Relationships Between Perceived Importance of Chaplain Presence and Health Professionals' Emotional Well-Being in the United States

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Abstract

Hospital-based chaplains receive specialized training to provide spiritual support to patients and healthcare staff during difficult health transitions. However, the impact of perceived chaplain importance on healthcare staff's emotional and professional well-being is unclear. Healthcare staff ($n = 1471$) caring for patients in an acute care setting within a large health system answered demographic and emotional health questions in Research Electronic Data Capture (REDCap). Findings suggest that as perceived levels of chaplain importance increase, burnout may decrease and compassion satisfaction may improve. Chaplain presence in the hospital setting may support healthcare staff emotional and professional well-being following occupational stressors including COVID-19-related surges.

Keywords Burnout · Chaplains · Compassion satisfaction · Healthcare staff · Emotional health · Stress

Introduction

During COVID-19-related hospital surges, healthcare staff faced augmented occupational and emotional stressors and were found to suffer a high prevalence of depression, anxiety, and post-traumatic stress disorder (Li et al., 2021). Several underlying reasons may have contributed to poor emotional outcomes for healthcare staff working during COVID-19. For example, healthcare staff reported fear of being

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infected with the virus when caring for patients. At times, staff faced critical shortages of personal protective equipment, contributing to the fear of infection while at work. Staff expressed worries that, if infected, they would experience extended missed work and risk of transferring the virus to family and friends outside of work. Additionally, hospitals limited visitors to prevent spread of the virus, causing staff to experience moral distress by witnessing events such as patients dying alone (Billings et al., 2021).

Distressing experiences related to the COVID-19 virus are linked to an increased risk of emotional exhaustion among healthcare staff. Poor emotional well-being can lead to worsened occupational outcomes such as decreased quality of patient care (Tawfik et al., 2019). Yet, occupational outcomes such as job satisfaction, missed days of work, work-related injuries, and intentions to quit, may become more favorable when emotional exhaustion is minimized (Salvagioni et al., 2017). One construct of occupational emotional health is Professional Quality of Life, defined by three components: compassion satisfaction, secondary traumatic stress, and burnout (Stamm, 2010).Stamm, 2010).

Compassion satisfaction (CS) is defined as the fulfillment caregivers derive from creating an empathic connection with patients and providing effective care (Sacco & Copel, 2018). Secondary traumatic stress is conceptualized as a reduced capacity to bear the suffering of others following repeated exposure to traumatic stress. Burnout is defined as mental exhaustion caused from work stress (Sacco & Copel, 2018). Both burnout and secondary traumatic stress negatively impact occupational outcome such as job satisfaction and intent to stay (Gensimore et al., 2020; Lee et al., 2021; Moss et al., 2016). Compassion satisfaction among healthcare staff has an inverse relationship with burnout and is protective against both burnout and secondary traumatic stress (Kawar et al., 2019; Lee et al., 2021; Sacco et al., 2015). Therefore, it is essential to identify and understand factors that enhance healthcare staff's emotional and professional well-being.

Research indicates a correlation between higher levels of spirituality and lower levels of burnout among healthcare providers (De Diego et al., 2021). Hospital-based chaplains are often employed to provide specialized, spiritual support services to patients and their loved ones, yet according to the scope and standards of practice for professional chaplains, an important responsibility of a chaplain is to provide spiritual support to employees such as healthcare staff (Association of Professional Chaplains, 2022). Emerging evidence support the benefits that healthcare staff enjoy from interacting with chaplains in the hospital. In qualitative studies, healthcare staff report gratitude for how chaplains build relationships with them and support their personal and professional well-being (Taylor et al., 2015), and for the diversity of settings where they interact with chaplains, including debriefings traumatic patient care events (Aiken, 2022).

A small study conducted in the Eastern United States reported that increased frequency of interactions with chaplains as well as perceived importance of chaplains related to lower stress scores among frontline nursing staff (Liberman et al., 2020). Similarly, the main objective of this study was to explore relationships between interdisciplinary healthcare members' perceptions of the importance of chaplains in the hospital setting and the main outcome of staff's emotional and professional

well-being as measured by burnout and compassion satisfaction. A secondary objective was to characterize healthcare staff perceptions of chaplain importance in the hospital setting. To the knowledge of the authors, this is the first multi-site, quantitative study sampling a diverse population of healthcare staff to accomplish these objectives.

Methods

Study Design and Ethical Statement

An observational, cross-sectional survey design was selected to study relationships between healthcare staff perceptions of the importance of hospital-based chaplains and emotional and professional well-being. The governing Institutional Review Board of Primary Investigators reviewed the study and approved the work as expedited prior to recruitment and data collection. Participants provided implied consent by reading the study preface and proceeding to take the survey.

Participants and Setting

Healthcare staff caring for patients who were 18 years and older working in acute care hospitals were eligible to participate in the study. Individuals were recruited via emails and flyers posted in staff-specific locations from 31 participating hospitals within a nonprofit Catholic health system employing over 100,000 personnel across 52 hospitals and 1,000 outpatient clinics in seven states of the United States. Recruitment began in February 2022 and ended in April 2022. Co-site investigators were instrumental in the recruitment process. Specifically, site investigators met with unit managers, and had face-to-face interactions with healthcare staff, and posted flyers to promote the study. All survey participants were entered into a raffle to win one of eighty $20 electronic gift cards. Respondent data were considered eligible for analysis if all questions were answered for the outcome variables of professional well-being. See data analysis section below for more details.

Instrument Development

The main outcome of interest for this study was healthcare staff emotional and professional well-being. This construct was measured with a valid and reliable instrument, the Professional Quality of Life version 5 (ProQOL) (Stamm, 2010). The Pro-QOL has 30 questions, 10 questions in each of its sub-scales: burnout, compassion satisfaction, and secondary traumatic stress. Compassion satisfaction (CS) measures a positive aspect of caring for people while burnout and secondary traumatic stress measure the negative aspects. Each response is rated from 1 (never) to 5 (very often) with scores between 10–50. Five questions in the burnout scale are reverse scored. Professional Quality of Life has been well utilized in the healthcare population with recent Cronbach's alpha scores of 0.92 in compassion satisfaction, 0.82 burnout, and

0.82 in secondary traumatic stress (Fu et al., 2021). In this study, the Cronbach's alpha values for compassion satisfaction, burnout, and secondary traumatic stress were 0.93, 0.83, and 0.85, respectively.

Stress was measured using the Perceived Stress Scale four, (PSS-4), a four-question instrument abbreviated from the original 14 questions format (Cohen et al., 1983; Warttig et al., 2013). The PSS-4 is a five-point Likert scale 0 (never) – 4 (very often); scores are summed (0–16) with high scores indicating higher perceived stress. The four questions have appropriate psychometric proprieties with a Cronbach's alpha score of 0.77 (Warttig et al., 2013), and in this study, 0.81.

To examine relationships between emotional well-being and healthcare staff perceptions of chaplains, non-chaplain healthcare staff responded to a question: "Chaplains are present and available where I work". If the answer was "yes", then the participant answered a subsequent author-created question: "Chaplain presence is important in the hospital setting" with responses on a 7-point Likert scale ranging from "strongly disagree" to "strongly agree". Participants who answered "no" or "I don't know" to the "chaplain availability" question did not have the option to answer this Likert-scale item.

Demographic variables included job-related information and personal information. Job-related variables included: individual's role within the organization (i.e., nurse leader, direct care nurse, nursing assistant, doctor, physician assistant, nurse practitioner, technician, pharmacist, therapist [characterized as either a physical, speech, respiratory or occupational therapist role], or other); number of years of experience working in current role; unit schedule; hospital bed size where employed; and department of work. Personal participant variables include sex assigned at birth, race/ethnicity, and religious affiliation. Participants were asked to rate their perceptions of the importance of chaplain presence in the hospital setting.

Data Collection

A cross-sectional, electronic survey was completed by eligible healthcare staff via the Research Data Capture (REDCap) system (Harris et al., 2009). Healthcare staff could participate in the survey by accessing a quick response (QR) code using a smart device or by clicking the link provided in a recruitment email sent by a study representative.

Data Analysis

Frequency and descriptive statistics were conducted to describe the sample of healthcare staff. All respondents were stratified into three groups. First, those who perceived chaplains as important for healthcare staff (indicated by a response of "moderately agree" or higher on the Likert scale item) were labeled "Agree chaplains important". Second, those who responded "neutral" or less on the importance of chaplains Likert scale item were defined as "Not agree chaplains important". Finally, those who responded "no" or "I don't know" when asked whether chaplains are present in their work environment were characterized as "Report chaplains not

present or available". Note that through branching logic, this group was not given the option to respond to the "perceived importance of chaplains" Likert scale item on the survey. Group differences were tested among variables when stratified by those who perceived chaplains were important for healthcare staff and those who did not. T-tests (or Mann–Whitney U, if non-parametric) for continuous variables and chi-square for categorical variables were used. Correlations were conducted between demographic and personal variables, stress scores, and professional quality of life scores. Spearman's rho was selected based on non-normality of data.

Multiple linear regression models were conducted once assumptions for normality were met to determine best-fit for explaining variance in both burnout scores and compassion satisfaction scores in a stepwise fashion. First, all continuous variables with significant correlations to the outcome variables were entered simultaneously into separate models, one for compassion satisfaction and one for burnout. Next, to create a parsimonious model, variables were entered into the model based on largest effect size to smallest and were only retained if noted to significantly increase the adjusted R_2 value (by at least 10%) and if independently contributing to the outcome (as evidenced by a p-value of 0.05 or less). All tests were two-tailed to remain conservative and a p-value of 0.05 was considered significant. Analyses were conducted in SPSS (v.27).
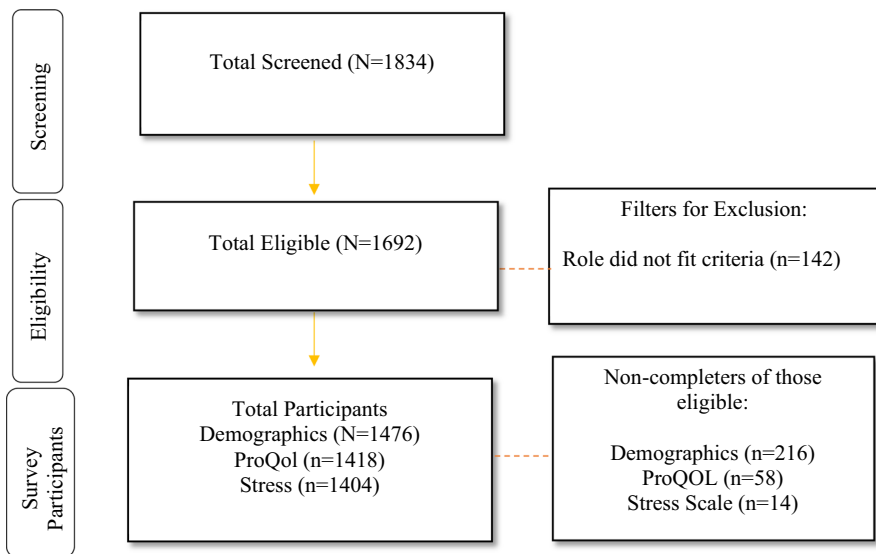

Fig. 1 Participation Flow Diagram

Results

In this large, observational survey study of acute care staff working in a nonprofit Catholic healthcare system in the United States following the acute phase of the COVID-19 pandemic, over 1,400 respondents met criteria for data analysis (Fig. 1). Of the eligible participants, most (86%; $n = 1,212$) reported that chaplains are present and available in their work environment, and 69% ($n = 841$) of those strongly or moderately agreed that hospital-based chaplains are important. Participating health care staff were predominately female, Caucasian, identified as Catholic or Protestant, and worked a day shift. The most common healthcare role reported was registered nurse. Significant differences in demographics were noted between groups by "chaplain perceptions". Notably, a significantly higher proportion of females, Catholic/Protestants, those rating self as highly spiritual, and those working critical care with five or more years of experience "agreed that chaplains are important" compared to the other groups (Table 1).

Several significant correlations were demonstrated among the outcomes of interest. Namely, variables inversely and significantly correlated with BO included years of experience, intent to stay, spirituality, and perceived importance of chaplains. Conversely, all of the latter variables were positively and significantly correlated with CS. Perceived stress was positively correlated with burnout and negatively correlated with CS (Table 2).

The preliminary multivariate regression model characterizing compassion satisfaction as the continuous outcome was significant ($F_{9, 1162} = 186.70$, $R^2_{adj} = 0.59$, $p < 0.001$). Aside from known predictors of BO and STS, independent coefficients included intent to stay, perceived importance of chaplains, and years of experience (Table 3). Similarly, the preliminary multivariate regression model testing burnout as the continuous outcome was significant ($F_{10, 1141} = 364.14$, $R^2_{adj} = 0.76$, $p < 0.001$) with independent coefficients of spirituality, perceived stress, and years of experience in addition to known confounders of CS and STS (Table 4).

Parsimonious models were created for each outcome to avoid over-inflation of the R value. The final model characterizing CS had the same R^2_{adj} value as the initial model ($F_{5, 1177} = 339.60$, $R^2_{adj} = 0.59$, $p < 0.001$). Independent coefficients remained the same and included perceived importance of chaplains ($\beta = 0.27$, $p < 0.01$), intent to stay ($\beta = 0.32$, $p < 0.01$), and years of experience ($\beta = 0.23$, $p < 0.01$). The parsimonious model testing the outcome of BO had a similar R^2_{adj} value to the initial ($F_{5, 1162} = 701.83$, $R^2_{adj} = 0.75$, $p < 0.001$), with significant independent predictors of years of experience ($\beta = 0.20$, $p < 0.01$), perceived importance of chaplains ($\beta = -0.13$, $p = 0.03$), and perceived stress ($\beta = 0.48$, $p < 0.01$).

Discussion

Our study aimed to characterize healthcare provider perceptions of hospital-based chaplains and test for relationships between these perceptions and professional well-being. Our findings revealed several demographic differences among participants

Table 1 Demographic differences stratified by perceived importance of hospital chaplains

	Agree chaplains important (n=841)	Not agree chaplains important (n=371)	Report chaplains not present/available (n=204)	p
	n (%)	n (%)	n (%)	
Gender at birth				
Male	109 (13%)	65 (18%)	34 (17%)	0.07
Female	732 (87%)	306 (82%)	170 (83%)	
Race				
Caucasian	656 (78%)	283 (77%)	169 (83%)	0.18
Non-Caucasian	185 (22%)	88 (23%)	35 (27%)	
Religion				
Catholic/Protestant	569 (68%)*	169 (46%)*	131 (64%)	<0.01
Atheist/Agnostic/No religion	186 (22%)*	168 (45%)*	55 (27%)*	
Other religion	86 (10%)	34 (11%)	18 (9%)	
Years of experience				
Less than 5 years	347 (41%)*	202 (54%)*	107 (52%)	<0.01
5 or more years	494 (59%)*	169 (46%)*	97 (48%)	
Shift				
Days	620 (74%)	262 (77%)*	127 (62%)*	0.05
Evening or Night	221 (26%)	109 (23%)	77 (38%)	
Role				
Registered Nurse	561 (67%)*	204 (55%)*	118 (58%)	<0.01
Nurse Assistant/Technician	59 (7%)	45 (12%)	24 (12%)	
Prescriber	74 (9%)	34 (9%)	7 (3%)	
Therapist	80 (10%)	53 (14%)	21 (10%)	
Other	64 (8%)*	32 (9%)	33 (16%)*	
Specialty				
Critical care or emergency	208 (25%)*	81 (22%)	15 (7%)*	<0.01
Non-critical care	633 (75%)*	290 (78%)*	189 (93%)*	
Self-rated spirituality				
Highly spiritual	657 (78%)*	162 (44%)*	60 (29%)*	<0.01
Mildly or not spiritual	184 (22%)	209 (56%)	144 (71%)	

when stratified by perceptions of chaplain importance and presence. As anticipated, participants self-identifying as Catholic or Protestant (68%; n=569) faith were significantly more likely to strongly or moderately agree that hospital chaplains are important compared to the subgroup self-identifying as Atheist, Agnostic, or having no religion. This finding may be in line with the responsibilities outlined by chaplains as closely associated with religious ceremonies including prayer, baptism, offering of sacred, faith-based materials (Association of Professional Chaplains,

Table 2 Spearman's correlation matrix

	Stress	CS	BO	STS	Intent to stay	Spirituality	Perceived importance chaplains	Bed size	Years of experience
Stress CS	−0.47**								
Burnout	0.65**	−0.74**							
STS	0.52**	−0.38**	0.64**						
Intent to stay	−0.14*	0.33**	−0.28**	−0.18**					
Spirituality	−0.10*	0.27**	−0.24**	−0.01	0.23**				
Chaplain importance	−0.15*	0.29**	−0.19**	−0.03	0.23**	0.39**			
Bed size	0.04	−0.02	0.05*	0.05*	−0.04	−0.03	0.03		
Years of experience	−0.10**	0.12**	−0.08**	−0.11**	0.06*	0.12**	0.16**	0.04	

*p < 0.05; **p < 0.01

Table 3 Factors influencing compassion satisfaction, preliminary regression model ($n = 1172$)

Factor	β	p	95%Confidence interval β
Hospital bed size	0.00	1.00	− 0.28, 0.28
Perceived stress	0.03	0.54	− 0.07, 0.14
Gender	0.04	0.91	− 0.66, 0.74
Spirituality	− 0.10	0.21	− 0.26, 0.06
Burnout	− 0.90	< 0.01	− 0.97, − 0.84
Intent to stay	0.32	< 0.01	0.16, 0.52
Perceived importance of chaplains	0.27	< 0.01	0.15, 0.50
Years of experience	0.23	< 0.01	0.06, 0.41
Secondary traumatic stress	0.17	< 0.01	0.12, 0.22

Table 4 Factors influencing burnout, preliminary regression model ($n = 1163$)

Factor	β	p	95%Confidence interval β
Perceived stress	0.48	< 0.01	0.41, 0.56
Compassion satisfaction	− 0.46	< 0.01	− 0.49, − 0.43
Secondary traumatic stress	0.31	< 0.01	0.28, 0.34
Years of experience	0.22	< 0.01	0.10, 0.34
Spirituality	− 0.39	< 0.01	− 0.50, − 0.28
Gender	− 0.31	0.23	− 0.81, 0.20
Perceived importance of chaplains	− 0.13	0.53	− 0.09, 0.17
Intent to stay	0.01	0.89	− 0.12, 0.14
Bed size	0.20	0.84	− 0.18, 0.22

2022). Yet, given that chaplains are trained to serve people of all faiths, future studies may be warranted to explore the impact of healthcare staff religion on perceived importance of chaplains in the hospital setting.

Similarly, those who self-rated as highly spiritual were more likely to perceive hospital chaplains as important compared to those who did not. Furthermore, although not statistically significant, females were more likely to perceive chaplains as very important in the hospital compared to males. According to the United States Census Bureau, over 75% of healthcare providers are female (Laughlin & Wisnieski, 2021), and women are more likely to report strong religious affiliations compared to men (Wormald, 2015), thus supporting our findings.

Several occupational differences emerged among participants. First, participants with five or more years of experience were more likely to agree hospital chaplains are important compared to those with less than five years of experience. Longitudinal evidence from the general population does support an increase in religiosity over the lifespan (Bengtson et al., 2015), which could explain our study findings. Additionally, working day shift versus night or other shifts supported a statistically significant difference in the perception of hospital chaplain

importance ($p = 0.05$). Notably, chaplains may have a more visible presence on day shifts compared to night shifts, and as such, most respondents reported working a day shift schedule. Staff working night shift report fewer resources and staffing availability. They thus often feel less visible to their day shift peers (Weaver et al., 2022). This notable difference offers opportunity for future studies focusing on staff working night shift. Furthermore, staff working in the critical care or emergency room specialty was significantly less likely than others to report that chaplains are not present or available. In alignment with our findings, healthcare staff in critical care or emergency specialties report high volume of situations requiring collaboration with chaplains to meet the needs of patients and their support persons (Donesky et al., 2020; Ruth-Sahd et al., 2018).

In line with prior research, statistically significant ($p < 0.01$) correlations were noted between emotional and professional well-being outcomes of lower burnout and higher compassion satisfaction and several continuous variables (Lee et al., 2021). Importantly, these variables included higher reported importance of chaplains, increased spirituality, a stronger intent to stay in one's job for the next twelve months, more years of experience, and lower perceived stress over the past 30 days. These findings are validated by prior evidence linking spirituality to improved mental wellness (Helio et al., 2022; Hodapp & Zwingmann, 2019; Speed et al., 2020), lower nurse burnout (De Diego et al., 2021), and increased perceptions of chaplain importance (Liberman et al., 2020). Thus, spirituality and perceptions of chaplains as spiritual support staff should be considered when characterizing emotional and professional well-being among healthcare staff.

Increased years of experience emerged as a significant predictor in multivariate models explaining the variance in both higher BO and increased CS. Prior research affirms that years of experience relates to both BO and CS (Algamdi, 2022). Opportunities may exist to target more experienced healthcare staff to leverage levels of CS and reduce levels of BO, optimizing occupational well-being and performance. Literature suggests that the demographic variable of sex influences CS and BO (Algamdi, 2022; Kawar et al., 2019; Lee et al., 2021), although this study did not uncover the same finding. This is possibly due to the small number of males who participated in our study compared to females, warranting future studies with increased male participation.

Intent to stay emerged as an independent predictor of CS but not BO. Prior studies also support that as compassion satisfaction increases among healthcare staff, so do intentions to stay in current role (Algamdi, 2022; Lee et al., 2021). Future work investigating targeted strategies to increase compassion satisfaction among healthcare staff may therefore support the occupational outcome of reduced turnover. Enhancing healthcare staff retention is of critical importance in the face of enormous healthcare provider shortages being reported today.

As anticipated, perceived stress was revealed as a significant predictor of BO but not CS in our study. Given the definition of BO encompassing the conception of stress (Sacco & Copel, 2018), and our construct of stress including all sources of stress experienced in the prior 30 days (Warttig et al., 2013), it is expected that the two variables are highly correlated. Prior research support this relationship (Tawfik

et al., 2019). Future work focusing on strategies to reduce perceived stress and therefore alleviate burnout among healthcare staff should be prioritized.

According to our study, the perceived importance of chaplain presence in the hospital setting is related to emotional and professional well-being outcomes of BO and CS in fully-adjusted, parsimonious, multivariate models. In the preliminary model for BO, spirituality and not perceived importance of chaplains, was noted as a significant predictor. This phenomenon likely happened due to the moderate level of correlation between the two variables ($r=0.39$) suggesting strong similarities between the two concepts (Table 2). The relationships between perceived importance of chaplains and both CS and BO in multivariate models are novel and warrant further exploration, particularly in secular healthcare settings. Indeed, in 2015, it was estimated that only 70% of hospitals in the United States had chaplains on staff (Weiner, 2017). Future work should be conducted to compare healthcare staff emotional and professional well-being among those working in hospitals with and without chaplains and to further characterize the unique contributions that chaplains may make to improve healthcare staff well-being.

Limitations

Several limitations should be considered when reviewing the results of this study. First, although this study was a multisite study, recruitment was primarily led by site-specific registered nurse leads, potentially limiting the volume of non-nurse healthcare workers represented in this study. Several hospitals within the health system did not have a local site-specific registered nurse lead and, therefore, only 31 of the 53 hospitals chose to take part in the study. Yet, given that nearly 40% of hospital employees are registered nurses and our sample reflects 40% participation from non-nurses, our team is confident that all eligible healthcare roles were equitably represented. Secondly, response and confirmation bias may have been present as caregivers who did not strongly perceive the importance of hospital-based chaplains may not have felt motivated to participate. However, given that nearly one-third of the sample reported an atheist or no religious preference we are confident that caregivers of all faith beliefs were represented in the survey.

Because this is a cross-sectional study, no causative conclusions can be drawn from the findings. Instead, our results may help generate hypotheses to inform future prospective intervention studies. Additionally, it is unclear how the recruitment of staff employed in a nonprofit Catholic healthcare system may impacts responses on items such as self-reported spirituality or perceptions of chaplain importance, offering an avenue for future research. However, receiving responses from nearly one-third of participants who self-identified as agnostic, atheist, or having no religion improves our confidence in representativeness of participants and validity of findings. Finally, our team was unable to monitor whether participants took the survey multiple times, although having a large sample size across 31 hospitals increases our confidence in the validity of unique participant responses.

Conclusion

To our knowledge, this is the first large-scale study conducted among interdisciplinary healthcare staff that explored relationships between perceived importance of chaplain presence in the hospital setting and healthcare staff emotional well-being. Our results revealed a high prevalence of staff reporting the importance of chaplains in the hospital setting. Further results identified personal and professional factors differing between groups agreeing or not agreeing that chaplains are important, as well as those reporting that chaplains are not available in their work setting. As expected from the literature, variables predicting both BO and CS included intent to stay in current role for 12 months, years of experience, spirituality, and perceived stress. Our study contributes to the novel finding that perceived importance of chaplains emerged as an independent factor predicting higher levels of compassion satisfaction and lower burnout in parsimonious models. These results suggest chaplains may support emotional and professional well-being among a variety of healthcare professional roles. Opportunities to test innovative, chaplain-led, targeted interventions to support staff emotional healing which could influence intent to stay in practice, especially following the recent COVID-19 pandemic, may be warranted.

Declarations

Conflict of interest All authors and study personnel attest there are no conflicts of interest in this work.

Ethical Approval All study procedures conducted in this project remained in accordance with the ethical standards of the participating organization, national research committee, and all standards contained within the 1964 Helsinski declarations, to include all amendments. The study was granted an expedited review by the organization's governing Institutional Review Board due to the non-invasive nature of the survey-based research and minimal risk posed to participants. No drugs or devices were tested, and animals were not involved in the procedures.

Informed Consent Informed consent was implied if the participant clicked the link and was deemed eligible to take the survey. No formal consent was required by the IRB due to the nature of the study.

References

Aiken, C. (2022). Australian chaplaincy support of health care staff: Presence, professional and relational. *Journal of Religion and Health, 61*, 948–961. https://doi.org/10.1007/s10943-022-01526-4

Algamdi, M. (2022). Prevalence of oncology nurses' compassion satisfaction and compassion fatigue: Systematic review and meta-analysis. *Nursing Open, 9*(1), 44–56. https://doi.org/10.1002/nop2.1070

Association of Professional Chaplains. (2022). *Standards of Practice for Professional Chaplains,* https://www.professionalchaplains.org/content.asp?pl=200&sl=198&contentid=514

Bengtson, V. L., Silverstein, M., Putney, N. M., & Harris, S. C. (2015). Does religiousness increase with age? Age changes and generational differences over 35 years. *Journal for the Scientific Study of Religion, 54*(2), 363–379. https://doi.org/10.1111/jssr.12183

Billings, J., Ching, B. C. F., Gkofa, V., Greene, T., & Bloomfield, M. (2021). Experiences of frontline healthcare workers and their views about support during COVID-19 and previous pandemics: A systematic review and qualitative meta-synthesis. *Biomed Central [BMC] Health Services Research, 21*(1), 1–17. https://doi.org/10.1186/s12913-021-06917-z

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*(4), 385–396. https://doi.org/10.2307/2136404

Coelho-Júnior, H. J., Calvani, R., Panza, F., Allegri, R. F., Picca, A., Marzetti, E., & Alves, V. P. (2022). Religiosity/spirituality and mental health in older adults: A systematic review and meta-analysis of observational studies. *Frontiers in Medicine.* https://doi.org/10.3389/fmed.2022.877213

De Diego-Cordero, R., Iglesias-Romo, M., Badanta, B., Lucchetti, G., & Vega-Escaño, J. (2021). Burnout and spirituality among nurses: A scoping review. *Explore, 18*(5), 612–620. https://doi.org/10.1016/j.explore.2021.08.001

Donesky, D., Sprague, E., & Joseph, D. (2020). A new perspective on spiritual care: Collaborative chaplaincy and nursing practice. *Advances in Nursing Science, 43*(2), 147–158. https://doi.org/10.1097/ANS.0000000000000298

Fu, C.-Y., Kao, C.-C., & Wang, R.-H. (2021). The effects of an educational program on the professional quality of life and health of nurses: A cluster experimental design. *The Journal of Nursing Research, 29*(3), e149. https://doi.org/10.1097/JNR.0000000000000426

Galanis, P., Vraka, I., Fragkou, D., Bilali, A., & Kaitelidou, D. (2021). Nurses' burnout and associated risk factors during the COVID-19 pandemic: A systematic review and meta-analysis. *Journal of Advanced Nursing, 77*(8), 3286–3302. https://doi.org/10.1111/jan.14839

Gensimore, M. M., Maduro, R. S., Morgan, M. K., McGee, G. W., & Zimbro, K. S. (2020). The effect of nurse practice environment on retention and quality of care via burnout, work characteristics, and resilience: A moderated mediation model. *The Journal of Nursing Administration, 50*(10), 546–553. https://doi.org/10.1097/NNA.0000000000000932

Harris, P. A., Taylor, R., Thielke, R., Payne, J., Gonzalez, N., & Conde, J. G. (2009). Research electronic data capture (REDCap)—A metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics, 42*(2), 377–381. https://doi.org/10.1016/j.jbi.2008.08.010

Hodapp, B., & Zwingmann, C. (2019). Religiosity/spirituality and mental health: A meta-analysis of studies from the German-speaking area. *Journal of Religion and Health, 58*(6), 1970–1998.

Kawar, L. N., Radovich, P., Valdez, R. M., Zuniga, S., & Rondinelli, J. (2019). Compassion fatigue and compassion satisfaction among multisite multisystem nurses. *Nursing Administration Quarterly, 43*(4), 358–369. https://doi.org/10.1097/NAQ.0000000000000370

Laughlin, L, & Wisnieski, M. (2021) Unequally Essential: Women and Gender Pay Gap During Covid-19. https://www.census.gov/library/stories/2019/08/your-health-care-in-womens-hands.html, March 23, 2021.

Lee, H. J., Lee, M., & Jang, S. J. (2021). Compassion satisfaction, secondary traumatic stress, and burnout among nurses working in trauma centers: A cross-sectional study. *International Journal of Environmental Research and Public Health, 18*(14), 7228. https://doi.org/10.3390/ijerph18147228

Li, Y., Scherer, N., Felix, L., & Kuper, H. (2021). Prevalence of depression, anxiety and post-traumatic stress disorder in health care workers during the COVID-19 pandemic: A systematic review and meta-analysis. *PLoS ONE, 16*(3), e0246454. https://doi.org/10.1371/journal.pone.0246454

Liberman, T., Kozikowski, A., Carney, M., Kline, M., Axelrud, A., Ofer, A., Rossetti, M., & Pekmezaris, R. (2020). Knowledge, attitudes, and interactions with chaplains and nursing staff outcomes: A survey study. *Journal of Religion and Health, 59*(5), 2308–2322. https://doi.org/10.1007/s10943-020-01037-0

Moss, M., Good, V. S., Gozal, D., Kleinpell, R., & Sessler, C. N. (2016). An official critical care societies collaborative statement: Burnout syndrome in critical care health care professionals: A call for action. *American Journal of Critical Care, 25*(4), 368–376. https://doi.org/10.4037/ajcc2016133moss

Ruiz-Fernández, M. D., Pérez-García, E., & Ortega-Galán, Á. M. (2020). Quality of life in nursing professionals: Burnout, fatigue, and compassion satisfaction. *International Journal of Environmental Research and Public Health, 17*(4), 1253. https://doi.org/10.3390/ijerph17041253

Ruth-Sahd, L. A., Hauck, C. B., & Sahd-Brown, K. E. (2018). Collaborating with hospital chaplains to meet the spiritual needs of critical care patients. *Dimensions of Critical Care Nursing, 37*(1), 18–25. https://doi.org/10.1097/DCC.0000000000000279

Sacco, T. L., Ciurzynski, S. M., Harvey, M. E., & Ingersoll, G. L. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse, 35*(4), 32–43. https://doi.org/10.4037/ccn2015392

Sacco, T. L., & Copel, L. C. (2018). Compassion satisfaction: A concept analysis in nursing. *Nursing Forum, 53*(1), 76–83. https://doi.org/10.1111/nuf.12213

Salvagioni, D. A. J., Melanda, F. N., Mesas, A. E., González, A. D., Gabani, F. L., & Andrade, S. M. D. (2017). Physical, psychological and occupational consequences of job burnout: A systematic review of prospective studies. *PLoS ONE, 12*(10), e0185781. https://doi.org/10.1371/journal.pone.0185781

Speed, D., Barry, C., & Cragun, R. (2020). With a little help from my (Canadian) friends: Health differences between minimal and maximal religiosity/spirituality are partially mediated by social support. *Social Science & Medicine*. https://doi.org/10.1016/j.socscimed.2020.113387

Stamm, B. H. (2010). *The Concise ProQOL Manual, ID: ProQOL.org* (2nd ed.). Pocatello.

Tawfik, D. S., Scheid, A., Profit, J., Shanafelt, T., Trockel, M., Adair, K. C., Sexton, J. B., & Ioannidis, J. P. A. (2019). Evidence relating health care provider burnout and quality of care: A systematic review and meta-analysis. *Annals of Internal Medicine, 171*(8), 555–567. https://doi.org/10.7326/M19-1152

Taylor, J. J., Hodgson, J. L., Kolobova, I., Lamson, A. L., Sira, N., & Musick, D. (2015). Exploring the phenomenon of spiritual care between hospital chaplains and hospital based healthcare staff. *Journal of Health Care Chaplaincy, 21*(3), 91–107. https://doi.org/10.1080/08854726.2015.1015302

Warttig, S. L., Forshaw, M. J., South, J., & White, A. K. (2013). New, normative, English-sample data for the short form perceived stress scale (PSS-4). *Journal of Health Psychology, 18*(12), 1617–1628. https://doi.org/10.1177/1359105313508346

Weaver, S. H., de Cordova, P. B., Vitale, T. R., Hargwood, P., & Salmond, S. (2022). Experiences and perceptions of nurses working night shift: A qualitative systematic review. *Johanna Briggs Institute Evidence Synthesis*. https://doi.org/10.11124/JBIES-21-00472

Weiner, S. (2017, November 20). *Is There a Chaplain in the House? Hospitals Integrate Spiritual Care*. Association of American Medical Colleges. https://www.aamc.org/news-insights/there-chaplain-house-hospitals-integrate-spiritual-care.

Wormald, B. (2015). America's changing religious landscape, pew research Center's Religion & Public Life Project. https://policycommons.net/artifacts/619134/americas-changing-religious-landscape/1600198/. September 02, 2022. CID: 20.500.12592/3bmppv.

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