LIBERTY BAPTIST THEOLOGICAL SEMINARY

PASTORAL CARE: A NEW MODEL FOR ASSESSING THE SPIRITUAL NEEDS OF HOSPITALIZED PATIENTS

A thesis project submitted to
Liberty Baptist Theological Seminary in
partial fulfillment of the requirements
for the degree

DOCTOR OF MINISTRY

By

Douglas Edward Robinson

Bakersfield, California

August 2012

LIBERTY BAPTIST THEOLOGICAL SEMINARY

THESIS PROJECT APPROVAL SHEET

_____
GRADE

_____
MENTOR
DR. CHARLIE DAVIDSON

_____
READER
DR. RODNEY DEMPSEY

ABSTRACT

PASTORAL CARE: A NEW MODEL FOR ASSESSING THE SPIRITUAL NEEDS OF HOSPITALIZED PATIENTS

Douglas E. Robinson

Liberty Baptist Theological Seminary, 2012

Mentor: Dr. Charlie Davidson

Hospitalized patients are at an elevated risk of suffering from spiritual distress. Patients value and expect having spiritual and emotional needs met when hospitalized. A direct correlation exists between spiritual and physical health, making spiritual assessment and care a pastoral priority. Research indicates a lack of proper training for pastors making hospital visits. The purpose of this project is to provide pastors with resources and understanding of spiritual assessment of hospitalized patients. This project also provides pastors with a template for a new model of spiritual assessment to aid with establishing a spiritual assessment tool to meet their ministry needs, and fit their ministry personality, administer self-care, and evaluate their assessment and intervention.

Abstract length: 113 words

TABLE OF CONTENTS

INTRODUCTION

When contemplating the journey this author has made during transition from working as a Stockbroker, Financial Advisor, Chief Financial Officer, and Salesman, to finally becoming a pastor and then hospital chaplain, many insights occurred to me. It was definitely not an event, but a process of learning, growing, humbling, sacrifice, and commitment. Many challenges and sacrifice existed through the transition, namely lower income, college tuition, investment of time, and time away from family and friends. On the other hand, the experience included significant personal and spiritual growth. It also includes an indescribable fulfillment that comes with living the life for which God created one to live.

A significant contrast is evident when comparing the hospital visitation and care ministry performed by this author as Associate pastor versus the care ministry performed following hospital specific chaplaincy training. The process more clearly defined and confirmed ministry calling, as well as pastoral role and identity as hospital chaplain and parish minister.

Today, most church pastors have received some form of theological training. Some receive training through seminary, where they pursue master and doctoral level degree programs. Other pastors receive training through Bible and preaching programs specific to their doctrinal inclination, while others receive training from mentors, are self-taught, or learn on the job through personal experience.

It is no secret that the dynamics of today's pastor stretch him to fulfill the many needs of his congregation. It is also no secret that his deacons and membership are very willing to inform the pastor when they believe he is not meeting their expectations. 1Corinthians 12 itemizes the multitude of spiritual gifts and verse eleven reads, *"All these are the work of one and the same Spirit, and he distributes them to each one, just as he determines."*[1] The *"work of one"* obviously refers to the Holy Spirit, but many congregations or deacons seemingly interpret it to mean their pastor, but forget the end of the verse that reads, *"He distributes them . . . as he determines."* The point here is that no pastor possesses all of the spiritual gifts and not every pastor possesses the necessary gifts required to function as a professional hospital chaplain. The reality is that many pastors find themselves in a position that requires them to make pastoral hospital visits to friends, neighbors, and members of his congregation.

The primary goal of the research[2] in this project is to gain insight into how pastors currently make hospital visits to patients and patient families. Another purpose of the research is to compare and contrast the differences between chaplains, lay ministers, associate pastors, and senior pastors. This author also wished to compare hospital ministry performance and experience between men and women, as well as rookies and veterans.

The research survey includes questions about pediatric hospital visitation in the areas of experience level, comfort level visiting children in general, comfort level visiting children as compared to adults, and how pastors with young children of their own might be influenced in their hospital ministry when visiting children.

---

[1] 1Corinthians 12 (NIV).

[2] *Pastoral Hospital Visitation and Chaplaincy Survey.*

The *Pastoral Hospital Visitation and Chaplaincy Survey* also helps provide insight into the types of training pastors, chaplains, and lay ministers receive prior to engaging in hospital ministry. Specific training areas of interest in the study include whether respondents received any type of psychosocial, grief counseling, crisis intervention, spiritual assessment, and/or other hospital specific training. Another goal of the survey is to gauge pastoral awareness about transference and counter transference issues by asking them to identify visits they found to be challenging, and or that generate strong, negative feelings. The survey also asks about how much pastors think their own life experiences and personal beliefs influence their ministry, and whether pastors have a history of personal hospitalization.

The survey indentifies the average number of pastoral visits made to patients during each hospitalization, the average amount of time pastors spend with patients during each visit, and the primary agenda of the pastor when making visits. This information aids in the process of analyzing and evaluating overall hospital visitation performance in order to compare and contrast between chaplains, pastors, and lay ministers.

How pastor administer self-care is an important issue in hospital ministry. The survey asks pastors to identify their primary support for debriefing and decompressing following difficult hospital visits. It also inquires regarding secondary trauma, also known as compassion fatigue. Secondary trauma is "the stress resulting from helping or wanting to help a traumatized or suffering person."[3] Dr. Laurie Pearlman, an expert in the trauma field prefers the term *'vicarious trauma'* to describe the "cumulative

---

[3] Charles R. Figley, *Compassion Fatigue: Secondary Traumatic Stress Disorders from Treating the Traumatized* (New York: Brunner/Mazel, 1995), 7.

transformative effect of working with survivors of traumatic life events."[4] Common symptoms associated with secondary or vicarious trauma include, but are not limited to chronic fatigue, sadness, anger, poor concentration, detachment, emotional exhaustion, fearfulness, shame, physical illness, and absenteeism.[5] Pastors identified how frequently they experienced intense feelings, depression, loss of appetite, panic, anger, and or anxiety following difficult hospital visits. Over 28% of respondents of the *Pastoral Hospital Visitation and Chaplaincy Survey* report having experienced unexplained panic, anxiety, anger, and other intense feelings following difficult hospital visits. Nearly 25% of respondents experienced loss of sleep or appetite, or felt down or depressed for more than one day following difficult hospital visits.

The report also surveys to compare and contrast ministry roles when it comes to outreach and evangelism. Related questions ask respondents to estimate the percentage of hospital visits they make to members of their congregation and hospital visits made to non-Christian patients. Overall, pastors and lay ministers averaged about 70% of their visits to members of their own congregation. According to more than 70% of the responding pastors, less than 10% of their hospital visits are to non-Christian patients.

Finally, the report compares and contrasts feelings of pastors, chaplains, and lay ministers surrounding spiritual assessment and training between those who have received training and who actively utilize spiritual assessment tools, with those who do not. The results were troublesome at best and highlighted below in item number five. The survey

---

[4] Karen W. Saakvitne and L.A. Pearlman, *Transforming the Pain: A Workbook on Vicarious Trauma* (New York: W.W. Norton, 1996), 25-29.

[5] Ibid. 51-70.

revealed some areas of concern surrounding pastoral hospital visitation. These concerns include, but are not limited to the following:

1. Pastors and lay ministers are receiving, little, inadequate, or no hospital visitation training from their churches, denomination, and or seminaries.
2. Pastors and lay ministers possess very little or no psychosocial, crisis intervention, grief, end of life, and other necessary training to help them understand patient/family needs and potential issues associated with hospitalization and illness. These types of training are necessary because contrary to some commonly held pastoral perspectives, not all crisis' are spiritually or theologically based;[6] in fact, indicators associated with spiritual distress, i.e., pain, alienation, anxiety, guilt, loss, and despair, may often relate to both spiritual and psychosocial problems.[7]
3. Nearly 20% of polled pastors and lay ministers (many of whom received no hospital visit of psychosocial training) have no support system for debriefing and or decompressing following difficult pastoral hospital visits, making them vulnerable to secondary trauma.
4. Regarding patient confidentiality, a small percentage of pastors and lay ministers believe that it is best to share as much patient information as possible with everyone in their church so they can be praying for the patient. The percentages are relatively low, however it only takes one incident to cause problems and incur potential lawsuits.

---

[6] William Clements and Norma Sinclair, *Horrific Traumata: A Pastoral Response to the Post-Traumatic Stress Disorder* (New York: Haworth, 1993), 7*ff.*

[7] North American Nursing Diagnosis Association, *NANDA Nursing Diagnoses* (Ann Arbor: University of Michigan,1999), 67.

5. Nearly 80% of pastors and lay ministers believe that assessment is important or very important when making pastoral hospital visits. Only 3% believe assessment tools are unimportant. At the same time, nearly 80% do not utilize, or only sometimes utilize any type of spiritual assessment tool(s).

The problem with major focus in this project is item number five. Spiritual assessment is something that cannot remain overlooked and underutilized. Assessment is a vital tool in all types of counseling and diagnoses. Assessment tools make meaningful intervention more likely and more relevant to patient needs. Time after time, personal experience proves the importance of understanding the spiritual assessment process and having a useful spiritual assessment model in place.

Personal experience, along with research, and survey findings are the primary reason for choosing the topic of spiritual assessment to address in this work. Other motivators are personal need for improvement in the area, passion for hospital ministry, and need for improvement in the hospital care ministry. This author understands and accepts that hospital visitation is not a ministry calling for everyone. This author also understands that a vocation as pastor does not typically fit into the strict confines of job description. Communities and congregations thrust significant expectation upon pastors, requiring pastors to adapt and perform in areas beyond comfort level, training, experience, desire, calling, and ability.

As a pastor, this author is well aware that situations exist when expectation is often higher than support levels. While making hospital visits as an associate care pastor, this author received virtually no training and very little support. There was no psychosocial, crisis intervention, or spiritual assessment training. There also was no

training around self-care. It was more like, “here’s a list of sick and hospitalized people within the congregation, follow up and then file a report with my secretary.” Perhaps this sounds familiar.

Overwhelming research exists on the subject of spiritual care and the impact spiritual beliefs and practice have on holistic patient health. During the many hospital visits made by this author, one thing remains constant; patients and their families are often in crisis and experiencing distress during hospitalization. Other things that remain constant include need for self-awareness, self-care, peer support, and systematic spiritual assessment and intervention. It is the hope of this author that the information in this work provides pastors with a useful tool for making productive hospital visits, even if hospital ministry is not necessarily their passion or calling.

Studies reveal that the majority of Americans believe in God, confess that God is an important aspect of their lives, and when hospitalized, value and expect their emotional and spiritual need met. Research proves a connection between physical and spiritual health. It further evidences a direct correlation between spiritual distress and wellbeing with patient coping ability. Research surrounding the connection between spiritual and physical health is overwhelming to the point of influencing the medical industry to stop, think, and act, resulting in recent revisions to professional standards and requirements for patient spiritual screening and assessment.

Hospitals and the medical industry have incorporated new standards geared towards patient religion and spirituality. This is good news, but research supports that most hospitals have responded to those standards by having hospital staff screen patients about not much more than their religious preference. Research further supports that

pastors and chaplains are more qualified to provide spiritual care to hospitalized patients than nurses, physicians, or other designated staff members. It is for this reason pastors must do whatever is necessary to become better equipped and more qualified to administer spiritual care to hospitalized patients.

The medical industry and ministry understand the benefits associated with spiritual care and assessment. With that said, spiritual assessment tools continue to be under-utilized. Spiritual assessment tools have proven to improve patient communication, to be predictive of health outcomes, reveal patient ability to cope, and identify causes and levels of spiritual distress. Assessments are useful in identifying intervention, and help develop pastoral authority and trust.[8] Assessments provide pastors with a deeper understanding of a patient's faith and belief as they relate to the current issues of their hospitalization.

As mentioned, this author conducted original research titled, *Pastoral Hospital Visitation and Chaplaincy Survey.* More than 600 pastors, chaplains, and lay ministers participated in this survey to compare and contrast procedure, training, experience, feelings, and opinion about the hospital visits they make. The survey revealed that 80% of respondents believe assessment is important when making hospital visits, while only 20% utilize or sometimes utilize spiritual assessment tools. More than 50% of respondents have been working within their current ministry for ten or more years. A majority of respondents reported making hospital visits several times per month. Approximately 4% of respondents report they currently make no hospital visits. A majority of pastors and lay ministers make hospital visits to members within their own

[8] J.F. Muncy, "Muncy Comprehensive Spiritual Assessment," *American Journal of Hospice and Palliative Care 13*(5) (1996): 44-45.

congregation. Nearly 70% report that hospital visits average in length between ten and thirty minutes. Approximately 65% cite pastoral presence and providing comfort as their primary agenda for the visit. More than 60% have visited five or more patients dealing with end of life issues.

One troubling statistic revealed that 60% of respondents report that they do not keep records or personal notes to help manage patient hospital visits. Another area of concern is that nearly 43% report that their spouse or other family member is their primary source of support for debriefing and decompressing following difficult hospital visits. Additionally, 28% report having experienced unexplained panic, anxiety, anger, and other intense feelings following difficult visits. Nearly 25% report experiencing loss of sleep or appetite, or felt down or depressed for more than one day following difficult visits. Approximately 33% have no crisis intervention knowledge or training beyond self-directed reading. This project addresses the importance of these concerns.

The primary focus of this project is spiritual assessment. This project will address the historical background for spiritual assessment and problems associated with not utilizing spiritual assessment tools. It discusses why the problems associated with not utilizing spiritual assessment tools needs to be addressed, and identifies current available assessment models. Significant research is included to identify problems with current assessment models, reasons why assessment tools are necessary when providing spiritual care, benefits associated with proper spiritual care, and potential pitfalls associated with providing inadequate pastoral care. This project discusses the process of spiritual assessment and reviews specific spiritual assessment tools used within the medical

setting. Discussions include differences between religion and spirituality, and key definitions, and components/symptoms of spiritual distress.

This project includes a *"New Model of Spiritual Assessment"* for pastors to use in developing a spiritual assessment model that meets patient needs, while meeting pastor's ministry needs and fitting their ministry personality. The *New Model* section provides important advice about properly timing hospital visits, dealing with uncomfortable hospital visits, additional training suggestions, grief, hope, and resources for learning more about crisis intervention, psychosocial studies, and end of life issues. Finally, it offers pastors a template to help organize and review assessment data and interventions.

Statement of Methodology

This project is the result of two methodological approaches. The first is an extensive review of relevant research and literature, and the second is original research in the form of a professional survey. Both approaches yielded theoretical and practical information. The topic of this project is still in need of additional research made by professional pastors and chaplains, as such, much of the research and literature used is the result of professional clinicians such as physicians, nurses, social workers, psychologists, and university professors. Original research consists of 607 pastoral responses to 30 survey questions relevant to the subject matter of this project. Survey participants include professional and ordained chaplains, senior pastors, associate pastors, and lay ministers. With the exception of 4%, all participants have experience making pastoral hospital visits.

This project consists of six chapters, organized in the following manner:

1. The first chapter provides background information regarding the problem this project addresses. This chapter discusses why the subject of this project is of interest to this author, why a need exists to address the subject of this project, as well as provide historical background of the problem this project addresses.
2. The second chapter examines and discusses the research and literature associated with the subject of this project. This chapter includes relevant research and literature that validates the problems addressed in this project, as well as to provide original research conducted by this author for the benefit of this project. This chapter includes statement of limitations, terms, definitions, method of research, research outcome, and discovered areas of concern.
3. The third chapter reviews the process, components, and definitions associated with spiritual assessment. Provided in this chapter are industry specific process recommendations and along with time-tested assessment methodology. Clarification between what is religion and what is spirituality is included. This chapter also includes detailed definitions of spiritual assessment and spiritual distress.
4. The fourth chapter provides a review of spiritual assessment tools and screening models. There is a distinction made between qualitative and quantitative assessment models. This chapter includes a list of 25 commonly used spiritual assessment tools. Detailed attention is included in this chapter of the 7X7, F.I.C.A, and H.O.P.E. models of spiritual assessment.
5. The fifth chapter contains two parts. Part I provides readers with a procedural guide to the new model for spiritual assessment offered by this author in this

project. Procedural guidelines covered in part I of this chapter include timing hospital visits, discomfort associated with making visits, training suggestions, stages of grief and case example of grief, crisis intervention, psychosocial studies, and end of life issues. Part II provides readers with adaptive spiritual assessment elements of the new model provided in this project. Part II discusses functional issues including gathering introductory and pre-visit information about the patient, pastoral feelings, perceptions, and observations. It also discusses pastoral transference, counter transference, the new model assessment elements, and a template for making a categorical written assessment report.

6. The sixth chapter provides the conclusion of this project. The conclusion summarizes the project and offers guidance to pastors for adapting a spiritual assessment model they can use when making hospital visits. Following this chapter are two appendices. Appendix A is a copy of the original research survey titled, *Pastoral Hospital Visitation and Chaplaincy*. Appendix B is a copy of the invitation email letter sent to pastors and chaplains, inviting them to participate in the survey.

CHAPTER ONE

THE PROBLEM

Why This Project Is of Interest to the Writer

There are many reasons for choosing the topic and practice of pastoral hospital visitation. Reasons include, but are not limited to calling, passion, experience, need for personal improvement, and need for improvement within the ministry.

Pastoral hospital visitation is not a ministry calling for everyone. Usually, within one or two hospital visits, and sometimes prior to making a first hospital visit, pastors determine whether the ministry is the right fit for them. Some may cringe at the very thought of hospital ministry. In the same manner, a severe introvert or pastor who is uncomfortable making public speeches likely does not feel called as a preaching pastor.

The reality however is that many pastors must make hospital visits out of necessity and or obligation, just as with this author, who is not too gifted a preacher, must cover the pulpit for the senior pastor whenever he is away. When making pastoral hospital visits, or when visiting people who are in crisis or who are dying, this author feels like he is living exactly for the purpose for which God has created him. This author feels like Eric Liddell in Chariots of Fire. When asked why he runs, he responded, “I believe God made me for a purpose, but he also made me fast; and when I run I feel His pleasure.” No other ministry allows this author to feel God’s pleasure to the same degree

as hospital chaplaincy. It is the hope of this author that the information in this project will provide useful tools to other pastors making hospital visits, even if hospital ministry is not their passion or calling.

Experience has shown this author that there is always room to improve. Prior to completing Clinical Pastoral Education, this author's ministry was that of congregational care within a well-known televised mega-church. The amount of training this author received specific to care ministry and hospital visitation was minimal at best. Most of what this author learned was from personal reading and experience. Other than training received during earlier work as a suicide and crisis counselor, this author had not received training in crisis intervention. There was no training around psychosocial, assessment, or self-care. Admittedly, this author made some classic pastoral mistakes early in his career. This author did not know how much he did not know until he learned more.

This author was enlightened during his first C.P.E. internship. The training included a great deal of emphasis upon self-discovery and self-awareness. This author learned much about his unhealthy unconscious motivators, growing-edges, and significant presuppositions. The experience allowed this author to look back to see the many mistakes he made in pastoral care ministry. It also taught him the importance of self-care, proper spiritual assessment, and his role as a pastor and member of the patient's psychosocial team.

Children's Hospital is where this author completed his final C.P.E. internship, consisting of three additional units. Pediatric care is similar to adult care is some ways, but significantly different in many others. One thing that remains constant is that patients

and patient families were often in crisis and experiencing spiritual distress. Other things that remain constant are the need for self-awareness, self-care, peer support, and a need for systematical spiritual assessment and intervention.

Perhaps some of the most damaging pastoral visits this author witnessed over the years are visits made by him, prior to receiving adequate training and support, and prior to understanding spiritual distress and the need for accurate assessment. Some of the other damaging pastoral visits witnessed by this author came from congregational pastors visiting the hospital to comfort members of their church and or children from their church. No doubt, all pastors were well intentioned, but many times the lack of proper training, lack of understanding trauma and crisis, lack of understanding psychosocial and family dynamics issues, and ultimately lack of ability to properly assess, caused more harm than had the pastor not visited. Many pastors try to "fix" what they perceive is the problem rather than learn the problem or simply provide pastoral comfort and presence. This author has witnessed countless pastoral attempts at intervention that involved nothing more than unhelpful statements, "God never gives us more than we can handle," "You just need to pray more," It must be God's will," You need to confess your sin," "Heaven must have needed another angel," and "You just need more faith."In other situations, pastors presume spiritual distress when spiritual distress is not present, insisting that a person or family 'must' feel a certain way or that they are in a different stage of crisis or grief than they are actually. This author has witnessed times when the situation in the hospital was so unbearable for the pastor, that the family members who are in crisis had to care for the pastor while trying to tend to their own grief. This author has cried with patients and there are appropriate times and appropriate levels for tears.

This author has made some of the same pastoral mistakes highlighted above. It is for those reasons this author has chosen the topic of pastoral hospital visitation.

Overwhelming research exists on the subject of spiritual care and the impact spiritual belief and practice have upon holistic patient health. Many reports and surveys differ regarding techniques and terms, but nearly all of them stress the patient desire for and benefit of spiritual care while hospitalized, and emphasize the importance of spiritual assessment. When conducting the research survey of over 600 chaplains and pastors on the subject of hospital visitation, it troubled this author to learn that nearly 80% regard spiritual assessment as important to very important, while 77% report they do not utilize, or only sometimes utilize any type of spiritual assessment tool(s) when making pastoral hospital visits. It is also for this reason this author chooses to emphasize spiritual assessment.

Theoretical Basis for the Project

The theoretical basis of this project results from reviewing relevant research and literature, personal experience and training, and original research using information obtained from pastors who are experienced in making pastoral hospital visits. Empirical research indicates that hospitalized patients are at in increased risk of spiritual distress. It further indicates that from the perspective of stress and coping, religious practice and belief is a cultural means of providing people with ways of appraising and coping with stress. Religious frameworks provide a meaning for the occurrence of stress.[1] Unhealthy religious or spiritual beliefs provoke anger, lack of understanding, blame, and may leave patients feeling victimized by a higher authority. According to Gregory

[1] Carolyn Aldwin, *Stress, Coping, and Development: An Integrative Perspective* (New York: Guilford Press, 1994), 244.

Bateson, "we select and edit the reality we see to conform to our beliefs about what sort of world we live in."[2]

There exists a direct correlation between spiritual health and physical/mental health. Spiritual wellness and religious participation help ease symptoms associated with patient illness, including, but not limited to isolation, levels of pain, feelings of hope and well-being, anxiety, etc. Additional research offers that American patients and the medical industry as a whole understand the value of spiritual well-being in patients. Further, patients have expressed a desire and expectation to have spiritual needs met during hospitalization. Unfortunately, research shows that most medical clinicians do not discuss spiritual issues with patients, citing time constraints and lack of knowledge and ability to do so.

To their credit, the healthcare industry is beginning to acknowledge the need for patient spiritual well-being and have mandated some minimum spiritual screening standards to determine a patient's religious affiliation and or spirituality. At issue is the fact that medical professionals are not professionally equipped to do much more than this, making them less likely to identify spiritual distress and provide intervention. The industry acknowledges that the best persons to provide spiritual care are professionals with theological and spiritual training. In other words, chaplains and pastors are the most qualified to provide patients with spiritual care.

The original research survey provided in this project polled over 600 pastors who have experience making pastoral hospital visits. The results show that even among professional chaplains, there is a greater need for training pastors for hospital specific

---

[2] Gregory Bateson, *Steps to an Ecology of Mind: A Revolutionary Approach to Man's Understanding of Himself* (New York: Ballantine, 1972), vii.

ministry. Denominations, churches, and seminaries are not providing hospital specific training to any meaningful level, leaving pastors to teach themselves or to invest hundreds of hours completing internship training through a Clinical Pastoral Education program. This research also revealed that a majority of pastors making hospital visits agree that having a spiritual assessment system is important, but the same majority admit never using or only rarely using any spiritual assessment tool as part of their hospital visitation ministry.

Physicians and counselors use differential diagnosis in their practices to rule out and compare disease symptoms of sick patients. This, along with testing and other procedures serve as their assessment tools to help them identify the underlying problems causing symptoms and to then develop a treatment plan. Assessment has proven to be necessary in curing all other aspects of patient's health. For spiritual well-being to be accurately treated it should be approached in the same manner as physical and mental well-being.

Research further discovered that not only is lack of training and lack of use of assessment tools a problem, but pastors are at risk of suffering from secondary trauma as a result of working with patients who are in crisis. Counter transference issues, burn out, and lack of support are a reality among pastors making hospital visits. Training is necessary to help pastors understand and identify these risks and have a system of support in place.

Personal experience and practice has proven to this author that education, training, and the use of a spiritual assessment model not only makes for a healthier patient, but a healthier and more productive hospital pastor. The benefits of utilizing a

categorical assessment report include, but are not limited to identifying patient needs, developing intervention, consulting with other professionals, and identifying potential feelings that can negatively interfere with patient spiritual care.

Historical Background

History shows that hospitalized patients value and expect having spiritual and emotional needs met. The National Inpatient Priority Index Composite ranks hospital performance and patient importance by surveying approximately 1.4 million patients since 1998, emotional and spiritual needs ranks second.[3] A Gallup poll of Americans in 2000[4] revealed that 91% believe in God, with 87% reporting feelings that "God is highly important" in their lives. Another study polled 1,000 people in the United States to find that 79% believe that spiritual faith can help people recover from disease . . . another 63% believe that physicians should inquire about the spiritual beliefs of patients.[5] Spiritual care is so important to hospitalized patients that when polled, patients responded that when pastors help, the patient is more likely to choose that institution again for future hospitalization.[6]

The growing body of scientific knowledge about the connectedness of spirituality and health attest to the idea that attention to the spiritual aspects of patients is thought to

---

[3] Paul Clark, Maxwell Drain, and Mary Malone, "Addressing Patients' Emotional and Spiritual Needs," *Joint Commission Journal on Quality and Safety 29* (2003): 659-670.

[4] Marita Carballo, "Religion in the World at the End of the Millennium," *Gallup International Millennium Survey* (Washington: Gallup International, 1999).

[5] Tom McNichol, "The New Faith in Medicine," *USA Today vol. 4* (April 5, 1996): 4-5.

[6] James Gibbons, J. Thomas, L. VandeCreek, and A. Jessen, "The Value of Hospital Chaplains: Patient Perspectives," *Journal of Pastoral Care 45*(2) (1991): 117-125.

be vital for providing quality care.[7] A growing body of research indicates that spirituality is often a significant patient strength[8] and often a core animating principle in a persons' view of reality, their spirituality, thus often fosters a culturally distinct worldview.[9] Ellison and Levin add that several hundred studies exist on spirituality and religion, with the majority emphasizing spirituality as a key strength in personal well being.[10] The fact is that as a means of coping, patients often turn to their spiritual beliefs during crisis.[11] Many people believe that their spiritual beliefs can help in their recovery from disease[12] and 82% of Americans reported that they believe in the healing power of personal prayer.[13] Studies reveal that as many as 70% of patients are aware of one or more spiritual needs that relate to their illness.[14] A study of older adults found that more than half reported that their religion was the most important resource that helped them cope with illness.[15] In another study, 44% of the patients reported that religion was the most

---

[7] Kristin Mauk and Nola Schmidt, *Spiritual Care in Nursing Practice* (Philadelphia: Lippincott Williams and Wilkins, 2004), vii.

[8] Harold Koenig, Dana King, and Verna Carson, *Handbook of Religion and Health* (New York: Oxford University Press, 2012), 141-162.

[9] Thomas Plante and Naveen Sharma, "Religious Faith and Mental Health Outcomes, In T.G. Plante and A.C. Sherman, *Faith and Health: Psychological Perspectives* (New York: Guilford Press, 2001), 240-261.

[10] Christopher Ellison, and Jeff Levin, "The Religion-Health Connection: Evidence, Theory, and Future Directions," *Health Education and Behavior 25*(6) (1998): 700-720.

[11] Kenneth Pargament, *The Psychology of Religion and Coping: Theory, Research, Practice,* (New York: Guilford Press, 1997), 144-162.

[12] McNichol, 4.

[13] Marty Kaplan, "Ambushed by Spirituality," *USA Time Magazine* (June 24, 1996): 62.

[14] George Fitchett, Laurel Burton, and Abigail Sivan, "The Religious Needs and Resources of Psychiatric Inpatients," *Journal of Nervous and Mental Disease 185*(5) (1997): 320-326.

[15] Harold Koenig, David Moberg, and James Kvale, "Religious Activities and Attitudes of Older Adults in a Geriatric Assessment Clinic," *Journal of the American Geriatrics Society 36* (1988): 362-374.

important factor that helped them cope with their illness or hospitalization.[16] Studies of patients in acute care hospitals report that between one-third and two-thirds of all patients want to receive spiritual care.[17]

Despite the importance of spiritual care of hospitalized patients, many physicians proclaim that they do not have the time or the training necessary to make a spiritual assessment, and or they feel uncomfortable or uncertain when patients pose spiritual issues.[18] [19] Many physicians simply lack the awareness of the importance of patient spiritual beliefs.[20] Even with recent efforts made by JCAHO, the Joint Commission on Accreditation of Healthcare organizations, WHO, the World Health Organization, and NANDA, the North American Nursing Diagnosis Association toward addressing awareness and promoting spiritual care, many patients still go through hospitalization without thorough spiritual assessment and care.

Traditionally, any spiritual assessment and spiritual care a hospital patient receives will come from either their church minister, or a pastor who volunteers at a local hospital. If patients are fortunate enough, they will receive spiritual care from a professionally trained chaplain or priest, should the hospital be a faith-based institution and or employ such hospital clergy. The professional hospital clergy will likely have

---

[16] Harold Koenig, Margot Hover, Lucille Bearon, and James Travis, "Religious Perspectives of Doctors, Nurses, Patients, and Families," *Journal of Pastoral Care 45*(3) (1991): 254-267.

[17] George Fitchett, Peter Meyer, and Laurel Burton, "Spiritual Care: Who Requests It? Who Needs It?" *Journal of Pastoral Care 54*(2) (2000): 173-186.

[18] John Chibnall and Christy Brooks, "Religion in the Clinic: The Role of Physician Beliefs," *Southern Medical Journal 94* (2001): 374-379.

[19] Mark Ellis, Daniel Vinson, and Bernard Ewigman, "Addressing Spiritual Concerns of Patients: Family Physicians' Attitudes and Practices," *Journal of Family Practice 48* (1999): 105-109.

[20] A. Ward Jones, "A Survey of General Practitioners' Attitudes to the Involvement of Clergy in Patient Care," *British Journal of General Practice 40* (1990): 280-283.

specific training in the areas necessary to provide the patient with optimum spiritual care. They likely will utilize a formal spiritual assessment model to aid in delivering proper spiritual care. In recent years, hospitals are developing an understanding of the significance of spiritual care, and spiritual assessment, sparking some positive industry changes however, duty lies heavily with pastors and chaplains.

Fortunately, pastors and chaplains tend to have a better understanding of and training in theological and spiritual matters. Unfortunately, not ever pastor or chaplain possesses the required training, knowledge, and or calling to be effective in providing patient spiritual care. Many pastor likely make hospital visits out of necessity and or obligation, while others, though well meaning, may approach spiritual issues of patients with shallow theological interpretation and or presupposition. As a whole, the profession of hospital chaplaincy has done very little of its own research on spiritual care, while the research reported in pastoral care and counseling journals tend to remain mixed,[21] at best. It is for these reasons pastors and hospital chaplains must begin to utilize spiritual assessment tools when making pastoral hospital visits.

Review of the Literature

Charles R. Figley, "*Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized."* [22]

In *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, Dr. Charles Figley introduces readers to the concept

---

[21] John Gartner, David Larson, and Carole Vachary-Mayberry, "A Systematic Review of the Quantity and Quality of Empirical Research Published in Four Pastoral Counseling Journals: 1975-1984," *The Journal of Pastoral Care 44* (1999): 115-123.

[22] Charles R. Figley, *Compassion Fatigue: Coping with Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York: Brunner/Mazel, 1995).

of compassion fatigue, also referred to as secondary trauma. *Compassion Fatigue* provides an overview and basis for assessment and treatment of secondary trauma. The book further discusses the differences between burnout, P.T.S.D., and counter-transference. Finally, the book offers suggestions for preventing secondary trauma.[23] Secondary trauma, burnout, and counter-transference are areas of significant concern to this author and this project.

Karen Saakvitne and Laurie Pearlman, "*Transforming the Pain: A Workbook on Vicarious Trauma."*[24]

Pearlman and Saakvitne authored *Transforming the Pain: a Workbook on Vicarious Trauma* for professionals who are at risk of secondary trauma. This workbook is for use with its companion book, "*Trauma and the Therapist."*[25] This workbook helps professional caregivers by helping them to identify the symptoms and risks associated with working with trauma victims, while providing guidance for self-care. Pastors making hospital visits are at an elevated risk of experiencing secondary trauma and need to implement measures of self-care. The term 'vicarious trauma' better depicts the risks to caregivers than does the term 'secondary trauma.'

James Gibbons, J. Thomas, Larry VandeCreek, and A. Jessen. *"The Value of Hospital Chaplains: Patient Perspectives."* [26]

"The Value of Hospital Chaplains: Patient Perspectives" is a *Journal of Pastoral Care* article with resulting data from a questionnaire mailed to recently discharged

---

[23] Ibid. xiv.

[24] Karen Saakvitne and Laurie Pearlman, *Transforming the Pain: A Workbook on Vicarious Trauma* (New York: W.W. Norton, 1996).

[25] Laurie Pearlman and Karen Saakvitne, *Trauma and the Therapist* (New York: W.W. Norton, 1995).

[26] Gibbons, *The Value of Hospital Chaplains,* 117-125.

hospital patients. Results of the questionnaire reveal that spiritual care is so important to hospitalized patients that when pastors help, the patient is more likely to choose that institution again for future hospitalization. One of the most important points to this project is that it reveals the value and need of patients to receive pastoral spiritual care during hospitalization.

Harold Koenig, Dana King, and Verna Carson, *"Handbook of Religion and Health."*[27]

More than simple discussion about the relationship between religious participation and health, or simply asking if religious involvement is good or bad to health, *Handbook of Religion and Health* studies the conditions under which religion promotes health . . . or harms well-being.[28] *Handbook of Religion and Health* provides relevant research to support the benefit of spirituality to hospitalized patients. The authors make the point that not everyone is religious, but everyone is spiritual. It is important for pastors to understand the spiritual issues faced by each patient, whether religious, or not.

Kenneth Pargament, "*The Psychology of Religion and Coping: Theory, Research, Practice."*[29]

The Psychology of Religion and Coping: Theory, Research, Practice offers readers significant information about how people respond during crisis. Dr. Pargament discusses the many ways religious beliefs positively and negatively influence coping abilities. The three underlying reasons in this book as to the importance of studying religion and coping include that it exposes and unmasks human nature and coping methods, it helps make religious understanding less of an abstract concept, and to help in understanding how

---

[27] Harold Koenig, *Handbook of Religion,* 141-162.

[28] Ibid. xi.

[29] Pargament, *The Psychology,* 144-162.

religion influences us at pivotal periods.[30] Significant empirical documentation is included in this work to support this author's thesis that patients turn to spiritual beliefs as a coping method during crisis and hospitalization.

Harold Koenig, David Moberg, and James Kvale, *"Religious Activities and Attitudes of Older Adults in a Geriatric Assessment Clinic."*[31]

Religious Activities and Attitudes of Older Adults in a Geriatric Assessment Clinic is a *Journal of American Geriatrics* article with resulting data from a survey of adults older than 65 years of age. The result of the study is that more than half reported that their religion was the most important resource that helped them cope with illness. The study further suggests that religious orientation and practice correlates to mental and physical health. When understanding these findings, pastors making hospital visits can help patients find coping strength using their religious orientation.

George Fitchett, Laurel Burton, and Abigail Sivan, *"The Religious Needs and Resources of Psychiatric Inpatients."* [32]

The Religious Needs and Resources of Psychiatric Inpatients is a *Journal of Nervous and Mental Disease* article that highlights the resulting data from a survey of 51 psychiatric patients compared to 50 age and gender matched medical/surgical patients. The findings revealed that psychiatric patients had lower spiritual well-being scores and need prompting to address spiritual needs. The study reveals 70% of patients are aware of one or more spiritual needs that relate to their illness and many patients are spiritual and

---

[30] Ibid. 4-6.

[31] Harold Koenig, *Religious Activities,* 362-374.

[32] Fitchett, *The Religious Needs,* 320-326.

utilize religious beliefs to help cope with medical crisis. This study reminds pastors making hospital visits the importance of inquiring about and assessing for spiritual needs.

William Clements and Norma Sinclair, "*Horrific Traumata: A Pastoral Response to the Post-Traumatic Stress Disorder*." [33]

Contrary to some commonly held pastoral perspectives, not all crisis' are spiritually or theologically based; in fact, indicators associated with spiritual distress, i.e., pain, alienation, anxiety, guilt, loss, and despair, may often relate to both spiritual and psychosocial problems. Sinclair looked beneath the surface of Post Traumatic Stress Disorder at the emotional and spiritual needs of victims. This book offers several true accounts of victims that help pastors understand the reality of their pain so that they can provide meaningful pastoral care. This author proposes that pastors making hospital visit need an understanding of crisis, spiritual distress, and psychosocial issues affecting hospitalized patients.

L.M. Benedict, "Spiritual Distress." In C. Koopsen and C. Young, "*Integrative Health: A Holistic Approach for Health Professionals."*[34]

In Koopsen's *Integrative Health,* Benedict provides an accurate list of symptoms associated with spiritual distress, defining spiritual distress as "a disruption (or risk of disruption) in the life principle that pervades a person's entire being and that integrates and transcends one's biological and psychological nature."[35] Benedict states that while experiencing spiritual distress, the persons self is disintegrating. Providing meaningful

---

[33] William Clements and Norma Sinclair, *Horrific Traumata: A Pastoral Response to the Post-Traumatic Stress Disorder* (Binghamton: Routledge, 1993).

[34] L.M. Benedict, "Spiritual Distress," In C. Koopsen and C. Young, *Integrative Health: A Holistic Approach for Health Professionals* (Sudbury: Jones and Bartlett, 2009).

[35] Ibid.

spiritual care and assessment requires that pastors understand spiritual distress and recognize its symptoms.

Carol Smucker, *"A Phenomenological Description of the Experience of Spiritual Distress."*[36]

A Phenomenological Description of the Experience of Spiritual Distress is an *International Journal of Nursing Terminologies and Classifications* article that highlights the resulting data from a survey of patients regarding spiritual distress issues. The goal of the study was to help nursing diagnosis of spiritual distress and understand its characteristics. The study determined that spiritual distress has a detrimental effect on physical and mental health. The study incorporated a two-phase process to help patients move from distress to growth. This author submits that the assessment process is the proper tool for pastors to utilize to help facilitate patient movement from distress to growth, strength, and wellness.

Gowri Anandarajah and Ellen Hight, *"Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment."*[37]

Anandarajah highlights the connection between spirituality and medicine. The finding of studies reveal that patients want to discuss spiritual concerns with their healthcare providers, that physicians incorporate beliefs into planned care, that a positive connection exists between spirituality and health, and that spiritual assessment is a necessary tool. This work discusses the HOPE spiritual assessment tool developed by Anadarajah, which is the tool used by many healthcare providers. Pastors can benefit

---

[36] Carol Smucker, "A Phenomenological Description of the Experience of Spiritual Distress," *International Journal of Nursing Terminologies and Classifications 7*(2) (1996): 81-91.

[37] Gowri Anandarajah and Ellen Hight, "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment," *American Family Physician 63*(1) (2001): 81-88.

from understanding even a basic spiritual assessment tool such as the HOPE tool. The Hope Assessment focuses on hope, meaning, love, strength, peace, and comfort, without focusing upon organized religion.

George Everly, "*Pastoral Crisis Intervention*."[38]

Everly offers an excellent pocket resource for pastors who help those in crisis. *Pastoral Crisis Intervention* concisely provides techniques to identify distress and intervene. Everly discusses Critical Incident Stress Debriefing perspective and offers models for pastoral intervention. Throughout this work, Everly promotes and strongly encourages the use of assessment tools to aid those in crisis. Spiritual assessment is at the heart of this author's thesis and *Pastoral Crisis Intervention* is an excellent resource for all pastors making hospital visits.

Fiona Randall and Robert Downie, *Palliative Care Ethics: a Good Companion*."[39]

Palliative Care Ethics: a Good Companion is for those who work with terminally ill and end of life patients. Randall discusses the many ethical issues associated with patient autonomy contrasted with life prolonging technology. The two themes at work in this book are that emotional and physical care received is at the desire of the patient, and that individuals who provide patient care possess 'professional expertise.' The writers provide empirical evidence that suggests professional pastors and or individuals possessing expertise in spiritual and religious care should be the ones to perform patient spiritual assessment and care.

---

[38] George Everly, *Pastoral Crisis Intervention* (Ellicott City: Chevron Publishing, 2007).

[39] Fiona Randall and Robert Downie, *Palliative Care Ethics: a Good Companion* (Oxford: Oxford University Press, 1996), 1-29.

Edward Canda and Leola Furman, "*Spiritual Diversity in Social Work Practice: The Heart of Helping."*[40]

This book provides spiritual information for all types of belief systems, reminding us that not everyone practices religion the same, and not everyone is religious; all are however spiritual. At the heart of this book is empirical evidence supporting that a person's spiritual meaning, purpose, connectedness, and religious involvement are associated with enhanced well-being.[41] Pastors making hospital visits need to understand the many ways people find meaning and purpose in spirit, in life, and in crisis.

Dana King and Bruce Bushwick, *"Beliefs and Attitudes of Hospital Inpatients About Faith Healing and Prayer."*[42]

Beliefs and Attitudes of Hospital Inpatients about Faith Healing and Prayer is a *Journal of Family Practice* article that highlights the resulting data from a survey of 200 adult patients interviewed about their views of the relationship between religion and health. The study found that 77% of patients indicated they would like spiritual issues considered as part of their medical care, while 68% stated their physicians never did. The conclusion is that patients desire spiritual care during hospitalization that clinicians are not providing, making the role of hospital pastor more relevant.

---

[40] Edward Canda and Leola Furman, *Spiritual Diversity in Social Work Practice: The Heart of Helping* (Oxford: Oxford University Press, 2010).

[41] Ibid. 4.

[42] Dana King and Bruce Bushwick, "Beliefs and Attitudes of Hospital Inpatients About Faith Healing and Prayer," *Journal of Family Practice 39*(4) (1994): 349-352.

Review of Scripture

1Thessalonians 2

Portions of this chapter provide an example of the experiences and purpose of pastoral hospital visitation. The first verse begins with, *"You know brothers and sisters that our visit to you was not without results."* The fourth verse continues that, *"we speak as those approved by God to be entrusted with the gospel."* Then finally in verses seven and eight, *". . . just as a nursing mother cares for her children, so we cared for you. Because we loved you so much, we were delighted to share with you not only the gospel of God but our lives as well."*[43]

This passage of scripture reminds pastors that when we are making hospital visits we are doing so as representatives of God. In chapter three of this project, this writer states that, *"Pastors are specialist in their professions, board certified by God, and saints, equipped for God's purposes."* The passage also points out that visits should not be without results. Throughout the entirety of this project there is an emphasis placed upon training and technique necessary to produce results in spiritual care. Identifying spiritual distress to make intervention possible [results] requires the use of an assessment model. Not only are hospital pastors result oriented, they are providing a comforting presence, caring and loving in a giving manner that is fulfilling; sharing our lives with the patient and patient family.

2Corinthians 5:17-21

> *"Therefore, if anyone is in Christ, the new creation has come: The old has gone, the new is here! All this is from God, who reconciled us to himself through Christ and gave us the ministry of reconciliation: that God was reconciling the world to himself in Christ, not counting people's sins against them. "And he has committed to us the message of reconciliation. We are therefore Christ's ambassadors, as*

[43] 1Thessalonians 2:1, 4, 7-8, (NIV)

> *though God were making his appeal through us. We implore you on Christ's behalf: Be reconciled to God. God made him who had no sin to be sin for us, so that in him we might become the righteousness of God."*[44]

This passage emphasizes reconciliation. A major component of spiritual distress, especially with end of life issues is reconciliation. Hospital pastors become facilitators of reconciliation for patients and patient families. Reconciliation may be between patient and God, patient and family members, and possibly with self. God is the great reconciler. Hospital Pastors are God's ambassadors.

Matthew 25:35-40

". . . I was sick and you looked after me, I was in prison and you came to visit me. Then the righteous will answer him, 'Lord . . . when did we see you sick . . . and go to visit you?" "The King will reply, 'Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me."[45]

This passage reminds us of the love of Christ that we must share with our fellow man. God blesses us and offers us entrance into His kingdom with the understanding that we are to live the life in Christ. We should treat others the way we expect to be treated and the way we want God to treat us. Hospital pastors visit the sick and feed the souls of patients and patient families.

Psalm 88

Psalm 88 provides an excellent insight into the types of spiritual distress experienced by hospitalized patients. Notice the spiritual pain in verse one, *"day and night I cry out to you,"* spiritual alienation and anxiety in verse 5, *"I am set apart with the dead, like the slain who lie in the grave, whom you remember no more, who are cut*

---

[44] 2Corinthians 5:17-21, (NIV)

[45] Matthew 25:35-40, (NIV)

*off from your care."*Notice the loss of loved ones, situational loss, and relationship problems in verse 8, *"You have taken from me my closest friends and have made me repulsive to them,"* verse 18, *"You have taken from me friend and neighbor," and verse 4, "I am counted among those who go down to the pit; I am like one without strength."*[46] This passage documents a true crisis of faith with classic signs of spiritual distress. This is the type of spiritual distress experienced by hospital patients as discussed in every chapter of this project.

Proverbs 27:12

"A prudent person foresees danger and takes precautions. The simpleton goes blindly on and suffers the consequences." [47]

Pastors who receive proper training and who develop a workable spiritual assessment model are more prepared to foresee spiritual distress or other issues of concern and help patients take precautions without being blind to the challenges that might be ahead of them during their illness and or hospitalization.

Proverbs 27:23 and John 10:3-4

"Know the state of your flocks, and put your heart into caring for your herds."[48]

"The gatekeeper opens the gate for him, and the sheep listen to his voice. He calls his own sheep by name and leads them out. When he has brought out all his own, he goes on ahead of them, and his sheep follow him because they know his voice."[49]

---

[46] Psalm 88:4,5, 8, 18, (NIV)

[47] Proverbs 27:12, (NLT)

[48] Proverbs 27:23, (NLT)

[49] John 10:3-4, (NIV)

Hospital pastors, like all pastors, are shepherds who care for their flock. They care for those placed into their trust. The need for knowing people in their care comes from building rapport and developing trust and authority. As discussed in chapter 5 of this project, "Assessments are useful in identifying intervention, and help develop pastoral authority and trust."[50] Authority for pastoral care comes from God, the gatekeeper. As representatives of God, pastors go before the patient by anticipating dangers and potential distress issues and develop an intervention. The patient will follow in the intervention because the pastor has gained pastoral transference and authority as discussed throughout chapter 5. The new model discussed in chapter five highlights some necessary training suggestions to help pastors better 'know the state' of their patients.

Proverbs 18:13 and Ecclesiastes 9:17

"To answer before listening—that is folly and shame."[51]

"The quiet words of the wise are more to be heeded than the shouts of a ruler of fools."[52]

This project discusses the need for proper assessment and provides a new model for assessment. Listening to what patients say, how they say it, and what they do not say is important in the spiritual assessment process. Non-verbal queues, facial expressions, and the mood of the patient room are all acts of quiet listening discussed in the new model presented in chapter 5. Also discussed, listening is gaining useful patient information from chart notes, family members, and hospital staff.

---

[50] Muncy, 44-45.

[51] Proverbs 18:13, (NIV)

[52] Ecclesiastes 9:17, (NIV)

1John 4:2-3, 1Corinthians 2:10-11, Romans 8:1, John 3:16, Ephesians 4:11-16, and Isaiah 1:10-15

"This is how you can recognize the Spirit of God: Every spirit that acknowledges that Jesus Christ has come in the flesh is from God, but every spirit that does not acknowledge Jesus is not from God."[53]

"The Spirit searches all things, even the deep things of God. For who knows a person's thoughts except their own spirit within them? In the same way no one knows the thoughts of God except the Spirit of God."[54]

"Therefore, there is now no condemnation for those who are in Christ Jesus."[55]

"For God so loved the world that he gave his one and only Son, that whoever believes in him shall not perish but have eternal life."[56]

> *"Christ gave gifts to men. He gave to some the gift to be missionaries, some to be preachers, others to be preachers who go from town to town. He gave others the gift to be church leaders and teachers. These gifts help His people work well for Him. And then the church which is the body of Christ will be made strong. All of us are to be as one in the faith and in knowing the Son of God. We are to be full-grown Christians standing as high and complete as Christ is Himself. Then we will not be as children any longer. Children are like boats thrown up and down on big waves. They are blown with the wind. False teaching is like the wind. False teachers try everything possible to make people believe a lie, but we are to hold to the truth with love in our hearts. We are to grow up and be more like Christ. He is the leader of the church. Christ has put each part of the church in its right place. Each part helps other parts. This is what is needed to keep the whole body together. In this way, the whole body grows strong in love."*[57]

> *"Hear the word of the LORD, you rulers of Sodom; listen to the instruction of our God, you people of Gomorrah! "The multitude of your sacrifices—what are they to me?" says the LORD. "I have more than enough of burnt offerings, of rams and the*

---

[53] 1John 4:2-3, (NIV)

[54] 1Corinthians 2:10-11, (NIV)

[55] Romans 8:1, (NIV)

[56] John 3:16, (NIV)

[57] Ephesians 4:11-16, (NLV)

> *fat of fattened animals; I have no pleasure in the blood of bulls and lambs and goats. When you come to appear before me, who has asked this of you, this trampling of my courts? Stop bringing meaningless offerings! Your incense is detestable to me. New Moons, Sabbaths and convocations —I cannot bear your worthless assemblies. Your New Moon feasts and your appointed festivals I hate with all my being. They have become a burden to me; I am weary of bearing them. When you spread out your hands in prayer, I hide my eyes from you; even when you offer many prayers, I am not listening."*[58]

Chapter 3 of this project discusses general differences between spirituality and religion, pointing to how "spirituality and religion are distinct and overlapping concepts, often used interchangeably,"[59] and that even "assessment tools make assumptions about the relationship between religion and spirituality."[60] From the Christian perspective, the differences between spirituality and religion are less general.

The Greek word used in the New Testament for "Spiritual" is *'pneumatikovß,'* meaning the spirit and or soul of man relating to the divine and or Holy Spirit of God. In other words, the term spiritual refers to walking and or living by the Spirit of God. For the Christian, the only spiritual issue that matters is that Jesus Christ came in the flesh, died for our sins, is king and savior, and provides us with the Holy Spirit to guide the Christian life. (1John 4:2-3, 1Corinthians 2:10-11, Romans 8:1, and John 3:16)

The Greek word used in the New Testament for "Religious" is *'deisidaimonia,'* meaning to reverence God or pious. It can also mean superstitious. It ultimately means following an organized belief system, but not necessarily the Christian belief system. Religion does however have its place in the Christian belief system. God calls Christians

---

[58] Isaiah 1:10-15, (NIV).

[59] M.M. Carroll, "Spirituality and Clinical Social Work: Implications of Past and Current Perspectives," *Arete 22*(1) (1997): 25-34.

[60] Tom Gordon, Ewan Kelly and David Mitchell, *Spiritual Care for Healthcare Professionals: Reflecting on Clinical Practice* (Oxford: Radcliffe Publishing, 2011), 71.

to gather for the purpose of strengthening one another, growing spiritually, and sharing the faith with others. (Ephesians 4:11-16)

On the other hand, God's primary concern is our spiritual well-being and how we follow His spiritual guidance, more than about showing up for church and exercising tradition, or putting on a good public show. Isaiah 1:10-15 warns us not to be religious for the sake of religion because it is empty and meaningless to Him.

The Need to Address the Problem

Spiritual health positively and negatively affects patient well being, coping, and overall health. A significant number of studies exist that prove the relationship between religious practices and beliefs and positive health outcomes.[61] Studies made of 122 patients with chronic musculoskeletal pain concluded that patients with spiritual and or religious beliefs experience pain differently than the general population without such beliefs, and emphasizes that religion and or spirituality may have both costs and benefits for the health of those with chronic pain.[62] This is a reminder that healthy religious beliefs benefit patients, while unhealthy beliefs cause further distress. A meta-analysis of data from 42 published mortality studies involving more than 126,000 people examined the association of a measure of religious involvement and all-cause mortality [all causes of death] to conclude that religious involvement was significantly associated with lower

---

[61] Koenig, *Handbook of Religion*, 4*ff.*

[62] Ann Rippentrop, Elizabeth Altmaier, Joseph Chen, Ernest Found, and Valerie Keffala, "The Relationship Between Religion/Spirituality and Physical Health, Mental Health, and Pain in a Chronic Pain Population," *Pain 116*(3) (2005): 311-321.

mortality, meaning religiously involved persons live longer than non-religiously involved.[63]

A study of nearly 600 severely ill elderly patients[64] revealed that those patients who sought a connection with God and received support from pastors and members of faith communities exhibited lower levels of depression and when asked, ranked their quality of life as higher, even after accounting for the severity of their illness. A study including 1,600 cancer patients exhibiting symptoms of fatigue and pain revealed that patients with higher levels of spiritual well being enjoy a significantly higher quality of life.[65] Another study involving breast cancer patients reports that 88% claimed religion is important to them and 85% stated that their religious beliefs help them to cope during the disease.[66] Similarly, 93% of gynecological cancer patients in one study reported that religion increased their sense of hope.[67] Another cancer patient study[68] revealed that 76% practice personal prayer as a way to cope with their diagnosis.

Studies point to the importance of spiritual distress, that is, unresolved religious or spiritual conflicts and doubts. This distress is associated with decreased health, recovery,

---

[63] Michael McCullough, William Hoyt, David Larson, Harold Koenig, and Carl Thoresen, "Religious Involvement and Mortality: A Meta-Analytic Review," *Health Psychology 19*(3) (2000): 211-222.

[64] Harold Koenig, Kenneth Pargament, and J. Nielsen, "Religious Coping and Health Status in Medically Ill Hospitalized Older Adults," *Journal of Nervous and Mental Disease 186*(9) (1998): 513-521.

[65] Marianne Brady, Amy Peterman, George Fitchett, May Mo, and David Cella, "A Case for Including Spirituality in Quality of Life Measurement in Oncology," *Psycho-Oncology 8*(5) (1999): 417-428.

[66] Sarah Johnson and Bernard Spilka, "Coping with Breast Cancer: The Roles of Clergy and Faith," *Journal of Religion and Health 30*(1) (1991): 21-23.

[67] James Roberts, Douglas Brown, Thomas Elkins, and David Larson, "Factors Influencing Views of Patients with Gynecological Cancer About End of Life Decisions," *American Journal of Obstetrics and Gynecology 176*(1) (1997): 166-172.

[68] Larry VandeCreek, E. Rogers, and J. Lester, "Use of Alternative Therapies Among Breast Cancer Outpatients Compared with the General Population," *Alternative Therapies 5*(1) (1999): 71-76.

and adjustment to illness.[69] [70] The reality is that attending to patient spiritual needs improves satisfaction with care and helps the patients cope with crisis associated with changes in health.[71]

A majority of patients in the United States believe that spiritual health is important to physical health. One study found that 94% of patients admitted into the hospital believe that spiritual health is as important as physical health, [72] while up to 77% of patients indicated they would like spiritual issues considered as part of their medical care.[73] The bottom line is that research strongly supports that many patients are spiritual and utilize their religious beliefs and practices to help them cope with health related crisis.[74]

WHO recognizes spirituality as an important dimension in quality of life, while NANDA includes spiritual distress, or as they define it, "distress of the human spirit," as a valid medical diagnosis associated with proven negative impact and risk upon patient health.[75] Findings such as these have resulted in JCAHO, the Joint Commission on Accreditation of Healthcare Organizations to mandate special assessment for patients

---

[69] Gary Berg, Norman Fonss, Arthur Reed, and Larry VandeCreek, "The impact of Religious Faith and Practice on Patients Suffering From a Major Affective Disorder: A Cost Analysis," *Journal of Pastoral Care 49*(4) (1995): 359-363.

[70] George Fitchett, Bruce Rybarczyk, Gail DeMarco, and John Nicholas, "The Role of Religion in Medical Rehabilitation Outcomes: A Longitudinal Study," *Rehabilitation Psychology 44*(4) (1999): 333-353.

[71] Clark, *Addressing Patients'*, 659-670.

[72] King, *Beliefs and Attitudes*, 349-352.

[73] Ibid.

[74] Fitchett, *The Religious Needs*, 320-326.

[75] Kenneth Pargament, Harold Koenig, Nalini Tarakeshwar, and June Hahn, "Religious Coping Methods as Predictors of Psychological, Physical, and Spiritual Outcomes Among Medically Ill Elderly Patients: A Two-year Longitudinal Study," *Journal of Health Psychology 9*(6) (2004): 713-730.

entering into any approved facility.[76] Unfortunately, the mandate does not require a pastor or spiritual professional to administer such an assessment. There also are no documentation procedures or assessment content specified in the mandate.[77] The Joint Commission does suggest that "As with any other kind of assessment, staff members conducting a spiritual assessment should be competent to do so."[78] With that said, most facilities tend to utilize nothing more than a basic intake-screening questionnaire to fulfill the mandate. No formal theological training is required of medical clinicians who are responsible for spiritual assessments. Although the importance and effectiveness of spiritual assessment has been proven to benefit overall patient health and coping ability, it remains underutilized and underdeveloped in social work[79] and pastoral care. When referring to Social Workers, Bullis notes, "spirituality and social work have much to learn from each other . . . they have been estranged for so long they seem long divorced with irreconcilable differences,"[80] Hospital Social Workers already carry overwhelming patient loads that create time restraints that disallow Social Workers to add spiritual assessment and care responsibilities. It is this author's personal observation and experience that many hospital Social Workers do not view hospital pastors as peers in patient psychosocial care, and many do not believe in the importance of spiritual care. Some are atheist or possess anti-Christian values. This further makes the task of spiritual care more important to pastors and patients.

---

[76] Joint Commission, "Evaluating Your Spiritual Assessment Process," *The Source 3*(2) (2005): 6-7.

[77] Ibid.

[78] Ibid.

[79] Mark Mattaini and Stuart Kirk, "Assessing Assessment in Social Work," *Social Work 36*(3) (1991): 260-266.

[80] Ronald Bullis, *Spirituality in Social Work Practice* (Denver: Love Publishing, 2009), 1*ff.*

Pastors need to ascertain what the patient is experiencing and feeling in order to stay connected to their emotional and spiritual pain. Acknowledging and understanding a patient's belief system as it relates to their illness can be a healing factor in their life. Missing these dynamics can leave the person cut-off from the ministry you are seeking to provide. Not assessing beliefs can also create conflicting agendas between the patient and pastor, hampering communication and understanding.

Formal spiritual assessment helps improve communication and understanding. Spiritual assessment tools have proven to be predictive of health outcomes,[81] reveal patient ability to cope, and identify spiritual distress. Assessment tools are useful in identifying useful intervention, while helping to develop pastoral authority and patient trust,[82] and provide pastors with deeper understanding of a person's faith and belief as they relate to the current issues of hospitalization. Jesus Christ said, *I have come into the world as a light, so that no one who believes in me should stay in darkness,"*[83] and the writer of Psalm 119 wrote, *"Your word is a lamp for my feet and a light for my path."*[84] Professional hospital ministers are skilled at eliciting stories that "evoke self understanding and creativity, and sometimes . . . bring light into the paths we travel in life."[85] When utilizing spiritual assessment tools, pastors are able to navigate patients to

---

[81] William R. Miller, *Integrating Spirituality Into Treatment: Resources for Practitioners* (DC: American Psychological Association, 1999), 47-64.

[82] Muncy, 44-45.

[83] John 12:46 (NIV)

[84] Psalm 119:105 (NIV)

[85] Linda Henry and James Henry, *Reclaiming Soul in Health Care: Practical Strategies for Revitalizing Providers of Care* (Chicago: AHA Press, 1999), 52.

diagnosis and intervention, just as having a lamp in a dark unfamiliar place makes it easier to navigate away from danger and towards safety.

However, determining spiritual distress can be elusive, even to the patient. Likewise, "A valid spiritual assessment tool has been as elusive as a definition is spirituality itself. The drive for clinical excellence and accountability in healthcare combined with a need for measurement and quality of care, naturally leads to the question of assessment."[86] Everly effectively synthesizes the need for spiritual assessment as follows:

> Having an assessment algorithm will guide interventionists in making statements that connect with the impaired individual to whom they are speaking. Without such a method of discernment, the well-meaning interventionist may default to whatever seems familiar in their primary professional identity as peer, clergy member, or therapist and respond to initial spiritual cries of distress and disturbing comments of a crisis of faith with comments that miss the mark.[87]

Spiritual assessment tools identify and clarify strengths and weaknesses as they relate to current coping ability and spiritual distress in patients. A majority of patients in the United States believe spiritual health is just as important as physical health and believe it is important to receive spiritual care while hospitalized. Studies prove the correlation between spiritual beliefs and practices with improved health and coping. The medical industry acknowledges that spiritual well being is an important aspect of holistic healing and is requiring spiritual screening of patients. A majority of pastors and chaplains admit to not using spiritual assessment tools to ensure proper intervention even though they acknowledge the need for them.

---

[86] Tom Gordon and David Mitchell, "A Competency Model for the Assessment and Delivery of Spiritual Care," *Palliative Medicine 18*(7) (2004): 646-651.

[87] George Everly, *Pastoral Crisis Intervention* (Ellicott City: Chevron Publishing, 2007), 26-27.

CHAPTER TWO

THE RESEARCH

Research to Validate the Problem

Spiritual assessment has accumulated an impressive body of empirical data documenting a wide range of patient benefits. These benefits include, but are not limited to, coping ability,[1] realization of personal strengths,[2] self-esteem,[3] mental health,[4] recovery from divorce,[5] sexual assault,[6] substance abuse,[7] and more.

The results of one study, "Needs of Hospitalized Patients" published in Health Science Journal[8] conducted international bibliographical research from review and research literature regarding hospitalized patient needs over a recent five-year period. According

---

[1] Pargament, *Psychology of Religion,* 71-132.

[2] Kenneth Maton and Deborah Salem, "Characteristics of Empowering Community Settings: A Multiple Case Study Approach," *American Journal of Community Psychology 23*(5) (1995): 631-656.

[3] Ellison, *Religious Involvement,* 1027-1055.

[4] Larry Ventis, "The Relationship Between Religion and Mental Health," *Journal of Social Issues 51*(2) (1995): 33-48.

[5] Irene Nathanson, "Divorce and Women's Spirituality," *Journal of Divorce and Remarriage 22*(3/4) (1995): 179-188.

[6] James Kennedy, Robert Davis, and Bruce Taylor, "Changes in Spirituality and Well Being Among Victims of Sexual Assault," *Journal for the Scientific Study of Religion 37*(2) (1998): 322-328.

[7] John Muffler, John Langrod, and David Larson, "There is a Balm in Gilead: Religion and Substance Abuse Treatment," In *Substance Abuse: A Comprehensive Textbook,* 2d Edition, eds. And Joyce Lowinson, Pedro Ruiz, Robert Millman (Baltimore: Williams and Wilkins, 1992), 584-595.

[8] Maria Polikandrioti and Miriana Ntokou, "Needs of Hospitalized Patients," *Health Science Journal 5*(1) (2011): 15-22.

to the result of that study, assessment is necessary because "patients' need" is a dynamic concept that changes over time and disease progression . . . and the view of patient need varies according to the spiritual and cultural traditions of the patient." The findings continue, "Not assessing patient needs of hospitalized patients exerts a negative influence on the outcome of the disease and imposes a tremendous financial burden on the National Health System in each country."[9] It further suggests that not assessing spiritual needs leads to a loss of information . . . poor communication . . . less patient compliance and behavior modification necessary for secondary prevention . . . all negatively affecting the outcome of the disease.[10]

Another study, *"Beliefs and Attitudes of Hospital Inpatients about Faith Healing and Prayer"* published in Journal of Family Practice[11] interviewed more than 200 family practice adult inpatients at two hospitals regarding their views on the relationship between religion and health. The conclusion of this study is that "it supports the hypothesis that although many patients desire more frequent and more in-depth discussions about religious issues with their physicians, physicians generally do not discuss these issues with their patients." [12] The study revealed that patients want medical staff involvement in spiritual issues. Approximately 77% said physicians should consider patients' spiritual needs, 37% wanted their physicians to discuss religious beliefs with

---

[9] Ibid.

[10] Ibid.

[11] King, *Beliefs and Attitudes*, 349-352.

[12] Ibid.

them more frequently, and 48% wanted their physicians to pray with them. However, 68% said their physician had never discussed religious beliefs with them.[13]

In another significant study, *"Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill,"* a majority of patients indicated that they want their physicians to ask whether patients have spiritual or religious beliefs that would influence their medical decisions if they became gravely ill.[14] Another study, *"A Survey of Physicians and Patients,"* found that 40% of patients felt that physicians should discuss pertinent religious issues with their patients, however only 11% of physicians do.[15]

One research study that offers insight into the contrast between patient desire for physician involvement, with the fact that such a small percentage of physicians show concern and or discuss patient spiritual concerns, is the *"Religious Beliefs and Practices in Family Medicine"* study.[16] The survey conducted a consecutive sample of 380 family medicine clinic outpatients and 31 family medicine faculty and medical residents to determine whether religious beliefs and behaviors of family medicine outpatients differed from those of their physicians, as well as whether religiousness affects patient expectations of their physicians regarding religious matters. The study reported that physicians are less likely than patients to hold intrinsic religious attitudes, less likely to

---

[13] Ibid.

[14] John Ehman, Barbara Ott, Thomas Short, Ralph Ciampa, John Hanson-Flaschen, "Do Patients want Physicians to Inquire about their Spiritual or Religious Beliefs if they Become Gravely Ill?," *Archives Internal Medicine 159* (1998): 1803-1806.

[15] Todd Maugans and William Wadland, "Religious and Family Medicine: A Survey of Physicians and Patients," Journal of Family Practice 32 (1998): 210-213.

[16] Osamu Oyama and Harold Koenig, "Religious Beliefs and Practices in Family Medicine," *Archive Family Medicine 7* (1998): 431-435.

pray privately, and less interested in knowing patient religious beliefs. The study concluded that patients were more likely to be interested in religious beliefs of their own physician.[17]

Not all is lost regarding physician spirituality however. *"Spiritual and Religious Beliefs and Practices of Family Physicians: a National Survey"* is a survey conducted to assess physician core-beliefs.[18] The study performed through a random sample included the mailing of an anonymous survey to active members of the American Academy of Family Physicians who had the self-designated professional activity of direct patient care. Physicians reported their religious and spiritual beliefs and practices, including frequency of religious service attendance and private prayer or spiritual practice, and self-reported intrinsic or subjective religiosity. Less than 5% of physicians stated they do not believe in God, while nearly 80% reported a strong religious or spiritual orientation. [19]

Another survey reported in *"Addressing Spiritual Concerns of Patients: Family Physicians' Attitudes and Practices"*[20] polled 231 physicians, providing them with the *"Ellison Spiritual Well-Being Scale."* Of respondents, 96% consider spiritual well-being an important health component and 86% support referring hospital patients with spiritual questions to chaplains. Less than 20% report discussing spiritual topics with patients. Further, 71% of physicians cited barriers to addressing spiritual issues as time restraints, 59% cited inadequate training, and 56% found it difficult to identify patients with spiritual issues. The conclusion is that most physicians believe spiritual well-being is an

---

[17] Ibid.

[18] Timothy Daaleman and Bruce Frey, "Spiritual and Religious Beliefs and Practices of Family Physicians: A National Survey," *Journal of Family Practice 48*(2) (1999): 98-104.

[19] Ibid.

[20] Ellis, 105–109.

important factor in health, however, most report infrequent discussion with patients for reasons cited. Most believe in referring patients to chaplains, but admit that they do so infrequently. The report provides insight into the challenges of elevating spiritual assessment values among hospital staff and reveals the greater need for pastors and chaplains to assess patient spiritual needs and work closely with hospital support staff to ensure more holistic patient care.

Original Work

Original research consists of a multiple-choice survey. The questionnaire specifically directs towards attitudes and opinions regarding pastoral hospital visitation. Questions and answer reflect also the process and perception regarding hospital visits by polled individuals. The survey is posted on SurveyMonkey.com and is accessible only to those individuals who are invited and posses the coded link. The survey consists of thirty multiple-choice questions specific to pastoral hospital visitation. The survey compares and contrasts more than 600 responses from individuals currently serving as ministers, regardless of experience level, age, sex, or denomination. Classification of ministry roles for the purpose of this study include: Chaplain, Senior Pastor, Associate Pastor, and Lay Minister. A copy of the Pastoral Hospital Visitation and Chaplaincy Survey questionnaire is included as “Appendix A” in this work.

Statement of Limitations

All questionnaire surveys possess inherent advantages and disadvantages. Some of the advantages of utilizing a web-based survey platform include, but are not limited to, less restriction of geographical responses, more convenience to participants, facilitate

larger number of responses, wider available demographic, more standardized and reliable format, flexibility to analysis, and easier, more reliable analyzing of large data-sets.

Some disadvantages include, but are not limited to potentially lower validity in areas of affective variable with closed-ended questions, reliability questions resulting from participant motivation, dependence upon participant memory and or ability to respond, and subjectivity of the participant.

A limitation of the survey includes the subjectivity of the person preparing the survey. Great effort is dedicated to the integrity of preparing and analyzing the survey however, conscious and or unconscious bias exist that can influence the results of the data in an immeasurable way. Participants also possess conscious and unconscious bias that that can influence the results of the data in an immeasurable way. Participants may respond in a manner that is relative only during the time of completing the questionnaire and be relative only to a personal abstract notion regarding question choice when answers include the measure using words such as slightly, very, somewhat, and much.

Survey responses are also limited to protestant respondents who primarily subscribe to the Southern-Baptist faith tradition. A majority of data received in this project come from members of the North American Mission Board, Southern-Baptist ministers, and students and graduates from Liberty University Doctoral and master programs. There is also a majority response from N.A.M.B. endorsed chaplains.

Terms and Definitions

Associate Pastor: An associate pastor is someone who works within or is in charge of a specific ministry. The ministry can be classified as “Care Ministry,” Singles Ministry,” “Music Ministry,” Small-Groups Ministry,” “Singles Ministry,” “Senior Ministry,” etc.

Associate pastors may assist senior pastors and or perform duties the senior pastor cannot perform. Associate pastors may work full or part-time, as employees or as volunteers. Associate pastors may or may not have a seminary degree. Associate pastors typically receive commissioning or ordination as pastors by their local congregation, and or denomination.

Association for Clinical Pastoral Education (A.C.P.E.): The Association for Clinical Pastoral Education, Inc. (ACPE) is a multicultural, multi-faith organization devoted to providing education and improving the quality of ministry and pastoral care offered by spiritual caregivers of all faiths using the clinical educational methods of Clinical Pastoral Education. It is nationally recognized as an accrediting agency in the field of clinical pastoral education by the U.S. Secretary of Education through the U.S. Department of Education."[21]

Association of Professional Chaplains (A.C.P.): "The Association of Professional Chaplains is a multi-faith non-profit organization of chaplaincy care providers endorsed by faith groups to serve persons in need, respecting their individual cultures and beliefs, in diverse settings throughout the world."[22] They are one of the major organizations responsible for board certification of hospital chaplains in the United States.

Chaplain: According to Dictionary.com, a chaplain is a person who says the prayer, invocation, etc., for an organization or at an assembly.[23] The chaplains identified in this survey are individuals who currently work as professional clergy within hospital,

---

[21] "The Association For Clinical Pastoral Education, Inc.," The Association for Clinical Pastoral Education, Inc., http://www.acpe.edu/ (accessed June 22, 2012).

[22] "Association of Professional Chaplains," Association of Professional Chaplains, http://professionalchaplains.org (accessed June 22, 2012).

[23] "Chaplain," *Dictionary.com Unabridged*, http://dictionary.reference.com/browse/chaplain (accessed July 22, 2012).

military, government, disaster relief, or other institutional setting. The role of clergy is to provide pastoral presence and care to individuals experiencing trauma, crisis, medical challenges, and or spiritual distress.

Clinical Pastoral Education (C.P.E.): C.P.E. is education provided by supervisors certified by The Association for Clinical Pastoral Education, Inc. The total C.P.E. process consists of two level one units and two level two units. Each unit consists of four hundred hours. One-hundred of these hours consist of didactic training within a small group of other students, usually up to six. The other three-hundred hours consists of experiential training as an intern interacting with patients. Training may only be performed using approved teaching agenda by an approved supervisor within an approved institution, such as a hospital, hospice, etc.

Crisis Intervention: Crisis intervention is emergency psychological care aimed at assisting individuals in a crisis-situation in order to restore equilibrium and or homeostasis to their bio-psychosocial functioning and to minimize the potential for psychological trauma.[24] [25]

End of Life Visit: End of life visits refer to pastoral visits to patients who are actively dying. During end of life visits, the patient may be dying at the very moment of the visit, or has the expectation of dying within days, weeks, and or months. The time at the end of life is different for each person. Each individual has unique needs for information and support.[26]

---

[24] Lisa Jackson-Cherry and Bradley Erford, *Crisis Intervention and Prevention* (Upper Saddle River: Prentice Hall, 2010), 1-24.

[25] Donna Aguiuera, *Crisis Intervention: Theory and Methodology* (Philadelphia: Mosby, 1998), 26-42.

[26] "End-of-life Care For People Who Have Cancer," National Cancer Institute Fact Sheet, http://www.cancertopics/factsheet/support/end-of-life-care (accessed June 22, 2012).

F.I.C.A. Spiritual History Tool: The acronym represents a group of assessment questions regarding **F**aith and Belief (Are there spiritual and religious beliefs?), **I**mportance (How important are those beliefs?), Community (Are you part of a spiritual or religious community?), and **A**ddress in care (How would you like spiritual and religious issues integrated into your care?). Dr. Pulchalski and a group of primary care physicians developed the F.I.C.A. Spiritual History tool to help healthcare professionals address spiritual issues with patients.[27] There is further discussion in chapter four of this project.

H.O.P.E. Assessment Tool: The mnemonic represents a group of assessment questions regarding the patient's sources of **H**ope, whether the patient is involved in **O**rganized religion, the patient's spiritual **P**ractices, and the **E**ffects of medical care and End of life issues. The H.O.P.E. questionnaire was developed by Gowri Anandarajah and Ellen Hight.[28] There is further discussion in chapter four of this project.

Lay Minister: Lay ministers perform ministry functions without ordination. Lay ministers tend to be members of a church congregation or denomination, called into ministry that is specific to their gifts and abilities. They tend to be volunteers who work in careers apart from their church or ministry. Lay ministers perform duties that serve their congregation, denomination, and or local community.

Non-Christian: A person is non-Christian when they do not believe is Christ as Lord and Savior, and or maintains a belief system or faith tradition outside of Christianity or in contrast or opposition to Christianity.

---

[27] Christina Puchalski, "Spiritual Assessment Tool," *End of Life Care 1*(6) (1999): 1-2.

[28] Gowri Anandarajah and Ellen Hight, "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment," *American Family Physician 63*(1) (2001): 81-88.

North American Mission Board (N.A.M.B.): North American Mission Board serves as the mission agency of the Southern Baptist Convention. This organization screens, trains, equips, and finances missionary, chaplaincy, church plant, and other mission and evangelism based efforts. N.A.M.B. also conducts continuing education for pastors, chaplains, missionaries, etc.[29]

Psychosocial training: The medical definition of "psychosocial," is "Involving aspects of both social and psychological behavior."[30] Psychosocial training includes understanding and recognizing the symptoms and affects of psychosocial issues, as well as methods of conducting psychosocial intervention.

Senior Pastor: Depending upon the size and needs of the congregation, the senior pastor may or may not be the only seminary educated and or ordained pastor on staff. The senior pastor tends to preach, teach, equip membership, and may be responsible for administration. For the purpose of the survey, the senior pastor's primary ministry function is not centered-around pastoral hospital visitation.

Spiritual Assessment: See chapter entitled, "Spiritual Assessment."

Survey Monkey: Survey Monkey is a private company that offers web-based survey solutions to its membership. Survey Monkey's mission is, "To set research free. Everyone deserves easy access to the information they need to make better decisions, and budgets . . . timelines and logistics should not get in the way. Survey Monkey is a cost-effective and modern alternative to traditional market research."[31]

---

[29] "North American Mission Board," http://www.namb.net (accessed June 24, 2012).

[30] "Psychosocial," *Dictionary.com Unabridged*, http://dictionary.reference.com/browse/psychosocial (accessed July 22, 2012).

[31] "Survey Monkey," http://www.surveymonkey.com (assessed February 08, 2012).

Method of Research

The development of the questionnaire used in the survey results from personal experience and consultation with other pastors experienced in pastoral hospital visits and chaplaincy. The goal of the questionnaire is to compare and contrast responses between chaplains, senior pastors, associate pastors, and lay ministers. The hope of the questionnaire is also to reveal any potential areas of concern regarding the process, knowledge, training, and attitudes of ministers regarding pastoral hospital visitation.

The questions reveal information in the following areas:

A. Experience level making pastoral hospital visits.
B. Training level making pastoral hospital visits.
C. Knowledge and training level in the areas of psychosocial science, crisis intervention, grief, and counter-transference issues.
D. Comfort level and attitude regarding specific types of hospital visits, including death and dying, children, Christian, and non-Christian.
E. Experience surrounding anxiety, depression, strong negative feelings, burnout, and or counter-transference issues. A recent survey of 1,050 pastors shows that 71% of pastors experience either burnout or battle depression beyond fatigue on a weekly and even daily basis.[32]
F. Type of pastoral hospital visits causing strong negative feelings, challenge, and or discomfort.

[32] Richard Krejcir, "Statistics on Pastors: What Is Going On with the Pastors in America?" Schaeffer Institute, http://www.intothyword.org/articles_view.asp?articleid=36562 (accessed July 30, 2012).

The completed, uploaded survey passed testing at the Survey Monkey website prior to its launch for participation. The survey was completed a number of times to check for potential issues. Final data analysis does not include deleted test responses.

Potential candidates for participation in the survey were located via personal contact by telephone and email, as well as by referral from others. Using email and telephone, I contacted fellow pastors and fellow Liberty University students and invited them to participate in the survey. Those contacted received a request to forward the survey invitation to other pastors in an effort to gain more extensive sampling. Other participants in the survey resulted from assistance received from the North American Mission Board. On April 03, 2012, N.A.M.B. sent an email to its 3,500 plus member chaplains requesting participation in the survey. A copy of the email is included in this project, marked Appendix B.

Research Outcome

Of the 600 plus responses, 91% are male, leaving 9% as female. Nearly 22% of responses come from senior pastors, nearly 10% associate pastor, over 10% lay minister, and approximately 58% chaplain. More than 59% of responders have worked more than ten-years in their current ministry. Less than 4% of responders indicate that they never make pastoral hospital visits. Approximately 70% of responders indicate that they make hospital visits, daily, monthly, and or several times monthly. Approximately 27% indicate that they make between one and four pastoral hospital visits annually.

Less than 1% of responders indicate that they received any type of pastoral hospital visitation training while in seminary. Only 2% indicate receiving no training. A recent survey of 1,050 pastors shows that 75% feel unqualified and or poorly trained by

their seminaries.[33]Among the responding chaplains, over 50% reported receiving some level of C.P.E. training in addition to denominational training and or training through their home church. Among the responding senior pastors, 73% indicate their only training is through denominational training and or their home church. The same is true for 63% of associate pastors and 57% of lay ministers. Nearly 7% of associate pastors and over 13% of lay ministers have received no training. At the same time, 55% of associate pastors and 76% of lay ministers state that they believe some sort of training prior to making hospital visits is important and or very important.

More than 20% of all respondents report having no psychosocial training. Within the survey, a larger number of responders, 32% have read journal articles and or books in an effort to self-train in the area of psychosocial issues. Nearly 20% of chaplains have received psychosocial training specific to hospital visitation, and 20% have completed professional psychosocial training and or certification. Approximately 27% of senior pastors, 18% of associate pastors, and 31% of lay ministers have received no psychosocial training. Although pastors tend to be frontline responders to emotional and spiritual problems, a survey found that pastors possess limited psychosocial and or counseling training . . . oftentimes, these pastors address serious problems similarly seen by secular mental health professionals.[34]

Among the responding chaplains, 94% report that they are familiar with the stages of grief, with 40% reporting they are very familiar with the stages of grief. Among the responding senior pastors, 34% report that they are only somewhat or not at all familiar

---

[33] Ibid.

[34] John R. Peteet, *Depression and the Soul: a Guide to Spiritually Integrated Treatment* (New York: Routledge, 2010), 173.

with the stages of grief. The same is true for 30% of associate pastors and 37% of lay ministers.

Chaplains were more likely to visit individuals outside of their church membership and or congregations. Over 68% of chaplains make more than 75% of their pastoral hospital visits to people outside of their congregations. To contrast, 54% of senior pastors, 55% of associate pastors, and 21% of lay ministers make between 75 and 100% of their pastoral hospital visits to members of their congregation. Lay ministers are more likely to visit non-members and less likely to visit non-Christians than are associate pastors, chaplains, and senior pastors.

Chaplains are most likely and lay minister least likely to visit non-Christian patients. Among the responding lay ministers, 51% report that at least 95% of their hospital visits are to members of their congregation. The same is true for 32% of senior and associate pastors and 15% of chaplains. Among the responding senior pastors, 7% report that no more than 50% of their hospital visits are to non-Christian patients. The same is true for 3% of lay ministers, 5% of associate pastors, and 32% of chaplains.

Among all respondents, 75% report limiting hospital visits to an average of ten to thirty minutes each. Senior pastors are most likely to make longer hospital visits. Across the board, 46% indicate that they make an average of between one and two hospital visits per hospitalization. Among all respondents, 36% indicate that they visit patients as many times as is necessary during each hospitalization.

When surveyed about what the primary agenda is for making pastoral hospital visits, 22% report that it is to provide comfort, 41% cite that it is to provide a pastoral presence, and 14% indicate that it is to provide ongoing counseling and support. Senior

pastors, associate pastors, and lay ministers are seven times more likely to make pastoral hospital visits with the agenda of being a friend.

Lay ministers (73%) are less likely to encounter end-of-life visits. Among the responding chaplains, 64% report having made more than five end-of-life visits, with more than 60% of senior and associate pastors making more than five end-of-life visits.

Overall, more than 53% indicate that they keep no records or notes of their hospital visits. Among responding senior pastors, 74% report keeping no notes, however 13% report filing some form of basic hospital visitation report with their church. Nearly 10% of chaplains keep personal record and or notes and 22% make notes in hospital charts.

Over all, 71% of respondents believe that personal life experiences significantly influence their pastoral hospital visits, with 20% believing that personal life experiences only slightly influences their pastoral hospital visits. More than 90% of all respondents indicate that their beliefs significantly influence their pastoral hospital visits. Surprisingly, more than 60% claim never to have experienced loss of sleep or appetite or felt down or depressed for more than one day following difficult hospital visits. Over 30% indicate that they occasionally experience loss of sleep or appetite or felt down or depressed for more than one day following difficult hospital visits.

Overall, more than 8% of respondents indicate that they have no support system for debriefing, and or decompressing following difficult pastoral hospital visits. Among responding lay ministers, 18% report having no support system whatsoever for debriefing and or decompressing following difficult pastoral hospital visits. More than 40% of responders indicate that their support system for debriefing and or decompressing

following difficult pastoral hospital visits is a spouse or family member. Nearly 12% of senior and associate pastors depend upon a friend for support and 24% find support from another person who also makes regular pastoral hospital visits.

When surveyed about training in crisis intervention, 42% of senior pastors, 48% of associate pastors, and 42% of lay ministers possess little or no crisis intervention knowledge and or training. Rogers believes that when pastors attempt to minister beyond their level of expertise, they are overstepping boundaries based on trust, and they are exploiting the parishioners vulnerability.[35] Among responding chaplains, 72% report that they have received specialized certification in critical incident stress debriefing, and or emergency stress management.

When surveyed about the use of formal spiritual assessment tools, 77% report not using them when making hospital visits. This contrasts with the fact that only 3% reported that assessment tools are not important, and 80% or all respondents reporting that assessment is important, and or very important when making pastoral hospital visits.

It is satisfying to see that nearly 90% of all respondents believe it is best to keep information about pastoral hospital visits confidential unless specifically authorized by the patient or family to share it with others. Additionally, 20% of associate pastors, 14% of senior pastors, and 10% of lay ministers believe it is best to share pertinent information with relevant church employees. A matter of potential concern is that 7% of senior pastors, 3% of lay ministers, and 2% of associate pastors believe it is best to share as much information as possible with everyone in the church so they can be praying for them.

---

[35] Dal′ene C. Fuller Rogers, *Pastoral Care for Post-Traumatic Stress Disorder: Healing the Shattered Soul* (New York: Routledge, 2002), 91-92.

Areas of Concern

One area of concern is that less 1% of responders indicate that they received any type of pastoral hospital visitation training while in seminary. The percentage of seminary graduates in unknown. However, a majority of responders have endorsements from N.A.M.B., A.C.P.E., and A.P.C., all of whom require a seminary degree. According to Shoko, in most instances pastors lack skills in counseling because theological training does not address the issues of today.[36] This author encourages that further research be done in this area to help gain a better understanding of how much or how little seminary students are prepared for making pastoral hospital visits.

Nearly 7% of associate pastors and over 13% of lay ministers have received no training. At the same time, 55% of associate pastors and 76% of lay ministers state that they believe some sort of training prior to making hospital visits is important and or very important.

Approximately 27% of senior pastors, 18% of associate pastors, and 31% of lay ministers have received no psychosocial training. To contrast this, less than 5% of responders report a belief that training is not at all important, while 72% report a belief that training is important and or very important. Foley suggest that when dealing with patient end of life issues, guidelines should include care that integrates the treatment of both physical symptoms and distress in the psychosocial, spiritual, and religious domains, recognizing their interrelatedness.[37]

---

[36] Munyaradzi Shoko, *The Role of Men in Hiv and Aids Management* (Bindura: GRIN Verlag, 2011), 16.

[37] Kathleen M. Foley, Hellen Gelband, and editors, *Improving Palliative Care for Cancer* (Washington, D.C.: National Academies Press, 2001), 199.

Overall, more than 53% indicate that they keep no records or notes of their hospital visits. Among responding senior pastors, 74% report keeping no records or notes of hospital visits, while 13% file a basic hospital visitation report with their church. Nearly 10% of chaplains keep personal record and or notes and 22% make notes in hospital charts. Among all respondents, 8% report having no support system in place for debriefing and or decompressing following difficult pastoral hospital visits. The same is true for 18% of lay ministers. This fact becomes more troubling when coupling it with the fact that these are the least likely ministers to have received any type of training.

Although only 3% do not believe assessment tools are important and nearly 80% report that assessment is important or very important, 77% still do not utilize, or only sometimes utilize some form of spiritual assessment tool when making hospital visits.

Another matter of potential concern is that 7% of senior pastors, 3% of lay ministers, and 2% of associate pastors believe it is best to share as much information possible with everyone in the church so they can be praying for them. Except for cases when breach of confidentiality is mandatory in matters of saving life, reporting injury, and or threatened injury or harm, breach of confidentiality is a major boundary violation.[38]

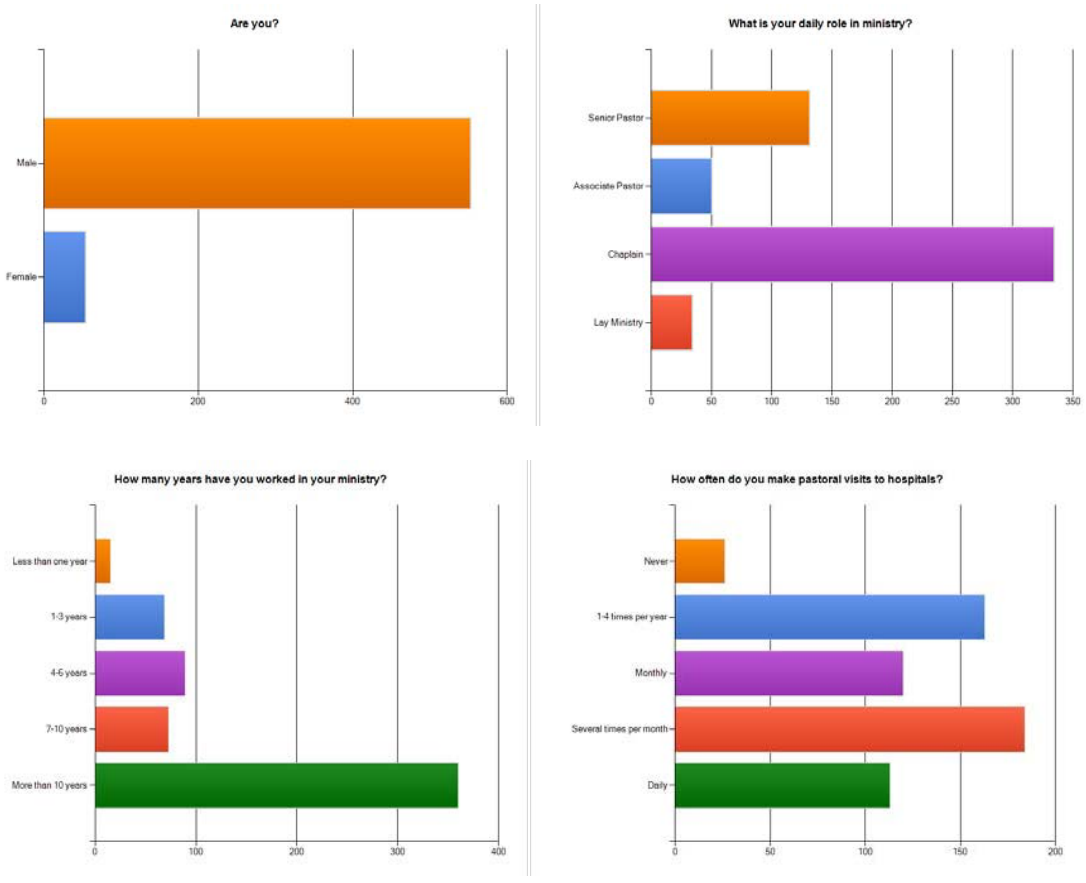
One of the more challenging questions on the survey asks responders to identify specific visit types they have found to be challenging and or have caused them to experience strong negative feelings. For whatever the reason, 55% did not respond to this questions, and or selected the 'does not apply response.' The 45% who answered this question experienced challenges and or strong negative feelings when visiting in the following percentages, with the following patient visit types:

---

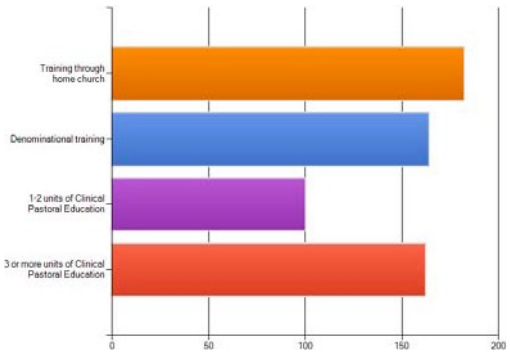
[38] Rogers, 91.

1. 15-20%: when making visits to someone actively dying
2. 16%: when making visits to someone of a different faith tradition
3. 14%: when making visits to someone abusing drugs or alcohol
4. 10%: when making visits to someone who is a criminal
5. 10-13%: when visiting homosexual identified patients
6. 30%: when visiting a person suspected of child abuse

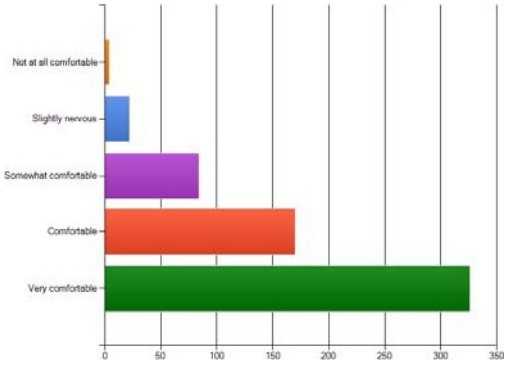
Graphical Depiction of Overall Original Research Data



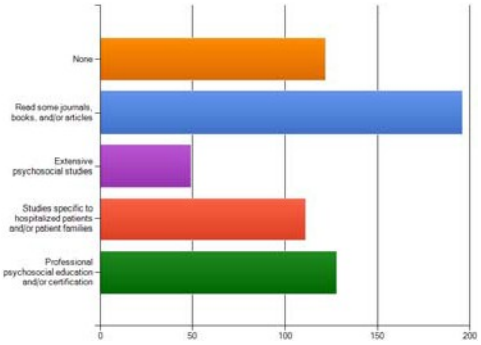
What 'YP* of traTning did you te tv to prep.are you tor pastoral hospital vi.stts?(Check l..lth<Itappty)



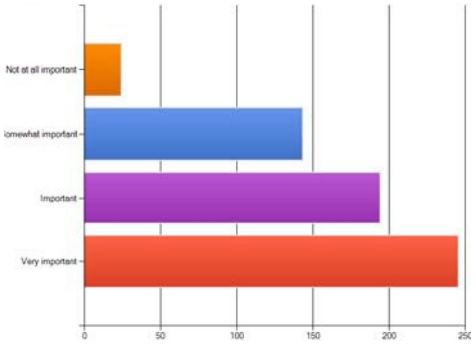
How eornforubat Is it tot you to ma.ke pastoral hospital visitS?



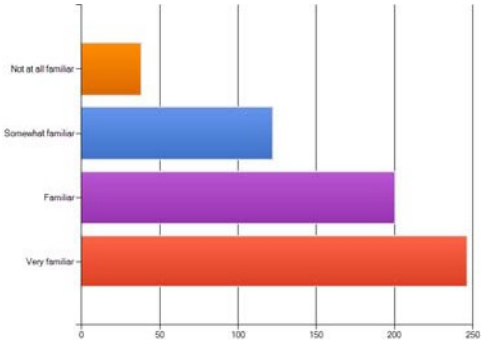
What typeof psychosoctal training have you recelYed?



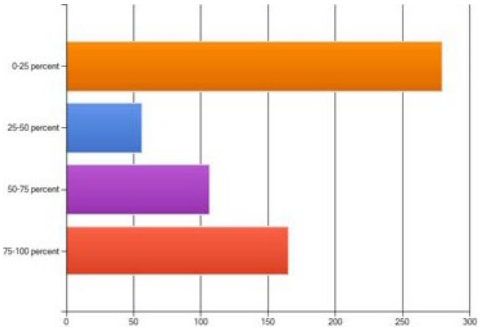
How important isit to have some sortof tninlng pricw to making pastoral hospital visits?



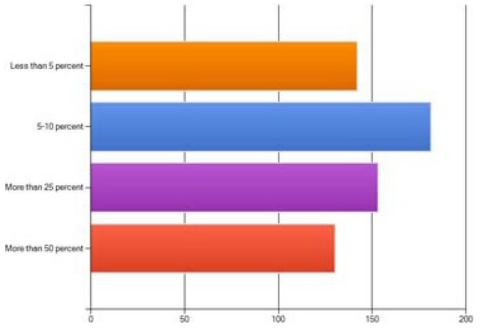
How lamUilt are you with the 6.7 stagesof grief?



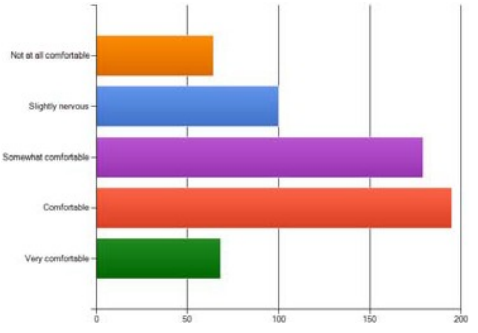
What percentage of patients with whom you make putonll hospltal vlslts are members ofY6lJtd\urd\oreonoreoaf6on?



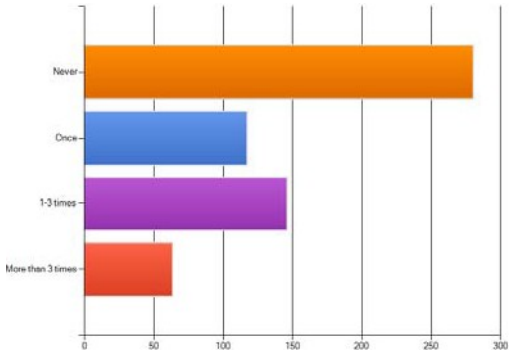
W!Uit percentage of patients wi'th whom you make pastoral hospitalvis.it:s arenon. Ctutst!an?



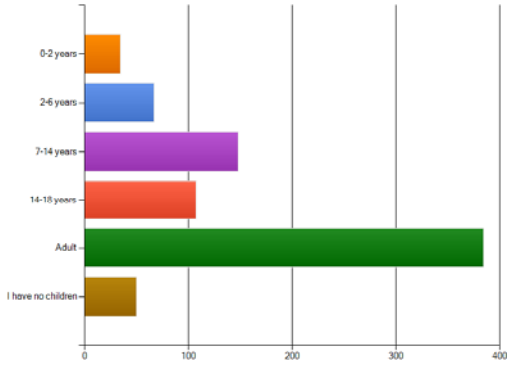
How comfortable isitfor you to make pastonlllo.apital vlsi'lswhen siclk «dying children atlnvotvtdi'



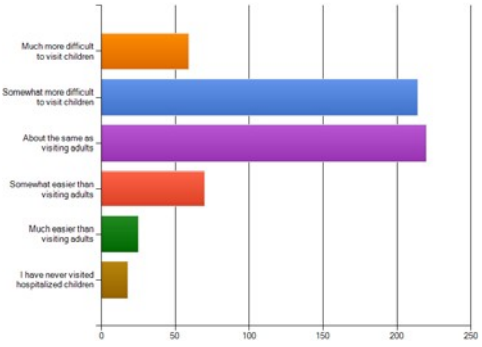
Othtr Nn *tot* l't lthV pre.or\anev lHll'Ytf'V *now* m3tly tiiTIHh: v. *V0V* bHf'll'lu dror th:1n thnH sKU'lived s?



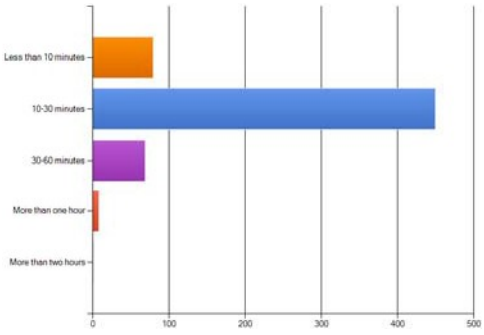
wn.Jt are tlagu ot your e.hldren? (Chck all that apply)



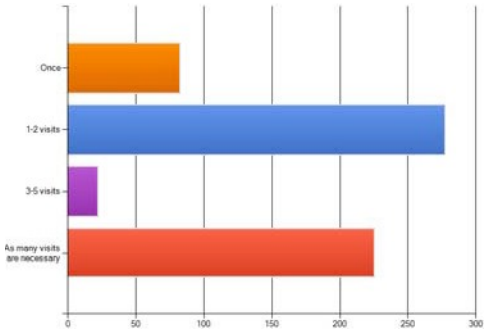
Compared to vlsltlng hospitalized adults, how dil'lku!t Is!t to visit hospitalized children?



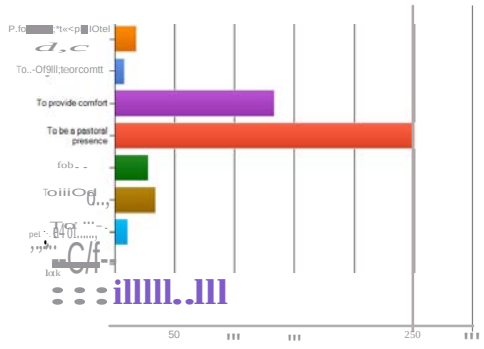
How much time do you typk.ally spend with ▪ pelient and/or patient family during ▪ hosplta! vlsJt?



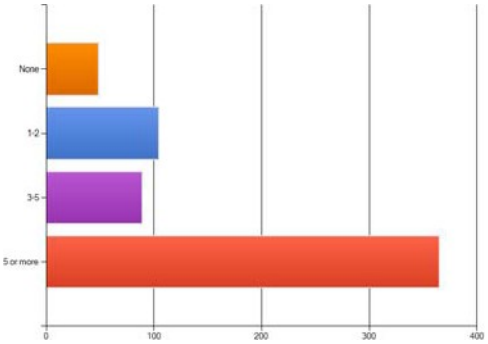
On▪▪en ge, how many tfmes do you vislta pelient and/for petient family during ▪ single MlpltaiiUdol\?



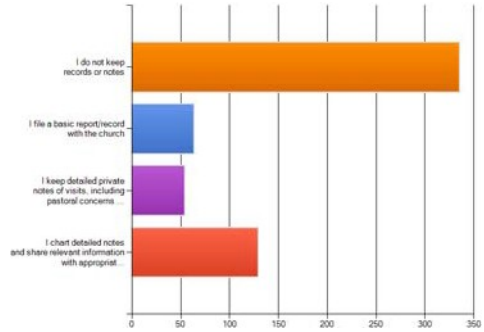
What cSo you be▪ve !s your primary agenda when making pastoral hospital visits?



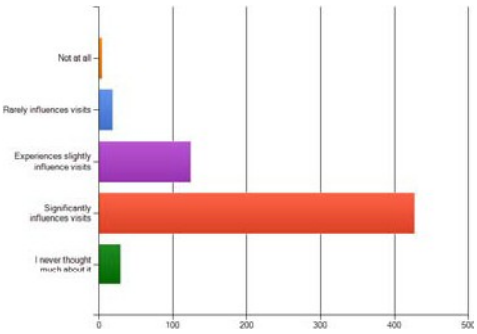
How many End of ure pastofill hospital visits have you made?



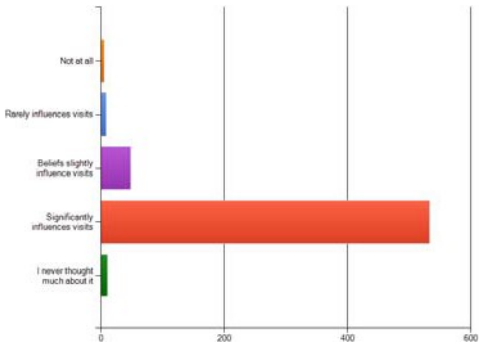
What type of notes *o1* reconfs do you keep When me.klnog putoraJ hospital vlsits? (Check all tlat appty)



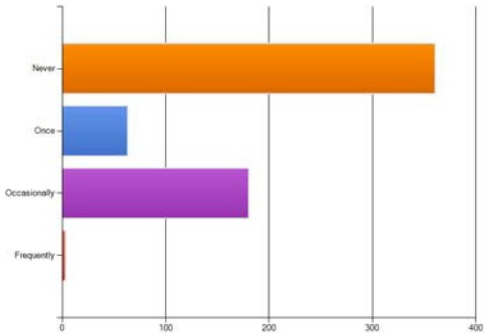
How much doyouthink your personal lifeex:periences lnftu.nceyow pastoral hospitlll viSits?



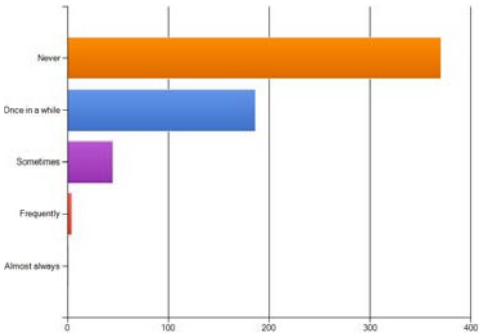
How much do you fe.l your beliefs influence yow putorai ho,pltal Yisits?



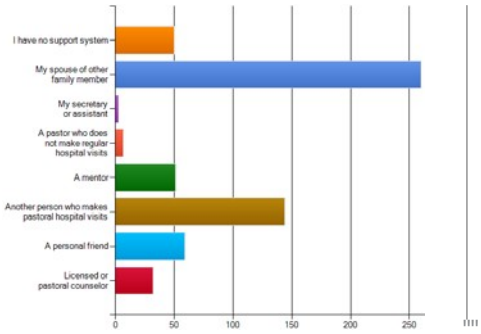
Ot.lringa 'toralho Yl,!l y.....experl - alned l aroJtoly.or OCIitfMttMt tMinos?



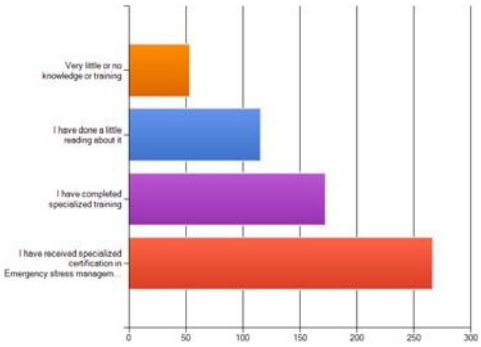
Have you ever experienced loss of sleep or appetite or felt down or depressed for more than one day following difficult hospital visits?



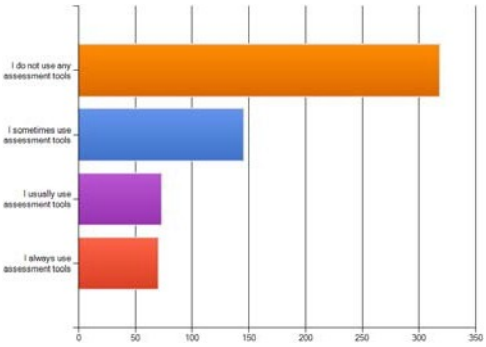
Who Is your primary support fordebriefing andf«decompfessing following diftlcult pastoralitlospl'laJ visitS?



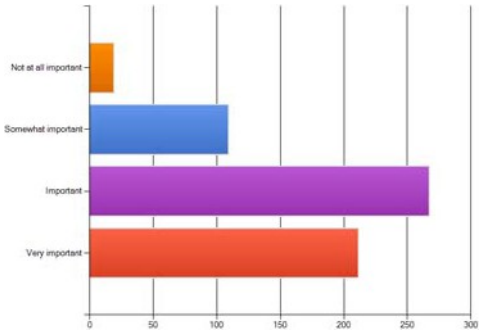
How much knowtedge orlnllnlng doyou h.ave regatdlng crisis and crisis intervenlion?

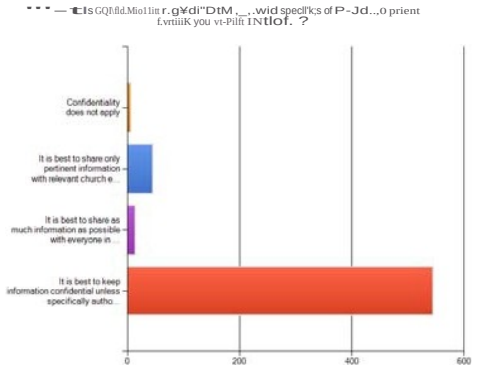


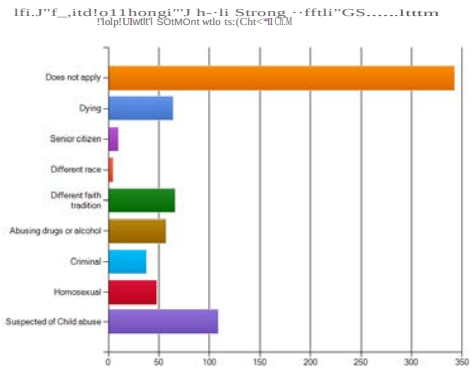
Oo you utllb.e anyof assessment toolfs) when making pastoral hospitlll visits?



HowImport.ntIs paISent and famlty spiritual assessment when makftg pa,toral hospitlll visits?




Confidentiality does not apply
It is best to share only pertinent information with relevant church e...
It is best to share as much information as possible with everyone in...
It is best to keep information confidential unless specifically autho...
0
200
400
600


Does not apply
Dying
Senior citizen
Different race
Different faith tradition
Abusing drugs or alcohol
Criminal
Homosexual
Suspected of Child abuse
0
50
100
150
200
250
300
350

CHAPTER THREE

SPIRITUAL ASSESSMENT: PROCESS, COMPONENTS, AND DEFINITIONS

Process of Spiritual Assessment

It is a positive step that the Joint Commission on Accreditation of Healthcare Organizations mandated member organizations to perform an initial spiritual intake screening of newly admitted patients. There is however, a possible risk of reducing spiritual care to nothing more than a tick-box assessment.[1] The Joint Commission on Accreditation of Healthcare Organizations mandate is for minimum standards stating that spiritual assessment should determine a patient's religious affiliation and any beliefs or spiritual practices important to the patient . . . The assessment should also determine whether more in-depth assessment is necessary.[2] As with any other kind of assessment, staff members conducting a spiritual assessment should be competent to do so. Empirical evidence states that pastors and or individuals possessing expertise in spiritual and religious care should be the ones to perform patient spiritual assessment and care.[3] The most competent person for making spiritual assessment then is a skilled pastor, chaplain, or Lay minister. Even more competent is one who has received specialized training and

[1] Gordon, *Spiritual Care,* 73.

[2] Joint Commission, 6-7.

[3] Randall, 1-29.

experience in assessing spiritual needs of patients. At minimum, there should be a system in place for proper spiritual assessment.

With that said it is hopeful that current spiritual assessment will grow beyond minimum standards of asking patients to identify their faith tradition by simply asking, “What religion are you?” It is important within spiritual assessment to determine patient religious affiliation, if any, but assessment must not stop there. Even patients who do not practice religion or who are anti-religious can possess significant spiritual needs. A proper assessment will help identify those needs and help determine a healthy course of intervention.

It is herein noteworthy that people choose to attend church, but most prefer not to choose becoming hospitalized. Reasons for hospitalization may be many, just as may be spiritual needs. This is why pastors need a system to identify those needs. Physicians who work in a hospital setting utilize differential diagnosis to determine patient needs. Differential diagnosis is a process of evaluating patient symptoms, laboratory findings, specialist reports, and signs, against two or more diseases to determine the most likely cause of the patient’s current condition. In the same way, pastoral care in the hospital setting becomes more about the patient’s need for spiritual care than their desire for spiritual care. A proper spiritual assessment is the pastor’s differential diagnosis tool to help identify those spiritual needs.

Pastors making hospital visits fulfill an important role in patient healthcare when they properly assess and understand patient spiritual needs and beliefs. Spiritual assessment can help determine how patient worldview, unresolved spiritual distress, or other issues affect care and treatment. This will help pastors and healthcare professionals

determine the best course of action to help the patient obtain holistic wellness. Proper assessment needs to be the cornerstone of pastoral care, both in and out of the hospital. The same is true for pastoral counselors. Proper spiritual assessment performed by a pastor is not the same as spiritual screening performed by a clinician or other hospital staff member. Pastors are specialist in their professions, board certified by God, and saints, equipped for God's purposes.

Spiritual Assessment Model

When considering spiritual assessment tools, it is important to understand that hospitalized patients are subject to a diverse range of spiritual needs that are in a constant state of flux. Not only are spiritual needs diverse in the hospital setting, but patients also are diverse. Diversity includes, but is not limited to social, economic, racial, cultural, religious, spiritual, and other diversities. Spiritual assessment should be sensitive to patient diversity by not being judgmental or impose a specific worldview or definition of spirituality upon them. The assessment needs to remain impartial and directed by the patient, with the guidance of pastoral presence, but not by the presumptions of the pastor performing the assessment.

By its very nature, spiritual assessment needs to be a flexible process to enable it to respond to the changing needs of patients and their families.[4] The diversity of hospitalized patient spiritual needs make it unlikely for a "one size fits all" spiritual assessment tool. Mc Sherry and Ross, long-time advocates of such a view, draw together contributions from experienced practitioners to debate spiritual assessment in depth, and conclude that no one tool exists or can be created to hold the answer to all spiritual

---

[4] Gordon, *Spiritual Care,* 76.

assessment needs.[5] For this reason, pastors should familiarize themselves with several different spiritual assessment models and develop a process that fits not only patient needs, but also pastoral style.

Simply following a questionnaire-style assessment tool containing yes and no answers does not constitute spiritual care. Indeed, assessment tools need to be simple and easy to administer, but too narrow an assessment confines the patient and pastor to generalized spiritual issues. They further risk forcing patients to conform their spirituality to the tool. When this happens, the pastor performing the spiritual assessment is disabled. He is no longer able to connect to the patient to conduct a productive assessment driven by the needs of the patient in a manner that results in helpful dialogue towards understanding those needs, and proper intervention. Sometimes, however, even assessment tools make assumptions about the relationship between spirituality and religion that can sidetrack our assessment along religious routes if used rigidly.[6] The fact that assumptions can arise from using spiritual assessment tools makes a point that prior to evaluating and discussing viable spiritual assessment tools and technique, it is important to gain a better understanding of some of the elements of spiritual care. For example, it is important to discuss the difference between spirituality and religion. It is also important to define spiritual distress and describe its symptoms. It even makes sense to have a better definition of spiritual assessment.

---

[5] Wilfred McSherry and Linda Ross (eds.), *Spiritual Assessment in Healthcare Practice* (Keswick: M & K Publishing, 2010), 69*ff.*

[6] Gordon, *Spiritual Care,* 71.

Spirituality and Religion

One definition of spirituality offered is, "a relationship with God, or whatever fosters one's sense of purpose and meaning in life."[7] Psychologists (and others) oftentimes over simplify and or inaccurately consider religion and spirituality to be one in the same,[8] or as Carroll states, "Spirituality and religion are distinct and overlapping concepts, often used interchangeably."[9] Johnson's[10] opinion on the meaning of spirituality and its distinction from religion yields the concession and or acceptance that the concept of spirituality "is almost impossible to define and the usefulness of the work on this subject is overshadowed by the ambiguous, subjective, and often intangible nature of spirituality."[11] Others assert that the multiplicity of definitions cause confusion and dilemma in spiritual care.[12] Some suggest, perhaps there are multiple definitions due to the multifaceted nature of spirituality.

Although definitions vary and oftentimes are subjective and ambiguous, it is clear that the cognitive and or philosophic aspects of spirituality include the search for meaning, purpose and truth in life,[13] and the beliefs and values by which an individual

---

[7] Patricia Sermabeikian, "Our Clients, Ourselves: The Spiritual Perspective and Social Work Practice," *Social Work 39*(2) (1994): 178-183.

[8] Brian Zinnbauer, Kenneth Pargament, Brenda Cole, Mark Rye, Eric Butter, Timothy Belavich, Kathleen Hipp, Allie Scott, and Jill Kadar, "Religion and Spirituality: Unfuzzying the Fuzzy," *Journal for the Scientific Study of Religion 36*(4) (1997): 549-564.

[9] Carroll, 25-34.

[10] C.P. Johnson, "Assessment Tools: are They an Effective Approach to Implementing Spiritual Health Care within the NHS?," *Accident and Emergency Nursing 9*(3) (2001): 177-186.

[11] Ibid.

[12] Wilfred McSherry and Linda Ross, "Dilemmas of Spiritual Assessment: Considerations for Nursing Practice," *Journal of Advanced Nursing 38* (2002): 478-488.

[13] Ellis, 105-109.

lives.[14] Some of the emotional aspects involve inner peace, support, comfort, love, and hope.[15] Fowler uses the word 'faith' as a verb more than a noun, seeing it as a "human universal" that functions so as to screen off the abyss of mystery that surrounds us." Faith "helps us form a dependable 'life space,' an ultimate environment," that gives us hope, a reason for being.[16]

Although many people interchangeably use the word religion and spirituality, the fact is that they are very much different. Spirituality is complex and multidimensional, arising from human experience and inner belief. Spirituality helps people to search their lives for meaning and purpose and helps them experience hope, love, inner peace, comfort, and support.[17] Religion refers to a person's belief system[18] and involves specific practices and rituals—spirituality expressed externally. Not everyone is religious and religion is not a requirement for spirituality. Some people find spirituality in non-religious ways, like communing with nature, music, arts, quest for scientific truth, or a specific set of values and principles. [19]

With that said then, spirituality is a deeply subjective and broad concept seated at the center of the trichotomy of man. It can include, but is not limited to, religious

---

[14] Denise McKee and John Chappel, "Spirituality and Medical Practice," *Journal of Family Practice 35* (1992): 205-208.

[15] Milton Hay, "Principles in Building Spiritual Assessment Tools," *American Journal of Hospice and Palliative Medicine 6* (1989): 25-31.

[16] James Fowler, *Stages of Faith: The Psychology of Human Development and the Quest for Meaning* (New York: Harper Collins, 1995), xii-xiii.

[17] Anandarajah, 81-88.

[18] Kristin Larson, "The Importance of Spiritual Assessment: One Clinician's Journey," *Geriatric Nursing 24*(6) (2003): 370-371.

[19] Anandarajah, 81-88.

expression.[20] While not everyone is religious, all people are spiritual.[21] No universally acceptable agreement exists regarding the definition of spirituality, and the concept can differ between individuals,[22] making spiritual assessment more challenging. The result is that many pastors and other professionals feel uncomfortable assessing patient spiritual beliefs, while others believe developing any instrument to assess spiritual needs is too difficult because of the nature of the elements of spirituality.[23]

Spiritual Distress

While spirituality is associated with better mental and physical health in several studies,[24] [25] other studies suggest that some negative aspects of spirituality (e.g., "low spiritual well-being" or "religious struggle"), might be associated with worse health outcomes.[26] [27] These definitions are classic examples of spiritual distress. As noted, spirituality is an important component of quality of life, and a resource in patients coping with illness.[28] Measuring the spiritual state, and particularly the lower end of the patient's

---

[20] Janice Meisenhelder, "An Example of Personal Knowledge: Spirituality," In P.K. Nicholas and K.A. Wolf (Eds.). *A History of Nursing Ideas* (Boston: Jones and Bartlett, 2006), 151-155.

[21] Koenig, *Handbook of Religion*, 38-41.

[22] Ian Govier, "Spiritual Care in Nursing: A Systematic Approach," *Nursing Standard 14*(17) (2000): 32-36.

[23] Peter Draper and Wilfred McSherry, "A Critical Review of Spirituality and Spiritual Assessment," *Journal of Advanced Nursing 39*(1) (2002): 1-2.

[24] Koenig, *Handbook of Religion*, 41*ff.*

[25] Harold Koenig, Linda George, and Patricia Titus, "Religion, Spirituality, and Health in Medically Ill Hospitalized Older Patients," *Journal of the American Geriatrics Society 52* (2004): 554-562.

[26] Ibid.

[27] Pargament, *Religious Coping Methods*, 713-730.

[28] Paul Mueller, David Plevak, and Teresa Rummans, "Religious Involvement, Spirituality, and Medicine: implications for Clinical Practice," *Mayo Clinic Proceedings 76* (2001): 1225-1235.

spiritual state, namely spiritual distress**,** is probably the most appropriate way to assess patient spirituality within the hospital setting. This measure [measuring spiritual distress] would serve to determine the need for specific interventions.[29]

In a recent systematic review,[30] only two out of thirty-five [spiritual assessment] instruments appeared adequate to assess a patient's current spiritual state.[31] [32] Moreover, these two instruments measure spiritual well-being rather than spiritual distress: "low spiritual well-being" is not necessarily equivalent to spiritual distress.[33]

Categorized as a diagnosis,[34] spiritual distress is among the most common issues of concern revealed by the use of formal spiritual assessment tools. Spiritual distress and spiritual crisis occur when individuals are unable to find sources of meaning, hope, love, peace, comfort, strength and connection in life, or when conflict occurs between their beliefs and what is happening in their life.[35] This distress can have a detrimental effect on physical and mental health. Medical illness and impending death can often trigger

---

[29] Stephanie Monod, Estelle Martin, Brenda Spencer, Etienne Rochat, and Christopher Bula, "Validation of the Spiritual Distress Assessment Tool in Older Hospitalized Patients," *BMC Geriatrics* 12:13, http://www.biomedcentral.com/content/pdf/1471-2318-12-13.pdf (accessed online June 22, 2012).

[30] Stephanie Monod, Etienne Rochat, Estelle Martin, Stephane Rochat and Christipher Bula, "Instruments Measuring Spirituality in Clinical Research: A Systematic Review," *Journal of General Internal Medicine 26*(11) (2011): 1345-1357.

[31] Amy Peterman, George Fitchett, Marianne Brady, Lesbia Hernandez, and David Cella, "Measuring Spiritual Well-Being in People with Cancer: The Functional Assessment of Chronic Illness Therapy—Spiritual Well-being Scale," *Annals of Behavioral Medicine 24*(1) (2002): 49-58.

[32] Timothy Daaleman and Bruce Frey, "The Spirituality Index of Well-Being: A New Instrument for health-Related Quality-of-Life Research," *Annals of Family Medicine 2*(5) (2004): 499-503.

[33] Monod, *Validation,* 12-13.

[34] Julia Emblen and Barbara Pesut, "Strengthening Meaning: A Model for the Spiritual Nursing Care of Patients Experiencing Suffering," *Journal of Holistic Nursing 19*(1) (1996): 42-56.

[35] Hay, *Principles*, 25-31.

spiritual distress in patients and family members.[36] According to North American Nursing Diagnosis Association, and Benedict, spiritual distress is "a disruption (or risk of disruption) in the life principle that pervades a person's entire being and that integrates and transcends one's biological and psychological nature."[37] [38] Taylor adds that spiritual distress is "any disruption or dis—ease in one's spirit.[39] Benedict states that while in spiritual distress, the persons self is disintegrating.[40] Finally, others state that spiritual distress "occurs when a lack of connection to life or people occurs and when their life situation is in conflict with their beliefs.[41]

According to studies by Mary Elizabeth O'Brien and data gathered from Learn Well Resources, Inc., characteristic indicators used to validate spiritual distress diagnosis are measured using seven manifestations that include spiritual pain, spiritual alienation, spiritual anxiety, spiritual guilt, spiritual anger, spiritual loss, and or spiritual despair.[42] [43] Spiritual distress is often precipitated by a medical illness or impending death.[44] Some of

---

[36] Carol Smucker, "A Phenomenological Description of the Experience of Spiritual Distress," *International Journal of Nursing Terminologies and Classifications 7*(2) (1996): 81-91.

[37] NANDA Staff, *Nanda Nursing Diagnoses: Definitions and Classification, 1999-2000* Oxford: North American Nursing Diagnosis, 1999), 67.

[38] Benedict, 55.

[39] Elizabeth Taylor, "Use of Prayer Among Persons with Cancer," *Holistic Nursing Practice 16*(3) (2002): 46-60.

[40] Benedict, 55.

[41] Anandarajah, 81-88.

[42] Mary O'Brien, "The need for spiritual integrity," In H.Yura and W. Walsh (Eds.), *Human Needs and the Nursing Process, vol.2,* (Norwalk: Appleton Century Crofts, 1982), 82-115.

[43] Learn Well Resources, Inc, "Spiritual Care: Help in Distress, A Learn Well course," Nursing continuing education online courses in health and ethics. http://www.learnwell.org/care.htm (accessed May 17, 2012).

[44] Anandarajah, 81-88.

the risk factors associated with spiritual distress include, losing a loved one, mental illness, substance abuse, low self-esteem, natural disaster, relationship problems, inability to forgive, extreme anxiety, situational loss, and or physical/psychological stress.[45]

Eugene Peterson's translational commentary of Psalm 88 provides an excellent insight into the types of spiritual distress experienced by hospitalized patients. Notice the spiritual pain, spiritual alienation, spiritual anxiety, spiritual guilt, spiritual anger, spiritual loss, and or spiritual despair. This is a true crisis of faith. Notice some of the risk factor results of spiritual despair present in this Psalm; losing loved ones, relationship problems, extreme anxiety, inability to forgive, situational loss, low self-esteem, and physical/psychological stress.

> God, you are my last chance of the day. I spend the night on my knees before you. Put me on your salvation agenda; take notes on the trouble I am [experiencing]. I have had my fill of trouble; I am camped on the edge of hell. I am written-off as a lost cause, one more statistic, a hopeless case. Abandoned as already dead, one more body in a stack of corpses, and [have] not so much as a gravestone—I am a black hole in oblivion. You have dropped me into a bottomless pit, sunk me in a pitch-black abyss. I am battered-senseless by your rage, relentlessly pounded by your waves of anger. You turned my friends against me, made me horrible to them. I am [stuck] in a maze and cannot find my way out, blinded by tears of pain and frustration.
>
> I call to you, GOD; all day I call. I wring my hands, I plead for help. Are the dead a live audience for your miracles? Do ghosts ever join the choirs that praise you? Does your love make any difference in a graveyard? [What about] your faithful presence [is it] noticed in the corridors of hell? [How about] your marvelous wonders [are they] ever seen in the dark, your righteous ways noticed in the Land of No Memory?
>
> I am standing my ground, GOD, shouting for help, at my prayers every morning, on my knees [with] each [new] day. Why, GOD, do you turn a deaf ear? Why do you make yourself scarce? For as long as I remember, I have been hurting. I have taken the worst you can hand out, and I have had it. Your wildfire anger has blazed through my life; I am bleeding, black-and-blue. You have attacked me

[45] Taylor, 46-60.

> fiercely from every side, raining down blows [until] I am nearly dead. You made lover and neighbor alike dump me; the only friend I have left is Darkness.[46]

Spiritual distress is a crisis of faith. Crisis of faith occurs when an individual's normal and established relationship with God and accompanying theology seems violated, helpless, and or useless in making sense of relationships with God and others.[47] From the perspective of stress and coping, religious practice and belief is a cultural means of providing people with ways of appraising and coping with stress. Religious frameworks provide a meaning for the occurrence of stress.[48]According to Gregory Bateson, "We create the world that we perceive, not because there is no reality outside of our heads, but because we select and edit the reality we see to conform to our beliefs about what sort of world we live in."[49]

Spiritual Assessment Defined

There are a number of different, yet similar definitions for spiritual assessment. According to Pierce, "An assessment is a statement of perception and a process of information gathering and interpretation."[50] Hodge offers that spiritual assessment is, "the process of gathering, analyzing, and synthesizing data into a multidimensional

---

[46] Eugene Peterson, *The Message//REMIX: The Bible in Contemporary Language*, Third Edition ed. (Colorado Springs, CO: NavPress, 2008), 1012-1013.

[47] Thomas Webb, "Crisis of Faith vs. Spiritual Cry of Distress," *International Journal of Emergency Mental Health 6*(4) (2001): 217-222.

[48] Aldwin, 244.

[49] Bateson, vii.

[50] Bruce Pierce, The Introduction and Evaluation of a Spiritual Assessment Tool in a Palliative Care Unit, *Scottish Journal of Healthcare Chaplaincy 7*(2) (2004): 39-43.

formulation that provides the basis for action decisions,"[51] while others describe it as, "the process by which health care providers can identify a patient's spiritual needs pertaining to care."[52]

There is no standard or universally approved definition of spiritual assessment, but regardless of the slight differences when defining spiritual assessment, the fact remains that spiritual assessment is a process that includes gathering and interpretation of information in order to conduct effective intervention for those persons struggling with issues of spiritual distress.

Spiritual assessment should be included in any form of spiritual care if intervention is to be most effective. What constitutes an appropriate spiritual assessment or the tools utilized to conduct a spiritual assessment remains controversial and is open to a variety of interpretation. Writers regarding the subject of spiritual assessment advocate that ministers making hospital visits utilize some sort of spiritual assessment tool in the practice of ministry.[53] Pastors making hospital visits can create or choose which spiritual assessment tools they wish to use and make them standard in their own ministry practice.

One should not understand a spiritual assessment as simply a standardized series of questions. Assessment questions are a guide in exploration of patient needs. The assessment process provides a framework that allows for the identification of patient spiritual needs. Assessment allows for efficient collection of information that is

---

[51] David Hodge, "Why Conduct a Spiritual Assessment? A Theoretical Foundation for Assessment, *Advances in Social Work 5*(2) (2004): 183-196.

[52] Anandarajah, 81-89.

[53] John Gleason, "Spiritual Assessment and Pastoral Response: A Schema Revised and Updated," *The Journal of Pastoral Care 44*(1) (1990): 66-73.

communicable with members of the care team.[54] Pastors who gain a more complete perspective and understanding of the patient, their strengths, challenges, and needs, have a better chance of walking alongside the patient through their current struggles. As the definitions denote, the simple gathering of data is not in itself an assessment. The data (spoken and unspoken) must be organized, integrated with theory, and made meaningful. Assessment, diagnosis, and appropriate interventions are all characteristics of excellent pastoral patient care. Any pastor wishing to take a holistic approach to patient spiritual care must assess patients with the presumption that patient spiritual needs influence all other aspects of patient well-being. As such, assessments need to examine physical, psychological, social, and cultural components.[55] Proper assessment is the only way to reach effective intervention.

Chapter Conclusion

The Commission on Accreditation of Healthcare Organizations standards mandate member organization to perform minimal spiritual screening to determine patient religious affiliation and indentify religious beliefs and practices important to the patient. The assessment should also determine whether more in-depth assessments are necessary.[56] Such minimal screening tactics pose a threat of reducing spiritual care to nothing more than a tick-box assessment.[57] Staff members conducting spiritual assessment should be competent. Research finds that individuals possessing expertise in

---

[54] Benedict, 55.

[55] Govier, *Spiritual Care*, 32-36.

[56] Joint Commission, 6.

[57] Gordon, *Spiritual Care*, 73.

spiritual and religious care are the most competent to perform patient spiritual assessment and care. [58]

People consciously choose to attend church and participate in religious events, but most patients, if given a choice, prefer not to be hospitalization. Spiritual care in the hospital setting is more needs based than desire based. Spiritual needs of hospitalized patients are subject to a diverse range of spiritual needs that are in a constant state of flux. Likewise, spiritual needs and patients are diverse requiring assessment to be sensitive to diversity of patients and fluid to accommodate diverse spiritual needs. The diversity of hospitalized patient spiritual needs makes it unlikely for a "one size fits all" spiritual assessment tool.

Sometimes assessment tools make assumptions about the relationship between spirituality and religion that can sidetrack our assessment along religious routes if used rigidly.[59] Many people use the words religion and spirituality interchangeably, when they are in fact different. Spirituality is complex and multidimensional arising from human experience and inner belief. It helps people to search their lives for meaning and purpose and helps them experience hope, love, inner peace, comfort, and support.[60] Religion refers to a person's belief system[61] and involves specific practices and rituals—spirituality expressed externally. Not everyone is religious and religion is not a

---

[58] Randall, 1-26.

[59] Gordon, *Spiritual Care*, 71.

[60] Anandarajah, 81-88.

[61] Larson, 370-371.

requirement for spirituality. Everyone is spiritual. Spirituality can include, but is not limited to religious expression. [62]

Spiritual distress is the most common spiritual issue among hospitalized patients. It is also the most commonly revealed issue when utilizing a formal spiritual assessment tool. Spiritual distress and spiritual crisis occur when individuals are unable to find sources of meaning, hope, love, peace, comfort, strength and connection in life, or when conflict occurs between their beliefs and what is happening in their life.[63] Spiritual distress is a crisis of faith. Crisis of faith occurs when an individual's normal and established relationship with God and accompanying theology seems violated, helpless, and or useless in making sense of relationships with God and others.[64]

There is no standard or universally approved definition of spiritual assessment, but regardless of the slight differences when defining spiritual assessment, the fact remains that spiritual assessment is a process that includes gathering and interpretation of information in order to conduct effective intervention for those persons struggling with issues of spiritual distress. Proper assessment is the only way to reach effective intervention.

Assessment questions are a guide in exploration of patient needs. Proper assessment is the only way to reach effective intervention. Proper assessment needs to be the cornerstone of pastoral care, both in and out of the hospital. Simply following a questionnaire-style assessment tool containing yes and no answers does not constitute spiritual care. As the definitions denote, the simple gathering of data is not in itself an

---

[62] Meisenhelder, *An Example,* 151-155.

[63] Hay, *Principles,* 25-31.

[64] Webb, 217-222.

assessment. The data (spoken and unspoken) must be organized, integrated with theory, and made meaningful.

CHAPTER FOUR

SPIRITUAL ASSESSMENT TOOLS: MODEL AND REVIEW

Spiritual Assessment Tools

Many types of assessment tools are available to patients, medical staff, and pastors making hospital visits. Most assessment tools fit within the category of Self-Assessment, Quantitative-Assessment, and Qualitative-Assessment.

Self-Assessment: Self-assessment is a term that is interchangeably with *self-evaluation* and or *self-study.* It is an internal evaluation performed without external involvement. It includes an honest reflection of the current internal condition. Self-assessment forms help guide the participant through a series of related questions designed to prompt thought or evaluation surrounding highlighted or specific issues. Spiritual Self-Assessment tools take many shapes and include open and closed-ended questions. Most initial spiritual Self-Assessment tools contain general questions with multiple-choice answers and or answers asking the participant to grade an issue on a scale, usually between one and four or between always and never, etc. Spiritual Self-Assessment tools help to identify potentially significant spiritual concerns needing additional exploration in an effort to determine potential areas of spiritual distress.

Quantitative Assessment: Quantitative Spiritual Assessment tools generally consist of basic questions followed by a series of options that the patient or pastor selects by

checking a box. A quantitative assessment may ask the patient or pastor to select the appropriate box that identifies his faith tradition and or choose from a list of spiritual, social, or other current needs. Quantitative assessments tend to be rigid and closed-ended, leaving little room for expanded responses or the inclusion of observation notes. Quantitative spiritual assessment tools have received criticism because they "leave little room for negotiating shared understanding of the individual experiences."[1] There are a number of quantitative assessments available. Refer to the Fetzer Institute,[2] and Hill and Hood[3] for additional information regarding these quantitative religious/spiritual assessments.

Qualitative Assessment: Qualitative tools, on the other hand, "tend to be holistic, open ended, individualistic, ideographic, and process oriented."[4] The resulting benefit is a better understanding of the patient's spiritual reality that provides a richness of information,[5] while fostering a collaborative strengths-based atmosphere.[6] Qualitative assessment tools can include taking a spiritual history, a spiritual questionnaire that utilizes a sentence-completion format and might include questions resembling, "I think spirituality is . . ." The questions of such an assessment method are typically open-ended.

---

[1] Hodge, *Why Conduct*, 183-196.

[2] Fetzer Institute, "Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research," http://www.fetzer.org/images/stories/pdf/MultidimensionalBooklet.pdf? (accessed July 22, 2012).

[3] Peter Hill and Ralph Hood (Eds.), *Measures of Religiosity* (Birmingham: Religious Education Press. 1999).

[4] Cynthia Franklin and Cathleen Jordan, "Qualitative Assessment: Methodological Review," *Families in Society 76*(5) (1995): 281-295.

[5] Mattaini, 260-266.

[6] Ann Hartman, "Diagrammatic assessment of family relationships," *Families in Society 76*(5) (1995): 111-112.

Open-ended questions are questions that cause the patient to stop and think about the question, and then provide an answer in their own words. This helps patients identify their spiritual issues without pigeon holing them into the confines of the assessment tool language. Hodge discusses one example of a tool that utilizes open-ended questions about awareness of the holy, providence, faith, grace or gratefulness, repentance, communion, and the individual's sense of vocation.[7]

Twenty-Five Commonly Used Spiritual Assessment Tools

There are far too many spiritual assessment tools for this work to cover that are available for pastors to use in their hospital visit ministry. Some assessment tools are most useful for initial assessment and screening, while other assessment tools require deeper investment and ongoing pastoral support and care. Understanding and examining the various assessment tools will aid pastors in developing an assessment process of their own. Different situations often require different technique and emphasis, while different patients may be more open to different model or process types. Pastors are encouraged to take some time to study for themselves, the various techniques and tools used for spiritual assessment. For further reference, the following are twenty-five of some commonly utilized spiritual assessment tools:

1. Christian Experience Inventory[8]
2. Spiritual Self-Assessment Form[9]

---

[7] David Hodge, "Spiritual Genograms: A Generational Approach to Assessing Spirituality," *Families in Society, 82*(1) (2001): 35-49.

[8] Margaret Alter, *Religious Experience Inventory Empirical Study of Christian Religious Maturity and its Relationship to Mental Health,* Doctoral Thesis, Berkeley, CA Graduate Theological Union, 1985.

[9] Lyn Brakeman, "Theology as a Diagnostic Tool in Assessing Spiritual Health," *The Journal of Pastoral Care 49*(4) (1995): 29-37.

3. God Image Inventory[10]
4. Spiritual Well-Being Scale[11]
5. Intrinsic and Extrinsic Righteousness[12] [13]
6. Hood's Mysticism Scale[14]
7. Spiritual History Scale in Four Dimensions[15]
8. Religious Experience Questionnaire [16]
9. Religious Attitude Inventory[17]
10. Religious Status Inventory[18]
11. Multi-dimensional Religiosity scales [19]

---

[10] Richard Lawrence, "Measuring the Image of God: The God Image Inventory and the God Image Scales," *Journal of Psychology and Theology 25* (1997): 214-226.

[11] Craig Ellison and Joel Smith, "Toward an Integrative Measure of Health and Well-Being," *Journal of Psychology and Theology 19* (1991): 35-48.

[12] Michael Donahue, "Intrinsic and Extrinsic Religiousness The Empirical Research," *Journal for the Scientific Study of Religion 24* (1985): 418-423.

[13] Richard Kahoe "The Development of Intrinsic and Extrinsic Religious Orientations," *Journal for the Scientific Study of Religion 24* (1985): 408-412.

[14] Ralph Hood, "The Construction and Preliminary Validation of a Measure of Reported Mystical Experience," *Journal for the Scientific Study of Religion 14* (1975): 29-41.

[15]Judith Hays, Keith Meador, Patricia Branch, and Linda George, "The Spiritual History Scale in Four Dimensions (SHS-4): Validity and Reliability," *Gerontologist 41* (2001): 239-249.

[16] Keith Edwards, "Religious Experience Questionnaire," *Dissertation Abstracts International 36* (1976).

[17] David Foy, James Lowe, Lee Hildman, and Keith Jacobs, "Reliability, Validity and Factor Analysis of the Religious Attitude Inventory," *Southern Journal of Educational Research 10* (1976): 235-241.

[18] David Massey, *The Construction and Initial Factor Analysis of the Religious Status Inventory* (Pasadena: Fuller Theological Seminary, 1989).

[19] Morton King and Richard Hunt, "Measuring the Religious Variable: Replication," *Journal for the Scientific Study of Religion 11* (3) (1972): 240-251.

12. Index of Core Spiritual Experience [20] [21]

13. Mental, Physical and Spiritual Well-Being Scale[22]

14. Committed and Consensual Religiosity[23]

15. The God Questionnaire [24]

16. Helping Styles Inventory[25]

17. Systems of Belief Inventory[26]

18. Four Worlds of Spiritual Care Assessment[27]

19. Religious Life Inventory[28]

20. Spiritual Themes and Religious Responses Test[29]

---

[20] Larry VandeCreek, "Using INSPIRIT to Conduct Spiritual Assessments," *The Journal of Pastoral Care 49* (1995): 83-90.

[21] George Fitchett, *Spiritual Assessment in Pastoral Care: A Guide to Selected Resources* (Decatur, JPC Publications, 1993), 33-34.

[22] Dianne Vella-Brodrick and Felicity Allen, "Development and Psychometric Validation of the Mental, Physical, and Spiritual Well-Being Scale," *Psychological Reports 77* (2) (1995): 659-674.

[23] Russell Allen and Bernard Spilka, "Committed and Consensual Religion: A Specification of Religion-Prejudice Relationships," *Journal for the Scientific Study of Religion 6*(2) (1967): 191-206.

[24]Ana-Mana Rizzuto, *The Birth of the Living God A Psychoanalytic Study* (Chicago, ILL The University of Chicago, 1979).

[25] Peter VanKatwyk, "The Helping Styles Inventory: A Tool in Supervised Pastoral Education," *The Journal of Pastoral Care 42*(4) (1988): 319-328.

[26]J.C. Holland, K.M. Kash, S. Passik, M.K. Gronert, A. Sison, M. Lederberg, S.M. Russak, L. Baider, and B. Fox, "A Brief Spiritual Beliefs Inventory for Use in Quality of Life Research in Life-Threatening Illness," *Psycho-Oncology 7*,(1998): 460-469.

[27] John Gleason, "The Four Worlds of Spiritual Assessment and Care," *Journal of Religion and Health 38*(4) (1999): 305-317.

[28] C. Daniel Batson, "Religion as Pro-Social: Agent or Double Agent?," *Journal for the Scientific Study of Religion 15*(1) (1976), 29-45.

[29] Marilyn Saur and William Saur, "Transitional Phenomena as Evidenced in Prayer," *Journal of Religion and Health 32*(1) (1993): 55-65.

21. 7x7 Model of Spiritual Assessment[30] [31]

22. Spiritual Assessment Inventory[32]

23. JAREL Spiritual Well-Being Scale[33]

24. F.I.C.A.[34]

25. H.O.P.E.[35]

Among the most useful and easily administered spiritual assessment tools available are the 7X7 Model of Spiritual Assessment, F.I.C.A. tool (Faith and belief, importance, community, and address in care), and the H.O.P.E. questionnaire.

7X7 Model for Spiritual Assessment

The 7X7 Model for Spiritual Assessment presumes that assessment is a vital piece of the spiritual care puzzle and is the cornerstone for the spiritual care intervention plan pastors provide. The authors of the 7X7 model make clear the contrast between spiritual assessment and mere spiritual screening, noting spiritual assessment requires pastoral care while screening does not. They also note that spiritual assessment is intentional and

---

[30] George Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers* (Minneapolis: Augsburg Press, 1993), 39-51.

[31] George Fitchett and J Russell Burch, "A Multi-Dimensional Functional Model for Spiritual Assessment," *The Caregiver Journal 7* (1990): 43-62.

[32] Todd Hall and Keith Edwards, "The Initial Development and Factor Analysis of the Spiritual Assessment Inventory," *Journal of Psychology and Theology 24 (*1996): 233-246.

[33] Joann Hunglemann, Eileen Kenekel-Rossi, Loretta Klassen, and Ruth Stollenwerk, "Focus on Spiritual Well-Being Harmonious Interconnectedness of Mind-Body-Spirit-Use of the JAREL Spiritual Well-Being Scale," *Geriatric Nursing 17*(6) (1996): 262-266.

[34] Christina Puchalski, "Spiritual Assessment Tool," *End of Life Care 1*(6) (1999): 1-2.

[35] Andarajah, *Spirituality*, 81-88.

can shape both pastor and patient response during pastoral consultation and intervention.[36]

The 7X7 Model is an ongoing spiritual assessment, enhanced during ongoing care through rapport and familiarity. The assessment is multi-dimensional and functional in that it is concerned with a person's belief about God, how they find meaning and purpose in life and experiences. It looks at behavior and response, emotions, practices, traditions, and relationships. This assessment functions with the use of open-ended questions that draw out the narrative of the strengths, beliefs, and challenges of the patient. Questions may be standardized or fluid. [37]

The 7X7 Model for Spiritual Assessment is concerned with two hemispheres of assessment, Holistic Assessment and Spiritual Assessment. The following figure is a depiction of the two:

Illustration of 7X7 Model for Spiritual Assessment[38]

Holistic Assessment	Spiritual Assessment
Medical (Biological) Dimension	Beliefs and Meaning
Psychological Dimension	Vocation and Obligations
Family Systems Dimension	Experience and Emotions
Psychosocial Dimension	Courage and Growth
Ethnic, Racial, Cultural Dimension	Rituals and Practice
Social Issues Dimension	Community
Spiritual Dimension	Authority and Guidance

[36] Kevin Massey, George Fitchett, and Patricia Roberts, "Assessment and Diagnosis in Spiritual Care," In K.L. Mauk, and N.K. Schmidt (Eds.), *Spiritual Care in Nursing Practice* (Philadelphia, PA: Lippincott, Williams and Wilkins, 2004), 209-242.

[37] Fitchett, *Assessing Spiritual Needs*, 39-51.

[38] George Fitchett, "The 7x7 Model for Spiritual Assessment: A Brief Introduction and Bibliography," Chicago: Rush University Medical Center, available via www.rushu.rush.edu/rhhv, (accessed June 22, 2012).

Dimensions of Holistic Assessment[39] [40]

Medical (Biological) Dimension: What are the patient's past and current medical issues, diagnosis, prognosis, and plan for treatment?

Psychological Dimension: Are there any psychological issues presenting currently under treatment and or diagnosed?

Family Systems Dimension: Is there current or past history within the patient's family or relational system contributing negatively or positively to the current situation?

Psychosocial Dimension: Take an inventory of the patient's social influence, i.e. family origin, employment history, birthplace, financial resources, current living situation, and other important experiences and relationships.

Ethnic, Racial, Cultural Dimension: What is the patient's ethnic, racial, and or cultural background and does it influence their current issues?

Social Issues Dimension: Do larger social issues contribute to or are they the cause of the patient's issues?

Dimensions of Spiritual Assessment[41] [42]

Beliefs and Meaning: What beliefs give meaning and purpose to patient's life? Are there any major symbols that reflect or express meaning? What is the patient's personal story and history leading to their current beliefs and meaning? Have the current patient issues

---

[39] Fitchett, *Assessing Spiritual Needs*, 39-51.

[40] Fitchett, *The 7x7 Model*, 1-4.

[41] Fitchett, *Assessing Spiritual Needs*, 39-51.

[42] Fitchett, *The 7x7 Model*, 1-4.

changed beliefs and meaning? Do current issues transform or reinforce belief and meaning? Does the patient have a formal system of belief and or faith tradition?

Vocation and Obligations: What moral obligations, compromises, conflict, and or sacrifice to beliefs and meaning does the patient's current medical issues cause or potentially cause?

Experience and Emotions: What religious or divine experiences has the patient had in the past and during their current medical issues? How do their divine experiences affect patient beliefs and meaning? What emotions do the divine experiences cause?

Courage and Growth: Do current issues require patient to incorporate new experiences and problems into beliefs and meaning? Do they require transforming past beliefs and meaning into new ones?

Rituals and Practice: What rituals and practices are associated with the patient's beliefs and meaning? Do current or potential ongoing issues prohibit them from participating in meaningful rituals and practices?

Community: Does the patient belong to a church or community sharing the same beliefs, meaning, rituals, and or practice? How does the patient participate in that community? What is their role in their faith community?

Authority and Guidance: Where does the patient find authority and guidance for their beliefs and meaning? This could be a pastor/chaplain, friend or family member, mentor, or other person; perhaps directly from God. Does the patient look inward or outward for guidance, and to what degree?

The "7X7" model has become a classic from of spiritual assessment. Many of the other spiritual assessment tools are a derivation of this tool. It is from this model that

many of the Association for Clinical Pastoral Education supervisors design their training verbatim to use with their intern trainees. The 7X7 model is the preferred spiritual assessment model of this author. Many of the spiritual assessment recommendations contained in the New Model section of this report come from using this model and modifying it to fit the needs and personality of this author. It is up to each individual pastor to become familiar and comfortable with spiritual assessment model that fit within individual need and comfort level.

F.I.C.A. Assessment Tool

The F.I.C.A. Assessment Tool is one of the more general assessment instruments, better used for spiritual screening and initial assessment. This model of assessment is general enough to be relevant in use by medical clinicians and or nursing staff to determine if the patient may benefit from spiritual care or if they are experiencing spiritual distress associated with their illness or hospital stay. This Assessment provides information about what or who gives the patient a transcendent meaning of life.[43] This tool is useful to pastors for making a quick initial assessment and when making an initial pastoral visit. It is also useful for starting a spiritual conversation in a manner that is less intimidating to some patients. This assessment tool focuses upon four areas of concern, Faith and Belief, Importance, Community, and Address in care.

The F.I.C.A. Assessment Tool includes the following useful questions and areas for assessment:[44]

---

[43] David Girardin, "Integration of Complementary Discipline into the Oncology Clinic, Part IV: Implications for Spirituality with Oncology Patients," *Current Problems in Cancer24* (5) (2000): 268-279.

[44] Christina Puchalski and Anna Romer, "Taking a Spiritual History Allows Clinicians to Understand Patients More Fully," *Journal of Palliative Medicine 3(1)* (2000):129-137.

Faith and Belief: Do you consider yourself spiritual or religious? Do you have spiritual beliefs that help you cope with stress? IF the patient responds by answering "No," the following question might be, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

Importance: What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?

Community: Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people whom you really love or whom you consider important? Communities such as churches, temples, and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

Address in Care: How would you like me, your healthcare provider, to address these issues in your healthcare? (Clinician) Would you like me (Pastor) to address these issues? Would you like me to refer you to a member of your community and or leader in your faith tradition?

HOPE Assessment

The Hope Assessment is a spiritual assessment tool developed to teach medical students and staff how to incorporate spiritual assessment into their medical interviews with patients. It is the screening or assessment tool recommended for use of hospital clinicians by the Joint Commission on Accreditation of Healthcare Organizations.[45] The Hope Assessment questionnaire is brief, making it useful in time-limited situations. It is also one of the less intrusive initial assessments, sensitive to a wide range of belief

[45] Joint Commission, 6-7.

systems and cultures. The Hope Assessment focuses on hope, meaning, love, strength, peace, and comfort, without focusing upon organized religion. The Hope questionnaire as published by Anandarajah and Hight in 2001[46] follows:

The mnemonic of H.O.P.E. is as follows:

H: What are the patient's sources of hope, meaning, comfort, strength, peace, love, and connection? Example questions offered:

1. We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support?
2. What are your sources of hope, strength, comfort, and peace?
3. What do you hold on to during difficult times?
4. What sustains you and keeps you going?
5. For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with the ups and the downs in life, is this true for you? If the answer is "Yes," go on to the "O" and "P" sections of the questionnaire.

O: Is the patient involved in organized religion? Example questions offered:

1. Do you consider yourself part of an organized religion? How important is this to you?
2. What aspects of religion are helpful and not helpful to you?
3. Are you part of a religious or spiritual community? Does it help you? How does it help?

P: What are the patient's Personal spirituality and practices? Example questions offered:

1. Do you have personal spiritual beliefs that are independent of organized religion? What are they?

[46] Anandarajah, 81-88.

2. Do you believe in God? What kind of relationship do you have with God?
3. What aspect of your spirituality or spiritual practices do you personally find most helpful to you? (e.g., prayer, meditation, reading scripture, attending religious services, listening to music, hiking, community with nature)

E: What are the effects of medical care and end-of-life issues? Example questions offered:

1. Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God)
2. Would it be helpful to speak to a leader within your faith community?
3. Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?
4. Are there any specific practices or restrictions affecting your medical treatment/treatment plan?

CHAPTER FIVE

PART I

NEW MODEL: PROCEDURAL GUIDE

Introduction

As a pastor, chaplain, or lay minister making hospital visits, you now possess a better understanding of the need for proper spiritual assessment. You understand the role of spiritual care in the holistic healing process for hospitalized patients. Perhaps you avoided learning about or utilizing spiritual assessment in your intervention because you never received proper hospital ministry training like many others who participated in the *Pastoral Hospitalization and Chaplaincy Survey*. Perhaps there are other reasons why you did not know and understand. The point is that, now you know. You know how important spiritual care is to patients, you understand the desire and expectation of hospitalized patients to have spiritual needs addressed and tended. You are now familiar with the various models of spiritual assessment tools. You know the differences between spiritual and religious issues. You know the components and causes of spiritual distress in hospitalized patients. Now it is time for you to adopt a spiritual assessment model of your own. What do you need in order to accomplish this?

Before discussing the necessary elements of proper spiritual assessment from which to derive your own model, it is important to cover some process items. Three

important process items are timing, discomfort, and training. Poor timing, discomfort, and lack of training are a few of the barriers that can prohibit effective spiritual assessment.[1] It is important for pastors to understand how their own personal beliefs and experiences influence their ministry. Understanding this will help in understanding potential conscious and unconscious issues likely to be behind any discomfort. Properly timing visits with patients will come with experience and common sense. It is also helpful to acquire additional training specific to the issues of hospitalized patients. The following is useful information regarding timing, discomfort, and training.

Timing Hospital Visits

Proper timing of pastoral hospital visits is an important issue. Timing issues may be different for chaplains who work in or for the hospital compared to pastors who are visiting members of their congregation. Parish pastors and lay ministers are more likely to be making pastoral hospital visits at the request of the patient or patient family. In either case, it is best to call before arriving to the hospital to ensure the comfort, availability, and convenience of the patient and or patient family. Times that may be inconvenient to visit include, but are not limited to, when the patient is undergoing medical tests or treatment, when the patient is not feeling up to receiving visitors, when the patient is contagious, when the patient already has many visitors present, when the physician or nurse request no visitors, and when the patient is heavily sedated.

Calling ahead is also a good idea so that patients can prepare for the visit. This might include allowing the patient to be more fully clothed and or groomed. Some patients become embarrassed regarding their appearance while in the hospital. Others

---

[1] Joint Commission, 6-7.

may be exposed. Another reason to call is to find out what the patient and or family needs or expects from the visit. Do they need liturgy, baptism, counseling, a Bible, or other spiritual literature? Perhaps the patient wants to time the visit to allow a spouse or other family member to leave during your visit. Oftentimes, spouses have errands to run and feel more comfortable doing so knowing the patient is not alone. Other times, the patient may have spiritual or family issues to discuss apart from their spouse.

Finally, calling before the visit gives the patient a hopeful expectation while allowing him to maintain a certain amount of control in their situation. It is good for patients to have hopeful expectation, a positive event in an otherwise not so positive situation. It is also healthy for patients to have a feeling of control over their hospital environment. For the most part, everything that happens in the hospital is out of their control, blood work, medications, testing, meals, treatment, doctor visits, etc. Even the disease putting them in the hospital is likely beyond their control. Calling ahead honors the patient and can save pastors a wasted trip to the hospital.

Discomfort Associated with Hospital Visits

It is important for pastors to be aware of the dynamics of projection and transference so they can provide pastoral care without having their personal experiences negatively influence the process.[2] Making pastoral hospital visits can be uncomfortable to pastors for many different reasons. Sometimes the reasons are obvious and at other times, not so obvious. Obvious reasons may include, but are not limited to end of life, physical or sexual abuse, child patient, and or obvious physical trauma issues. Pastors may be very close to the patient, making the visit more uncomfortable. Less obvious reasons might

[2] Rogers, 56-57.

include, but not be limited to counter transference issues related to the pastor's beliefs, worldview, presuppositions, and or past life experience.

According to Sigmund Freud, counter transference issues are the result of a patient's influence on the unconscious feelings of the [pastor] therapist.[3] Reich continues on the subject of counter transference by adding that, "In such cases the patient represents for the analyst an object of the past on to whom, past feelings and wishes are projected."[4] Jung warned against "cases of counter-transference when the analyst really cannot let go of the patient...both fall into the same dark hole of unconsciousness."[5] In other words, counter transference issues are about the pastor, more than about the patient. It is a result of over identifying with the patient.

On the opposite side of the same coin, discomfort may come from visiting patients who do not share or even be opposed to the pastor's beliefs. Nearly 40% of responding pastors in the *Pastoral Hospital Visitation and Chaplaincy Survey* when asked, "I have found it challenging and or have experienced strong negative feelings when attempting hospital visits with someone who is . . ." identified strong negative feelings present when visiting patients who are of a differing faith tradition, atheist, non-Christian, or homosexual. Another 22% felt strong negative feelings when visiting criminals, child abusers, drugs abusers or alcoholics, and mentally ill or suicidal patients. The negative feelings, no doubt, come from issues associated to the pastor's beliefs and life experiences.

---

[3] Sigmund Freud quoted, In Peter Gay, *Freud: A Life for Our Time* (London: Anchor Books and Doubleday, 1989), 254 and 302.

[4] Annie Reich, "On Counter-Transference," *International Journal of Psycho-Analysis 32* (1951): 25-31. (26)

[5] Carl Jung, *Analytical Psychology: its Theory and Practice* (London: Routledge and Kegan, 1976), 157-159.

Training Suggestions for Pastors Making Hospital Visits

As with any profession, training is important and should be ongoing. As discussed earlier, a majority of pastors making hospital visit have received little or no training. Training is necessary in order to become a skilled hospital visitation pastor. Developing an understanding of and adopting a proficient spiritual assessment model is crucial. It is also very helpful to seek additional training in the following areas:

1. Stages of Grief and Grief Counseling
2. Hope
3. Crisis Intervention and or Critical Incident Stress Debriefing
4. Psychosocial Studies
5. End of Life Issues

Stages of Grief and Grief Counseling

Dr. Elisabeth Kübler-Ross introduced the now famous idea that there exist five stages in the loss and grief process. These five stages include denial and isolation, anger, bargaining, depression, and acceptance.[6]

The intensity of the first wave of pain received from news regarding terminal illness, death, and or potential for death is too overwhelming to comprehend, accept, and or imagine. It is natural to deny the reality of the situation. We block out the words and hide from the facts. Denial is a normal reaction to rationalize overwhelming emotions . . . a defense mechanism that buffers the immediate shock. Denial is usually a temporary defense soon replaced with partial acceptance.[7] Typical responses from persons in denial

---

[6] Elisabeth Kübler-Ross, *On Death and Dying* (New York: Scribner, 1997), 51-146.

[7]Ibid. 53

might include, “Not me,” “There must be a mistake,” “It cannot be true,” and or “but he/she was improving,” “I just spoke to or seen him/her.” During the denial stage, one will seek confirmation of the accuracy or validity of the situation, oftentimes seeking agreement that the situation is not true and or that there must be a mistake.

As the reality of the situation becomes apparent and the initial shock dissipates, the pain reemerges. With the reemergence of pain and lack of control comes the response of anger. We do not cope well with feeling vulnerable and or helpless. Anger is a defense mechanism that causes us to deflect from our internal feelings of vulnerability and direct them elsewhere-externally. Anger is often times directed at the patient or deceased, the physician, complete strangers, inanimate objects, friends, pastor, and or family members. One might also become angry at one’s self.

Working with families of sick and injured children in the hospital setting, this author has witnessed many outbreaks of anger. Blaming another person, such as a spouse or physician is very common. When babies are born premature or stillborn, husbands can make comments to the mother about the one-time they smoked or took cold medicine, etc. If genetic issues are present, there may be allegations that the problem must have come from, “your side of the family.” Of course, people oftentimes will blame God for what has or is currently happening. The nature of the flesh is to find someone to blame when you are in trouble. Adam blamed Eve, Eve blamed the serpent, [8] and people have been blaming someone else ever since.

Patient family members sometimes throw items of furniture or other items. They may throw themselves onto the ground and or inflict pain upon self. There are incidents of violent attacks made against physicians and or nursing staff. Chaplains and pastors are

[8] Genesis 3:11-13.

not immune to such outbursts. This author personally has had anger directed towards him. It is important for the pastor to be aware of anger as a natural response to grief so that you may be aware of the symptoms, be prepared to take appropriate measures, and to understand where people are in the coping process.

In an effort to regain control over situations for which we are vulnerable and helpless, we begin to bargain. Denial and anger may likely remain, but we begin to seek answers and make sense of the trauma. Some common statements made by one in the bargaining stage typically begin with, “If only I/We . . .” The “if only” may include being a better parent, getting a second opinion, being aware of earlier symptoms, being a better Christian. It is very common during this stage to make deals with God or a higher power in an effort to postpone the inevitable. “God, if you save my child, I will . . .,” “be a better parent,” give you my life,” “go to church more regularly,” “stop doing things I know I shouldn’t be doing, etc.” The opposite side of this is that the person is blaming God or blaming self for causing and or allowing the trauma to take place and persist.

As the reality persists, depression begins to be more prevalent. Symptoms of depression might include excessive or inappropriate feelings of guilt and worthlessness, fatigue, lack of interest in anything, lack of energy, sleeplessness or too much sleep, loss of appetite, difficulty concentrating and or making decisions, and thoughts of death or suicide. As with all the stages of grief and loss, depression may be present throughout the entirety of the process to one degree or another, and may persist, even after acceptance. The final stage of grief and loss is acceptance. Not everyone reaches this final stage, and some people take many years to reach it.

Case Example in Stages of Hope

An eight-year old child is exhibiting symptoms that lead doctors to believe that she has leukemia. Additional diagnosis is required to obtain certainty over the condition, but doctors estimate that their initial suspicions are 85% correct. If doctors are correct, treatment of such cancer will yield an approximate 15% survival rate, meaning an approximate 85% mortality rate.

During crisis, from beginning to end, there is always hope. Initially, hope may correspond with disbelief—there is hope that the reality or information is incorrect or untrue. Another version of this is belief that the situation is not as bad as the facts may portray and or that the odds of such reality do not apply. Patient and or patient family will hope that the doctors are incorrect regarding potential diagnosis. They may further hope that if the diagnosis is determined correct, that patient will be one of the fortunate 15% of the population who will recover.

Further testing reveals that the child is positive for leukemia and doctors advise the parents as to treatment options available. With treatment for leukemia beginning, the new hope may be that the patient will survive the cancer and that treatment will be successful. There is hope that the patient will be part of the fortunate 15% who survive. In some cases, there may be less than 1% chance of survival, none-the-less, there is still hope of survival.

If the patient's treatment to the leukemia is successful, hope may be that the child will have no relapse of the cancer. If treatment appears unsuccessful, then hope may shift to a miraculous healing. This hope may be maintained throughout the course of treatment and while the child actively succumbs to her illness. Once the reality of potential for loss is accepted, hope will be that the child does not suffer.

Once the child dies, hope may be to see the child again in the afterlife, presuming that there is any sort of spiritual belief that accommodates such a hope. In many cases, this author has found that parents who exhibited no such spiritual belief while their child was living and well, develop such belief during the illness and or upon the child's death.

There are important notes to remember regarding hope for hospitalized patients and patient families. The first is to remember that hope is always something they seek. Even during times when all seems hopeless, hope exists. It is also important to note that hope can be as fluid as the situation. As the above case study reveals, hope can change directions along with the prognosis, treatment, and progress of the patient. It is important for pastors to help patients and their families find whatever hope they can during medical crisis.

Crisis Intervention and Critical Incident Stress Debriefing

Crisis intervention is emergency psychological care aimed at assisting individuals in a crisis-situation in order to restore equilibrium to their bio-psychosocial functioning and to minimize the potential for psychological trauma.[9] [10] Recommended resources for additional study include *Pastoral Crisis Intervention*[11], *Critical Incident Stress*

---

[9] Jackson-Cherry, *Crisis Intervention,* 1-24.

[10] Aguilera, *Crisis Intervention,* 26-42.

[11] George Everly, *Pastoral Crisis Intervention* (Ellicott City: Chevron Publishing, 2007).

Management – CISM: A New Era and Standard of Care in Crisis Intervention[12], and *Assisting Individuals in Crisis.*[13]

Psychosocial Studies

The medical definition of "psychosocial," is "Involving aspects of both social and psychological behavior."[14] Psychosocial training includes understanding and recognizing the symptoms and affects of psychosocial issues, as well as methods of conducting psychosocial intervention. Social Psychology is another term for psychosocial studies. For a better overview of social psychology issues of hospitalized patients read *Psychosocial Aspects of Healthcare*,[15] *Elements of the Helping Process: a Guide for Clinicians*,[16] and *Spiritual Diversity in Social Work Practice: the Heart of Helping.*[17]

End of Life Issues

End of life visits refer to pastoral visits to patients who are actively dying. During end of life visits, the patient may be dying at the very moment of the visit, or has the expectation of dying within days, weeks, and or months. The time at the end of life is

---

[12] George Everly, and Jeffrey Mitchell, *Critical Incident Stress Management -CISM-: A New Era and Standard of Care in Crisis Intervention* (Ellicot City: Chevron, 1999).

[13] George Everly, *Assisting Individuals in Crisis*, 4th ed. (Ellicott City: International Critical Incident Stress Foundation, 2006).

[14] "Psychosocial," *Dictionary.com Unabridged,* http://dictionary.reference.com/browse/psychosocial (accessed July 22, 2012).

[15] Meredith Drench, Ann Noonan, and Nancy Sharby, *Psychosocial Aspects of Health Care*, 2nd ed. (Upper Saddle River: Prentice Hall, 2007).

[16] Raymond Fox, *Elements of the Helping Process: A Guide for Clinicians*, 2nd ed. (New York: Haworth Social Work Practice Press, 2001).

[17] Edward Canda and Leola Furman, *Spiritual Diversity in Social Work Practice: The Heart of Helping* (Oxford: Oxford University Press, 2010).

different for each person. Each individual has unique needs for information and support.[18] Pastors assist patients and family members in identifying their personal values regarding end of life treatment choices. Clarifying values and improving communication can reduce expensive, unwanted care.[19] Some excellent resources to begin with include *"How Do People Make Sense of Loss,"*[20] *Death and the Quest for Meaning: Essays in Honor of Herman Feifel*[21], *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Professional,*[22] *"Paternal and Maternal Coping with the Death of a Child,"*[23] and *Patterns of Transcendence: Religion, Death, and Dying.*[24]

---

[18] "End-of-life Care For People Who Have Cancer," National Cancer Institute Fact Sheet, http://www.cancertopics/factsheet/support/end-of-life-care (accessed June 22, 2012).

[19] Gail Daly, "Ethics and Economics," *Nursing Economics 18*(4) (2000): 194-201.

[20] Christopher Davis and Susan Nolen-Hoeksema, "How Do People Make Sense of Loss," *American Behavioral Scientist 44*(5) (2001): 726-741.

[21] Stephen Strack and Herman Feifel (eds.), *Death and the Quest for Meaning: Essays in Honor of Herman Feifel* (Northvale: J. Aronson, 1997).

[22] William Worden, *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Professional* (New York: Springer Pub., 1982).

[23] Reiko Schwab, "Paternal and Maternal Coping with the Death of a Child," *Death Studies14* (1990): 407-422.

[24] David Chidester, *Patterns of Transcendence: Religion, Death, and Dying* (Belmont, CA: Wadsworth, 1990).

CHAPTER FIVE

PART II

NEW MODEL: ELEMENTS OF ADAPTIVE SPIRITUAL ASSESSMENT

Introduction

The F.I.C.A. and H.O.P.E. spiritual assessment models are recommended for use by medical clinicians and or nursing staff to determine if the patient may benefit from spiritual care or if they are experiencing spiritual distress associated with their illness or hospital stay. The F.I.C.A. and H.O.P.E. spiritual assessment tools are primarily for initial screening and usually administered in the hospital setting by individuals not necessarily properly trained to provide spiritual care. These tools may be useful to pastors for making a quick initial assessment when making an initial pastoral visit. They might also prove useful for starting a spiritual conversation in a manner that is less intimidating to some patients, especially if patients are not members of the pastor's congregation, and or the pastor is unaware of the patient's faith tradition or spiritual beliefs.

As previously mentioned, the 7 X 7 spiritual assessment tool is an excellent model from which to adapt your own assessment model. It provides the most holistic approach to patient wellness and helps the pastor to gain a better understanding of the multiple dynamics affecting the patient physical and spiritual health. Remember, not all crisis' are

spiritually or theologically based;[1] and the indicators associated with spiritual distress (pain, alienation, anxiety, guilt, loss, and despair) may often relate to both spiritual and psychosocial problems.[2] The 7X7 assessment model helps improve communication and understanding between the pastor and the patient to reveal patient ability to cope, and identify spiritual distress levels. The 7X7 model is fluid and can go as deep as time and the patient permit. In the process, it helps indentify productive intervention, develop pastoral authority and trust,[3] and provide pastors and patients with understanding their faith and belief and how they relate to the current issues of their hospitalization.

Introductory and Pre-visit information

Prior to making the hospital visit, it is helpful for the pastor to gain as much information as about the patient as is available. This knowledge can help the pastor better understand the potential challenges and spiritual distress the patient is likely to be experiencing. Useful information may be as basic as a patient's name, gender, and age. Information might also include ethnicity, length of hospitalization, diagnosis, prognosis, or current treatment plan. Other useful information might include family and marital status, faith tradition, or support system. Pre-visit information is helpful to making proper assessment and to guiding the conversation during the assessment and intervention process.

---

[1] Clements, 11*ff.*

[2] NANDA Staff, 67.

[3] Muncy, 44-45.

Initial Feelings, Perceptions, and Observations

Spiritual assessment is not just about questions and answer. It is every bit as important for pastors to use their experiences, feelings, perceptions, and observations. Sometimes what the patient does not say during a conversation is more revealing than the conversation itself. Sometimes facial expressions or body language can reveal areas of concern needing additional assessment. Initial observations can also be revealing, e.g. When you enter into a patient room you find that all of the lights are off, the blinds are closed, and the patient appears to have been crying. This can reveal potential depression, loneliness, fear, or other issues of concern. You can tell the patient of your observations and ask if these feelings are present. Perhaps you enter into a patient's room to find that there is a Bible, some spiritual literature, and or some other religious items like a cross, rosary, etc. This can reveal that the patient is finding strength through his beliefs and or that they have received visitor or support from members of their faith community. Again, you can inform the patient of your observations and ask if he is receiving support from his faith community or strength from his beliefs.

Although H.I.P.P.A. regulations restrict access to patient medical information, sometimes speaking to the patient's physician or nurse prior to the visit can provide fruitful information. It is not out of line for clergy to ask a physician or nurse for their impression regarding the spiritual wellbeing of the patient. Nurses especially spend significant time with patients. They are aware of visitors the patient receives, they are aware of the prognosis of the patient, and they witness how the patient has responded during their hospitalization. Some useful information received from nurses prior to visiting a patient include but are not limited to, whether the patient has received visitors,

whether the patient has received spiritual support, whether the patient appears to be coping well, whether the patient has voiced spiritual and or psychosocial concerns, and whether the patient has received bad news or good news. Nurses might also know whether the patient is fearful of upcoming tests or procedures. All of this information is useful when providing spiritual care.

Personal Feelings

Prior to, and during patient visitation, it is important for pastors to be aware of their own personal feelings. As previously discussed, presupposition, fear, and counter transference issues can negatively affect spiritual assessment, care, and intervention. The best way to manage strong internal feelings is to first be aware of them, and then try to determine where they come from. It is important for the pastor to remember that the crisis belongs to the patient, the assessment process is about the patient, and the spiritual care and intervention is about the patient. Pastors want to avoid making the patient or patient family feel as though they need to provide the pastor with spiritual care, especially when they are struggling with their own issues.

There are times when it is best to know your pastoral hospital visitation limitations. It is okay to admit that you struggle with certain cases or that you are ill equipped to provide meaningful care and intervention. During this authors experience working in the critical care unit at a Children's Hospital, there were times when connecting with patients or their families was difficult and seemingly impossible. When dealing with non-accidental trauma (N.A.T.) of injured children, this author, when attempting to provide spiritual care to certain parents suspected of child abuse learned that he was more concerned with justice than forgiveness, and that the strong inner feelings experienced overpowered his ability during those moments to care for the

patient. In those situations, it is acceptable to refer the case to another pastor or hospital chaplain. We are human and have feelings. We must be honest with feelings that can impair our pastoral abilities.

It is important for pastors to have a support system in place. Many pastors have mentors, counselors, friends, family, or other pastors to meet with on a regular basis. Self-care is a requirement, especially when decompressing following a hospital visit such as the type discussed. Regarding self-care, Rogers adds that, "Engaging in self-care on a regular basis contributes to the prevention of burnout and models self-respect. When pastors nurture and replenish themselves they become better conditioned, and create a respectful and comfortable context for pastoral care. Then pastors are able to honor and value others and establish appropriate boundaries when they see those who seek their care."[4]

Having an outlet to someone who can provide honest, non-judgmental feedback is an imperative for pastors providing care. Pastors are among those who are at the highest risk of suffering from secondary trauma. Another note, the Pastoral Hospital Visitation and Chaplaincy Survey revealed that a high percentage of pastors depend upon their spouse or other family member for support and decompression. Be careful when discussing your graphic and difficult encounters with them so that you do not subject them to secondary trauma.

Pastoral Transference

Pastoral transference is not the same as the counter transference previously discussed. Pastoral transference is the act of the patient transferring to or acknowledging

[4] Rogers, 92.

you as a pastoral authority. Pastoral authority, or pastoral transference, is necessary for meaningful spiritual assessment, care, and intervention. The patient may not view you as a spiritual leader or minister because they may be of a different faith tradition, are anti-religious, anti-Christian, or simply do not know your role as a pastor making the hospital visit. Sometimes you can gain the patient's trust over time. It is important to gain pastoral authority, but you cannot insist upon it.

During the earlier stages of this author's hospital chaplaincy training, pastoral transference or authority was difficult to gain. The following situations resulted many times in failed pastoral transference or authority:

1. When visiting Jehovah's Witness patients. This is a close-knit faith tradition whose members prefer to receive spiritual care and support from members and pastors of their own faith tradition.
2. When visiting some Catholic patients. Many Catholic patients only give pastoral authority to priests. This is not always the case in the hospital setting, but it is common.
3. When visiting members of other faith traditions or Non-Christian patients.
4. When not properly identifying self as a pastor or not explaining the pastoral role as pastor or chaplain.

Sometimes, gaining pastoral authority requires little more than explaining your pastoral role, and stating the purpose of your visit. This is especially true if you introduce yourself as a chaplain. Many people do not understand the role of a chaplain in the hospital setting. Some patients believe when a chaplain or priest visits them in the hospital it is because they are going to die. This author recalls several visits made in a

Catholic hospital where there is a high demographic of Hispanic patients. Many older Hispanic patients became wide-eyed with fear whenever I would make my introduction to them. After learning of their belief that chaplains or priests typically visits when death is imminent, this author became intentional about explaining the purpose of the visit. It is important when making the first visit to introduce yourself as a pastor and explain the purpose of your visit. You might say something like, "Hello, my name is Doug and I am a pastor at Chapman Avenue Baptist Church. The reason for my visit is that your neighbors Jim and Sue are concerned about you and asked that I come by to see how you are doing during your hospital stay . . . Do you know what a pastor does?" You may then ask simple screening questions to determine if they will benefit from spiritual care and if they are experiencing spiritual distress.

Spiritual Assessment

To this point, you have gained any introductory and pre-visit information available, made initial observations, allowed your instinct to perceive, are consciously aware of strong feelings about the patient or patient situation, and have secured pastoral authority. You are on your way in the spiritual assessment process. What do you do now? It is time to assess and evaluate the dimension of holistic and spiritual dimension identified in the 7 X 7 model for spiritual assessment. [5] [6]

For review, the two hemispheres of assessment are the Holistic and Spiritual. The Holistic assessment hemisphere includes the medical/biological, psychological, family systems, psychosocial, ethnic, racial, cultural, social issues, and spiritual dimensions. The

---

[5] Fitchett, *Assessing Spiritual Needs,* 39-51.

[6] Fitchett, *The 7x7 Model,* 1-4.

Spiritual assessment hemisphere includes beliefs and meaning, vocation and obligations, experience and emotions, courage and growth, rituals and practice, community, and authority and guidance. It is likely that you will not gain all the information you seek in the first visit, or during all of your visits. Time does not always permit this thorough an assessment.

Remember that hospital patient needs and challenges can rapidly change. Hospitalized patients may present with multiple issues. When this is the case, you may first need to address the most crucial issue, before tending to the others. The important thing to remember is that spiritual care in the hospital is need-based and fluid. Let the patient direct you to the areas in greatest need of intervention. Spiritual welfare and appropriate intervention is always more important than getting all the information. Promoting such integration requires an appropriate assessment of patient spirituality, and definition of conditions for spiritual interventions, that improve patient care.[7] [8]

Dimensions of Holistic Assessment[9] [10]

Medical (Biological) Dimension: What are the patient's past and current medical issues, diagnosis, prognosis, and plan for treatment? Sometimes this is Introductory or Pre-visit information you received from referral, family members or from the patient. If you are a hospital chaplain or pastor working directly for the hospital, this information

[7] Christina Puchalski, Betty Ferrell, Rose Virani, Shirley Otis-Green,Pam Baird, Janet Bull, Harvey Chochinov, George Handzo, Holly Nelson-Becker, Maryjo Prince-Paul, Karen Pugliese, and Daniel Sulmasy, "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference," *Journal of Palliative Medicine 12*(10) (2009): 885-904.

[8] Mark Brennan and Deborah Heiser (eds.), *Spiritual Assessment and Intervention with Older Adults: Current Directions and Applications* (Binghamton: Haworth Pastoral Press, 2004), 1-6.

[9] Fitchett, *Assessing Spiritual Needs*, 39-51.

[10] Fitchett, *The 7x7 Model*, 1-4.

may be available in the patient's chart notes. If you do not know this information prior to making the visit, you will likely gather it during your assessment conversation with the patient. This information is helpful in two ways. First, it provides insight into current challenges and potential issues associated with those challenges. Secondly, if the patient has past experience with these challenges, you can learn from the patient what they did to help them cope previously and how and or where they found strength and support.

Psychological Dimension

Are there any psychological issues presenting currently under treatment and or diagnosed? Is the patient presenting with significant psychological issues, this is information likely to be determined by speaking to the patient nurse, physician, social worker, or family member. Otherwise, this information can be determined during the assessment conversation with the patient. As previously discussed, you want to depend upon your observation and feelings to sense potential psychological issues and then guide the assessment to determine if your suspicions are correct. There are some cases when patient psychological issues are significant enough to cause concern and caution. If a patient is delusional, violent, suicidal, or a threat to pastor safety or otherwise makes pastoral intervention unlikely, it is best to wait for the patient to improve, or at minimum, have a social worker or licensed staff member present.

Family Systems Dimension

Is there current or past history within the patient's family or relational system contributing negatively or positively to the current situation? Are there post-hospitalization family issues present, including availability of family to provide

support?[11] Again, this information may be readily available from staff or family member or be included in the patient chart note. Family systems issues that present in hospitalized patients may include, but are not limited to, abuse, loss, ability or inability of family members to visit, support or lack of support, divorce or separation, spiritual or medical authority within the family dynamic, etc. Patients will often identify family system issue if they are causing problems or offering support. It is important to listen between the lines of conversation. It may also help to witness patient interaction with family members.

Psychosocial Dimension

Take an inventory of the patient's social influence, i.e. family origin, employment history, birthplace, financial resources, current living situation, and or other important experiences and relationships. These are not spiritual issues, however, psychosocial dimension can reveal stressors present within the patient's life. Sometimes spiritual belief and practices can help comfort and guide patients during psychosocial challenges.

Ethnic, Racial, Cultural Dimension

What is the patient's ethnic, racial, and or cultural background and does it influence their current issues? As previously stated, issues in this category will likely be raised by the patient. It is important to be aware and pay attention to patient comments.

Social Issues Dimension

Do larger social issues contribute to or are they the cause of the patient's issues? As previously stated, issues in this category will likely be raised by the patient. It is important to be aware and pay attention to patient comments. Some social issues

---

[11] JCAHO, *Hospital Patient Assessment: Meeting the Challenges.* (Oakbrook Terrace: Joint Commission Resource, 2003), 152-153.

presenting might include, but are not limited to patient lifestyle, i.e., homosexual identified, drug or alcohol addiction, homelessness, etc.

Dimensions of Spiritual Assessment[12] [13]

Beliefs and Meaning

What beliefs give meaning and purpose to patient's life? Are there any major symbols that reflect or express meaning? What is the patient's personal story and history leading to their current beliefs and meaning? Have the current patient issues changed beliefs and meaning? Do current issues transform or reinforce belief and meaning? Does the patient have a formal system of belief and or faith tradition? These are all good questions to ask during assessment conversation.

Vocation and Obligations

What moral obligations, compromises, conflict, and or sacrifice to beliefs and meaning does the patients current medical issues cause or potentially cause? Examples of this may include, but are not limited to, considering an abortion due to rape or genetic fetal anomalies, having a blood transfusion when their faith tradition opposes, stem-cell therapy, etc.

Experience and Emotions

What religious or divine experiences has the patient had in the past and during their current medical issues? How do their divine experiences affect patient beliefs and meaning? What emotions do the divine experiences cause? These are all good questions

---

[12] Fitchett, *Assessing Spiritual Needs*, 39-51.

[13] Fitchett, *The 7x7 Model*, 1-4.

to ask during assessment conversation. Examples of divine experiences may include, but are not limited to visions, dreams, voices, Biblical revelation, etc.

Courage and Growth

Do current issues require patient to incorporate new experiences and problems into beliefs and meaning? Do they require transforming past beliefs and meaning into new ones? Perhaps the patient has unrealistic or unhealthy beliefs that need to transform. Unhealthy beliefs may include, but are not limited to God punishing us with illness or loss because we don't go to church, the patient will not be healed because they have sin they have not confessed, God is punishing them for whatever reason, etc.

Rituals and Practice

What rituals and practices are associated with the patient's beliefs and meaning? Do current or potential ongoing issues prohibit them from participating in meaningful rituals and practices? Jehovah's Witness patients receiving blood transfusion are at risk of excommunication, or as they call it, disfellowship. Bed ridden patients might be unable to attend church services of faith community functions.

Community

The influence of spirituality and the role of faith community in helping patients is important and has developed renewed interest.[14] Does the patient belong to a church or community sharing the same beliefs, meaning, rituals, and or practice? How does the patient participate in that community? What is their role in their faith community? Other important questions include, whether their faith community is aware of, or needs to be aware of the patient hospitalization, what level of comfort and support the patient is

[14] Jerome Kurent, "The Future," in Mathy D. Mezey RN EdD FAAN, ed., *The Encyclopedia of Elder Care: the Comprehensive Resource On Geriatric and Social Care* (New York: Springer Publishing Company, 2001), 496.

receiving from their faith community, whether the patient wants a visit from a pastor or leader from within their faith community, etc.

Authority and Guidance

Where does the patient find authority and guidance for their beliefs and meaning? This could be a pastor/chaplain, friend or family member, mentor, or other person. Perhaps authority and guidance come directly from God. Does the patient look inward or outward for guidance, and to what degree? This is not exactly the same as pastoral transference or authority. Although once establishing pastoral transference the patient might turn to them for guidance and authority. Patients will make significant decisions based upon authority and guidance. Decisions may include, but are not limited to end of life decisions, whether to accept treatment, compliance with medical intervention, etc.

Categorizing Written Spiritual Assessment Report

At this point, you have gathered significant information during the spiritual assessment process. As you are probably learning, spiritual assessment is art and science combined. The science is the spiritual assessment tool, mentally utilized as a template for patient interaction. The art is being able to extract useful assessment through observation, information, feeling, experience, and patient prompting. If you recall, assessment is "the process of gathering, analyzing, and synthesizing data into a multidimensional formulation that provides the basis for action decisions."[15] In other words, you must evaluate the information that you gathered during assessment conversations to identify patient strength and weaknesses in coping, and develop a plan of spiritual care intervention. To help analyze, and synthesize data into a multidimensional formulation

[15] Hodge, *Why Conduct*, 183-196.

that provides the basis for action decisions, you must categorize relevant spiritual and other information and potential issues in your assessment report. This author categorizes spiritual issues and other information as follows:

1. Introductory and Pre-visit information
2. Initial Feelings, Perceptions, and Observations
3. Personal Feelings
4. Pastoral Transference
5. Belief System
6. Faith Community/Support
7. Presenting Spiritual Dynamics
8. Spiritual/Religious Expression, Experience, and Practice
9. Spiritual Guidance and Authority
10. Spiritual Care for Future Ministry/Visits
11. Self-Evaluation of Visit

Introductory and Pre-visit information, Initial Feelings, Perceptions, and Observations, Personal Feelings, and Pastoral Transference has already been addressed. Information gathered for these areas need to be categorically included in your assessment report.

Belief System

This section of the assessment report includes, but is not necessarily limited to the following:

A. Patient religious tradition and teaching

B. Spiritual and or philosophical outlook in regards to coping with crisis and beliefs that are important during the hospitalization

C. Personal beliefs

D. Significant spiritual or philosophical images and or thoughts

E. Any patient "should and ought" beliefs

F. Beliefs about their current situation and or crisis

G. Meaning of illness, injury, or crisis—how are they making sense of it?

Faith Community/Support

This section of the assessment report includes, but is not necessarily limited to the following:

A. Is the patient a member or participant in a church, synagogue, mosque, or other group?

B. What kind of support, if any, is patient receiving from faith community?

C. What degree of support and or helpfulness of faith community does patient receive?

D. Is there a lack of support, or degree of hindrance from the faith community?

E. Is there clergy support or involvement from within faith community?

Presenting Spiritual Dynamics

Hicks provides an extensive study of spiritual dynamics and offers that 'dynamics' is the science of force; force can be latent or active and can cause motion, arrest or change in direction of motion . . . force is any cause that can produce effect.[16] In this case, it is spiritually related, what spiritual force is producing positive and negative effect?

[16] Amanda Hicks, *Spiritual Evolution* (Berkley: The Merchant Press, 1917), 19-23.

List the patient emotional and Intellectual strengths and challenges/weaknesses for contrast and comparison. In the emotional strengths column, include comfort, self- worth, courage, patience, encouragement, love, inner strength, or any other emotional positive strength that is helping the patient in coping with their current illness, injury, and or crisis. In the intellectual strengths column include faith, helpful perspective, balanced hope, trust for what is beyond control, and or any other intellectual positive strength that is helping the patient in coping with their current illness, injury, and or crisis.

In the emotional challenges/weaknesses column, include grief, guilt, anxiety, shame, anger at God or others, frustration with faith, abandonment, or any other emotional negative challenge/weakness that is hindering the patient in coping with their current illness, injury, and or crisis. In the intellectual challenges/weaknesses column include "Why me," Theodicy, Conflict with religious teachings, struggle with meaning or purpose, concerns about afterlife, or any other intellectual negative challenges/weaknesses that is hindering the patient in coping with their current illness, injury, and or crisis. Theodicy is a religious conflict issue that questions why human beings suffer if God is omnipotent and perfectly good.[17] This can lead a patient to 'theodicy judgment,' a decision making process that result in a religious answer, stated in terms of the retaliation, plan or compassion model, to the dilemma invoked by innocent human suffering: whether to renounce faith or seek help from faith.[18]

---

[17] Paul Vermeer, *Learning Theodicy: the Problem of Evil and the Praxis of Religious Education* (Boston: Brill Academic Pub, 1999), 1.

[18] Ibid. 120-121.

Following is a graphical depiction of how to format presenting spiritual dynamics in your assessment report:

STRENGTHS	**WEAKNESSES/CHALLENGES**
Emotional Comfort, self-worth, courage, patience, Encouragement, love, inner strength, or any other emotional positive strength	**Emotional** Grief, guilt, anxiety, shame, anger at God or others, frustration with faith, abandonment, or any other emotional negative
Spiritual Faith, helpful perspective, balanced hope, trust for what is beyond control, and or any other intellectual positive strength	**Spiritual** "Why me," Theodicy, Conflict with religious teachings, struggle with meaning or purpose, concerns about afterlife, or any other intellectual negative

Spiritual/Religious Expression, Experience, and Practice

This section of the assessment report includes, but is not necessarily limited to the following important and or meaningful spiritual/religious expression, experience, and practice:

A. Regular spiritual practices
B. Rituals
C. Sacred scriptures and or texts
D. Spiritual/Religious objects and or symbols
E. Religious Rites—Baptism, Communion, Blessing, Dedication

F. Core religious experiences or direct encounters with spiritual realm

G. Spiritual insight, inspiration, and communication

H. Spiritual Disciplines—Prayer, Reading, Fasting, Confession, Journaling, Attending Church, Diet, Service to others, Personal faith to influence events

I. Mood about spirituality: i.e. Peaceful, Trusting, Centered, Grateful, Uncertain, Fearful, Angry, Guilty, Stoic, Disinterested

Spiritual Guidance and Authority

This section of the assessment report includes, but is not necessarily limited to the where the patient turns for spiritual guidance and authority.

A. How does faith influence decisions?

B. Where does authority for decisions come from? (Self, Clergy, Family, Scriptures, Religious Teachings, Inner voice, spirit of lost loved one, Nature, etc.)

C. What are the consequences of a particular decision? (Spiritually, Socially, emotionally, psychologically)

Spiritual Care for Future Ministry/Visits

This section is where you chart your concerns for intervention. This section will include spiritual distress and or other issues you have identified through assessment. It will also include thoughts and ideas for intervention surrounding the indentified spiritual distress and or other issues. Sometimes intervention will simply be to make a referral to a hospital social worker or other staff member. Intervention might also include consulting with another pastor or involving family members or leaders and or clergy from the patient’s faith community.

Another column in this section can include suspected potential issues identified, but not confirmed. You should chart any suspicions that you have so that you can later follow up on them. Perhaps you have identified some spiritual issues that are less important or less pressing than other issues, however later, you want to remember and address them.

This section may also include a column with consultation questions to present to peers or to your support person or counselor. Question might pertain to second opinion, outside insight and suggestion, or counter transference or other personal issues surrounding the patient.

Self-Evaluation of Visit

London states that Jesus taught that authentic faith starts at the inner life . . . Christianity insists that actions and attitudes flow from what is inside a person . . . for this reason, a pastor's inner life needs constant renewal and self-evaluation.[19] You probably want to get into the habit of reflecting upon your patient visits. What did you do right? What could you have done differently? Did you have any strong feelings or emotions during your visit? Are you aware of any potential counter transference issues? This is your section so you can be as honest with yourself as you wish. You may choose to share this information with your support person or peer.

[19] H.B. London and Neil B. Wiseman, *Married to a Pastor*, rev. ed. (Ventura: Regal, 1999), 95-96.

CHAPTER SIX

CONCLUSION

Hospitalized patients are at an elevated risk of suffering from spiritual distress. Spiritual distress is often precipitated by a medical illness or impending death.[1] Distress can have a detrimental effect on physical and mental health. Medical illness and impending death can often trigger spiritual distress in patients and family members.[2] Spiritual distress and spiritual crisis occur when individuals are unable to find sources of meaning, hope, love, peace, comfort, strength and connection in life or when conflict occurs between their beliefs and what is happening in their life.[3] Spiritual distress "occurs when a lack of connection to life or people occurs and when their life situation is in conflict with their beliefs.[4] From the perspective of stress and coping, religious practice and belief is a cultural means of providing people with ways of appraising and coping with stress. Religious frameworks provide a meaning for the occurrence of stress.[5] According to Gregory Bateson, "we select and edit the reality we see to conform to our

[1] Anandarajah, 81-88.

[2] Smucker, 81-91.

[3] Hay, 25-31.

[4] Anandarajah, 81-88.

[5] Aldwin, 244.

beliefs about what sort of world we live in."[6] Faith "helps us form a dependable 'life space,' an ultimate environment," that gives us hope, a reason for being.[7]

Spiritual distress is among the most common issues of concern revealed by the use of formal spiritual assessment tools. Characteristic indicators used to validate spiritual distress diagnosis are measured using seven manifestations that include spiritual pain, spiritual alienation, spiritual anxiety, spiritual guilt, spiritual anger, spiritual loss, and or spiritual despair.[8] [9] Spiritual assessments tools used to identify spiritual distress in hospitalized patients have proven to be predictive of health outcomes,[10] reveal patient ability to cope, and identify spiritual distress levels. With that said however, determining distress of a spiritual nature can be elusive, even to the patient. "A validated spiritual assessment tool has been as elusive as a definition of spirituality itself. Spiritual Assessment tools are useful in indentifying helpful intervention [to treat spiritual distress].[11]

Not only is spiritual assessment important in identifying and treating patients suffering with spiritual distress, according to research, the meeting of spiritual and emotional needs while hospitalized has become an expected value by most Americans. Recall that a majority of Americans believe in God. The National Impatient Priority Index Composite ranks hospital performance and patient importance by surveying

---

[6] Bateson, vii.

[7] Fowler, Stages of Faith, xii-xiii.

[8] O'Brien, 106-107.

[9] Learn Well Resources, *Spiritual Care*.

[10] Miller, 47-64.

[11] Muncy, 44-45.

approximately 1.4 million patients and since 1998, emotional and spiritual needs ranks second.[12] A Gallup poll of Americans in 2000[13] revealed that 91% believe in God, with 87% feeling that "God is highly important" in their lives. Another study polled 1,000 adults in the United States to find that 79% believe that spiritual faith can help people recover from disease . . . another 63% believe that physicians should inquire about the spiritual beliefs of their patients.[14] When chaplains help a patient's family, the patient is more likely to choose that institution again for future hospitalization.[15]

As a means of coping, patients often turn to their spiritual beliefs during crisis.[16] Many believe that their spiritual beliefs can help in their recovery from disease[17] and 82% of Americans believe in the healing power of personal prayer.[18] Studies reveal that as many as 70% of patients are aware of one or more spiritual needs that relate to their illness.[19] A study of older adults found that more than half reported that their religion was the most important resource that helped them cope with illness.[20] In another study, 44% of the patients reported that religion was the most important factor that helped them cope with their illness or hospitalization.[21] Studies of patients in acute care hospitals indicate

---

[12] Clark, 659-670.

[13] Carballo, *Gallup International Millennium Survey*.

[14] McNichol, 4-5.

[15] Gibbons, *The Value of Hospital Chaplains: Patient Perspectives,* 117-125.

[16] Pargament, *Psychology of Religion,* 71-132.

[17] McNichol, 4.

[18] Kaplan, 62.

[19] Fitchett, *Religious Needs*,320-326.

[20] Koenig, *Religious Activities,* 362-374.

[21] Koenig, *Religious Perspectives*, 254-267.

that between one third and two thirds of all patients want to receive spiritual care.[22] The "Beliefs and Attitudes of Hospital Inpatients about Faith Healing and Prayer" published in Journal of Family Practice[23] study of more than two-hundred family practice adult inpatients concluded that findings "support the hypothesis that although many patients desire more frequent and more in-depth discussions about religious issues with their physicians, physicians generally do not discuss these issues with their patients." Perhaps patients have known all along what the medical industry has recently discovered and come to accept; that a direct correlation exists between physical health and spiritual health.

A growing body of research indicates that spirituality is often a significant patient strength[24] and often a core animating principle in a persons' view of reality, their spirituality, thus, often fosters a culturally distinct worldview.[25] Studies have proven the correlation between spiritual beliefs and practices with improved health and coping. A meta-analysis of data from 42 published mortality studies involving approximately 126,000 participants revealed that individuals reporting frequent religious involvements were significantly more likely to live longer in comparison to persons who were infrequently religiously involved.[26]

A study of nearly 600 severely ill elderly patients revealed that those who sought a connection with God, as well as support from pastors and their faith community were

---

[22] Fitchett, *Spiritual Care*, 173-186.

[23] King, 349-352.

[24] Koenig, *Handbook,* 141-162.

[25] Plante, 240-261.

[26] McCullough, 211-222.

less depressed and ranked quality of life as higher, even after accounting for the severity of their illness.[27] Another study of 1,600 cancer patients exhibiting symptoms of fatigue and pain revealed that patients with higher levels of spiritual wellbeing enjoyed a significantly higher quality of life.[28] Another study of breast cancer patients revealed that 88% claimed religion was important to them and 85% stated that their religious beliefs helped them to cope during the disease.[29] Similarly, 93% of gynecological cancer patients report that religion increased their sense of hope.[30] Another cancer patient study revealed that 76% prayed as a way to cope with their diagnosis. [31]

Studies point to the importance of spiritual distress, that is, un- resolved religious or spiritual conflicts and doubts. This distress is associated with decreased health, recovery, and adjustment to illness.[32] [33] Ellison and Levin proclaim that several hundred studies exist on spirituality and religion, with the majority emphasizing spirituality as a key strength in personal well-being.[34] A significant number of studies exist that prove the relationship between religious practices and beliefs and positive health related outcomes.[35] The reality is that attending to patient spiritual needs improves satisfaction

---

[27] Koenig, *Religious Coping*, 513-521.

[28] Brady, 417-428.

[29] Johnson, *Coping*, 21-33.

[30] Roberts, 166-172.

[31] VandeCreek, *Use of Alternative*, 71-76.

[32] Berg, 359-363.

[33] Fitchett, *Role of Religion*, 333-353.

[34] C. G. Ellison and J.S. Levin The Religion-Health Connection: Evidence, Theory, and Future Directions. Health Education and Behavior, 25(6), 700-720. 1998.

[35] Koenig, *Handbook*, 4*ff.*

with care and helps patients cope with crisis resulting from changes in health.[36] Spiritual assessments help in communicating and understanding patient needs. Spiritual assessment tools have proven to be predictive of health outcomes,[37] reveal patient ability to cope, and identify spiritual distress levels. Studies demonstrate that spiritual wellbeing helps patients to moderate feelings that accompany illness: anxiety,[38] hopelessness,[39] and isolation.[40] Many hospitalized patients expect pastors to help them with such distressing feelings.

Medical institutions have become more aware of the value and expectations patients place on having their spiritual needs met. No longer can they ignore the need for holistic care. Research continues to confirm the facts surrounding the correlation between spiritual and physical health. All these observations support the growing consensus about the need to better integrate the spiritual dimension into hospital care.[41] The medical industry acknowledges that spiritual wellbeing is an important aspect of holistic healing, requiring spiritual assessment of patients.

WHO, the World Health Organization recognizes spirituality as an important dimension in quality of life, while NANDA, the North American Nursing Diagnosis

---

[36] Clark, 659-670.

[37] Miller, 47-64.

[38] Jane Kaczorowski, "Spiritual Well-Being and Anxiety in Adults Diagnosed with Cancer, *The Hospice Journal 5*(3/4) (1989): 105-116.

[39] Jacqueline Mickley, Karen Soeken, and Anne Belcher, "Spiritual Well-Being, Religiousness and Hope Among Women with Breast Cancer," *Journal of Nursing Scholarship 24*(4) (1992): 267-272.

[40] Shoshana Feher and Rose Maly, "Coping With Breast Cancer in Later Life: The Role of Religious Faith," *Psycho-Oncology 8*(5) (1999): 408-416.

[41] Alan Astrow, Ann Wexler, KennethTexeira, M. Kai He, and Daniel Sulmasy, "Is failure to Meet Spiritual Needs Associated with Cancer Patients' Perceptions of Quality of Care and Their Satisfaction with Care?," *Journal of Clinical Oncology* 25(36): (2007): 5753-5757.

Association lists spiritual distress, or 'distress of the human spirit' as a valid medical diagnosis that includes proven negative impact and risk upon patient health.[42] The Joint Commission on the Accreditation of Healthcare Organizations (J.C.A.H.O.) makes clear, "Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values."[43] J.C.A.H.O., WHO, and NANDA are addressing the awareness and promoting of spiritual care, but many patients still go through hospitalization without thorough spiritual assessment and or care. Findings such as these have resulted in JCAHO to mandate spiritual assessment for patients entering into any approved facility.[44] Unfortunately, the mandate does not require a pastor or spiritual professional to administer such an assessment. There also are no documentation procedures and or assessment content specified in the mandate.[45]

Institutions that ignore the spiritual dimension as part of their mission or daily provision of care increase their risk of becoming only "biological garages where dysfunctional human parts are repaired or replaced."[46] Such "prisons of technical mercy"[47] obscure the integrity and scope of the holistic person. With that said, most facilities tend to utilize nothing more than a basic intake-screening questionnaire to fulfill

---

[42] Pargament, *Religious Coping*, 713-730.

[43] Joint Commission, 6-7.

[44] George Fitchett, Patricia Murphy, Jo Kim, James Gibbons, Jacqueline Cameron, and Judy Davis, "Religious Struggle: Prevalence, Correlates, and Mental health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients," *International Journal of Psychiatric Medicine* 32(2) (2000): 179-186.

[45] Joint Commission, 6-7.

[46] James Gibbons and S.L. Miller, "An Image of Contemporary Hospital Chaplaincy," *Journal of Pastoral Care 43*(4) (1989): 355-361.

[47] Wendell Berry, "A Parting," In *Entries: Poems by Wendell Berry* (New York: Pantheon Books, 1994), 11.

the mandate. No formal theological training is required of medical clinicians who are responsible for spiritual assessments.

Unfortunately, medical staff members are ill equipped to provide holistic spiritual care to patients; the responsibility defaulting then, to those most qualified to provide spiritual care, pastors and chaplains. Many physicians proclaim that they do not have the time or training necessary to make a spiritual assessment, and or they feel uncomfortable or uncertain when patients pose spiritual issues.[48] [49] Many physicians simply lack the awareness of the importance of patient spiritual beliefs.[50] At the same time, 96% of the 231 physicians polled regarding spiritual wellbeing[51] consider spiritual care important to health and 86% support referring hospital patients with spiritual question to chaplains. In the same study, less than 20% of physician report discussing spiritual topic with patients. Of respondents, 71% said they did not address spiritual issues due to time constraints, 59% cited inadequate training, and 56% found it difficult to identify patients with spiritual issues.

The conclusion of studies is that most physicians believe spiritual well-being is an important factor in health, however, most report infrequent discussion with patients for reasons cited. Most physicians believe in referring patients to chaplains, but admit that they do so infrequently. This explains why spiritual assessment value among hospital staff is not at a higher priority. This also reveals the greater need for pastors and chaplains to assess patient spiritual needs and work closely with hospital support staff to

---

[48] Ellis, 105-109.

[49] Chibnall, 374-379.

[50] Jones, 280-283.

[51] Ellis, 105-109.

ensure more holistic patient care. In recent years, hospitals have started to understand the significance of spiritual care and spiritual assessment, sparking some positive changes, however, duty still lies heavily with pastors and chaplains. Recall that The Joint Commission does suggest that "As with any other kind of assessment, staff members conducting a spiritual assessment should be competent to do so."[52]

Fortunately, pastors and chaplains tend to have a better understanding of and training in theological and spiritual matters. Unfortunately, the hospital pastor profession has completed very little research on spiritual care overall, leaving the medical industry to depend upon pastoral care and counseling journals[53] for information and guidance about spiritual assessment and care. The problem is that the authors of most journal articles are physicians, nurses, counselors, and or other hospital staff members who do not have training and expertise in theological or spiritual matters. In other words, the industry turns to itself to learn about information it knows too little about, in an effort to learn more. It is for these reasons pastors and hospital chaplains must begin to utilize spiritual assessment tools when making pastoral hospital visits. Understanding the spiritual needs of patients requires more than an initial intake screening consisting of nothing more than a tick-box assessment.[54] The assessment should also determine whether more in-depth assessments are necessary.[55] As with any other kind of assessment, staff members conducting a spiritual assessment should be competent to do so. The medical industry has delegated its responsibility for competent spiritual

---

[52] Joint Commission, 6.

[53] John Gartner, 115-123.

[54] Gordon, *Spiritual Care*, 73.

[55] Joint Commission, 6.

assessment and care to the clerical community. It is up to pastors to do everything within their power to be competent in doing so.

Research revealed that a majority of pastors making hospital visits received inadequate training in important areas necessary for effective spiritual assessment and intervention. The *Pastoral Hospital Visitation and Chaplaincy Survey* found that out of more than 600 pastors, less than 1% claimed receipt of any type of pastoral hospital visitation training while enrolled in seminary. The number of seminary graduates and attendees in the study is unknown. There is a high likelihood of seminary graduates in this study due to a majority of responders are endorsed by N.A.M.B., A.C.P.E., and A.P.C. All of whom require a seminary degree. Nearly 7% of associate pastors and over 13% of lay ministers have received no training whatsoever. Approximately 27% of senior pastors, 18% of associate pastors, and 31% of lay ministers have received no psychosocial training.

Overall, more than 53% indicate that they keep no record or notes of their hospital visits. Among senior pastors, 74% indicate that they keep no notes, while 13% file a basic hospital visitation report with their church. Nearly 10% of chaplains keep personal record and or notes and 22% make notes in hospital charts. Part of proper ongoing assessment and care is evaluating notes to track progress and chart potential distress issue. Proper spiritual assessment and self-evaluation requires pastors to keep assessment notes. Approximately 77% admitted they do not utilize or only sometimes utilize any type of assessment tool(s) when making pastoral hospital visits, but when asked, only 3% responded that assessment tools are not important.

Other necessary areas of training that are lacking for pastors making hospital visits include transference, counter transference, secondary trauma, and proper self-care. Nearly 40% of responding pastors in the *Pastoral Hospital Visitation and Chaplaincy Survey* when asked, "I have found it challenging and or have experienced strong negative feelings when attempting hospital visits with someone who is . . ." identified strong negative feelings present when visiting patients who are of a differing faith tradition, atheist, non-Christian, or homosexual. Another 20% felt strong negative feelings when visiting criminals, child abusers, drugs abusers or alcoholics, and mentally ill or suicidal patients. The negative feelings, no doubt, come from issues associated to the pastor's beliefs and life experiences.

In regards to self-care and secondary trauma, pastors identified how frequently they experienced intense feelings, depression, loss of appetite, panic, anger, and or anxiety following hospital visits. Over 28% of respondents of the *"Pastoral Hospital Visitation and Chaplaincy"* survey indicated that they have experienced unexplained panic, anxiety, anger, and other intense feelings following hospital visits. Nearly 25% of respondents experienced loss of sleep or appetite, or felt down or depressed for more than one day following difficult hospital visits.

Proper training and awareness surrounding patient hospital visitation issues make pastors more effective in ministry and help them achieve higher levels of professional and personal growth. Understanding how beliefs and experiences inform and influence ministry help pastors to be more aware of counter transference issues previously unknown to them. It also helps create an awareness of situations likely to cause secondary trauma, making it more likely to avoid, or easier to manage. Training and

better understanding in all of these areas make for a healthier, happier, and more effective pastor.

This project discussed and reviewed current assessment models, looking at types, strengths and weaknesses, features, and benefits of using spiritual assessment tools. Examples were given of three of the most useful and easily administered spiritual assessment tools available to pastors making hospital visits, 7X7 Model of Spiritual Assessment, F.I.C.A. tool (Faith and belief, importance, community, and address in care), and H.O.P.E. questionnaire.

The F.I.C.A. Assessment Tool is one of the more general assessment instruments, better used for spiritual screening and initial assessment. This Assessment provides information about what or who gives the patient a transcendent meaning of life.[56] This tool is useful to pastors for making a quick initial assessment and when making an initial pastoral visit. It is also useful for starting a spiritual conversation in a manner that is less intimidating to some patients. This assessment tool focuses upon four areas of concern, faith and belief, importance, community, and address in care.

The H.O.P.E. Assessment is a spiritual assessment tool developed to teach medical students and staff how to incorporate spiritual assessment into their medical interviews with patients. It is the assessment tool recommended by the J.C.A.H.O.[57]The Hope Assessment questionnaire is brief, making it useful in time-limited situations. It is also one of the less intrusive initial assessments, sensitive to a wide range of belief systems and cultures. The Hope Assessment focuses on hope, meaning, love, strength, peace, and comfort, without focusing upon organized religion.

---

[56] Girardin, 268-279.

[57] Joint Commission, 6-7.

The 7X7 Model of Spiritual Assessment is the most complete assessment tool, offering a holistic approach to patient wellbeing without ignoring the spiritual dimensions of patient care. The 7X7 model, by its very design accommodates triage and ongoing spiritual care. This model is fluid to allow for the many changing needs of hospitalized patients. Remember, not all crisis' are spiritually or theologically based;[58] and the indicators associated with spiritual distress (pain, alienation, anxiety, guilt, loss, and despair) may often relate to both spiritual and psychosocial problems.[59] The 7X7 assessment is multi-dimensional and functional in that it is concerned with a person's belief about God, how they find meaning and purpose in life and experiences. It looks at behavior and response, emotions, practices, traditions, and relationships. This assessment functions with the use of open-ended questions that draw out the narrative of the strengths, beliefs, and challenges of the patient. Questions may be standardized or fluid. [60] [61] The *"New Model of Spiritual Assessment for Pastors Making Hospital Visits"* chapter in this work derived from the 7X7 Model of Spiritual Assessment.

This study revealed that there is no standard or universally approved definition of spiritual assessment, but regardless of the slight differences when defining spiritual assessment, the fact remains that spiritual assessment is a process that includes gathering and interpretation of information in order to conduct effective intervention for those persons struggling with issues of spiritual distress. Proper assessment needs to be the cornerstone of pastoral care, both in and out of the hospital. Proper spiritual assessment

---

[58] Clements, 11*ff.*

[59] NANDA Staff, 67.

[60] Fitchett, *Assessing Spiritual Needs,* 39-51.

[61] Fitchett, *The 7x7 Model,* 1-4.

performed by a pastor is not the same as spiritual screening performed by a clinician or other hospital staff member.

The *"New Model: Elements of Adaptive Spiritual Assessment"* included in this project, allows for the diversity of patients, patient beliefs, and patient spiritual issues. It is impartial and directed by the patient, with the guidance of pastoral presence, but not by the presumptions of the pastor performing the assessment. As with the very nature of any useful spiritual assessment tool, the *"New Model"* is a flexible process that responds to the changing needs of patients and their families.[62] The *"New Model"* is fluid and interchangeable, not a "one size fits all" spiritual assessment tool.

The *"New Model"* addresses assumptions that can arise from using spiritual assessment tools and the importance of assessing pastors to understand the elements of spiritual care discussed in this work, i.e. differences between spirituality and religion, defining spiritual distress and describing its symptoms, and clarifying the definition, process, and purposes of spiritual assessment. Recall that not all patients are religious, but everyone is spiritual; not everyone believes in God, but everyone believes in something. Anyone, regardless of belief can struggle with spiritual distress issues. In fact, cognitively, the belief [or unbelief] is the most likely cause of the distress.

The *"New Model"* process and format offers resources in the relevant areas of Stages of Grief and Grief Counseling, Hope, Crisis Intervention and or Critical Incident Stress Debriefing, Psychosocial Studies, and End of Life Issues. It discusses the important visitation issues of preparing for the initial visit, gathering pre-visit information, timing of the visit, initial perceptions, feeling, and observation, personal feelings, pastoral transference, counter transference, and process and dynamic of spiritual

[62] Gordon, *Spiritual Care,* 76.

assessment. The *"New Model"* assessment format assesses both the physical and spiritual hemispheres of holistic well being. It provides a template for documenting patient assessment findings, areas for potential concern, potential interventions, and self-evaluation of ministry. The template allows you to categorize assessment in a meaningful way by categorically documenting the following findings:

1. Introductory and Pre-visit information
2. Initial Feelings, Perceptions, and Observations
3. Personal Feelings
4. Pastoral Transference
5. Belief System
6. Faith Community/Support
7. Presenting Spiritual Dynamics
8. Spiritual/Religious Expression, Experience, and Practice
9. Spiritual Guidance and Authority
10. Theology of the Visit
11. Spiritual Care for Future Ministry/Visits
12. Self-Evaluation of Visit

As mentioned, not every pastor is skilled and called specific to hospital ministry. Some pastors may even dislike or feel great discomfort making hospital visits. The reasons behind pastor discomfort in making hospital visits are as vast and diverse as patients and their issues. The reality is that many pastors find themselves in a position that requires him to make pastoral hospital visits to friends, neighbors, and members of his congregation. Training in the proper areas helps with discomfort and contributes to

becoming a skilled hospital pastor. Developing an understanding of and adopting a proficient spiritual assessment model is crucial. It is also very helpful to seek the recommended additional training.

Providing spiritual care and performing spiritual assessment is more than "the process of gathering, analyzing, and synthesizing data into a multidimensional formulation that provides the basis for action decisions."[63] It is about people, it is about providing the presence of Christ and hope to the hopeless. It is about coming out of distress and into peace, and out of discontent into purpose. Remember, people choose to attend church, but most prefer not to choose becoming hospitalized. In addition, many religious patients do not notify their clergy of their hospitalization [64] [65] and nearly 60% of patients do not have a religious community to turn to during healthcare crisis. [66] What an opportunity for ministry! It is the ultimate hope of this author that pastors making hospital visits benefit from this work and that the information in this work will educate, inspire, and motivate them to become skilled at making pastoral hospital visits and that you will experience the same level of fulfillment as this author when making those visits. Remember, as a pastor you are specialist in your professions, board certified by God, and are saints, equipped for God's purposes.

---

[63] Hodge, *Why Conduct*, 183-196.

[64] Abigail Sivan, George Fitchett, and Laurel Burton, "Hospitalized Psychiatric and Medical Patients and the Clergy," *Journal of Religion and Health, 35*(1) (1996): 11-19.

[65] Larry VandeCreek and Stephanie Gibson, "Religious Support from Parish Clergy for Hospitalized Parishioners: Availability, Evaluation, Implications." *Journal of Pastoral Care 51*(4) (1997): 403-414.

[66] Sivan, 11-19.

APPENDIX A

PASTORAL HOSPITAL VISITATION AND CHAPLAINCY SURVEY

1. Are you?

- ☐ Male
- ☐ Female

2. What is your daily role in ministry?

- ☐ Senior Pastor
- ☐ Associate Pastor
- ☐ Chaplain
- ☐ Lay Ministry

Other (please specify)

3. How many years have you worked in your ministry?

- ☐ Less than one year
- ☐ 1-3 years
- ☐ 4-6 years
- ☐ 7-10 years
- ☐ More than 10 years

4. How often do you make pastoral visits to hospitals?

- ☐ Never
- ☐ 1-4 times per year
- ☐ Monthly
- ☐ Several times per month
- ☐ Daily

5. What type of training did you receive to prepare you for pastoral hospital visits? (Check all that apply)

- ☐ Training through home church
- ☐ Denominational training
- ☐ 1-2 units of Clinical Pastoral Education
- ☐ 3 or more units of Clinical Pastoral Education

Other (please specify)

6. How comfortable is it for you to make pastoral hospital visits?

- ☐ Not at all comfortable
- ☐ Slightly nervous
- ☐ Somewhat comfortable
- ☐ Comfortable
- ☐ Very comfortable

7. What type of psychosocial training have you received?

- ☐ None
- ☐ Read some journals, books, and/or articles
- ☐ Extensive psychosocial studies
- ☐ Studies specific to hospitalized patients and/or patient families
- ☐ Professional psychosocial education and/or certification

8. How important is it to have some sort of training prior to making pastoral hospital visits?

- ☐ Not at all important
- ☐ Somewhat important
- ☐ Important
- ☐ Very important

9. How familiar are you with the 5-7 stages of grief?

- ☐ Not at all familiar
- ☐ Somewhat familiar
- ☐ Familiar
- ☐ Very familiar

10. What percentage of patients with whom you make pastoral hospital visits are members of your church or congregation?

- ☐ 0-25 percent
- ☐ 25-50 percent
- ☐ 50-75 percent
- ☐ 75-100 percent

11. What percentage of patients with whom you make pastoral hospital visits are non-Christian?

- ☐ Less than 5 percent
- ☐ 5-10 percent
- ☐ More than 25 percent
- ☐ More than 50 percent

12. How comfortable is it for you to make pastoral hospital visits when sick or dying children are involved?

- ☐ Not at all comfortable
- ☐ Slightly nervous
- ☐ Somewhat comfortable
- ☐ Comfortable
- ☐ Very comfortable

13. Other than for healthy pregnancy delivery, how many times have you been hospitalized for more than three consecutive days?

- ☐ Never
- ☐ Once
- ☐ 1-3 times
- ☐ More than 3 times

14. What are the ages of your children?
(Check all that apply)

- ☐ 0-2 years
- ☐ 2-6 years
- ☐ 7-14 years
- ☐ 14-18 years
- ☐ Adult

- [ ] I have no children

15. Compared to visiting hospitalized adults, how difficult is it to visit hospitalized children?

- [ ] Much more difficult to visit children
- [ ] Somewhat more difficult to visit children
- [ ] About the same as visiting adults
- [ ] Somewhat easier than visiting adults
- [ ] Much easier than visiting adults
- [ ] I have never visited hospitalized children

16. How much time do you typically spend with a patient and/or patient family during a hospital visit?

- [ ] Less than 10 minutes
- [ ] 10-30 minutes
- [ ] 30-60 minutes
- [ ] More than one hour
- [ ] More than two hours

17. On average, how many times do you visit a patient and/or patient family during a single hospitalization?

- [ ] Once
- [ ] 1-2 visits
- [ ] 3-5 visits
- [ ] As many visits are necessary

18. What do you believe is your primary agenda when making pastoral hospital visits?

- [ ] Perform expected pastoral obligation to members of my congregation
- [ ] To evangelize or convert
- [ ] To provide comfort
- [ ] To be a pastoral presence
- [ ] To be a friend
- [ ] To read Scripture or pray
- [ ] To cheer up the patient and/or family
- [ ] provide communion, baptism, or other ceremonial task

- [ ] Provide ongoing pastoral counseling or support

Other (please specify)

19. How many End of Life pastoral hospital visits have you made?

- [ ] None
- [ ] 1-2
- [ ] 3-5
- [ ] 5 or more

20. What type of notes or records do you keep when making pastoral hospital visits? (Check all that apply)

- [ ] I do not keep records or notes
- [ ] I file a basic report/record with the church
- [ ] I keep detailed private notes of visits, including pastoral concerns and/or intervention
- [ ] I chart detailed notes and share relevant information with appropriate hospital staff

Other (please specify)

21. How much do you think your personal life experiences influence your pastoral hospital visits?

- [ ] Not at all
- [ ] Rarely influences visits
- [ ] Experiences slightly influence visits
- [ ] Significantly influences visits
- [ ] I never thought much about it

22. How much do you feel your beliefs influence your pastoral hospital visits?

- [ ] Not at all
- [ ] Rarely influences visits
- [ ] Beliefs slightly influence visits
- [ ] Significantly influences visits
- [ ] I never thought much about it

23. During a pastoral hospital visit have you ever experienced unexplained panic, anxiety, anger, or other intense feelings?

- ☐ Never Once
- ☐ Occasionally
- ☐ Frequently
- ☐

24. Have you ever experienced loss of sleep or appetite; or felt down or depressed for more than one day following difficult hospital visits?

- ☐ Never
- ☐ Once in a while
- ☐ Sometimes
- ☐ Frequently
- ☐ Almost always

25. Who is your primary support for debriefing and/or decompressing following difficult pastoral hospital visits?

- ☐ I have no support system
- ☐ My spouse of other family member
- ☐ My secretary or assistant
- ☐ A pastor who does not make regular hospital visits
- ☐ A mentor
- ☐ Another person who makes pastoral Hospital visits
- ☐ A personal friend
- ☐ Licensed or pastoral counselor

26. How much knowledge or training do you have regarding crisis and crisis intervention?

- ☐ Very little or no knowledge or training
- ☐ I have done a little reading about it
- ☐ I have completed specialized training
- ☐ I have received specialized certification in Emergency stress management, Critical incident stress debriefing, or other program or system

27. Do you utilize any type of assessment tool(s) when making pastoral hospital visits?

- ☐ I do not use any assessment tools
- ☐ I sometimes use assessment tools
- ☐ I usually use assessment tools
- ☐ I always use assessment tools

28. How important is patient and family spiritual assessment when making pastoral hospital visits?

- Not at all important
- Somewhat important
- Important
- Very important

29. How important is confidentiality regarding the names and specifics of patients and patient families you visit in the hospital?

- Confidentiality does not apply
- It is best to share only pertinent information with relevant church employees
- It is best to share as much information as possible with everyone in the church so they can be praying for them
- It is best to keep information confidential unless specifically authorized by the patient or family to share it with others

30. I have found it challenging and/or have experienced strong negative feelings when attempting hospital visits with someone who is:
(Check all that apply)

- Does not apply
- Dying
- Senior citizen
- Different race
- Different faith tradition
- Abusing drugs or alcohol
- Criminal
- Homosexual
- Suspected of Child abuse

Other (please specify)

APPENDIX B

NAMB INVITATION EMAIL LETTER

North American Mission Board — Chaplaincy UPDATE

April 3, 2012

Chaplains,

Chaplain Doug Robinson is working on his DMin project and is requesting your participation in a brief, 30-question survey of multiple-choice questions regarding pastoral hospital visitation. The purpose of the project is to compare and contrast the way hospital ministry is performed by pastors, chaplains, and lay ministers in areas that include training, objective, purpose, impact, transference, and affect.

The study is strictly confidential for the purpose of collecting research statistics for his doctoral thesis project. No identifiable personal data is collected, stored, or shared.

The survey takes approximately ten minutes to complete and is located on Survey Monkey at: https://www.surveymonkey.com/s/BZ2X62L.

Thank you for supporting Doug in his research.

Blessings,

Your Chaplaincy Evangelism Team

SEND NORTH AMERICA

Subscribe to This Newsletter | Previous Issues | Comments | NAMB.net

BIBLIOGRAPHY

Aguiuera, Donna. *Crisis Intervention: Theory and Methodology.* Philadelphia: Mosby, 1998.

Aldwin, Carolyn. *Stress, Coping, and Development: An Integrative Perspective*. New York: Guilford Press, 1994.

Allen, Russell, and Bernard Spilka. "Committed and Consensual Religion: A Specification of Religion-Prejudice Relationships." *Journal for the Scientific Study of Religion 6*(2) (1967): 191-206.

Alter, Margaret. *Religious Experience Inventory Empirical Study of Christian Religious Maturity and its Relationship to Mental Health.* Doctoral Thesis. Berkeley, CA Graduate Theological Union, 1985.

Anandarajah, Gowri, and Ellen Hight. "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment." *American Family Physician 63*(1) (2001): 81-88.

"Association of Profession Chaplains." Association of Professional Chaplains. http://professionalchaplains.org (accessed July 22, 2012).

Astrow, Alan, Ann Wexler, Kenneth Texeira, M. Kai He, and Daniel Sulmasy. "Is failure to Meet Spiritual Needs Associated with Cancer Patients' Perceptions of Quality of Care and Their Satisfaction with Care?" *Journal of Clinical Oncology* 25(36): (2007): 5753-5757.

Batson, C. Daniel. "Religion as Pro-Social: Agent or Double Agent?" *Journal for the Scientific Study of Religion 15*(1) (1976), 29-45.

Bateson, Gregory. *Steps to an Ecology of Mind: A Revolutionary Approach to Man's Understanding of Himself*. New York: Ballantine, 1972.

Benedict, L.M. "Spiritual Distress." In C. Koopsen and C. Young, *Integrative Health: A Holistic Approach for Health Professionals.* Sudbury: Jones and Bartlett, 2009.

Berg, Gary, Norman Fonss, Arthur Reed, and Larry VandeCreek. "The impact of Religious Faith and Practice on Patients Suffering From a Major Affective Disorder: A Cost Analysis." *Journal of Pastoral Care 49*(4) (1995): 359-363.

Berry, Wendell. "A Parting," In *Entries: Poems by Wendell Berry.* New York: Pantheon Books, 1994.

Brady, Marianne, Amy Peterman, George Fitchett, May Mo, and David Cella "A Case for Including Spirituality in Quality of Life Measurement in Oncology." *Psycho Oncology 8*(5) (1999): 417-428.

Brennan, Mark, and Deborah Heiser (eds.). *Spiritual Assessment and Intervention with Older Adults: Current Directions and Applications.* Binghamton: Haworth Pastoral Press, 2004.

Bullis, Ronald. *Spirituality in Social Work Practice.* Denver: Love Publishing, 2009.

Canda, Edward, and Leola Furman. *Spiritual Diversity in Social Work Practice: The Heart of Helping.* Oxford: Oxford University Press, 2010.

Carballo, Marita. "Religion in the World at the End of the Millennium." *Gallup International Millennium Survey.* Washington: Gallup International, 1999.

Carroll, M.M. "Spirituality and Clinical Social Work: Implications of Past and Current Perspectives." *Arete 22*(1) (1997): 25-34.

Chibnall, John, and Christy Brooks. "Religion in the Clinic: The Role of Physician Beliefs." *Southern Medical Journal 94* (2001): 374-379.

Chidester, David. *Patterns of Transcendence: Religion, Death, and Dying*. Belmont, CA: Wadsworth, 1990.

Clark, Paul, Maxwell Drain, and Mary Malone. "Addressing Patients' Emotional and Spiritual Needs."*Joint Commission Journal on Quality and Safety 29* (2003): 659-670.

Clements, William, and Norma Sinclair. *Horrific Traumata: A Pastoral Response to the Post-Traumatic Stress Disorder.* Binghamton: Routledge, 1993.

"Dictionary.com." *Dictionary.com Unabridged*. Random House, Inc. http://dictionary.reference.com (accessed: June 22, 2012).

Daaleman, Timothy, and Bruce Frey. "Spiritual and Religious Beliefs and Practices of Family Physicians: A National Survey." *Journal of Family Practice 48*(2) (1999): 98-104.

Daaleman, Timothy, and Bruce Frey. "The Spirituality Index of Well-Being: A New Instrument for health-Related Quality-of-Life Research." *Annals of Family Medicine 2*(5) (2004): 499-503.

Daly, Gail. "Ethics and Economics," *Nursing Economics 18*(4) (2000): 194-201.

Davis, Christopher, and Susan Nolen-Hoeksema. "How Do People Make Sense of Loss." *American Behavioral Scientist 44*(5) (2001): 726-741.

Donahue, Michael. "Intrinsic and Extrinsic Religiousness The Empirical Research." *Journal for the Scientific Study of Religion 24* (1985): 418-423

Draper, Peter, and Wilfred McSherry. "A Critical Review of Spirituality and Spiritual Assessment." *Journal of Advanced Nursing 39*(1) (2002): 1-2.

Drench, Meredith, Ann Noonan, and Nancy Sharby. *Psychosocial Aspects of Health Care*, 2nd ed. Upper Saddle River: Prentice Hall, 2007.

Edwards, Keith. "Religious Experience Questionnaire." *Dissertation Abstracts International 36* (1976).

Ellis, Mark, Daniel Vinson, and Bernard Ewigman. "Addressing Spiritual Concerns of Patients: Family Physicians' Attitudes and Practices." *Journal of Family Practice 48* (1999): 105-109.

Ellison, Christopher. "Religious Involvement and Self-perception Among Black Americans." *Social Forces 71*(4) (1993): 1027-1055.

Ellison, Craig, and Joel Smith. "Toward an Integrative Measure of Health and Well Being." *Journal of Psychology and Theology 19* (1991): 35-48.

Ellison, Christopher, and Jeff Levin, "The Religion-Health Connection: Evidence, Theory, and Future Directions." *Health Education and Behavior 25*(6) (1998): 700-720.

Emblen, Julia, and Barbara Pesut. "Strengthening Meaning: A Model for the Spiritual Nursing Care of Patients Experiencing Suffering." *Journal of Holistic Nursing 19*(1) (1996): 42-56.

End-of-life Care For People Who Have Cancer." National Cancer Institute Fact Sheet. http://www.cancertopics/factsheet/support/end-of-life-care (accessed June 22, 2012).

Everly, George. *Assisting Individuals in Crisis*, 4th ed. Ellicott City: International Critical Incident Stress Foundation, 2006.

Everly, George. *Pastoral Crisis Intervention*. Ellicott City: Chevron Publishing, 2007.

Everly, George, and Jeffrey Mitchell. *Critical Incident Stress Management -CISM-: A New Era and Standard of Care in Crisis Intervention*. Ellicot City: Chevron, 1999.

Ehman, John, Barbara Ott, Thomas Short, Ralph Ciampa, John Hanson-Flaschen. "Do Patients want Physicians to Inquire about their Spiritual or Religious Beliefs if they Become Gravely Ill?." *Archives Internal Medicine 159* (1998): 1803-1806.

Feher, Shoshana, and Rose Maly. "Coping With Breast Cancer in Later Life: The Role of Religious Faith." *Psycho-Oncology 8*(5) (1999): 408-416.

Fetzer Institute. Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research. http://www.fetzer.org/images/stories/pdf/MultidimensionalBooklet.pdf? (accessed July 22, 2012).

Figley, Charles R. *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized.* New York: Brunner/Mazel, 1995.

Fitchett George, and J Russell Burch. "A Multi-Dimensional Functional Model for Spiritual Assessment." *The Caregiver Journal 7* (1990): 43-62.

Fitchett, George. *Assessing Spiritual Needs: A Guide for Caregivers.* Minneapolis: Augsburg Press, 1993.

Fitchett, George. "The 7x7 Model for Spiritual Assessment: A Brief Introduction and Bibliography." Chicago: Rush University Medical Center, available via www.rushu.rush.edu/rhhv. (accessed June 22, 2012).

Fitchett, George. *Spiritual Assessment in Pastoral Care: A Guide to Selected Resources.* Decatur, JPC Publications, 1993.

Fitchett, George, Bruce Rybarczyk, Gail DeMarco, and John Nicholas. "The Role of Religion in Medical Rehabilitation Outcomes: A Longitudinal Study." *Rehabilitation Psychology 44*(4) (1999): 333-353.

Fitchett, George, Patricia Murphy, Jo Kim, James Gibbons, Jacqueline Cameron, and Judy Davis, "Religious Struggle: Prevalence, Correlates, and Mental Health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients." *International Journal of Psychiatric Medicine 34*(2), (2004): 179-196.

Fitchett, George, Peter Meyer, and Laurel Burton. "Spiritual Care: Who Requests It? Who Needs It?" *Journal of Pastoral Care 54*(2) (2000): 173-186.

Fitchett, George, Laurel Burton, and Abigail Sivan. “The Religious Needs and Resources of Psychiatric Inpatients.” *Journal of Nervous and Mental Disease 185*(5) (1997): 320-326.

Foley, Kathleen M., Hellen Gelband, and editors. *Improving Palliative Care for Cancer*. Washington, D.C.: National Academies Press, 2001.

Fox, Raymond. *Elements of the Helping Process: A Guide for Clinicians*. 2nd ed. New York: Haworth Social Work Practice Press, 2001.

Foy, David, James Lowe, Lee Hildman, and Keith Jacobs. “Reliability, Validity and Factor Analysis of the Religious Attitude Inventory.” *Southern Journal of Educational Research 10* (1976): 235-241.

Franklin, Cynthia, and Cathleen Jordan. “Qualitative Assessment: Methodological Review.” *Families in Society 76*(5) (1995): 281-295.

Freud, Sigmund, quoted, In Peter Gay. *Freud: A Life for Our Time.* London: Anchor Books and Doubleday, 1989.

Gartner, John, David Larson, and Carole Vachary-Mayberry. “A Systematic Review of the Quantity and Quality of Empirical Research Published in Four Pastoral Counseling Journals: 1975-1984.” *The Journal of Pastoral Care 44* (1999): 115-123.

Gibbons, James, J. Thomas, Larry VandeCreek, and A. Jessen. “The Value of Hospital Chaplains: Patient Perspectives.” *Journal of Pastoral Care 45*(2) (1991): 117-125.

Gibbons, James, and S.L. Miller, “An Image of Contemporary Hospital Chaplaincy,” *Journal of Pastoral Care 43*(4) (1989): 355-361.

Girardin, David. “Integration of Complementary Discipline into the Oncology Clinic, Part IV: Implications for Spirituality with Oncology Patients.” *Current Problems in Cancer24* (5) (2000): 268-279.

Gleason, John. “Spiritual Assessment and Pastoral Response: A Schema Revised and Updated.” *The Journal of Pastoral Care 44*(1) (1990): 66-73.

Gleason, John. “The Four Worlds of Spiritual Assessment and Care.” *Journal of Religion and Health 38*(4) (1999): 305-317.

Gordon, Tom, and David Mitchell. “A Competency Model for the Assessment and Delivery of Spiritual Care.” *Palliative Medicine 18*(7) (2004): 646-651.

Gordon, Tom, Ewan Kelly, and David Mitchell. *Spiritual Care for Healthcare Professionals: Reflecting on Clinical Practice.* Oxford: Radcliffe Publishing, 2011.

Govier, Ian. "Spiritual Care in Nursing: A Systematic Approach." *Nursing Standard 14*(17) (2000): 32-36.

Hall, Todd, and Keith Edwards. "The Initial Development and Factor Analysis of the Spiritual Assessment Inventory." *Journal of Psychology and Theology 24 (*1996): 233-246.

Hartman, Ann. "Diagrammatic assessment of family relationships." *Families in Society 76*(5) (1995): 111-112.

Hay, Milton."Principles in Building Spiritual Assessment Tools." *American Journal of Hospice and Palliative Medicine 6* (1989): 25-31.

Hays, Judith, Keith Meador, Patricia Branch, and Linda George. "The Spiritual History Scale in Four Dimensions (SHS-4): Validity and Reliability." *Gerontologist 41* (2001): 239-249.

Hicks, Amanda. *Spiritual Evolution.* Berkley: The Merchant Press, 1917.

Hill, Peter, and Ralph Hood (Eds.). *Measures of Religiosity.* Birmingham: Religious Education Press. 1999.

Henry, Linda, and James Henry. *Reclaiming Soul in Health Care: Practical Strategies for Revitalizing Providers of Care.* Chicago: AHA Press, 1999.

Hodge, David. "Spiritual Genograms: A Generational Approach to Assessing Spirituality." *Families in Society, 82*(1) (2001): 35-49.

Hodge, David. "Why Conduct a Spiritual Assessment? A Theoretical Foundation for Assessment. *Advances in Social Work 5*(2) (2004): 183-196.

Holland, J.C., K.M. Kash, S. Passik, M.K. Gronert, A. Sison, M. Lederberg, S.M. Russak, L. Baider, and B. Fox, "A Brief Spiritual Beliefs Inventory for Use in Quality of Life Research in Life-Threatening Illness," *Psycho-Oncology 7*,(1998): 460-469.

Hunglemann, Joann, Eileen Kenekel-Rossi, Loretta Klassen, and Ruth Stollenwerk. "Focus on Spiritual Well-Being Harmonious Interconnectedness of Mind-Body Spirit-Use of the JAREL Spiritual Well-Being Scale." *Geriatric Nursing 17*(6) (1996): 262-266.

Hood, Ralph. "The Construction and Preliminary Validation of a Measure of Reported Mystical Experience." *Journal for the Scientific Study of Religion 14* (1975): 29-41.

Jackson-Cherry, Lisa, and Bradley Erford. *Crisis Intervention and Prevention.* Upper Saddle River: Prentice Hall, 2010.

JCAHO. *Hospital Patient Assessment: Meeting the Challenges.* Oakbrook Terrace: Joint Commission Resource, 2003.

Johnson, C.P. "Assessment Tools: are they an Effective Approach to Implementing Spiritual Health Care within the NHS?" *Accident and Emergency Nursing 9*(3) (2001): 177-186.

Johnson, Sarah, and Bernard Spilka. "Coping with Breast Cancer: The Roles of Clergy and Faith." *Journal of Religion and Health 30*(1) (1991): 21-23.

Joint Commission, "Evaluating Your Spiritual Assessment Process," *The Source 3*(2) (2005): 6-7.

Jones, A. Ward. "A Survey of General Practitioners' Attitudes to the Involvement of Clergy in Patient Care." *British Journal of General Practice 40* (1990): 280-283.

Jung, Carl. *Analytical Psychology: its Theory and Practice.* London: Routledge and Kegan, 1976.

Kaczorowski, Jane. "Spiritual Well-Being and Anxiety in Adults Diagnosed with Cancer. *The Hospice Journal 5*(3/4) (1989): 105-116.

Kahoe, Richard. "The Development of Intrinsic and Extrinsic Religious Orientations." *Journal for the Scientific Study of Religion 24* (1985): 408-412

Kaplan, Marty. "Ambushed by Spirituality." *USA Time Magazine* (June 24, 1996): 62.

Kennedy, James, Robert Davis, and Bruce Taylor. "Changes in Spirituality and Well Being Among Victims of Sexual Assault." *Journal for the Scientific Study of Religion 37*(2) (1998): 322-328.

King, Dana, and Bruce Bushwick. "Beliefs and Attitudes of Hospital Inpatients About Faith Healing and Prayer." *Journal of Family Practice 39*(4) (1994): 349-352.

King, Morton, and Richard Hunt. "Measuring the Religious Variable: Replication." *Journal for the Scientific Study of Religion 11* (3) (1972): 240-251.

Koenig, Harold, Dana King, and Verna Carson. *Handbook of Religion and Health.* New York: Oxford University Press, 2012.

Koenig, Harold, David Moberg, and James Kvale. “Religious Activities and Attitudes of Older Adults in a Geriatric Assessment Clinic.” *Journal of the American Geriatrics Society 36* (1988): 362-374.

Koenig, Harold, Kenneth Pargament, and J. Nielsen. “Religious Coping and Health Status in Medically Ill Hospitalized Older Adults.” *Journal of Nervous and Mental Disease 186*(9) (1998): 513-521.

Koenig, Harold, Linda George, and Patricia Titus. “Religion, Spirituality, and Health in Medically Ill Hospitalized Older Patients.” *Journal of the American Geriatrics Society 52* (2004): 554-562.

Koenig, Harold, Margot Hover, Lucille Bearon, and James Travis. “Religious Perspectives of Doctors, Nurses, Patients, and Families.” *Journal of Pastoral Care 45*(3) (1991): 254-267.

Krejcir, Richard. “Statistics on Pastors: What Is Going On with the Pastors in America?”Schaeffer Institute. http://www.intothyword.org/articles_view.asp?articleid=36562 (accessed July 30, 2012).

Kurent, Jerome. “The Future” in Mathy D. Mezey RN EdD FAAN, ed. *The Encyclopedia of Elder Care: the Comprehensive Resource On Geriatric and Social Care.* New York: Springer Publishing Company, 2001, 496.

Kübler-Ross, Elisabeth. *On Death and Dying.* New York: Scribner, 1997.

Larson, Kristin. “The Importance of Spiritual Assessment: One Clinician’s Journey.” *Geriatric Nursing 24*(6) (2003): 370-371.

Lawrence, Richard. “Measuring the Image of God: The God Image Inventory and the God Image Scales.” *Journal of Psychology and Theology 25* (1997): 214-226.

Learn Well Resources, Inc. “Spiritual Care: Help in Distress, A Learn Well course” Nursing continuing education online courses in health and ethics. http://www.learnwell.org/care.htm (accessed May 17, 2012).

London, H.B., and Neil B. Wiseman. *Married to a Pastor*. Rev. ed. Ventura: Regal, 1999.

Massey, David. *The Construction and Initial Factor Analysis of the Religious Status Inventory.* Pasadena: Fuller Theological Seminary, 1989.

Massey, Kevin, George Fitchett, and Patricia Roberts. “Assessment and Diagnosis in Spiritual Care.” In K.L. Mauk, and N.K. Schmidt (Eds.). *Spiritual Care in Nursing Practice.* Philadelphia, PA: Lippincott, Williams and Wilkins, 2004.

Maton, Kenneth, and Deborah Salem. “Characteristics of Empowering Community Settings: A Multiple Case Study Approach.” *American Journal of Community Psychology 23*(5) (1995): 631-656.

Mattaini, Mark, and Stuart Kirk. “Assessing Assessment in Social Work.” *Social Work 36*(3) (1991): 260-266.

McKee, Denise, and John Chappel. “Spirituality and Medical Practice.” *Journal of Family Practice 35* (1992): 205-208.

McSherry, Wilfred, and Linda Ross. “Dilemmas of Spiritual Assessment: Considerations for Nursing Practice.” *Journal of Advanced Nursing 38* (2002): 478-488.

McSherry, Wilfred, and Linda Ross (eds.). *Spiritual Assessment in Healthcare Practice.* Keswick: M & K Publishing, 2010.

Maugans, Todd, and William Wadland. “Religious and Family Medicine: A Survey of Physicians and Patients.” Journal of Family Practice 32 (1998): 210-213.

Mauk, Kristin, and Nola Schmidt. *Spiritual Care in Nursing Practice.* Philadelphia: Lippincott Williams and Wilkins, 2004.

McCullough, Michael, William Hoyt, David Larson, Harold Koenig, and Carl Thoresen. “Religious Involvement and Mortality: A Meta-Analytic Review.” *Health Psychology 19*(3) (2000): 211-222.

McNichol, Tom. “The New Faith in Medicine.” *USA Today vol. 4* (April 5, 1996): 4-5.

Meisenhelder, Janice. “An Example of Personal Knowledge: Spirituality.” In P.K. Nicholas and K.A. Wolf (Eds.). *A History of Nursing Ideas.* Boston: Jones and Bartlett, 2006.

Mickley, Jacqueline, Karen Soeken, and Anne Belcher. “Spiritual Well-Being, Religiousness and Hope Among Women with Breast Cancer.” *Journal of Nursing Scholarship 24*(4) (1992): 267-272.

Miller, William. *Integrating Spirituality Into Treatment: Resources for Practitioners.* DC: American Psychological Association, 1999.

Monod, Stephanie, Etienne Rochat, Estelle Martin, Stephane Rochat and Christipher Bula. "Instruments Measuring Spirituality in Clinical Research: A Systematic Review." *Journal of General Internal Medicine 26*(11) (2011): 1345-1357.

Monod, Stephanie, Estelle Martin, Brenda Spencer, Etienne Rochat, and Christopher Bula, "Validation of the Spiritual Distress Assessment Tool in Older Hospitalized Patients." *BMC Geriatrics* 12:13. http://www.biomedcentral.com/content/pdf/1471-2318-12-13.pdf (accessed online June 22, 2012).

Mueller, Paul, David Plevak, and Teresa Rummans. "Religious Involvement, Spirituality, and Medicine: implications for Clinical Practice." *Mayo Clinic Proceedings 76* (2001): 1225-1235.

Muffler, John, John Langrod, and David Larson, "There is a Balm in Gilead: Religion and Substance Abuse Treatment." In *Substance Abuse: A Comprehensive Textbook*, 2nd ed., eds. and Joyce Lowinson, Pedro Ruiz, Robert Millman. Baltimore: Williams and Wilkins, 1992, 584-595.

Muncy, Jerry. "Muncy Comprehensive Spiritual Assessment." *American Journal of Hospice and Palliative Care 13*(5) (1996): 44-45.

NANDA Staff. *Nanda Nursing Diagnoses: Definitions and Classification, 1999-2000.* Oxford: North American Nursing Diagnosis, 1999.

Nathanson, Irene. "Divorce and Women's Spirituality." *Journal of Divorce and Remarriage 22*(3/4) (1995): 179-188.

"North American Mission Board." http://www.namb.net (accessed June 24, 2012).

North American Nursing Diagnosis Association. *NANDA Nursing Diagnoses.* Ann Arbor: University of Michigan,1999.

O'Brien, Mary. "The need for spiritual integrity." In H.Yura and W. Walsh (Eds.), *Human Needs and the Nursing Process, vol. 2.* Norwalk: Appleton CenturyCrofts, 1982.

Oyama, Osamu, and Harold Koenig. "Religious Beliefs and Practices in Family Medicine." *Archive Family Medicine 7* (1998): 431-435.

Pargament, Kenneth, Harold Koenig, Nalini Tarakeshwar, and June Hahn. "Religious Coping Methods as Predictors of Psychological, Physical, and Spiritual Outcomes Among Medically Ill Elderly Patients: A Two-year Longitudinal Study." *Journal of Health Psychology 9*(6) (2004): 713-730.

Pargament, Kenneth. *The Psychology of Religion and Coping: Theory, Research, Practice.* New York: Guilford Press, 1997.

Pearlman, Laurie and Karen Saakvitne. *Trauma and the Therapist.* New York: W.W. Norton, 1995.

Peteet, John R. *Depression and the Soul: a Guide to Spiritually Integrated Treatment*. New York: Routledge, 2010.

Peterman, Amy, George Fitchett, Marianne Brady, Lesbia Hernandez, and David Cella. "Measuring Spiritual Well-Being in People with Cancer: The Functional Assessment of Chronic Illness Therapy—Spiritual Well-being Scale." *Annals of Behavioral Medicine 24*(1) (2002): 49-58.

Peterson, Eugene, *The Message//REMIX: The Bible in Contemporary Language*, Third Edition ed. Colorado Springs, CO: NavPress, 2008.

Pierce, Bruce. The Introduction and Evaluation of a Spiritual Assessment Tool in a Palliative Care Unit. *Scottish Journal of Healthcare Chaplaincy 7*(2) (2004): 39-43.

Plante, Thomas, and Naveen Sharma, "Religious Faith and Mental Health Outcomes. In T.G. Plante and A.C. Sherman, *Faith and Health: Psychological Perspectives.* New York: Guilford Press, 2001.

Puchalski, Christina. "Spiritual Assessment Tool." *End of Life Care 1*(6) (1999): 1-2.

Puchalski, Christina, and Anna Romer. "Taking a Spiritual History Allows Clinicians to Understand Patients More Fully." *Journal of Palliative Medicine 3(1)* (2000):129 137.

Puchalski, Christina, Betty Ferrell, Rose Virani, Shirley Otis-Green,Pam Baird, Janet Bull, Harvey Chochinov, George Handzo, Holly Nelson-Becker, Maryjo Prince Paul, Karen Pugliese, and Daniel Sulmasy. "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference." *Journal of Palliative Medicine 12*(10) (2009): 885-904.

Randall, Fiona, and Robert Downie. *Palliative Care Ethics: a Good Companion*. Oxford: Oxford University Press.

Reich, Annie. "On Counter-Transference." *International Journal of Psycho-Analysis 32* (1951): 25-31.

Roberts, James, Douglas Brown, Thomas Elkins, and David Larson. "Factors Influencing Views of Patients with Gynecological Cancer About End of Life Decisions." *American Journal of Obstetrics and Gynecology 176*(1) (1997): 166-172.

Rippentrop, Ann, Elizabeth Altmaier, Joseph Chen, Ernest Found, and Valerie Keffala. "The Relationship Between Religion/Spirituality and Physical Health, Mental Health, and Pain in a Chronic Pain Population." *Pain 116*(3) (2005): 311-321.

Rogers, Dal′ene C. Fuller. *Pastoral Care for Post-Traumatic Stress Disorder: Healing the Shattered Soul*. New York: Routledge, 2002.

Saakvitne, Karen, and Laurie Pearlman. *Transforming the Pain: A Workbook on Vicarious Trauma.* New York: W.W. Norton, 1996.

Saur, Marilyn, and William Saur. "Transitional Phenomena as Evidenced in Prayer." *Journal of Religion and Health 32*(1) (1993): 55-65.

Schwab, Reiko. "Paternal and Maternal Coping with the Death of a Child." *Death Studies14* (1990): 407-422.

Sermabeikian, Patricia. "Our Clients, Ourselves: The Spiritual Perspective and Social Work Practice." *Social Work 39*(2) (1994): 178-183.

Shoko, Munyaradzi. *The Role of Men in Hiv and Aids Management* . Bindura: GRIN Verlag, 2011.

Sivan, Abigail, George Fitchett, and Laurel Burton. "Hospitalized Psychiatric and Medical Patients and the Clergy." *Journal of Religion and Health, 35*(1) (1996): 11-19.

Smucker, Carol. "A Phenomenological Description of the Experience of Spiritual Distress." *International Journal of Nursing Terminologies and Classifications 7*(2) (1996): 81-91.

Strack, Stephen, Herman Feifel (eds.) *Death and the Quest for Meaning: Essays in Honor of Herman Feifel*. Northvale: J. Aronson, 1997.

"Survey Monkey." http://www.surveymonkey.com (assessed February 08, 2012).

Taylor, Elizabeth. "Use of Prayer Among Persons with Cancer." *Holistic Nursing Practice 16*(3) (2002): 46-60.

"The Association For Clinical Pastoral Education, Inc." The Association for Clinical Pastoral Education, Inc. http://www.acpe.edu/ (accessed July 22, 2012).

VandeCreek, Larry. “Using INSPIRIT to Conduct Spiritual Assessments” *The Journal of Pastoral Care 49* (1995): 83-90.

VandeCreek, Larry, E. Rogers, and J. Lester. “Use of Alternative Therapies Among Breast Cancer Outpatients Compared with the General Population.” *Alternative Therapies 5*(1)(1999): 71-76.

VandeCreek, Larry, and Stephanie Gibson. “Religious Support from Parish Clergy for Hospitalized Parishioners: Availability, Evaluation, Implications.” *Journal of Pastoral Care 51*(4) (1997): 403-414.

VanKatwyk, Peter. “The Helping Styles Inventory: A Tool in Supervised Pastoral Education.” *The Journal of Pastoral Care 42*(4) (1988): 319-328.

Vella-Brodrick, Dianne, and Felicity Allen. “Development and Psychometric Validation of the Mental, Physical, and Spiritual Well-Being Scale.” *Psychological Reports 77* (2) (1995): 659-674.

Vermeer, Paul. *Learning Theodicy: the Problem of Evil and the Praxis of Religious Education*. Boston: Brill Academic Pub, 1999.

Ventis, Larry. “The Relationship Between Religion and Mental Health.” *Journal of Social Issues 51*(2) (1995): 33-48.

Webb, Thomas. “Crisis of Faith vs. Spiritual Cry of Distress.” *International Journal of Emergency Mental Health 6*(4) (2001): 217-222.

Worden, William. *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Professional*. New York: Springer, 1982.

Zinnbauer, Brian, Kenneth Pargament, Brenda Cole, Mark Rye, Eric Butter, Timothy Belavich, Kathleen Hipp, Allie Scott, and Jill Kadar. “Religion and Spirituality: Unfuzzying the Fuzzy.” *Journal for the Scientific Study of Religion 36*(4) (1997): 549-564.

VITA

Rev. Douglas E. Robinson

EDUCATIONAL

B.A., Hampton College, 1986.
Certificate Paralegal, Pacific Coast College, 1988.
Certificate Crisis & Suicide Counselor, New Hope, 2003
M.A.R., Liberty Baptist Theological Seminary 2007.
M.Div., Liberty Baptist Theological Seminary, 2008.
Level I & II C.P.E., Association of Professional Chaplains. (Four units)

MINISTERIAL

Commissioned: June, 2003, Reformed Church in America – Pacific West Region
Ordained: February 20, 2011, Southern Baptist Convention; Chapman Avenue Baptist Church, Garden Grove, CA

PROFESSIONAL

Stock Broker, Financial Advisor – Morgan Stanley Dean Witter – 1996-2000
Associate Manager – American General Life and Accident Insurance – 2000-2002
Executive Director – Custom Benefits Consultants – 2002-2003
Pastor of Care Ministry – Crystal Cathedral Ministries – 2003-2011
Chief Financial Officer – N.B.M., Inc. – 2003-2009
Hospital Chaplain Intern– St. Joseph Hospital – 2009-2010
Hospital Chaplain Intern– Rady Children's Hospital – 2010-2011
Disaster Relief Chaplain – CA Southern Baptist Disaster Relief – 2011-Current
Disaster Relief Chaplain - S.B.C. North American Mission Board–2011- Current
Ordained Chaplain – Chapman Avenue Baptist Church – 2011-Current
Executive Director – All Children's Assistance Fund, Inc. – 1996-Current

PROFESSIONAL SOCIETIES

Member, Crisis Prevention International
Member, American Association of Christian Counselors
Member, Society for Christian Psychologists
Member, Association of Professional Chaplains