Journal Club at the Laboratory of Clinical Psychopharmacology of Addictions (LCPA) is a monthly gathering to discuss research papers with a focus on addiction.

Mission: to promote a better understanding of the research process and an improve ability to critically appraise research in addiction and related diseases (e.g. infectious, mental health, etc.).

Discussion topics and learning objectives include (but not limited by) the concepts of addiction, terminology used in the field, socio-cultural and biological risk factors, contemporary public health issues and policies, prevention, treatment and treatment systems.

Values:

- Learning
- Respect
- Collaboration
- Multidisciplinary
- Excellence

Please be open, flexible, realistic, and understanding!

Housekeeping notes

Video-recording

The meeting will be entirely video-recording and published on the Pavlov University website and YouTube, so if you wish not be in the recorded video, please make sure that your webcam off during the meeting.

Q&A

The seminar is interactive and we strongly encourage you to actively ask questions during the presentation but keep in mind that we have dedicated time at the end of the webinar (10 minutes) to group discussion and Q&A. Please raise your hand if you have any questions or comment. You also may use chat option to post your questions or comments. Please introduce yourself before asking questions.

Mic and Video

Please keep your mic mute during entire meeting unless you want to make a question or comment. We recommend keeping your camera on during the meeting.

Post-meeting survey

After the meeting we would like to send you the survey. Please make sure that we have your email.

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“Are You at Peace?”
One Item to Probe Spiritual Concerns at the End of Life

Karen E. Steinhauser, PhD et al.

Presenter: Daniil I. Shmidt,
5-year medical student.

FEATURED ARTICLE

ORIGINAL INVESTIGATION

"Are You at Peace?"

One Item to Probe Spiritual Concerns at the End of Life

Karen E. Steinhauser, PhD; Corrine I. Voils, PhD; Elizabeth C. Clipp, RN, MS, PhD; Hayden B. Bosworth, PhD; Nicholas A. Christakis, MD, PhD, MPH; James A. Tulsky, MD

Background: Physicians may question their role in probing patients' spiritual distress and the practicality of addressing such issues in the time-limited clinical encounter. Yet, patients' spirituality often influences treatment choices during a course of serious illness. A practical, evidence-based approach to discussing spiritual concerns in a scope suitable to a physician-patient relationship may improve the quality of the clinical encounter.

Methods: Analysis of the construct of being "at peace" using a sample of patients with advanced cancer, congestive heart failure, or chronic obstructive pulmonary disease. Descriptive statistics were used to compare response distributions among patient subgroups. Construct validity of the concept of being "at peace" was evaluated by examining Spearman rank correlations between the item and existing spirituality and quality-of-life subscales.

Results: Variation in patient responses was not explained by demographic categories or diagnosis, indicating broad applicability across patients. Construct validity showed that feeling at peace was strongly correlated with emotional and spiritual well-being. It was equally correlated with faith and purpose subscales, indicating applicability to traditional and nontraditional definitions of spirituality.

Conclusions: Asking patients about the extent to which they are at peace offers a brief gateway to assessing spiritual concerns. Although these issues may be heightened at the end of life, research suggests they influence medical decision making throughout a lifetime of care.

Arch Intern Med. 2006;166:101-105

A cross-sectional survey study

Journal "Archives Of Internal Medicine"
Jan 2006
Volume 166
Impact factor: 9.655 (2006)

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PROBLEM

1. Spiritual distress are common in terminally ill patients
2. Spiritual distress is important source of suffering. Recognising spiritual suffering is important for comprehensive palliative care.
3. Spiritual distress may influence treatment decisions and adherence to treatment.
4. Appropriate assessment of spiritual issues by clinician is difficult in time-limited setting

How spiritual distress can be assessed in an quick, appropriate, reproducible and efficient way?

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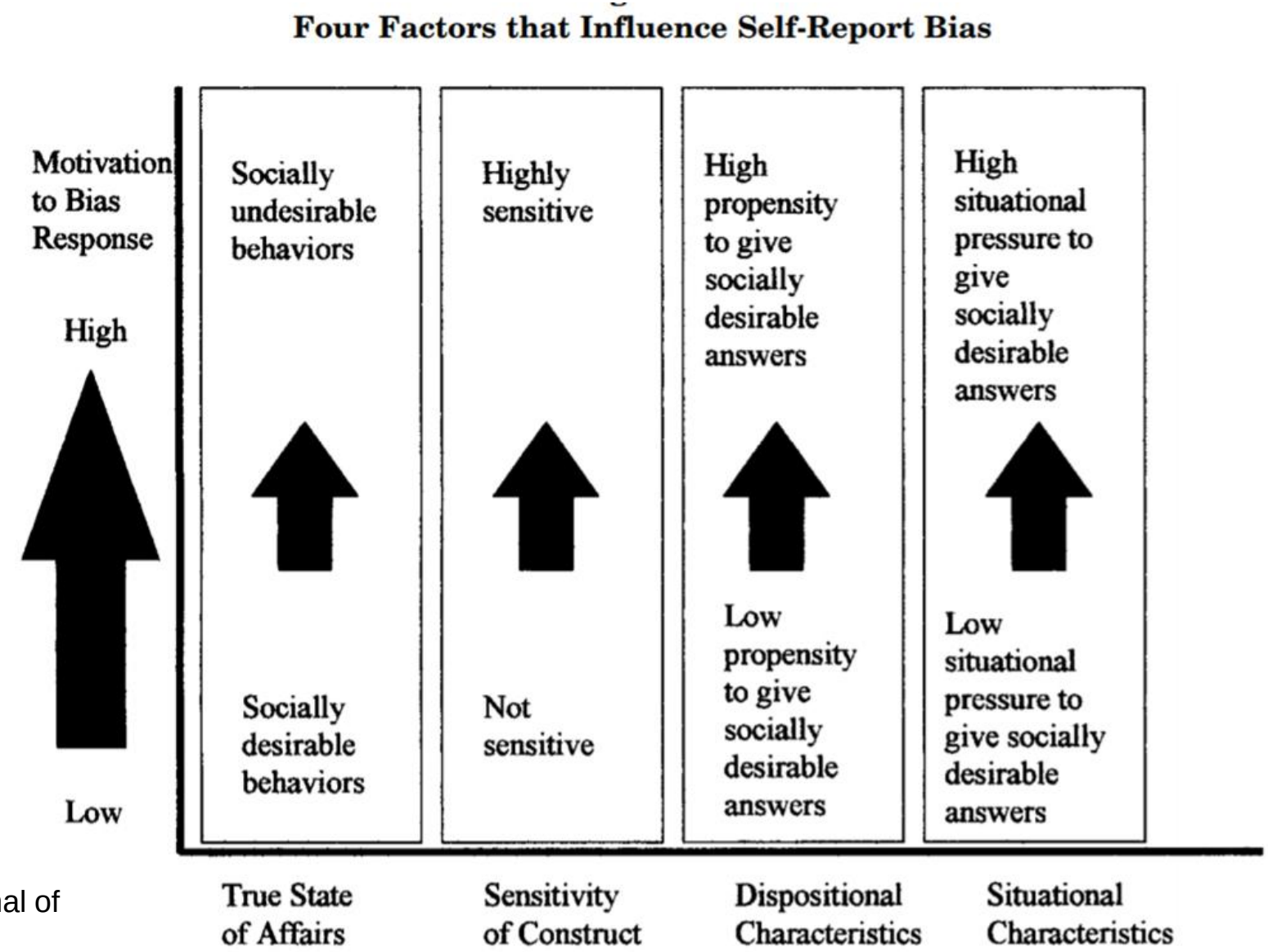
INTRODUCTION

1. Spiritual distress is an important issue in the end-of-life setting contributing for quality of life and treatment decisions [1,2].
2. “Being at peace” was reported by patient, family members, and healthcare providers to be an important constituent of a “good” death [3].
3. 89% of patients and 91.5% of family members agreed with the importance of “coming to peace with God” [3].
4. Peacefulness is strongly associated with emotional and spiritual well-being [4].

1.Post et al., 2000
2. Daaleman et al., 2001
3. Steinhauser et al. 2000
4. Steinhauser et al., 2002

Survey studies

Surveys that rely on participants' self-reports of behaviors, attitudes, beliefs, or actions are indirect measures and are susceptible to **self-report** and **social-desirability biases**



Donaldson, S. I., & Grant-Vallone, E. J. (2002). Journal of Business and Psychology

Survey studies

Surveys that rely on participants' self-reports of behaviors, attitudes, beliefs, or actions are indirect measures and are susceptible to **self-report** and **social-desirability biases**

http://www.joostverweij.nl/experience-design/bias-social-desirability-bias/

Item development

“coming to peace with God” considered important at the end of life in national survey

Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. JAMA. 2000

“at peace with God”, “at peace in my personal relationships”, “at peace with myself” correlations with other items and within-item distributions were not significantly different;

Steinhauser KE et al. Initial assessment of a new instrument to measure quality of life at the end of life. J Palliat Med. 2002

to promote inclusiveness, the final item employed wording “Are you in peace?”

Concept of peacefulness: definition

be at peace

1. To feel an overall sense of contentment or acceptance of a situation.

I was at peace with the world as I stared down at my infant daughter's sweet face.

I hate running, but Matt is at peace when he's jogging through the woods.

2. To not be in conflict.

These warring factions will finally be at peace once the armistice is signed.

3. To be free of pain and suffering, as of one who has died.

As much as I miss her, I'm glad that Grandma is finally at peace after such a long illness.

See also: **peace**

be at peace. (n.d.) *Farlex Dictionary of Idioms*. (2015). Retrieved June 20 2020 from https://idioms.thefreedictionary.com/be+at+peace

Concept of peacefulness: definition

Варианты перевода и формулировки вопроса на русский язык:

1. Находитесь ли Вы в мире с собой, окружающим миром, с Богом, с близкими?
2. Чувствуете ли Вы смирение?
3. Я смирился (оцените степень согласия по 5-балльной шкале)
4. Спокойно ли у Вас в душе?
5. У меня мир в душе (оцените степень согласия по 5-балльной шкале)

Concept of peacefulness: correlations

having a chance to say goodbye

having someone with whom to share their deepest thoughts

Peacefulness

making a positive difference in the lives of others

giving to others in time, gifts, or wisdom

having a sense of meaning in their lives

Steinhauser KE et al. Initial assessment of a new instrument to measure quality of life at the end of life. J Palliat Med. 2002

STUDY OBJECTIVE

To explore the construct of being at peace using quantitative data collected from patients with advanced, life-limiting illness.

To examine correlations with other assessments of spirituality and quality of life to identify constructs associated with the experience of being at peace.

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Methods: Population

Terminally ill patients (n=320) from 2 hospitals (Durham Veterans Affairs (VA) or Duke University Medical Centers, Durham, NC). No comparison group.

Inclusion criteria:

- advanced serious illness as defined:
  - stage IV cancer OR
  - congestive heart failure with an ejection fraction of 20% or less OR
  - chronic obstructive pulmonary disease with a forced expiratory volume of 1.0 L or less OR
  - dialysis dependent end-stage renal disease

Exclusion criteria:

- Cognitive decline as defined by Short Portable Mental Health Status Questionnaire score of 7 or less

Methods: Population

320 patients were reached

- 53 patients refused to participate
- 19 demonstrated significant cognitive impairment

248 patients completed the interview

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Methods: Survey

1. QUAL-E, a 31-item assessment of quality of life at the end of life
2. Functional Assessment of Chronic Illness Therapy–Spiritual (FACIT-SP),
3. Social support subscale from the Duke University Established Population for Epidemiologic Studies of the Elderly (EPESE)

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QUAL-E

4 domains:

1. life completion
2. relationship with health care provider
3. symptom impact
4. preparation for the end of life

1 item asks patients about the extent to which they are “at peace”

26 questions with answers in 5-point Likert scale

Validated and reliable tool. Validated on terminally ill patients.

Steinhauser KE et al. Initial assessment of a new measure of quality of life at the end of life (QUAL-E). Journal of Palliative Medicine. 2002

Steinhauser KE et al. Measuring quality of life at the end of life: Validation of the QUAL-E. Palliative and Supportive Care, 2004

20. I have been able to help others through time together, gifts, or wisdom.

Not at all	*A little bit*	*A moderate amount*	*Quite a bit*	*Completely*
1	*2*	*3*	*4*	*5*

21. I have been able to share important things with my family.

Not at all	*A little bit*	*A moderate amount*	*Quite a bit*	*Completely*
1	*2*	*3*	*4*	*5*

22. Despite my illness, I have a sense of meaning in my life.

Not at all	*A little bit*	*A moderate amount*	*Quite a bit*	*Completely*
1	*2*	*3*	*4*	*5*

23. I feel at peace.

Not at all	*A little bit*	*A moderate amount*	*Quite a bit*	*Completely*
1	*2*	*3*	*4*	*5*

24. There is someone in my life with whom I can share my deepest thoughts.

Not at all	*A little bit*	*A moderate amount*	*Quite a bit*	*Completely*
1	*2*	*3*	*4*	*5*

25. In general, how important is the feeling that your LIFE IS COMPLETE to your overall quality of life?

Not at all	*A little bit*	*A moderate amount*	*Quite a bit*	*Completely*
1	*2*	*3*	*4*	*5*

FACIT-SP

Functional Assessment of Chronic Illness Therapy–Spiritual
5 domains:

- spiritual well-being
  - faith
  - purpose
- physical well-being
- functional well-being
- social and family well-being
- emotional well-being.

Was not designed specifically for use with terminally ill patients but remains a broadly used,well-validated, and reliable general quality-of-life assessment tool.

EPESE

13-item social support subscale from the Duke University Established Population for Epidemiologic Studies of the Elderly (EPESE)

Was not validated for the use in terminally ill patients. Was used to study predictors of mortality, hospitalization, and placement in long-term care facilities and to investigate risk factors for chronic diseases and loss of functioning in elderly (age>65).

Methods: statistical analysis

Variable 1	Variable 2	Test
“I feel at peace” (5-point Likert scale) **ordinal variable**	demographics (age, ethnicity, sex, marital status), diagnoses, and site of recruitment **interval or categorical variables**	Spearman correlation Wilcoxon-Mann Whitney test (?)
“I feel at peace” (5-point Likert scale) **ordinal variable**	FACIT-SP (subscales: emotional, social, physical, functional, and spiritual well-being) and EPESE (subscales: instrumental and affective) **ordinal variable**	Spearman correlation

Results

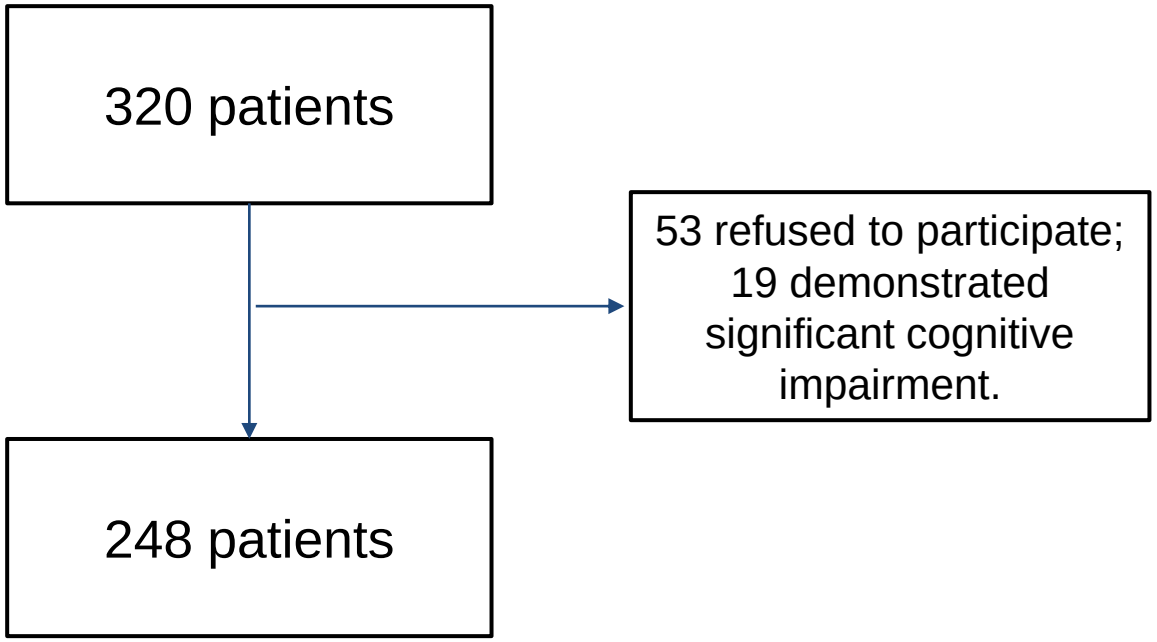

Table. Sample Profile of 248 Patients

Variable	Percentage
Sex	
Men	59
Women	41
Ethnicity	
Black	34
White	59
Native American	2
Other	5
Education*	
<High school	13
High school diploma	44
Associate's degree	23
Bachelor's degree	13
Graduate/professional degree	8
Marital status*	
Married/living with partner	62
Widowed	8
Divorced/separated	23
Never married	8
Diagnosis*	
Cancer	56
COPD	8
CHF	21
ESRD	15
Recruitment Site	
VAMC	40
DUMC	60
Age, y	Median, 61; range, 28-88

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Results

Association of “being at peace” with demographic factors:

- No significant relationships with ethnicity, education, sex, diagnosis, site of recruitment, or marital status.
- Small (i.e. <0.5) but positive correlation between age and feeling at peace (r=0.24).

Results

Correlation of “being at peace” with FACIT subscales:

- **emotional well-being (r=0.52);**
- **spiritual well-being (r=0.60);**
- **physical well-being (r=0.28);**
- **functional well-being (r=0.35);**
- **social well-being (r=0.41);**
- instrumental support (r=0.06);
- affective support (r=-0.08).

“We considered
weak associations to be 0.1–0.3;
moderate, 0.4–0.6;
and strong >0.6”

Spearman ρ	Correlation
≥0.70	Very strong relationship
0.40-0.69	Strong relationship
0.30-0.39	Moderate relationship
0.20-0.29	Weak relationship
0.01-0.19	No or negligible relationship

This descriptor applies to both positive and negative relationships.
(Adapted From Dancey and Reidy, 2004)[40]

Results

Correlations between peacefulness and the 2 dimensions within the FACIT spirituality subscales: purpose: r=0.47,P<.001; faith: r=0.51, P<.001

Interpretation: similar construct resonance for the meaning-making and the religious components of spirituality.

Conclusion

"Asking patients about the extent to which they are at peace offers a brief gateway to assessing spiritual concerns"

Can this conclusion be made on the given the study's results?

Could authors draw more accurate conclusion?

Conclusion

~~“Asking patients about the extent to which they are at peace offers a brief gateway to assessing spiritual concerns”~~

Can this conclusion be made on the given the study's results?

It may be something study suggests, but not proves.

Could authors draw more accurate conclusion?

The most straightforward conclusion would be:

Degree of consent with “I feel at peace” statement is strongly associated with spiritual well-being assessed by multi-item questionnaires.

DISCUSSION

1. Is the sample representative? Can results and conclusions be extrapolated to general population, to people of any age, race, culture, religion etc?

1. Is response given by patient in the setting of a survey similar to response given by patient to verbal version of the question “Are you at peace?”? Is there difference in responses between asking patient the one specific question and giving him a pile of surveys with question of interest among them?

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DISCUSSION

3. Is conclusion as presented by authors accurate?

3. Can language barrier be overcome, i.e. can we extrapolate results of the study to non-english speakers?

3. Authors imply that question “Are you at peace?” can be utilized as substitute to more detailed spiritual assessment. But is it sensitive enough?

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LIMITATIONS

1. Patients primarily resided in one region, some patients were drawn from national pool.
2. Most of the 100 patients recruited from the VA Medical Center were male. However, authors oversampled women at Duke University Medical Center to permit sufficient statistical power to detect differences between men and women.
3. Patients were predominantly white and black. Underrepresentation of asian race and spanish-speaking population.
4. Description of statistical analysis methods was inconclusive.

Resume

It can be stated that concept of being “in peace” is positively associated with overall spiritual condition assessed by various surveys. Wide applicability of the results, especially on different cultures, non-English speakers, non end-of-life setting is disputable.