

In FACT, chaplains have a spiritual assessment tool

Spiritual assessment has become part of healthcare chaplaincy. Mark LaRocca-Pitts outlines five 'spiritual history' tools (CSI-MEMO, FICA, HOPE, FAITH, and SPIRIT) and then presents FACT which, he argues, is a spiritual assessment tool for chaplains (and perhaps other healthcare clinicians) to use in an acute care setting.

Healthcare chaplaincy continues to develop as a clinical profession. Competencies for certification, professional codes of ethics, and standards of practices are part of the professional chaplain's landscape in the United States, as evidenced by the Spiritual Care Collaborative.¹ A new language for this new landscape is needed. Spiritual assessment is part of this new language and a professional chaplain needs to speak it.

Within this broad category called "spiritual assessment", distinctions can be made, such as the differences among a spiritual 'screen', a spiritual 'history', and a spiritual 'assessment'. This article will describe these differences and discuss the use of a spiritual history.² Furthermore, the category called "spiritual history" now constitutes a *genre*. This article will delineate the chief characteristics of this genre and provide examples. Against this backdrop, we will evaluate whether FACT qualifies as a spiritual *history*.

Screens, histories and assessments

A spiritual screen, a spiritual history and a spiritual assessment are distinct in form and function (Massey, Fitchett & Roberts, 2004).

A spiritual screen is the shortest and generally uses one or two static questions aimed at determining the patient's faith affiliation and whether the patient has special religious and/or cultural needs, such as diet, observances, and/or restrictions (e.g., blood products). A spiritual screen obtains information that rarely changes in the course of a patient's admission.

Generally, a clerk during registration performs the spiritual screen, though sometimes it forms part of a nursing admission form. Chaplaincy departments are constantly seeking the perfect one or two questions that will generate an appropriate chaplaincy referral (Fitchett and Risk, 2009).

A spiritual history is more involved than a screen. Its questions engage the dynamics of the patient's faith or spiritual experience identifying "specific ways in which a patient's religious [or spiritual] life, both past and present, impact the patient's medical care" (Massey, Fitchett, & Roberts, 2004).

Not only are the questions dynamic, but so are the answers in that they may change during the course of a patient's hospitalisation. A patient admitted with pneumonia may have sufficient spiritual resources to cope effectively, but if diagnostic procedures reveal the pneumonia is an opportunistic infection related to the patient's until-then-unknown HIV+ status, then the patient may find that he/she has insufficient spiritual resources to cope effectively. Just as the medical history changes to reflect this, so might the spiritual history.

A spiritual history may need to be performed more than once during a single hospitalisation and periodically during the progression of a disease. A physician, nurse or chaplain can take a spiritual history and place salient information in the medical chart (Massey, Fitchett, & Roberts, 2004).

Furthermore, whereas a spiritual screen is limited in its form and function (i.e., one or two static questions asked at the time of admission), the spiritual history can be used in various settings and at various times.

A spiritual history can be administered either as a formal checklist or as an informal one. When used as a formal checklist, it easily forms part of a larger, more in-depth assessment, such as a physician's history and physical, a nurse's admission assessment, or a professional chaplain's spiritual assessment. A spiritual history functions like a social history: identifying a need that may result in a referral.

When used as an informal checklist, it serves as a tacit guide around which a clinician can organise a conversation in order to obtain clinically relevant information pertaining to a patient's spiritual well-being.

This latter use fits well within the ongoing relationship a clinician develops with a patient. If and when significant changes occur in the patient's treatment process or if and when a patient initiates the topic of faith, the clinician can use that opportunity to reevaluate the patient's spiritual well-being by using what appears to be casual conversation.

When taking a spiritual history, a few guidelines are recommended.

- A clinician should always show respect for the patient's expression of his or her own faith or beliefs, even if the clinician's differs radically. Imposing one's faith on another is never the goal of a spiritual history.
- A spiritual history focuses less on *what* a person believes and more on how the person's faith and/or beliefs *function* to help them cope positively with their illness crisis.
- The clinician does not conduct a spiritual history in order to 'fix' anything. If something presents that makes the clinician uncomfortable or that is outside the clinician's training, then the clinician places the appropriate referral for follow up.
- Many patients use their faith to help them cope. When the clinician shows an interest in the patient's spiritual path, then the clinician provides a therapeutic intervention. Even when patients do not use faith or spirituality to help them cope, if the clinician respects this and is not judgmental, then the clinician again provides comfort.

A spiritual assessment differs significantly from a screen and a history. A spiritual assessment is an in-depth look at the patient's spiritual makeup with the goal of

identifying potential areas of spiritual concern and determining an appropriate treatment plan.

In general, a spiritual assessment begins with the patient's needs, hopes and resources in order to build a spiritual profile. Based on this profile, outcomes are determined that will contribute to the patient's healing and well-being. This results in a spiritual care plan that includes appropriate interventions and a way to measure effectiveness (VandeCreek & Lucas, 2001).

Often, along with a series of questions, a spiritual assessment may incorporate a complex algorithm in which various answers will result in different questions (e.g., If "yes," then ask ... If "no," then ask ...). Due to the in-depth nature of a spiritual assessment and the training needed to use such a complex tool, the administration of a spiritual assessment should remain in the hands of a professional chaplain who has the appropriate training.

Examples of spiritual assessment tools include Art Lucas' "The Discipline" (VandeCreek & Lucas 2001b), George Fitchett's "7x7" (Fitchett 2002), and Larry Austin's "A-SNAP" (Austin 2006).

Chaplain-developed spiritual assessment tools, however, have two problems: their depth and complexity. As noted by Massey, Fitchett, and Roberts (2004), Paul Pruyser laid the foundation for spiritual assessment in his *The Minister as Diagnostician* (1976). Pruyser's model, which was designed by a psychologist for the parish-based pastor, assumes both the time for in-depth uninterrupted pastoral conversations and the opportunity for repeated counselling sessions.

Chaplains providing spiritual care in an acute care setting do not have the luxury of time and multiple follow-ups in the same way pastors do or as their colleagues in sub-acute, long term care or hospice settings might have. Acute care chaplains need a spiritual assessment tool that fits the requirements of their setting: short and easy, versatile, and focused.

The spiritual history genre

A spiritual history arguably forms its own *genre*. A "genre" is defined as "a category of artistic, musical, or literary composition characterised by a particular style, form, or content" (Webster, 1977). Harold Koenig provides the groundwork for this genre study in *Spirituality in Patient Care* where he presents five criteria he considers critical for a spiritual history (2007):

1. It must be brief.
2. It must be easy to remember.
3. It must obtain appropriate information.
4. It must be patient-centred.
5. It must be validated as credible by experts.

When all five of these criteria are used together, the critic is able to adjudicate the strengths and weaknesses of various spiritual histories (LaRocca-Pitts, 2008b). However, when discussing spiritual histories as a distinct genre only the first three of these criteria are needed.

When we modify these three criteria in light of published spiritual histories, we get the following requirements for this genre:

1. A spiritual history is brief: it contains a brief series of categories or topics with pertinent questions.
2. A spiritual history is easy to remember: a memorable acronym is used to recall the categories.
3. A spiritual history obtains appropriate information: its questions address the patient's spiritual resources, the patient's use of them in his/her past and current situation, and how these resources and uses impact the patient's medical care.

In what follows, we will look briefly at five examples of this genre and then compare these findings with FACT (LaRocca-Pitts, 2008ab).

CSI-MEMO (Koenig, 2002)

CS – Do your religious/spiritual beliefs provide **C**omfort, or are they a source of **S**tress?

I – Do you have spiritual beliefs that might **I**nfluence your medical decisions?

MEM – Are you a **MEM**ber of a religious or spiritual community, and is it supportive to you?

O – Do you have any **O**ther spiritual needs that you'd like someone to address?

FICA (Puchalski & Romer, 2000).

F – **F**aith, **B**elief, **M**eaning: “Do you consider yourself spiritual or religious?” or “Do you have spiritual beliefs that help you cope with stress?”

I – **I**mportance or **I**nfluence of religious and spiritual beliefs and practices: “What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?”

C – **C**ommunity connections: “Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?”

A – **A**ddress/**A**ction in the context of medical care: “How would you like me, your healthcare provider, to address these issues in your healthcare?”

HOPE (Anandarajah & Hight, 2001)

H – Sources of **h**ope, meaning, comfort, strength, peace, love, and compassion: What is there in your life that gives you internal support? What are the sources of hope, strength, comfort, and peace? What do you hold on to during difficult times? What sustains you and keeps you going?

O – **O**rganised religion: Do you consider yourself as part of an organized religion? How important is that for you? What aspects of your religion are helpful and not so helpful to you? Are you part of a religious or spiritual community? Does it help you? How?

P – **P**ersonal spirituality/**p**ractices: Do you have personal spiritual beliefs that are independent of organised religion? What are they? Do you believe in God? What kind of relationship do you have with God? What aspects of your spirituality or spiritual practices do you find most helpful to you personally?

E – **E**ffects on medical care and end-of-life issues: 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?) As a doctor, is there anything that I can do to help you access the resources that usually help you? Are you worried about any conflicts

between your beliefs and your medical situation/care decisions? Are there any specific practices or restrictions I should know about in providing your medical care?

FAITH (King, 2002)

F – Do you have a **Faith** or religion that is important to you?

A – How do your beliefs **Apply** to your health?

I – Are you **Involved** in a church or faith community?

T – How do your spiritual views affect your views about **Treatment**?

H – How can I **Help** you with any spiritual concerns?

SPIRIT (Abridged: Maugans, 1997; Ambuel & Weissman, 1999)

S – **Spiritual belief system**: Do you have a formal religious affiliation? Can you describe this? Do you have a spiritual life that is important to you?

P – **Personal spirituality**: Describe the beliefs and practices of your religion that you personally accept. Describe those beliefs and practices that you do not accept or follow. In what ways is your spirituality/religion meaningful for you?

I – **Integration with a spiritual community**: Do you belong to any religious or spiritual groups or communities? How do you participate in this group/community? What importance does this group have for you? What types of support and help does or could this group provide for you in dealing with health issues?

R – **Ritualised practices and Restrictions**: What specific practices do you carry out as part of your religious and spiritual life? What lifestyle activities or practices do your religion encourage, discourage or forbid? To what extent have you followed these guidelines?

I – **Implications for medical practice**: Are there specific elements of medical care that your religion discourages or forbids? To what extent have you followed these guidelines? What aspects of your religion/spirituality would you like to keep in mind as I care for you?

T – **Terminal events planning**: Are there particular aspects of medical care that you wish to forgo or have withheld because of your religion/spirituality? Are there religious or spiritual practices or rituals that you would like to have available in the hospital or at home? Are there religious or spiritual practices that you wish to plan for at the time of death, or following death? As we plan for your medical care near the end of life, in what ways will your religion and spirituality influence your decisions?

FACT (LaRocca-Pitts, 2008ab)

F – **Faith (or Beliefs)**: What is your **Faith** or belief? Do you consider yourself a person of **Faith** or a spiritual person? What things do you believe that give your life meaning and purpose?

A – **Active (or Available, Accessible, Applicable)**: Are you currently **Active** in your faith community? Are you part of a religious or spiritual community? Is support for your faith **Available** to you? Do you have **Access** to what you need to **Apply** your faith (or your beliefs)? Is there a person or a group whose presence and support you value at a time like this?

C – **Coping (or Comfort); Conflicts (or Concerns)**: How are you **Coping** with your medical situation? Is your faith (your beliefs) helping you **Cope**? How is your faith (your beliefs) providing **Comfort** in light of your diagnosis? Do any of your religious

beliefs or spiritual practices Conflict with medical treatment? Are there any particular Concerns you have for us as your medical team?

Up to this point, FACT fits well with the spiritual history genre: it is brief, it is using a memorable acronym, and it is obtaining appropriate information. But with the next step, the **T** – Treatment plan, FACT moves beyond the content and purpose of the generic spiritual history and asks for a judgment.

Instead of obtaining information only, as with a generic spiritual history, FACT asks the clinician to make an assessment upon which the clinician provides an intervention. Thus, describing FACT as a spiritual *history* was unfortunate (LaRocca-Pitts, 2008b).

The question now becomes: What is the significance of this difference between FACT and the generic spiritual histories? Before answering this question, we will finish describing the tool.

T – Treatment plan: If patient is coping well, then either support and encourage or reassess at a later date as patient's situation changes. If patient is coping poorly, then 1) depending on relationship and similarity in faith/beliefs, provide direct intervention: spiritual counselling, prayer, Sacred Scripture, etc., 2) encourage patient to address these concerns with their own faith leader, or 3) make a referral to the hospital chaplain for further assessment.

Explicitly addressing treatment provided an important and significant difference when FACT, a chaplain-developed tool, was compared to other physician-developed tools (LaRocca-Pitts, 2008b). This sets it apart as a strength. It also sets it apart from spiritual histories in general. In fact, it falls exactly into the niche between the physician-developed spiritual history and the generally too in-depth and complex chaplain-developed spiritual assessment. In other words, FACT is a spiritual assessment tool that fits well the needs of an acute care chaplain: it is short and easy, versatile, and focused.

For example, FACT can be used effectively in the span of a five- to ten-minute initial visit. In the context of a discipline-appropriate conversation (i.e., “Hi, I’m the chaplain. ...”), the chaplain can take a brief spiritual history, assess immediate spiritual needs, and provide an appropriate intervention with the intended outcome of supporting the patient.

An intervention might range from simply supporting and encouraging the patient to providing a prayer (treatment option #1) to conducting, time and length of stay permitting, a more in-depth assessment (treatment option #3) at that time or in a follow-up visit.

In addition, some healthcare clinicians believe praying with patients is within their scope of practice (Koenig, 2007). Using FACT may prevent the clinician from crossing ethical and professional boundaries (Post, Puchalski, & Larson, 2000). If the clinician judges a direct and personal intervention is needed, such as praying with the patient, then the clinician may do so, but with extreme care (Sloan et al., 2000).

Choosing this option means the clinician has already administered a spiritual history and established the following things: (1) that the patient and the clinician share a similar faith; (2) that the patient would welcome such an intervention; and (3) that the clinician would not be imposing his or her beliefs onto the patient (Koenig, 2007).

With proper training, clinicians using FACT will also help identify patients who would benefit from treatment option #3 (referral to the chaplain).

Conclusion

The spiritual history is a genre unique from that of a spiritual screen and a spiritual assessment. Technically, FACT does not qualify as a spiritual *history* tool (LaRocca-Pitts, 2008ab): it is three parts spiritual history and one part spiritual assessment. In other words, it is a hybrid spiritual assessment tool that fits well the needs of a professional chaplain in an acute care setting.

It also works well with other healthcare clinicians who believe the scope of their practice includes addressing spiritual needs, such as providing spiritual encouragement or prayer and making referrals to chaplains.

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¹ The Spiritual Care Collaborative is comprised of six North American professional chaplaincy organizations: Association of Professional Chaplains, Association of Clinical Pastoral Education, National Association of Catholic Chaplains, American Association of Professional Counselors, National Association of Jewish Chaplains, and Canadian Association of Pastoral Practice and Education. See <http://www.spiritualcarecollaborative.org/>. Retrieved on 11/30/09.

² In a review that appeared in this journal, the reviewer, commenting on a previous article of mine (LaRocca-Pitts, 2008b), said, "To this writer, titling FACT as a spiritual history tool seems unfortunate. FACT does not gather a history in the way a physician gathers a medical history. Rather, it provides information for an assessment, upon which an intervention might be planned." This article is a response.