

Lessons For Ministry:

SPIRITUAL ASSESSMENT OF THE SUFFERING SOUL

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PREFACE

The purpose of this paper is to offer a review of models of spiritual assessment of the suffering for those serving in Ministry. In depth interventions to help relieve spiritual distress will themselves not be addressed here. But in the very act of doing a spiritual assessment of those who are suffering often opens empathetic doors to helping that would otherwise often remain closed and even unknown. But before we know how to help those in distress, we must first have some idea of the spiritual and religious beliefs of the sufferer, the resources available in his or her life and the causes of their pain in body, mind and soul. Thus the spiritual assessment by those called to pastoral care of the suffering souls GOD places in their hands.

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ABSTRACT

How should pastoral care be administered to suffering souls? It is helpful to divide intervention into spiritual care and religious care. Spiritual care is giving voice to the innermost being of the person and helping to restore the soul's interconnectedness with self, others and ultimately GOD. Religious care is the enabling of and providing for the organized beliefs and practices that express a soul's spirituality. Every soul in spiritual distress needs spiritual care, even the atheist, though not every person so afflicted will accept religious care.

GOD being The Creator of all things in heaven and earth, including the human soul and person, it is He Who is The Great Physician and Healer of spiritual distress. The degree to which the human soul is out of communion, lacking a loving relationship, with The Creator and his fellow man reflects the degree of spiritual distress. Systems that attempt to identify and quantify spiritual distress in the human soul while denying The Creator produce the oxymoron of secular spiritualism, which by definition does not exist. Therefore, identifying, quantifying and enabling healing of spiritual distress requires reference to The Divine. Thus the assessment for emotional/spiritual distress as evidenced by anxiety, impaired adjustment, ineffective family coping, dysfunctional grieving, fear, hopelessness, loneliness, social isolation, ineffective or defensive coping. The relative presence or absence of gratitude reflects connectedness with others and with GOD, and thus spiritual distress.

The first task of pastoral care is assessing for the presence and sources of spiritual distress in the suffering. We may begin with first tier quick spiritual assessments using various acronyms. We may use second tier deeper discussion spiritual assessment models. But regardless of what methods we use, we must keep in mind these things: First, our task is helping the suffering to reestablish and strengthen hope in relationship with The Divine, others and self. Second, we must realize that the answers to such cries of the suffering soul are not always immediately clear. Third, the need of the suffering soul's cry to be heard by The Almighty, other caring souls and the self.

No one model should be taken as so rigid that it can not be used flexibly. Indeed, there is no consensus as to any one best or right method for assessing spiritual distress. Perhaps the very act of assessing for spiritual distress, and providing spiritual and religious care, is itself a major part of the cure – the breaking of the despair of the soul that feels overwhelmed by aloneness. Whatever models we use for spiritual assessment in ministering to the suffering, it is not so much the tool itself, but the heart of the caregiver that is most crucial to helping others to rediscover hope in GOD, others and self.

EPIGRAPH

“Our hearts are restless, O LORD, until they rest in Thee.” – Saint Augustine.

DEDICATION

To the many suffering souls, and their loved ones, that cry out to The Almighty, “O GOD, send Thou us Thy ministers of peace and consolation, lest we perish in our tears!” And to those who answer The Call of The Lord, “Whom shall I send, and who will go for Us?” with the humble reply on bended knee, “Here am I, O Lord. Send Thou me!” [ISAIAH 6:8]

I. SPIRITUALITY AND RELIGION

In order to do a spiritual assessment of the suffering, we must first recognize that, although all patients in some form require spiritual care in the hospital setting, not all patients desire religious care. In “Textbook of Palliative Nursing” Taylor summarizes select current literature defining “spirituality” as the human soul’s “need for purpose and meaning, forgiveness, love and relatedness, hope, creativity.” Human spirituality often finds its expression in relation to GOD, others and self through “religious faith and its expression,” though not always.¹

Taylor further cites human spirituality as the “unifying force of a person, the essence of being that permeates all of life and is manifested in one’s being, knowing and doing; the interconnectness with self, others, nature and [ultimately] GOD...”² Timmins and Kelly, in their article “Spiritual Assessment in Intensive and Cardiac Care Nursing,” observe that spirituality is for many inseparable from their religious convictions, though it is often distinct, which “... strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any GOD...”³

Taylor defines “religion” as “the organized, codified and often institutionalized beliefs and practices that express one’s spirituality.”⁴ Timmins and Kelly cite this definition for religion, “an outward practice of a spiritual understanding through the use of frameworks for a system of beliefs, values, codes of conduct and rituals.” In contrast, Timmins and Kelly offer that spirituality “...suggests broadly a person’s belief in a power apart from their own existence that transcends the present.”⁵

Therefore our spiritual assessment tools must be flexible enough to discern the spiritual and religious convictions and needs of patients and their families. And though not every patient and family will want religious care, surely every soul that is placed in the hands of caregivers requires spiritual care, even those who are neither religious nor spiritual.

II. THE CRY OF THE HUMAN SOUL

Moses records in GENESIS 2:7, “And The LORD GOD formed man of the dust of the ground, and breathed into his nostrils the breath of life; and man became a living soul.”⁶ The word for the human “soul” in Hebrew is נֶפֶשׁ - NEFESH, meaning a man’s “soul, self, life, creature, person, appetite, mind, living being, desire, emotion, passion.” It is “the breathing substance or being,” the very “inner being of man,” for without the soul, the human body is but lifeless organized dust. It is “the living being” of the human “self” as “person,” the seat of all

¹ 1, Taylor, “Part IV. Spiritual Care, Chapter 30. Spiritual Assessment, Section 2. What Is Spirituality?” paragraph 1. Edited by Ferrell and Coyle, “Textbook of Palliative Nursing.” 2006.

² 1, Ibid.

³ 2, Timmins and Kelly, “Spiritual Assessment in Intensive and Cardiac Care Nursing,” Nursing Critical Care, Volume 13, Number 3, p 125, “Spirituality.” 2008.

⁴ 1, Taylor, “Part IV. Spiritual Care, Chapter 30. Spiritual Assessment, Section 2. What Is Spirituality?” paragraph 2. Edited by Ferrell and Coyle, “Textbook of Palliative Nursing.” 2006.

⁵ 2, Timmins and Kelly, “Spiritual Assessment in Intensive and Cardiac Care Nursing,” Nursing Critical Care, Volume 13, Number 3, 2008, p 128.

⁶ 3, KJV, GENESIS 2:7.

human desires and “appetites, emotions, passions,” where all the “activity of mind and will” take place.⁷

The cry of the human soul in pain, feeling estranged from communion with both The Creator and with other men and women, is thus the object of “spiritual assessment.” The soul cut off from GOD and other loving souls is desolate and empty. So David cries out to GOD in pain in PSALM 51:10-12, “Create in me a clean heart, O GOD; and renew a right spirit within me. Cast me not away from Thy Presence; and take not Thy Holy Spirit from me. Restore unto me the joy of Thy salvation; and uphold me with Thy free Spirit.”⁸

When we are afflicted in suffering and pain – in body, mind or spirit – when we are overwhelmed and fearful, our souls cry out to GOD. PSALM 102:1-2, “...Hear my prayer, O LORD, and let my cry come unto Thee. Hide not Thy face from me in the day when I am in trouble; incline Thine ear unto me: in the day when I call answer me speedily.”⁹ The soul of man takes its being from The Creator, and at physical death stands before Him. So The Words of JESUS CHRIST on The Cross are recorded in LUKE 23:46, “And when JESUS had cried with a loud voice, He said, Father, into Thy hands I commend My spirit...”¹⁰

The cry of the human soul in joy, feeling secure within communion with both The Creator and with other men and women, is also the object of “spiritual assessment.” The soul in communion with GOD and other loving souls may rest in GOD’s peace and fulfillment. So David sings out in praise of GOD for His care and deliverance in PSALM 13:5-6, O GOD, “...I have trusted in Thy mercy; my heart shall rejoice in Thy salvation. I will sing unto The LORD, because He hath dealt bountifully with me.”¹¹

And in PSALM 34:22, “The LORD redeemeth the soul of His servants: and none of them that trust in Him shall be desolate.”¹² And so Mary sings out in celebration of GOD’s mercy and blessings in LUKE 1:46-47, “...My soul doth magnify The Lord, And my spirit hath rejoiced in GOD my Saviour.”¹³ Therefore Saint Augustine says, “Our hearts are restless, O Lord, until they rest in Thee!”¹⁴

⁷ 4, WTM + BDB Lexicon, 6251, NEFESH - נֶפֶשׁ - the human “soul.”

⁸ 3, KJV, PSALM 51:10-12.

⁹ 3, KJV, PSALM 102:1-2.

¹⁰ 3, KJV, LUKE 23:46.

¹¹ 3, KJV, PSALM 13:5-6.

¹² 3, KJV, PSALM 34:22.

¹³ 3, KJV, LUKE 1:46-47.

¹⁴ 5, Catechism of The Catholic Church, # 30, p 18-19, adapted from Saint Augustine’s prayer, “You are great, O Lord...”

JESUS CHRIST sums up the spiritual and religious duty and purpose of man in The Two Great Commandments in LUKE 10:27, "...Thou shalt love The Lord Thy GOD with all thy heart, and with all thy soul, and with all thy strength, and with all thy mind; and thy neighbour as thyself."¹⁵ The human soul that lacks either a loving relationship with GOD or others is in spiritual distress. The greater the lack, the greater the distress.

III. DISCERNING SPIRITUAL DISTRESS AS PART OF NURSING CARE

The North American Nursing Diagnoses Association¹⁶ offers a spectrum of nursing diagnoses related to spiritual distress, ranging from a state of compromised spiritual distress, to a state of being in danger of spiritual distress, to a state of effective spiritual health: 1. "Spiritual Distress; 2. "Risk for Spiritual Distress;" 3. "Readiness for Enhanced Spiritual Well-being."¹⁷

Ackley and Ladwig define the nursing diagnosis of "Spiritual Distress:" as "Impaired ability to experience and integrate meaning and purpose in life through the individual's connectedness with self, others, art, music, literature, nature or a power greater than oneself."¹⁸ Or alternately, the state of the human soul where there is an "...altered sense of harmonious connectedness with all of life and the universe in which dimensions that transcend and empower the self may be disrupted."¹⁹

On the other side of the spectrum, NANDA offers the nursing diagnosis of "Readiness for Enhanced Spiritual Well-being" as "Ability to experience and integrate meaning and purpose in life through the individual's connectedness with self, others, art, music, literature, nature or a power greater than oneself."²⁰ Or alternately, "the process of an individual's developing/unfolding of mystery through harmonious interconnectedness that springs from inner strengths."²¹

Of note in these NANDA nursing diagnoses are the redefining of the human soul in relation to "connectedness" to other people, things and pursuits, omitting The Creator Who creates and sustains the human spirit and reducing The Almighty's involvement to the status of at most a mere "higher power" – with a small "h" and a small "p." Thus we have the oxymoron of atheistic or secular spirituality that makes no reference to GOD.

¹⁵ 3, KJV, LUKE 10:27.

¹⁶ 6, "NANDA-I." North American Nursing Diagnoses Association – International. Philadelphia, Pennsylvania. <http://www.nanda.org/> Retrieved 7/10/2008. This organization sets the standards for Nursing diagnoses.

¹⁷ 7, Ackley and Ladwig, "Nursing Diagnosis Handbook," NANDA definition "Spiritual distress," p 1140-1161. The North American Nursing Diagnoses Association offers 3 nursing diagnoses for patients related to spiritual health: Spiritual Distress; Risk for Spiritual Distress; Readiness for Enhanced Spiritual Well-being."

¹⁸ 7, Ackley and Ladwig, "Nursing Diagnosis Handbook," definition, "Spiritual Distress," p 1140.

¹⁹ 8, Highfield, "Gratitude: An Expression of The Spirit," Clinical Journal of Oncology Nursing, Volume 5, Number 3, 2001. Internet article printout, page 1, paragraph 2.

²⁰ 7, Ackley and Ladwig, "Nursing Diagnosis Handbook," NANDA definition, "Readiness for Enhanced Spiritual Well-being," p 1153.

²¹ 8, Highfield, "Gratitude: An Expression of The Spirit," Clinical Journal of Oncology Nursing, Volume 5, Number 3, 2001. Retrieved 7/12/2008. Internet article printout, page 1, paragraph 2.

However, NANDA offers 4 categories of “defining characteristics” of spiritual distress, in which the state of the human spirit is assessed for compromise: 1. “Connections to self;” 2. “Connections with others;” 3. “Connections with art, music, literature, nature;” 4. “Connection with power greater than self.” As a sop to The Divine, The Word “GOD” appears once in the 4th category:²²

1. compromised “Connections to self”

“Expresses lack of hope, meaning and purpose in life, peace/serenity, acceptance, love, forgiveness of self, courage; expresses anger, guilt, poor coping.

2. compromised “Connections with others”

“Refuses interactions with spiritual leaders; refuses interactions with friends and family; verbalizes being separated from their support system, expresses alienation.

3. compromised “Connections with art, music, literature, nature”

Demonstrates inability to express previous state of creativity (singing, listening to music, writing), disinterest in nature, and disinterest in reading spiritual literature.

4. compromised “Connection with power greater than self”

Demonstrates inability to pray, inability to participate in religious activities, expressions of being abandoned by or having anger toward GOD; requests to see a religious leader; demonstrates sudden changes in spiritual practices, inability to be introspective/inward turning; expresses being hopeless and suffering, inability to experience the transcendent.

The primary nursing diagnosis of spiritual distress should be accompanied with secondary causative “related to” diagnoses, which help to focus patient care more exactly. NANDA recognizes these secondary nursing diagnoses: anxiety, impaired adjustment, ineffective family coping, dysfunctional grieving, fear, hopelessness, loneliness, social isolation, ineffective coping, defensive coping.^{23 24}

Elizabeth Taylor, in “Textbook of Palliative Nursing” cites O’Brien, who moves secondary diagnoses of this type from the behavioral realm of nursing to the spiritual realm of pastoral care: “spiritual pain, spiritual alienation, spiritual anxiety, spiritual guilt, spiritual anger, spiritual loss and spiritual despair.”²⁵ Even so, where the dividing line is between mind and soul, the humble and pious man confesses that only The Almighty can say.

²² 7, Ackley and Ladwig, “Nursing Diagnosis Handbook,” “Defining Characteristics” of spiritual distress, p 1140.

²³ 1, Taylor, “Part IV. Spiritual Care, Chapter 30. Spiritual Assessment, Section 7. The Next Step – What to Do with a Spiritual Assessment,” paragraph 1. Edited by Ferrell and Coyle, “Textbook of Palliative Nursing.” 2006.

²⁴ 7, Ackley and Ladwig, “Nursing Diagnosis Handbook,” “Defining Characteristics” of spiritual distress, p 1140. The official NANDA secondary “related to” diagnoses offered for the primary nursing diagnosis of “spiritual distress” are listed as: “Self-alienation, loneliness, social isolation, anxiety, sociocultural deprivation, death and dying of self or others, pain, life change, chronic illness of self or others.”

²⁵ 1, Taylor, “Part IV. Spiritual Care, Chapter 30. Spiritual Assessment, Section 7. The Next Step – What to Do with a Spiritual Assessment,” paragraph 1. Edited by Ferrell and Coyle, “Textbook of Palliative Nursing.” 2006.

IV. GRATITUDE IN RELATION TO THE DIVINE

George Fitchett, in his book “Assessing Spiritual Needs,” defines “spiritual assessment” as identifying “the dimension of life that reflects the need to find meaning in existence and in which we respond to The Sacred.”²⁶ Martha Highfield, in her article “Gratitude: An Expression of the Spirit,” observes that the soul which dwells in thankfulness is a soul which dwells in spiritual well-being. Its relative absence, acute or chronic, tends to mark the human soul that dwells in spiritual distress. Highfield states,

“...gratefulness promotes spiritual well-being by helping us to celebrate our relationships with others and with ‘Divine Goodness.’ [capital letters added]” Empirically, “...Positive relationships are a key element of healthy spirituality. Gratitude helps us to connect positively with others and Deity. Therefore, gratitude is an indicator of spiritual health.”²⁷

So the pastoral care assessment seeks to discern where the human soul is on this spectrum of spiritual well being versus spiritual distress. Or alternately, one may look for indicators, or lack thereof, of the human soul which dwells in gratitude for blessings and healthy relationships with GOD and with others. Being able to do this with some objectivity and efficiency in a short time, often in the midst of crisis in the hospital setting, requires tools and guidelines for clinicians.

V. JCAHO MINIMAL SPIRITUAL NEEDS EVALUATION STANDARDS

The secular entity that sets standards and credentials hospitals in the United States, the “Joint Commission for the Accreditation of Hospital Organizations” or “JCAHO,” recognizes that meeting the spiritual needs of hospital patients is important in health care. JCAHO sets some basic standards for hospital “spiritual assessment” of patients and families:

“Spiritual assessment should, at a minimum, determine the patient's denomination, beliefs, and what spiritual practices are important to the patient. This information would assist in determining the impact of spirituality, if any, on the care/services being provided and will identify if any further assessment is needed. The standards require organization's to define the content and scope of spiritual and other assessments and the qualifications of the individual(s) performing the assessment.”²⁸

²⁶ 9, Fitchett, “Assessing Spiritual Needs,” p 16, “Spiritual Assessment: What is it?”

²⁷ 8, Highfield, “Gratitude: An Expression of The Spirit,” *Clinical Journal of Oncology Nursing*, Volume 5, Number 3, 2001. Internet article printout, page 1, paragraph 1.

²⁸ 10, JCAHO, “Spiritual Assessment.” The Joint Commission. 1/01/2004. Answer to the question, “Q: Does the Joint Commission specify what needs to be included in a spiritual assessment?”

Hodge, in a 2006 article entitled “A Template for Spiritual Assessment: A Review of the JCAHO Requirements and Guidelines for Implementation,” lists the suggested questions offered by JCAHO to assess for spiritual distress versus spiritual well-being, which JCAHO entitles “Examples of elements that could be but are not required in a spiritual assessment include the following questions directed to the patient or his/her family:”²⁹ This consists of 15 suggested questions, at least in Hodge’s article.

Of interest is that JCAHO’s current website has reduced this list to 14 suggested questions, removing # 11, “Has belief in GOD been important in the patient’s life?”³⁰ Using The Word that many use to make direct reference to The Creator of the human soul in JCAHO’s list of suggested questions to assess the human soul is, apparently, no longer appropriate as a standard of care in hospitals:

- 1. Who or what provides the patient with strength and hope?
- 2. Does the patient use prayer in their life?
- 3. How does the patient express their spirituality?
- 4. How would the patient describe their philosophy of life?
- 5. What type of spiritual/religious support does the patient desire?
- 6. What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?
- 7. What does suffering mean to the patient?
- 8. What does dying mean to the patient?
- 9. What are the patient's spiritual goals?
- 10. Is there a role of Church/Synagogue in the patient's life?
- 11. Has belief in GOD been important in the patient’s life?³¹
- 12. How does your faith help the patient cope with illness?
- 13. How does the patient keep going day after day?
- 14. What helps the patient get through this health care experience?
- 15. How has illness affected the patient and his/her family?

²⁹ 11, Hodge, “A Template for Spiritual Assessment....” Social Work, October 2006, p 320.

“Table 1: Spiritual Assessment Questions Provided by the Joint Commission on Accreditation of Healthcare Organizations,” from “Joint Commission on Accreditation of Healthcare Organizations, 2004.”

³⁰ 10, JCAHO, “Spiritual Assessment.” The Joint Commission. 1/01/2004. Answer to the question, “Q: Does the Joint Commission specify what needs to be included in a spiritual assessment?”

³¹ 10, JCAHO, “Spiritual Assessment.” The Joint Commission. 1/01/2004. Answer to the question, “Q: Does the Joint Commission specify what needs to be included in a spiritual assessment?” The current JCAHO website omits question 11, “Has belief in GOD been important in the patient’s life?”

VI. NON-ACRONYM MODELS FOR SPIRITUAL ASSESSMENT

So we may build a general set of questions as guides for spiritual assessment. Returning to Hodge's article, "A Template for Spiritual Assessment: A Review of the JCAHO Requirements and Guidelines for Implementation," we find this model:³²

1. I was wondering if spirituality or religion is important to you?
2. Are there certain spiritual beliefs and practices that you find particularly helpful in dealing with problems?
3. I was also wondering if you attend a church or some other type of spiritual community?
4. Are there any spiritual needs or concerns I can help you with?

Narayanasamy, in the article "The Puzzle of Spirituality for Nursing," offers this list of needs and questions as a guide to spiritual assessments. A patient's non-verbal answers to a caregiver's questions regarding spiritual health are surely at least as important as the verbal answers given. This model highlights the very obvious, but often overlooked point, that a spiritual assessment should also make observations of the patient's behaviors, relationships, communications and bedside surroundings, as well as his direct answers to questions:³³

1. Meaning and purpose
 - **What gives you a sense of meaning and purpose?
 - **Is there anything especially meaningful to you now?
 - **[Does the patient make any sense of illness/suffering?]
 - **[Does the patient show any sense of meaning and purpose?]
2. Sources of strength and hope
 - **Who is the most important person to you?
 - **To whom would you turn when you need help?
 - **Is there anyone we can contact?
 - **In what ways do they help?
 - **What is your source of strength and hope?
 - **What helps you the most when you feel afraid or need special help?
3. Love and relatedness
 - **[How does patient relate to family, relatives, friends, others, surroundings?]
 - **[Does patient appear peaceful?]
 - **[What gives patient peace?]
4. Self-esteem
 - **[Describe the state of patient's self esteem.]
 - **[How does patient feel about self?]

³² 11, Hodge, "A Template for Spiritual Assessment...." *Social Work*, October 2006, p 321. "Table 2: Brief Assessment Model that Conforms to the Joint Commission on Accreditation of Healthcare Organizations' Spiritual Assessment recommendations."

³³ 12, Narayanasamy, "The Puzzle of Spirituality for Nursing: a Guide to Practical Assessment." *British Journal of Nursing*, Volume 13, Issue 19 p 1143, 2004. "Table 3. Spiritual assessment guide."

5. Fear and anxiety

**[Is patient angry about anything?]

**[How does patient cope with anger?]

**[How does patient control this?]

6. Relation between spiritual beliefs and health

**What has bothered you most being sick or in what is happening to you?

**What do you think is going to happen to you?

VII. FIRST AND SECOND TIER SPIRITUAL ASSESSMENTS

Many caregivers at the hospital bedside find it helpful to use mnemonics for doing a baseline “first tier” spiritual assessment, which then can open doors to further discussion. These various initial spiritual acronym assessment tools are designed to ask 2 questions: First, “What are your spiritual and religious needs?” Second, “How can we help meet them while you are a patient here?”³⁴ Such first tier spiritual assessment models tend to be more rigid and centered around initial data collection. But if used in a sensitive and situational appropriate manner, these may naturally open doors for deeper sharing between sufferers and caregivers.

When spiritual assessments reveal some form of spiritual distress, the caregiver should then move into deeper “second tier” exploration of pain of the soul. The caregiver may then listen empathetically and probe gently the “Why, GOD?” questions, including the patient’s and family’s “beliefs about misfortune, perceptions of GOD and spiritual coping strategies.”³⁵ Such second tier spiritual assessment models tend to be more flexible and centered around discussion.

But first tier to second tier, models of spiritual assessment from formal to informal, from acronym to discussion formats, we have observed, seek certain basic information. Steven Spidell, in his article “Spiritual Assessment of the Patient [and Chaplain],” suggests the discerning of these “factors:”³⁶

**Relevance of faith and spirituality in the life of the patient.

**Patient’s involvement in religious practices.

**Emotional status of the patient.

**Spiritual issues in play in the illness experience.

**Spiritual resources available to the patient for resolution and/or coping.

**Family and community connections and support.

³⁴ 1, Elizabeth Johnston Taylor, “Part IV. Spiritual Care, Chapter 30. Spiritual Assessment, Section 6. General Observations and Suggestions For Conducting a Spiritual Assessment,” paragraph 1. Edited by Ferrell and Coyle, “Textbook of Palliative Nursing.” 2006.

³⁵ 1, Elizabeth Johnston Taylor, “Part IV. Spiritual Care, Chapter 30. Spiritual Assessment, Section 6. General Observations and Suggestions For Conducting a Spiritual Assessment,” paragraph 1. Edited by Ferrell and Coyle, “Textbook of Palliative Nursing.” 2006.

³⁶ 13, Spidell, “Spiritual Assessment of the Patient [and Chaplain].” Chaplaincy Today, Volume 24, Number 1, Spring/Summer 2008, p 27.

VIII. ACRONYM MODEL – FICA

“FICA” is a structured simple acronym for a quick introductory spiritual assessment that is easy to use at the bedside, developed by Christina Puchalski, which stands for “Faith or Beliefs; Importance and influence; Community; Address or Application:”^{37 38}

F - Faith or Beliefs:

**Do you consider yourself religious or spiritual?

**What is your Faith or Belief?

**What do you believe in that gives meaning to your life?

I - Importance and influence:

**What is important in your life?

**What importance does your faith or belief have in your life?

**What influence does it have on how you take care of yourself?

**How have your beliefs influenced your behavior during this illness?

**What role do your beliefs play in regaining your health?

C - Community:

**Are you part of a religious or spiritual community?

**Has your illness cut you off from this community?

**Is this of support to you and how?

**Is there a person or group that you really love that are very important to you?

A - Address:

**How would you like these issues to be addressed in your health care?

**How would you like us to address these issues in your healthcare?

**How might these things apply to your current situation?

**How can we assist you in your spiritual/religious care?

**Can we contact your Clergyman or religious community for you?

IX. ACRONYM MODEL – SPIRIT

Another bedside spiritual assessment acronym is “SPIRIT,” which brings the patient’s and family’s spiritual and religious belief systems to bear on patient care decisions: “Spiritual belief system; Personal spirituality; Integration with a spiritual community; Ritualized practices and restrictions; Implications for medical care; Terminal event planning.”^{39 40 41}

³⁷ 14, Puchalski and Romer, “Taking a Spiritual History Allows Clinicians to Understand Patients More Fully,” *Journal of Palliative Medicine*, Volume 3, Number 1, p 131, 2000. Table, “Spiritual Assessment Tool, FICA.”

³⁸ 15, Hallenbeck, “Palliative Care Perspectives,” Chapter 7, “FICA – A Spiritual Assessment Tool,” p 152-153.

³⁹ 2, Timmins and Kelly, “Spiritual Assessment in Intensive and Cardiac Care Nursing,” *Nursing Critical Care*, Volume 13, Number 3, 127, 2008. “Table 3 – Mnemonic devices for intentional spiritual assessment,” SPIRIT.

⁴⁰ 16, Maugans, “The SPIRITual History.” *Archives of Family Medicine*, Volume 5, p 11-16, Jan., 1996, page 12. Table, “Sample Questions for the SPIRITual History.”

⁴¹ 17, Cancer Center and Department of Internal Medicine, “Spirituality and Palliative Care – S.P.I.R.I.T.” *University of Maryland School of Medicine*. July 17, 2002, p 9-11. .

S – Spiritual belief system

**What is your formal religious affiliation?

**Name or describe your spiritual belief system.

*Do you have a spiritual life that is important to you?

**What is your clearest sense of the meaning of your life at this time?

P – Personal spirituality

**Describe the beliefs and practices of your belief system you personally accept.

**Describe the beliefs and practices that you do not accept or follow.

**Do you accept or believe... [specific tenets and practices]?

**In what ways is your spirituality/religion meaningful to you?

**What does your spirituality/religion mean to you?

**What is the importance of your spirituality/religion in daily life?

I – Integration with a spiritual community

**Do you belong to any spiritual or religious group or community?

**What is your position or role?

**What importance does this group have to you?

**In what ways is this group a source of support for you?

**What types of help or support does this group, or could this group, give you in dealing with your illness?

R – Ritualized practice and restrictions

**Are there specific practices that you carry out as part of your religion/spirituality, such as prayer or meditation?

**Are there certain lifestyle activities or practices that your religion/spirituality encourages or forbids, and do you comply?

**What meaning do these practices and restrictions have to you?

**Are there specific elements of medical care that you forbid on the basis of religious/spiritual grounds?

I – Implications for medical care

**What aspects of your religion/spirituality would you like us to keep in mind as we care for you?

**Would you like to discuss religious or spiritual implications of health care?

**What knowledge or understanding would strengthen our relationship as caregiver and patient?

**Are there any barriers to our relationship based on religious or spiritual issues?

T – Terminal event planning

**As we plan for your care near the end of life, how does your faith impact your decisions?

**Are there particular aspects of medical care that you do not want, or that you wish to have withheld, based on your religion/spirituality?

**Are there any spiritual or religious practices or rituals you would like to have available in the hospital or at home?

**Are there spiritual or religious practices that you wish to plan for at the time of death, or following death?

**Near or at death, what sources do you draw strength from, in order to cope?

**For what in your life do you still feel gratitude, even though you are ill?

**When you are afraid or in pain, how do you find comfort?

X. ACRONYM MODEL – ETHNICS

Another spiritual assessment acronym is “ETHNICS,” by Fred A. Kobylarz, MD, MPH, et al. This model was developed to assess the spiritual needs of geriatric patients to help determine treatment priorities, facilitating compliance to care and dealing with end-of-life care issues. However, it is flexible enough to be applied in many clinical situations. “ETHNICS” stands for “Explanation; Treatment; Healers; Negotiate; Intervention; Collaborate; Spirituality.”⁴²

E – Explanation

**Why do you think you have this [using the patient’s phrase for their] symptoms/illness/condition?

**What do friends, family and others say about these symptoms?

**Do you know anyone else who has had or who has this kind of problem?

**Have you heard about/read/seen it on television/radio/newspaper/internet?

**What concerns you most about your problems?

T – Treatment

**What have you tried for this (use the patient’s phrase for their) symptoms/illness/condition?

**What kind of medicines, home remedies or other treatments have you tried for this illness?

**Is there anything you eat, drink or do (or avoid) on a regular basis to stay healthy? .

**What kind of treatments are you seeking from me?

H – Healers

**Who else have you sought help from for this (use the patient’s phrase for their) symptom/illness/condition?

**Have you sought help from alternative or folk healers friends or other people who are not Doctors to help you with your problems?

N – Negotiate

**How best do you think I can help you?

**What options are mutually acceptable to you and we, your caregivers, that incorporates your beliefs rather than contradicting them?

I – Intervention

**This is what I think needs to be done now.

**What interventions can I as your caregiver offer you that incorporates practices and beliefs that are important to you?

C – Collaborate

**How can we work together on this and with whom else?

**Which family members, healers and community resources do you want us to work with on your behalf and how?

S – Spirituality

**What role does Faith/Religion/spirituality play in helping you with this (use the patient’s phrase for their) symptom/illness/condition?

**Tell me about your spiritual life.

**How can your spiritual beliefs help you with this?

⁴² 18, Kobylarz et al, “The ETHNIC(S) Mnemonic: A Clinical Tool for Ethnogeriatric Education,” *Journal of the American Geriatrics Society*, Volume 50, p 1584, 2002. “Table 1. ETHNIC(S): A Framework for Culturally appropriate Geriatric Care.”

XI. DISCUSSION MODEL – PAUL PRUYSER

Paul Pruyser developed a 7-part assessment for Clergy better recognize and quantify spiritual distress in their parishioners: ⁴³ This model was designed to give Clergy theological language in assessing psychological and social issues of life in relationship to The Divine in their lives. Identifying the relative strengths and weaknesses of a parishioner's spiritual and religious life, let us call it the joyful songs and sorrowful cries of the soul, can better focus a Clergyman's care of the suffering:

1. Awareness of The Holy [Awe of GOD's Presence]
 - **What, if anything, is sacred, revered?
 - **Any experiences of awe or bliss, when, in what situations?
 - **Any sense of mystery, of anything transcendent?
 - **Any sense of creatureliness, humility, awareness of own limitations?
 - **Any idolatry, reverence displaced to improper symbols?
2. Providence [GOD's plan and how He is working]
 - **What is GOD's intention toward me?
 - **What has GOD promised me?
 - **Belief in cosmic benevolence?
 - **Related to capacity for trust?
 - **Extent of hoping versus wishing?
3. Faith [Where one puts hope and trust]
 - **Affirming versus negating stance in life?
 - **Able to commit self, to engage?
 - **Open to world or constricted?
4. Grace or Gratitude
[Where is GOD's Grace in your life and what are you thankful for?]
 - **Kindness, generosity, the beauty of giving and receiving.
 - **No felt need for grace or gratefulness?
 - **Forced gratitude under any circumstances?
 - **Desire for versus resistance to blessing?
5. Repentance [guilt, confession, forgiveness and restoration]
 - **The process of change from crookedness to rectitude
 - **A sense of agency in one's own problems or one's response to them,
---versus being a victim,
---versus being too sorry for debatable sins.
 - **Feelings of contrition, remorse, regret?
 - **Willingness to do penance?
6. Communion [fellowship with GOD and others in community]
 - **Feelings of kinship with the whole chain of being?
 - **Feelings embedded or estranged, united or separated, in the world
---in relations with one's Faith group, one's Church?

⁴³ 9, Fitchett, "Assessing Spiritual Needs: A Guide for Caregivers," p 106-107, from "The Minister as Diagnostician" by Paul Pruyser, 1976.

7. Sense of Vocation [What life's work has GOD called you to?]
 - **Willingness to be a cheerful participant in creation?
 - **Sings of zest, vigor, liveliness, dedication?
 - **Aligned with Divine benevolence or malevolence?
 - **Humorous and inventive involvement in life versus grim and dogmatic?

XII. HODGES' CONVERSATION INTERVIEW SPIRITUAL HISTORY MODEL

Lastly we will consider a second tier conversation interview spiritual history model. David Hodge, in "Spiritual Assessment: A Handbook for Helping Professionals," offers a two-part framework: First, an "Initial Narrative Framework" set of open questions to invite the sufferer to begin to share their life experiences, struggles, victories and spiritual/religious history. Second, an "Interpretative Anthropological Framework" set of open questions to help the sufferer identify his spiritual and religious strengths and struggles.⁴⁴ Hodge suggests these 1st tier "Initial Narrative Framework" questions:⁴⁵

1. Describe the religious/spiritual tradition you grew up in.
 - **How did your family express its spiritual beliefs?
 - **How important was spirituality to your family...?
2. What sort of personal experiences/practices stand out to you during your years at home?
 - **What made these experiences special?
 - **How have they informed your later life?
3. How have you transitioned or matured from these experiences?
 - **How would you describe your current spiritual/religious orientation?
 - **Is your spirituality a personal strength? If so, how?

Hodge then offers these 2nd tier "Interpretative Anthropological Framework" questions:⁴⁶

1. Affect:
 - **What aspects of your spiritual life gives you pleasure?
 - **What role does your spirituality play in handling life's sorrows?
 - **Enhancing its joys?
 - **Coping with its pain?
 - **How does your spirituality give you hope for the future?
 - **What do you wish to accomplish in the future?
2. Behavior:
 - **Are there particular spiritual rituals or practices that help you deal with life's obstacles?
 - **What is your level of involvement in faith-based or religious communities?
 - **How are they supportive?
 - **Are there spiritually encouraging individuals with whom you maintain contact?

⁴⁴ 19, Hodge, "Spiritual Assessment: A Handbook for Helping Professionals," Table 1, p 21-22.

⁴⁵ 19, Ibid., "Table 1, "Initial Narrative Framework," p 21.

⁴⁶ 19, Hodge, "Spiritual Assessment: A Handbook for Helping Professionals," p 21-22. "Table 1, "Interpretative Anthropological Framework."

3. Cognitive:

- **What are your current religious/spiritual beliefs?
- **What are they based upon?
- **What beliefs do you find particularly meaningful?
- **What does your Faith say about trials?
- **How does this belief help you overcome obstacles?
- **How do your beliefs affect your health practices?

4. Communion:

- **Describe your relationship with GOD.
- **What has been your experience with GOD?
- **How does GOD communicate with you?
- **How have these experiences encouraged you?
- **Have there been times of deep spiritual intimacy?
- **How does your relationship help you face life challenges?
- **How would GOD describe you?

5. Conscience:

- **How do you determine right and wrong?
- **What are your key values?
- **How does your spirituality help you deal with guilt/sin?
- **What role does forgiveness play in your life?

6. Intuition:

- **To what extent do you experience intuitive hunches, flashes of creative insight, premonitions, spiritual insights?
- **Have these insights been a strength in your life? If so, how?

XIII. FIXING PROBLEMS, MOBILIZING RESOURCES, ENHANCING COPING

In depth discussion of spiritual care interventions beyond the spiritual assessment phase is beyond the scope of this paper. But to be fair, having collected our spiritual data, made our assessment and identified areas of spiritual distress in our patients needing intervention, it is quite fair to allow ourselves to ask the question, “What now?”

Here we should distinguish between “fixing” a “problem” contributing to a patient’s spiritual distress, such as isolation from his Faith community and support due to hospitalization, versus the need to “cope” with an ongoing life “difficulty.” But mobilizing resources and fixing “problems” can certainly enhance patient and family coping with the direct and related life “difficulties” surrounding the hospitalization.

Hallenbeck, in “Palliative Care Perspectives,” notes a case where intense spiritual distress was relieved markedly in a patient by the following simple assessment and intervention,

“...a man who reported 10 of 10 on a scale of suffering that related entirely to his spiritual care. He had regularly attended a certain service and was now unable to do so, which resulted in unbearable suffering. With permission the hospice team contacted the ministry, which sent a home ministry team to the patient's home. His suffering score drop to 0 of 10. As in this case, assistance for many will mean access. A simple phone call to the proper Clergy member can significantly relieve distress...”⁴⁷

Is the patient’s Clergyman not aware of the situation and hospitalization? Pray with the patient for The LORD to send his Ministers to his bedside, then ask permission to call the Clergyman after your visit. The patient may well rest easier when his Pastor is at the bedside with him and his family through the night! Are the wife and children of the patient financially overwhelmed and hovering on the edge of becoming destitute? Find a Scripture to read at the bedside on GOD’s loving Providence and then call the Social Worker before you move on to the next train wreck! That wife will have greater peace and strength to offer her dying husband if she doesn’t need to also worry that she and her kids will be hungry and homeless next week.

No, spiritual caregivers can not wave a magic wand, read a Scripture verse, offer up a prayer or make a phone call and expect that the suffering of patients and their families will suddenly be no more. But they can push some buttons, help mobilize resources and call in other troops into the lives of the suffering. And sometimes the mere attempted “fixing” of a problem will help the afflicted and the mourning to better cope with their difficulties. And what doors such simple acts of compassion, by GOD’s Grace, can open into the hearts of the distressed! Through such opened doors rivers of tears and joys of human souls often flow through between the sufferer and the caregiver.

XIV. IN CONCLUSION

The first task of pastoral care is assessing for the presence and sources of spiritual distress in the suffering. We must then also assess the spiritual and religious convictions and resources in the life of the sufferer and his or her family. We may begin with first tier quick spiritual assessments using various acronyms. We may use second tier deeper discussion spiritual assessment models.

But regardless of whatever methods or models we use in spiritual assessment, we must keep in mind these things: First, our task is helping the suffering to reestablish and strengthen hope in relationship with The Divine, others and self. Second, we must realize that the answers to such cries of the suffering soul are not always immediately clear. Third, the need of the suffering soul’s cry to be heard by The Almighty, by other caring souls and by the self.

⁴⁷ 15, Hallenbeck, “Palliative Care Perspectives,” Chapter 7, “FICA – A Spiritual Assessment Tool, Address or application,” p 152-153.

Job needed to know that he was heard by both GOD and men in his soul's cry of his "Why, GOD?" questions. So Job cries out in JOB 19:23-24, "Oh that my words were now written! oh that they were printed in a book! That they were graven with an iron pen and lead in the rock for ever!"⁴⁸ For Job, though answers were not always forthcoming to his "Why, GOD?" questions, his true friend walked with him as an agent of hope. Job came to know that he was heard and that he was not alone in the midst of his pain. His true friend's presence helped Job back to relationship with GOD and man, to the restoring of hope, to trusting in GOD and others again, back to peace within himself.

So Job confesses in Faith, even amidst his suffering, that his soul was secure in the hands of The LORD. He therefore confesses in JOB 19:25-27, "For I know that my Redeemer liveth, and that He shall stand at the latter day upon the earth: And though after my skin worms destroy this body, yet in my flesh shall I see GOD: Whom I shall see for myself, and mine eyes shall behold, and not another; though my reins be consumed within me."⁴⁹ Did Job's friends minister to him as agents of hope in GOD?⁵⁰ Or was their presence a suffocating source of discouragement?⁵¹

No one model should be taken as so rigid that it can not be used flexibly. Indeed, there is no consensus as to any one best or right method for assessing spiritual distress. Perhaps the very act of assessing for spiritual distress, and providing spiritual and religious care, is itself a major part of the cure – the breaking of the despair of the soul that feels overwhelmed by aloneness. Whatever models we use for spiritual assessment in ministering to the suffering, it is not so much the tool itself, but the heart of the caregiver that is most crucial to helping others to rediscover hope in GOD, others and self.

⁴⁸ 3, KJV, JOB 19:23-24.

⁴⁹ 3, KJV, JOB 19:25-27.

⁵⁰ 3, KJV, JOB 32:2-3, "Then was kindled the wrath of Elihu the son of Barachel the Buzite, of the kindred of Ram: against Job was his wrath kindled, because he justified himself rather than GOD. Also against his three friends was his wrath kindled, because they had found no answer, and yet had condemned Job."

⁵¹ 3, KJV, JOB 2:11, "Now when Job's three friends heard of all this evil that was come upon him, they came every one from his own place; Eliphaz the Temanite, and Bildad the Shuhite, and Zophar the Naamathite: for they had made an appointment together to come to mourn with him and to comfort him."

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