



The cultural expression of spiritual distress in Israel

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Abstract

Background Although spiritual distress is present across cultures, the ways in which patients experience it vary between cultures. Our goal was to examine the cultural expression and key indicators of spiritual distress in Israel.

Methods We conducted a structured interview of 202 oncology outpatients in a cross-sectional study. Self-diagnosis of spiritual distress, which is a demonstrated gold standard for identifying its presence, was compared with the Facit-Sp-12 and a number of other items (from the Spiritual Injury Scale and newly developed Israeli items) hypothesized as Israeli cultural expressions of spiritual distress, demographic and medical data, and patient desire to receive spiritual care.

Results Significant variation was found between Israeli cultural expression of spiritual distress and that found in studies from other countries. Key expressions of spiritual distress in this study included lack of inner peace, grief, and an inability to accept what is happening. Items related to faith were not significant, and loss of meaning showed mixed results. Patients requesting spiritual care were more likely to be in spiritual distress. No demographic or medical data correlated with spiritual distress.

Conclusions Specially designed interventions to reduce spiritual distress should address the expressions of the distress specific to that culture. Studies of the efficacy of spiritual care can examine the extent of spiritual distress in general or of its specific cultural expressions.

Keywords Spiritual distress · Spiritual care · Chaplaincy · Cultural match · Cultural variance

Introduction

Spirituality is embedded in culture. Researchers and clinicians alike increasingly understand the influence of culture on expressions of spirituality, including spiritual distress or well-being. All measures used should first be culturally validated, without assuming that the same measures capture the same information around the world [1]. In the case of spiritual distress, the defining characteristics of spiritual distress or well-being need to be examined in a particular cultural setting, and such studies have been carried out in countries from Brazil [2, 3] to Portugal [4] to Spain [5] to Africa [6] to India [7]. In light

of the negative health outcomes of poor spiritual well-being, screening for distress, including spiritual distress, and addressing it if present is now a standard of practice for oncology patients [8]. The expressions of spiritual distress indicate corresponding interventions for improving spiritual health [9], so that a deeper understanding of the culture-specific expression of spiritual distress aids in suggesting culturally appropriate focuses for interventions.

Researchers have indicated that three of their top interests in the field of spiritual care are understanding the prevalence of spiritual distress across cultural and religious settings, developing appropriate interventions, and evaluating the effectiveness of that spiritual care [10]. Assuming that spiritual distress is significantly influenced by medical condition, it makes the most sense to compare studies of similar patient populations. The prevalence of spiritual distress among Israeli cancer patients was found to be 23% [11]. This is low when compared to Brazilian and Portuguese studies of cancer patients employing that same methodology (39–42%) [3, 4, 12] and may represent cultural differences.

The present study aims to expand our understanding of cultural variation in spiritual distress by examining the cultural expression and key indicators of spiritual distress in a new

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setting, Israel. These results can then lay the foundation for addressing the other stated research needs—developing interventions and evaluating their efficacy. In order to reach this aim, a preliminary goal of this study was to assess the reliability of the newly translated study measures compared to the presence of spiritual distress.

Methods

Protocol

The study protocol was approved by our institutional review board. Research staff conducted scripted interviews with patients in the oncology day care clinic of our hospital between April 2014 and April 2015. Eligibility criteria were current receipt of oncologic treatment, ability to complete the 30-min interview, and Hebrew comprehension.

Sample

For this cross-sectional study, patients were approached non-selectively by research staff over the course of 95 1–2-h blocks of time when staff were available. Due to limited staff and large numbers of patients present at any given time, out of approximately a total of 790 patients present during periods of study administration, 412 (52%) were approached. Of these, 202 provided informed consent and completed the interview. One hundred and fifteen were excluded for language non-comprehension, 37 for being too ill to complete the interview, 17 for other reasons including cognitive impairment, while 41 chose not to participate but did not specify why.

Identification of spiritual distress

Patients were asked the key study question, whether they were currently experiencing spiritual distress (yes/no), and the NANDA-I definition of spiritual distress was read to them [13]. As previously demonstrated in multiple studies [3, 4, 14], the results of such self-diagnosis accord almost perfectly with professional diagnosis of the presence or absence of spiritual distress, and as such can be treated as a diagnostic gold standard.

Measures

We used three study instruments with a total of 25 items to be analyzed with respect to their correlation with the presence of spiritual distress. Patients responded to Facit-Sp-12, a 5-point Likert-type scale measuring spiritual well-being, whose 12 items can be divided into three subscales: Peace, Meaning, and Faith [15]. They also responded to the Spiritual Injury Scale (SIS), theorized to correspond closely with spiritual

distress, an 8-item measure on a 4-point Likert-type scale, where responses of 3 or 4 indicate spiritual injury within a given item [16]. Finally, five new items investigated potential expressions of spiritual distress that the authors hypothesized would be more common in Israel, as discussed below, including an inability to accept what was happening and a feeling like one is alone in one's coping. These measures were scored just as the SIS measures were.

Validation of measure translation

The owners of Facit-Sp-12 translated the measure, but it has not previously been tested to confirm that patients understand the intended meaning of the items. Using their interview form to test comprehension, we tested it on 10 patients. Based on Facit.org's analysis of the results and of the tester's feedback, and following the rest of Facit.org's protocol for testing translations, the translation was improved to be more clearly understood by a broader swath of the patient population, including those for whom Hebrew is not their native language.

Professional spiritual care

Respondents answered yes or no regarding whether they would like a visit from the professional spiritual caregiver and whether they had previously received such a visit.

Demographic information

Self-reported demographic information included items on age, gender, family status, educational level, religion, religiousness, spirituality, place of birth, native tongue, participation in ritual prayer, and physical proximity of family and friends. Medical information, both self-reported and extracted from the patient file, included type and stage of cancer, goal of current treatment, and patients' sense of their illness' seriousness.

Statistical analysis

Cronbach's alpha was calculated for the Facit-Sp-12 and the SIS. We used receiver operator characteristics (ROC) analysis to determine the optimal cut-off for quantitative parameters of the Facit-Sp-12. We used bivariate logistic regression, into which all the study items were entered, to calculate the odds ratios (OR) with 95% confidence intervals (95% CI), and *p*-values for determining the association of item responses with the test question of spiritual distress. We also calculated the sensitivity and specificity of those items where a significant association was found, in order to determine the cultural expressions of (sensitivity) and indicators for (specificity) spiritual distress. Specificity over 80% suggests a strong indicative value. Sensitivity values report what portion of the study

population in spiritual distress shared that particular expression of distress and, given the precise level of details of these items, we did not set a priori minimum significant values for sensitivity. Multivariable forward stepwise logistic regression analysis was then performed on those variables significantly associated with spiritual distress in the bivariate analysis. Statistical analyses were performed with IBM's SPSS (Statistics Products Solutions Services) 21.0 software for Windows.

Results

Sample characteristics

Key demographic and medical characteristics of the study sample are summarized in Table 1.

Facit-Sp-12 translation validation

In initial testing, certain “high-level” words (4 items) or English loan words (2 items) were unclear to a number of respondents, affecting respondents' comprehension of six of 12 items. These terms were replaced with equivalent but more common words rooted in Hebrew itself. One additional item was confusing because it presented respondents with a potential double negative, so this item was reworded to better reflect the English original. This process of testing and improving the translation carried out in partnership with Facit.org analysts following their standard protocol, produced the current, and validated translation.

Reliability of the Facit-Sp-12 and SIS

The reliability of the Facit-Sp-12 in the Israeli context has not been demonstrated previously. Cronbach's alpha measures internal consistency of the tool, to see if items are being understood as intended. The Facit-Sp-12 as a whole had a Cronbach's alpha of 0.82, indicating an acceptable level of reliability for this tool in Israel. We tested to see if any individual items reduced reliability, but there were no items for which the Cronbach's alpha increased when that item was taken out of the analysis. Looking at the three subscales independently, we find acceptable reliability within the Peace and Faith subscales (Cronbach's alpha 0.76 and 0.84, respectively), but lower reliability for the Meaning subscale (0.69). The reliability for the Faith subscale was even higher, 0.87, if item Sp12 (“I know that whatever happens with my illness, things will be okay”) was removed from the analysis.

The SIS had a Cronbach's alpha of 0.73, which rose to 0.74 if the first item “How frequently do you feel guilty about your behavior in the past?” was removed from the analysis. This was one of the only two items in the SIS not to correlate

Table 1 Select sample characteristics of study participants ($N = 202$)

	No.	%
Gender		
Female	121	60
Male	81	40
Religion		
Jewish	165	82
Muslim	15	7
Christian	14	7
Druze	7	3
Self-defined level of spirituality		
Not spiritual	38	19
Somewhat spiritual	113	56
Very spiritual	46	23
Self-defined level of religiousness		
Secular	84	42
Traditional	90	45
Religious	27	13
Cancer stage		
1	12	6
2	26	13
3	41	21
4	118	60
Native tongue		
Hebrew	114	56
Arabic	34	17
Russian	21	10
English	8	4
Other	24	12

individually with spiritual distress, perhaps suggesting that, in this cultural context, feelings of guilt are seen as a different area of experience.

Establishing cut-offs for the Facit-Sp-12 in Israel

Because the Facit-Sp-12 is not a clinical tool with demonstrated cut-off scores [17], we can establish those scores for our cultural context (at least for oncology patients) for spiritual distress using the ROC curve (following Hegel [18]). For the Facit-Sp-12 as a whole, the clinical cut-off between well-being and distress was found to be a score of 31.5 (out of 48), where higher scores indicate greater well-being. For the Peace subscale, the cut-off was 8.5 (out of 16). For the Meaning subscale, the cut-off was 15.5 (out of 16), meaning that any responses indicating less than the highest levels of meaning correlated with spiritual distress. Sensitivity/specificity from the ROC analysis determining the cut-offs for Facit-Sp-12 and the Peace subscale can be found in Table 2; for the Meaning subscale, it was 60/64%.

Table 2 Bivariate analysis of the measures studied and their associations with spiritual distress. Only items with a significant association are listed

Measure/item	<i>p</i> value	OR	95% CI	Sensitivity (%)	Specificity (%)
Facit-Sp-12	<0.001	3.5	1.8–6.9	57	72
Facit-Sp-12 (Peace subscale)	<0.001	6.4	2.7–14.9	45	85
SIS #2: Does anger or resentment block your peace of mind?	0.007	2.7	1.3–5.4	38	81
SIS #3: How often do you feel sad or experience grief?	<0.001	8.0	3.9–16.5	60	85
SIS #4: Do you feel that life has no meaning or purpose?	<0.001	9.4	3.3–26.6	28	96
SIS #5: How often do you feel despair or hopeless?	<0.001	12.5	4.5–34.4	34	96
SIS #6: Do you feel that God/life has treated you unfairly?	0.001	4.1	1.8–9.8	28	92
SIS #8: How often do you think about death?	<0.001	6.2	2.8–13.7	40	90
Israeli item: I am not able to free my thoughts about my illness.	<0.001	4.9	2.0–11.9	45	79
Israeli item: I am not able to accept that this is happening to me.	<0.001	6.2	2.7–14.1	43	86
Israeli item: I feel like I'm on my own in dealing with this.	0.004	4.2	1.6–10.9	21	94
Israeli item: I feel like I have been cursed.	<0.001	6.1	2.4–15.4	28	94

Bivariate correlates

The full list of items found to be significant in the bivariate analysis of Facit-Sp-12, SIS, and the five additional items theorized to be significant in Israel can be found in Table 2. As can be seen, the majority of items in the various measures strongly correlated with spiritual distress, showing a “cultural match” as an expression of spiritual distress in Israel. Yet a significant number of items did not correlate, suggesting that they are not the common cultural expression in Israel for spiritual distress. These items included the meaning subscale of Facit-Sp-12 (items such as lacking a reason to live or feeling that one's life has not been meaningful); the faith subscale of Facit-Sp-12 (items such as finding comfort or strength from one's faith or spiritual beliefs); feeling guilty over past behaviors (SIS #1); worrying about one's doubts/disbelief in God (SIS #7); and being unable to think of good deeds one has done (new item). Interestingly, in the bivariate analysis of the faith subscale, there was a significant correlation between spiritual distress and those who found themselves in the middle of the faith subscale (scores between 8 and 10 out of 16)—i.e., those whose faith was neither very strong nor very weak (OR 3.4, 95% CI 1.5–7.7, $p = 0.003$).

None of the demographic items were significantly associated with spiritual distress; nor were any of the medical items. Only patients' perception of seriousness of illness was significantly associated (OR 3.3, 95% CI 1.1–9.5, $p = 0.03$).

In a multivariate analysis of the items that were significant in the bivariate analysis, three items remained significant: not feeling peaceful, feeling unable to accept that this is happening, and self-perception of the illness being quite serious.

Desire for a spiritual care visit

Thirty-eight percent of patients stated that they would like a visit from the professional spiritual caregiver. We found a

significant correlation between desiring to receive a visit from the spiritual caregiver and actually being in spiritual distress (OR 2.3, 95% CI 1.2–4.4, $p < 0.02$, sensitivity = 53%, specificity = 67%). Demographic and medical factors correlating with an expressed wish for spiritual care included gender ($p = 0.001$, OR 3.0, 95% CI 1.6–5.6); self-identified level of spirituality (somewhat spiritual vs. not spiritual, $p = 0.004$, OR 4.4, 95% CI 1.6–12.0; very spiritual vs. not spiritual, $p < 0.001$, OR 8.6, 95% CI 2.8–25.9); and stage of illness (stage 4 vs. all other stages, $p = 0.02$, OR 2.0, 95% CI 1.1–3.8). All other items were not found to be significant. Of particular note, patients' self-reported religiousness was not a significant factor in predicting interest in receiving spiritual care.

Discussion

We chose to use the Facit-Sp-12 as one means of examining the Israeli cultural expression of spiritual distress. As this is the first study to use the Hebrew Facit-Sp-12, we needed to first examine the properties of the measure itself in the Israeli context. Our data demonstrate its reliability and establish clinical cut-off points. As in other studies [19], including a Middle Eastern study [20], our results suggest that factor item 12 might not fit best in the Faith subscale, and perhaps should be loaded into one of the other subscales.

It is interesting that the presence or absence of spiritual distress cuts across religious difference, age, gender, religiosity, spirituality, and every other demographic category we examined. Even living alone was not associated with higher levels of spiritual distress. Nor was there a distinction based on medical variables, such as the time since diagnosis, the cancer stage, or the type of treatment currently being undergone. This generally reinforces previous findings, although in other studies, individual items including education, the personal importance of religion, and cancer metastasis were

significantly associated with spiritual distress in individual studies [3, 21]. Spiritual distress seems to be a universal part of the human experience.

Understanding spiritual distress in a more nuanced way requires examining the cultural variance in the form the spiritual distress takes—its defining characteristics and common cultural expression. The experience of spiritual distress is found worldwide, but the form it takes, including how the patient puts it into words or otherwise experiences it, varies from culture to culture. Just comparing our results to one Portuguese study [4], where we might expect to find similar influences of Mediterranean culture, we see significant differences. In comparing those items that were very similar in content in the two studies, using sensitivity as one good measure of the cultural expression of the underlying spiritual distress, we find significant variance between Portugal and Israel, respectively: lack of meaning in life (55 vs. 28%), grief (42 vs 61%), lack of inner serenity (83 vs. 46%), and hopelessness (59 vs. 35%).

The present study provides some insight into the Israeli expression of spiritual distress, where Table 2 provides a picture of the range of ways in which the distress is expressed in this culture. (Sensitivity demonstrates cultural expression, while specificity means the item is an indicator for spiritual distress.) Israeli culture is diverse, reflecting the history of immigration characterizing its Jewish population. Additionally, two major geographical cultural influences are the Middle Eastern and, to a lesser extent, the Mediterranean culture. Both these cultures give great weight to the family system, whose functional presence or absence we then expect to find expression in the patient's spiritual experience [5]. In Middle Eastern culture, there is widespread adherence to the belief that one must accept one's fate, which is also one of the pillars of Islam [22]. Given this cultural background, we theorized that two new items would be likely expressions of spiritual distress in the Israeli cultural context, both of which were found to be significant. "On my own in dealing with this" reflects a lack of family support, and "not able to accept that this is happening to me" could express a feeling that the belief that one must accept one's fate was not providing the expected comfort. A third culture increasingly influencing Israeli society is Eastern spirituality, particularly Buddhism, which we would expect to find expression in assigning importance to and using the language of inner peace, perhaps partly explaining the result that the Peace subscale of Facit-Sp-12 was highly significant. In the multivariate analysis, these latter two items, not feeling peaceful and being unable to accept what is happening, were the two most significant cultural expressions of spiritual distress.

In terms of faith, there is significant religious-secular tension among Israeli Jews. In a study of Israeli Jewish university students, the single most common item of religious/spiritual struggle was "Felt angry at organized religion (30.5%)" [23]. Compared to countries such as the USA, many fewer people affiliate as religious, which may explain why faith struggles (the

faith subscale of Facit-Sp-12) were not found to be a cultural expression of spiritual distress in Israel. The other items found to not be associated with spiritual distress all related in a sense to faith: feeling guilty over past behaviors, inability to remember having done good deeds, or worrying about disbelief in God. It would seem that faith, whether present or absent, is relatively stable and, thus, is not the locus for the expression of spiritual distress. However, we should be careful not to overstate the strength of our conclusion in this as in other culture-dependent areas—this study demonstrates that the specific faith-related items tested are not significant cultural expressions of spiritual distress, but it is still possible that other formulations of faith-related distress would be significant.

Meaning (as measured by the meaning subscale of Facit-Sp-12) was not significantly associated with spiritual distress in the bivariate analysis. One could postulate that Israeli Jews, historically driven by ideology and united by a feeling of fighting for their survival, find their lives overall to be meaningful, so their spiritual distress is not expressed in this way. We may expect this to change in coming generations, since young Israelis express high levels of uncertainty regarding the meaning of their lives [23].

Alongside the value of these results, we must recognize that this study presumably did not examine all the significant expressions of Israeli spiritual distress. Sensitivity was under 50% for most of the items significantly associated with spiritual distress, indicating that, although they are significant, they do not capture the "full picture." This study, in relying primarily on existing tools, may not have given sufficient expression to certain areas of spiritual experience. In particular, a large majority of the study items relate to the intrapersonal realm (serenity, meaning, letting go, accepting, resentment, and grief), some relate to the transpersonal realm (cursed, fairness of life, hope, comfort, or strength thanks to faith), and only one item related to the interpersonal realm (coping alone). Another Mediterranean study suggests a very different balance of these three areas [5], and future study should consider examining the interpersonal and transpersonal realms in greater depth.

All the items in the present study significantly associated with spiritual distress have high specificity, suggesting that they are indicators specifically of spiritual distress, rather than of multiple parts of the experience of being ill with cancer. Results elsewhere include many items with very high sensitivity but fairly low specificity [4]. Clinical observation of items with high specificity for spiritual distress should certainly lead to a spiritual care referral. Interestingly, lack of inner peace had high specificity in our study, whereas its strength as an indicator was weaker elsewhere [4, 24].

One final expression of spiritual distress in our study was expressing a desire to receive spiritual care. The fact that those requesting spiritual care were in significantly higher spiritual distress is a significant one. It indicates that, in allocating limited time available for spiritual care provision, we can rely

on patients' self-referral. Patients who ask for spiritual care are more likely to be in actual need of spiritual care, and they are not only requesting it because they themselves are more spiritually inclined. Using this baseline data point, if a future study found that recipients of spiritual care have lower spiritual distress than non-recipients, we could attribute that in part to the spiritual care intervention. Finally, it is worth noting that, in this study, religiousness was not significant in predicting a desire for spiritual care. Five years prior, in a study carried out in the exact same setting, it was quite significant [25]. This suggests that, in the young Israeli field, over the course of 5 years, the general population's sense that spiritual care is not only a service for religious people grew substantially.

These data suggest a next step for research. Presumably, a key goal of spiritual care is to facilitate a spiritual experience that improves spiritual well-being and reduces spiritual distress. The key expressions of spiritual well-being and distress are culturally dependent. Next research steps should include measuring how culturally informed spiritual care impacts spiritual distress over time (using a scale and not just a binary question) and, specifically, how it impacts those cultural expressions of spiritual distress that are significant in the region being studied. Specific interventions related to that culture's common expressions of spiritual distress should also be designed and tested.

Weaknesses

The number of Arab participants in the study, while proportionally similar to national demographics as a segment of the study sample, was not large enough to check for detailed cultural differences between the Jewish and Arab segments of the population. As described above, the items to characterize spiritual distress may not have sufficiently captured the different elements of spirituality, particularly the interpersonal and transpersonal. Finally, the study excluded those who did not speak Hebrew, perhaps skewing the results against elderly Arabic and Russian speakers who are less likely to understand Hebrew than younger people.

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Compliance with ethical standards

The corresponding author has full control of all primary data and agrees to allow the journal to review the data if requested.

Conflict of interest The authors declare that they have no conflict of interest.

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