i> (%)	Neutral <i>N</i> (%)	Agree <i>N</i> (%)	Strongly agree <i>N</i> (%)
	1. I have had existential questions such as: "Why does God allow the people I serve to suffer?"**	81 (25.2)	81 (25.2)	54 (16.8)	85 (26.4)	21 (6.5)
	2. Have had time(s) in which I have completely lost faith	177 (55.0)	95 (29.5)	20 (6.2)	22 (6.8)	8 (2.5)
	3. I feel isolated as a PC chaplain (<i>n</i> = 321)	125 (38.9)	94 (29.3)	48 (15.0)	43 (13.4)	11 (3.4)
	4. I have thought about leaving work with PC or leaving chaplaincy (<i>n</i> = 321)	160 (49.8)	83 (25.9)	17 (5.3)	47 (14.6)	14 (4.4)
	5. I have had time(s) in which I feel worn out because of my work as a helper (<i>n</i> = 315)	45 (14.3)	44 (14.0)	34 (10.8)	141 (44.8)	51 (16.2)
Informal self-care	Thinking over the past three months, about how frequently have you engaged in the following self-care activities?	Never/less than monthly	1 or more times per month	≥1 times per week	Daily	
	1. Exercise (<i>n</i> = 318)	19 (6.0)	44 (13.8)	148 (46.5)	107 (33.6)	
	2. Meditation/yoga (<i>n</i> = 320)	99 (30.9)	44 (13.8)	108 (33.8)	69 (21.6)	
	3. Other spiritual activities (<i>n</i> = 321)	17 (5.3)	34 (10.6)	127 (39.6)	143 (44.5)	
	4. Non-work-related intellectually stimulating activity (<i>n</i> = 321)	25 (7.8)	72 (22.4)	149 (46.4)	75 (23.4)	
	5. Eating healthy (<i>n</i> = 321)	2 (.6)	22 (6.9)	107 (33.3)	190 (59.2)	
	6. Spending time with family/friends (<i>n</i> = 321)	4 (1.2)	19 (5.9)	111 (34.6)	187 (58.3)	
	7. Maintaining work/life balance (<i>n</i> = 316)	7 (2.2)	35 (11.1)	114 (36.1)	160 (50.6)	
Formal self-care	Thinking over the past three months, about how frequently have you engaged in the following activities?	Missing/not available/never/less than monthly	Monthly	Weekly/daily		
	1. Therapy/counseling	234 (72.7)	64 (19.9)	24 (7.5)		
	2. Spiritual direction	222 (68.9)	90 (28.0)	10 (3.1)		
	3. Hospital EAP	284 (88.2)	21 (6.5)	17 (5.3)		
Debriefing	Thinking over the past three months, about how often have you debriefed difficult cases with:	Missing/NA/never/less than monthly	1 or more times per month	≥1 times per week	Daily	NA [†]
	1. My spiritual care supervisor	157 (48.8)	110 (34.2)	51 (15.8)	4 (1.2)	65 (20.2)
	2. Non-PC chaplains	117 (36.3)	102 (31.7)	82 (25.5)	21 (6.5)	38 (11.8)
	3. PC chaplains	194 (60.2)	61 (18.9)	50 (15.5)	17 (5.3)	114 (35.4)
	4. Non-chaplain PC staff	103 (32.0)	96 (29.8)	94 (29.2)	29 (9.0)	32 (9.9)
	5. Other staff	166 (51.6)	78 (24.2)	64 (19.9)	14 (4.3)	24 (7.5)

Unless specified, *n* = 322.

EAP, employee assistance program; NA, not available; PC, palliative care.

**Subsequently labeled Distress from Theodicy.

†Reported separately here but only counted in the first column of the table.

Table 3. Spearman correlation coefficients of distress, self-care, and debriefing

	Distress		Self-care		Median (IQR)	Actual range
	Professional distress	Distress from theodicy	Informal self-care	Formal self-care		
Professional distress	1				7 (5–9.5)	3–15
Distress from theodicy	.226*	1			2 (1–4)	1–5
Informal self-care	–.277†	–.114‡	1		22 (20–24)	7–28
Formal self-care	.029	.061	.015	1	0 (0–1)	0–3
Debriefing	.003	.074	.066	.245†	4 (2–6)	0–13

N = 300–322.

*p < 0.010.

†p < 0.001.

‡p < 0.05.

Table 4. Spearman correlation coefficients for chaplain characteristics and distress, self-care, and debriefing

Group	Item	Distress		Self-care and debriefing		
		Professional distress	Distress from theodicy	Informal self-care	Formal self-care	Debriefing
Personal and professional background	Gender	–.092	.172*	.026	–.033	–.106
	Board-certified chaplain	–.033	.000	.077	–.010	.085
	Years' experience as chaplain	–.017	–.027	–.054	.039	–.104
	Additional PC training	.023	.160*	–.123†	–.025	–.095
Palliative care team integration	Time in PC	.207‡	–.022	–.148*	–.019	.118†
	Multiple chaplains on PC team?	–.004	–.040	–.018	.005	–.199‡
Caseload	Patients seen per day	.023	–.014	–.029	–.024	.058
	Required to see all new patients?	–.115†	.018	.044	.115†	.096
	How much PC time is spent in clinical care?	.021	–.123†	–.087	.023	.054
	Types of patients	.002	.056	.000	.122†	.142†
Chaplain activities	Chaplaincraft	–.076	–.135†	.102	.094	.081
	Involvement in goals of care	.070	–.012	.045	.178*	.152*
	Ritual support	–.137†	.015	.180*	.213‡	.061
	Address spiritual or existential distress	–.085	.084	.125†	.273‡	.085
Death exposure	Deaths per month	.040	.004	.037	–.007	.170*
	Patients remembered	.124†	.157*	.022	.118†	.211†

Gender: 1 = female, 2 = male; other PC training: 1 = yes, no = 2; type patients: 1 = adult only, 2 = some pediatrics; other PC chaplains: yes = 1, no = 2.

*p < 0.01.

†p < 0.05.

‡p < 0.001.

Koh et al., 2015), thus the following covariates add perspective for chaplains working in PC. The percent of the chaplains' time spent in any type of PC activities in a typical week (e.g., clinical, educational, administrative) was coded in three categories (15–40% occasionally, 41–85% half-time or often, and 86–100% frequently or always). The respondents also reported if there were any other part-time or dedicated PC chaplains in their institution (yes/no).

For caseload, respondents reported the number of PC patients they saw on average each day. The respondents reported if they were required to see all new PC patients; responses were coded in five categories (never or rarely to frequently or always). Respondents stated what percent of their PC time, in a typical week, was spent in clinical activities with four categories (occasionally to frequently or always). The type of PC patients cared

for by the chaplain was coded in two categories (adults only, any pediatric cases).

Chaplain activities

The survey included 22 items about chaplain activities. Each item was scored from 1 to 5 (1 for never or rarely; 5 for frequently or always). Factor analysis was used to create four groups of chaplain activities: Chaplaincraft, Ritual Support, Involvement in Goals of Care, and Address Spiritual or Existential Distress. The group Chaplaincraft contained five items of regular chaplain tasks (e.g., visit patients to build a relationship, provide care for actively dying or deceased patients and their loved ones), Cronbach's $\alpha = .762$. The group Provide Ritual Support contained four items (e.g., help patients pray, help patients connect with community of faith), Cronbach's $\alpha = .772$. The group Involvement in Goals of Care contained five items (e.g., visit patients to discuss goals of care, visit patients to facilitate communication between patient, loved ones and team), Cronbach's $\alpha = .779$. The group Address Spiritual or Existential Distress contained eight items (e.g., helped patients asking why me, helped patients asking about the meaning and purpose of suffering, helped patients asking what happens after death), Cronbach's $\alpha = .895$. These categories were derived from a factor analysis and differ slightly from an earlier report (Jeuland et al., 2017) in which the chaplain activity items were grouped based on their face validity.

Measures of death exposure included the average number of PC deaths per month and the number of deceased PC patients the chaplain reported thinking about from time to time over the past 3 months.

Analysis

Analysis included a description of the study participants, their background, work setting, and activities. The analysis included reporting the frequencies of distress, self-care, and debriefing. Next, to identify the relation between distress and self-care, we examined the correlation among the measures of distress, self-care, and debriefing. This was followed by examining the bivariate association (Spearman correlations) among chaplain background, work setting, and work activities and the measures of distress, self-care, and debriefing. The final step used separate multiple regression models to examine the independent association of all the covariates with the measures of distress, self-care, and debriefing. Because this was an exploratory study, we retained all the predictors from the bivariate analyses for these multivariable models.

There were missing data for many of the covariates in the study. We used the actual data for the descriptive and bivariate analyses. The bivariate analyses were also repeated with imputed data ($n = 322$) with results being essentially same as those using the actual data. Because of the missing data, the samples for the multiple regression analyses (using actual data) ranged from 181 to 191. Consequently, for these analyses, we used Multiple Imputation available in SPSS 24 using the variables in the analysis, yielding 322 complete cases, and report those results. Because this was an exploratory study, we did not adjust the p value for multiple tests of associations among variables.

Results

Table 1 reports the characteristics of the chaplains in the study; most were male (56.1%), white (89.1%), and identified as Protestant (71.7%). Professionally, the chaplains were primarily

board-certified (80.6%) and had additional PC training (70.2%). Most of the participants worked at general hospitals (52.2%), provided PC for adults only (79.4%), and 23.5% reported being required to visit all new patients. The majority of the participants (>80%) were not involved full-time in PC.

Table 2 reports the frequencies of our primary measures and shows that the proportion of chaplains who endorsed distress ("agreed" or "strongly agreed") varied from 9.3% to 61% depending on the item. Loss of faith was somewhat rare (9.3%), but one-third of the chaplains (32.9%) reported experiencing some Distress from Theodicy in the past 3 months. At times, feeling worn out was the item with the highest endorsement (61%). With regard to self-care, participating chaplains identified high levels of Informal Self-care. A large majority of identified exercising (80.1%), using other spiritual activities (84.1%), eating healthy (92.5%), or spending time with family/friends (92.9%) once a week or more. The median of 0 (Table 3) indicates that one-half of the chaplains reported no involvement in Formal Self-care (e.g., counseling, spiritual direction); however, nearly one-third (31.1%) reported at least monthly spiritual direction, and more than one-quarter (27.4%) reported at least monthly counseling. Approximately one-third of the chaplains reported at least weekly debriefing with a non-chaplain PC colleague (38.2%) or a non-PC chaplaincy colleague (32%). Substantial proportions of the chaplains reported not having chaplaincy colleagues (35.4%) or a spiritual care supervisor (20.2%) available for debriefing. Table 3 shows the correlations among the key study measures and shows that Informal Self-care was inversely associated with Professional Distress and Distress from Theodicy. The item asking about loss of faith was not associated with the other key measures or covariates and was deleted from further analysis.

Analysis examined the bivariate association between chaplain personal and work covariates and the distress, self-care, and debriefing items. Professional Distress, as detailed in Table 4, shows a small (Portney & Watkins, 2015) association with the time spent in PC and a small association with remembering patients. Distress from Theodicy, also associated with patients remembered, showed little (Portney & Watkins, 2015) association with additional PC training and gender. We identified a relationship between Informal Self-care and providing ritual support and addressing spiritual and existential distress. Formal Self-care had a fair (Portney & Watkins, 2015) association with the frequency of addressing spiritual and existential distress and a small (Portney & Watkins, 2015) association with a requirement to see all new patients, the type of patients in a caseload, and involvement in goals of care conversations. Finally, debriefing showed a small (Portney & Watkins, 2015) relationship with the amount of time spent in PC, deaths per month, and patients remembered. It had a small (Portney & Watkins, 2015) negative relationship with multiple chaplains on the PC team.

Table 5 reports the regression coefficients for chaplain characteristics and the distress and self-care items. Items predictive of Professional Distress included an increase in the percent of time spent in PC, more frequent goals of care conversations, and identifying as male. Items included in Chaplaincraft negatively predicted Distress from Theodicy, as did Informal Self-care. The use of Formal Self-care was predicted by an increased frequency in addressing spiritual or existential distress of patients and involvement in goals of care. Providing PC to both adults and some pediatric patients predicted an increased frequency of debriefing.

Table 5. Regression coefficients for chaplain distress and self-care (with imputed data)

Group	Item	Distress		Self-care and debriefing		
		Professional distress	Distress from theodicy	Informal self-care	Formal self-care	Debriefing
Personal and professional background	Gender	-.669*	.459 [†]	.047	.048	-.567
	Board-certified chaplain	-.080	.088	1.101*	.100	.572
	Years' experience as chaplain	-.027	-.005	.006	.011	-.019
	Additional PC training	.215	.401*	-1.235 [‡]	-.024	-.618
PC team integration	Time in PC	.632 [‡]	-.057	-.446*	-.092	-.036
	Multiple chaplains on PC team?	-.089	.023	-.066	-.043	-1.052 [‡]
Caseload	Patients seen per day	-.047	.004	-.092	.004	.008
	Required to see all new patients?	-.184	.005	.134	.064*	.137
	How much PC time is spent in clinical care?	-.145	-.112	-.196	-.008	-.089
	Types of patients	.013	.177	-.159	.280*	.924*
Chaplain activities	Chaplaincraft	-.035	-.058*	-.011	-.049 [†]	-.002
	Involvement in goals of care	.117*	.029	.003	.034*	.085
	Ritual support	-.107	.010	.167*	.031	.008
	Address spiritual or existential distress	-.052	.026	.038	.038 [†]	-.019
Death exposure	Deaths per month	.009	.011*	.007	-.005	.010
	Patients remembered	.031	-.001	.026	.015	.065*
Self-care	Informal self-care	-.163 [†]	-.047*			
	Formal self-care	.362*	.043			
	Debriefing	-.119	.041			
<i>R</i> ² for model		.19	.14	.11	.15	.12

Gender: 1 = female, 2 = male; other PC training: 1 = yes, no = 2; type patients: 1 = adult only, 2 = some pediatrics; other PC chaplains: yes = 1, no = 2.

**p* < 0.05.

[†]*p* < 0.01.

[‡]*p* < 0.001.

Discussion

This study provides the first in-depth examination of distress, self-care, and debriefing activities of chaplains working in PC. Some chaplain distress seems prevalent in more than one-third of the sample. Chaplains working in PC frequently use Informal Self-care strategies and one-third engage in spiritual direction. Acute spiritual distress (loss of faith) was rare (9.3%), but one-third of the participants experienced Distress from Theodicy and a majority (61%) reported feeling worn out in the past 3 months. Other studies of healthcare chaplains suggest a low prevalence of burnout (Flannelly et al., 2005; Oliver et al., 2018; Taylor et al., 2006; Yan & Beder, 2013). The higher proportion of chaplains reporting distress in the present study may be due to their work in PC; however, a chaplain's exposure to death did not predict increased Professional Distress or Distress from Theodicy. This could be explained by a chaplain's ability to cope with death or self-awareness, as suggested by earlier research (Sansó et al., 2015). Earlier research has also suggested chaplains may cope with such experiences differently than other healthcare professionals (Ekedahl & Wengstrom, 2008).

Experience as a chaplain also did not predict distress, which is inconsistent with previous studies of chaplains (Galek et al., 2011), but similar to studies of PC professionals (Kamal et al., 2016; Koh et al., 2015). Similar with findings that suggest PC clinicians experience greater burnout when working more hours (Kamal et al., 2016; Koh et al., 2015), greater time spent in PC was associated with greater distress. The associations between chaplain activities and distress are difficult to interpret, but suggest some relation with distress.

Chaplains seem attentive to Formal and Informal Self-care. As with other studies (Mills et al., 2017; Sansó et al., 2015), physical (informal) self-care seems widely prevalent. Substantial minorities engaged in spiritual direction and counseling, but very few use employee assistance program services. Informal Self-care was inversely associated with Professional Distress and Distress from Theodicy in both bivariate and multivariable analyses. The extent that practicing chaplains are involved in debriefing or clinical supervision has not been previously studied. Debriefing, identified elsewhere as a social component of self-care (Mills et al., 2017; Sansó et al., 2015) with chaplaincy supervisor, colleagues, or PC

colleagues, is a potential way to address stress of PC chaplaincy. PC professionals perceive regular debriefing and staff processing opportunities as important in preventing burnout (Jonas & Bogetz, 2016). A unique finding identified that one in five chaplains reported not having a spiritual care supervisor available for debriefing. Factors associated with debriefing among professional chaplains deserve further study.

A limitation of this study, as with most studies that examine burnout or distress, is the potential for sampling bias. Specifically, those under significant stress at the time of the survey may have been less likely to respond. Unlike studies of other PC professionals (Kamal et al., 2016), the majority of the chaplains who participated in this study were not involved in PC on a full-time basis. Although it is a limitation, it is not surprising because it is most common for a PC team to use a part-time chaplain or unit chaplain; chaplains are the professionals least likely to be included in the PC team (Spetz et al., 2016). The cross-sectional and exploratory nature of the study design is another limitation, precluding conclusions about the causal direction among study variables. An additional limitation is that we did not use validated measures of distress or self-care. This study also did not directly capture years of experience as a chaplain or chaplain age.

Future research needs to include the examination of whether clinical context is associated with distress among all healthcare chaplains, guided by a model or theory about distress among health professionals (Back et al., 2016), and use validated measures. Finally, the recent finding that theodicy is associated with chaplain well-being (Currier et al., 2017), reinforces, alongside our study, the need for further exploration about whether religious or spiritual beliefs or practices provide protection against the stressors associated with caring for people at the end of life.

Conflicts of interest. The authors have no conflicts of interest or competing financial interests.

Author ORCIDs.  Kelsey B. White, 0000-0002-4806-1414.

References

- Back AL, Steinhauer KE, Kamal AH, et al. (2016) Building resilience for palliative care clinicians: An approach to burnout prevention based on individual skills and workplace factors. *Journal of Pain & Symptom Management* 52, 284–91.
- Boston PH and Mount BM (2006) The caregiver's perspective on existential and spiritual distress in palliative care. *Journal of Pain & Symptom Management* 32, 13–26.
- Carter JL, Trungale KR, and Barnes SA (2013) From bedside to graveside: Increased stress among healthcare chaplains. *Journal of Pastoral Care and Counseling* 67, 4.
- Currier JM, Drescher KD, Nieuwsma JA, et al. (2017) Theodicies and professional quality of life in a nationally representative sample of chaplains in the Veterans' Health Administration. *Journal of Prevention & Intervention in the Community* 45, 286–96.
- Dumanovsky T, Augustin R, Rogers M, et al. (2016) The growth of palliative care in US hospitals: A status report. *Journal of Palliative Medicine* 19, 8–15.
- Ekedahl M and Wengstrom Y (2008) Coping processes in a multidisciplinary healthcare team—a comparison of nurses in cancer care and hospital chaplains. *European Journal of Cancer Care* 17, 42–48.
- Flannely KJ, Roberts SB, and Weaver AJ (2005) Correlates of compassion fatigue and burnout in chaplains and other clergy who responded to the September 11th attacks in New York City. *Journal of Pastoral Care & Counseling* 59, 213–24.
- Galek K, Flannely KJ, Greene PB, et al. (2011) Burnout, secondary traumatic stress and social support. *Pastoral Psychology* 60, 633–49.
- Handzo G, Flannely KJ, Kudler T, et al. (2008) What do chaplains really do? II. Interventions in the New York chaplaincy study. *Journal of Health Care Chaplaincy* 14, 39–56.
- Harrison KL, Dzeng E, Ritchie CS, et al. (2017) Addressing palliative care clinician burnout in organizations: A workforce necessity, an ethical imperative. *Journal of Pain & Symptom Management* 53, 1091–96.
- Jankowski KR, Vanderwerker LC, Murphy K.M, et al. (2008) Change in pastoral skills, emotional intelligence, self-reflection, and social desirability across a unit of CPE. *Journal of Health Care Chaplaincy* 15, 132–48.
- Jeuland J, Fitchett G, Schulman-Green D, et al. (2017) Chaplains working in palliative care: Who they are and what they do. *Journal of Palliative Medicine* 20, 502–08.
- Jonas DF and Bogetz JF (2016) Identifying the deliberate prevention and intervention strategies of pediatric palliative care teams supporting providers during times of staff distress. *Journal of Palliative Medicine* 19, 679–83.
- Kamal AH, Bull JH, Wolf SP, et al. (2016) Prevalence and predictors of burnout among hospice and palliative care clinicians in the US. *Journal of Pain & Symptom Management* 51, 690–96.
- Kavalieratos D, Siconolfi DE, Steinhauer KE, et al. (2017) "It is like heart failure. It is chronic...and it will kill you": A qualitative analysis of burnout among hospice and palliative care clinicians. *Journal of Pain & Symptom Management* 53, 901–10.
- Koh MY, Chong PH, Neo PS, et al. (2015) Burnout, psychological morbidity and use of coping mechanisms among palliative care practitioners: A multi-centre cross-sectional study. *Journal of Palliative Medicine* 29, 633–42.
- Massey K, Barnes MJ, Villines D, et al. (2015) What do I do? Developing a taxonomy of chaplaincy activities and interventions for spiritual care in intensive care unit palliative care. *BMC Palliative Care* 14, 10.
- Mills J, Wand T, and Fraser JA (2017) Self-care in palliative care nursing and medical professionals: A cross-sectional survey. *Journal of Palliative Medicine* 20, 625–30.
- Oliver R, Hughes B, and Weiss G (2018) A study of the self-reported resilience of APC chaplains. *Journal of Pastoral Care & Counseling* 72, 99–103.
- Pereira SM, Fonseca AM, and Carvalho AS (2011) Burnout in palliative care: A systematic review. *Nursing Ethics* 18, 317–26.
- Portney LG and Watkins MP (2015) *Foundations of clinical research*, 3rd ed. Philadelphia PA: F.A. Davis Company.
- Prin JT, van der Heijden FM, Hoekstra-Weebers JE, et al. (2009) Burnout, engagement and resident physicians' self-reported errors. *Psychology, Health, & Medicine* 14, 654–66.
- Sansó N, Galiana L, Oliver A, et al. (2015) Palliative care professionals' inner life: Exploring the relationships among awareness, self-care, and compassion satisfaction and fatigue, burnout, and coping with death. *Journal of Pain & Symptom Management* 50, 200–07.
- Sinsky CA, Willard-Grace R, Schutzbank AM, et al. (2013) In search of joy in practice: A report of 23 high-functioning primary care practices. *Annals of Family Medicine*, 11, 272–78.
- Spetz J, Dudley N, Trupin L, et al. (2016) Few hospital palliative care programs meet national staffing recommendations. *Health Affairs (Millwood)* 35, 1690–97.
- Taylor BE, Flannely KJ, Weaver AJ, et al. (2006) Compassion fatigue and burnout among rabbis working as chaplains. *Journal of Pastoral Care & Counseling* 60, 35–42.
- Tei S, Becker C, Kawad R, et al. (2014) Can we predict burnout severity from empathy-related brain activity? *Translational Psychiatry* 4, e393.
- West CP, Huschka MM, Novotny PJ, et al. (2006) Association of perceived medical errors with resident distress and empathy: A prospective longitudinal study. *JAMA* 296, 1071–78.
- Whitebird RR, Asche SE, Thompson GL, et al. (2013) Stress, burnout, compassion fatigue, and mental health in hospice workers in Minnesota. *Journal of Palliative Medicine* 16, 1534–39.
- Williams ES, Manwell LB, Konrad TR, et al. (2007) The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal patient care: Results from the MEMO study. *Health Care Management Review* 32, 203–12.
- Yan GW and Beder J (2013) Professional quality of life and associated factors among VHA chaplains. *Military Medicine* 178, 638–45.