HealthCare
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Discerning Patient Needs: Spiritual Assessment Perspectives for Health Care Chaplains

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I. Rationale

Despite growing professional awareness of the importance of religion and spirituality in health and human welfare, patients' religious backgrounds and spirituality may be overlooked by physicians, nurses, psychologists, and other health care professionals. Chaplains can fulfill a crucial role in health care settings by making sure that patients' spiritual beliefs and needs are carefully assessed and fully understood. This information may prove valuable for all members of the health care team. By understanding patients' spiritual worldviews, health care professionals are better able to empathically understand them. Spiritual assessment can also help health care professionals determine if clients have unresolved spiritual concerns or needs. Physical healing and psychological coping may be complicated if patients are experiencing spiritual distress. Appropriately addressing patients' spiritual concerns and needs can contribute to more rapid recovery and better prognosis. A spiritual assessment can also help health care professionals identify patients' whose spiritual and psychological distress is sufficiently severe and persistent as to warrant referral for longer-term professional help after hospital discharge. A number of potentially useful religious-spiritual assessment strategies and methods have been described in the professional literature. This bibliographic series introduces chaplains to this literature. Ultimately, for health care professionals who believe that human beings may receive enlightenment and inspiration from the divine, a spiritual assessment may be more than just conceptualizing information that has been gathered in intake questionnaires, clinical interviews, and objective or projective assessment measures. A spiritual assessment may also include prayerful or meditative efforts to seek spiritual impressions and insights about patients and their problems and how to assist them.

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II. Three-Five of the Best Books or Articles The first entry summary and commentary on Fitchett and the second on Fitchett and Risk are reprints from Reverend George Handzo's "By Its Fruits: The Science of Health Care Chaplaincy" in *Practical Bearings: The Critical Bibliography for Health Care Chaplains*, Vol. 1, No. 1, (February, 2009). The first three books/articles in this section were written by pastoral professionals for pastoral professionals and have direct relevance to the work of chaplains. The second two chapters/articles were written for primarily for physicians, but they are included because they provide much insight that is of importance to health care chaplains.

Fitchett, G. (1993) *Assessing Spiritual Need: A Guide for Caregivers*. Minneapolis, Minnesota: Augsburg/Fortress Press.

Summary

George Fitchett presents a model for spiritual assessment that he and his colleagues developed, as illustrated with case studies. This "7X7" model has become a classic from which many other models are derived. He reviews three other models and provides a framework for evaluating them. The framework includes the model's concept of spirituality, norms and authority, and assessment context and process. The models include Paul Pruyser's *The Minister as Diagnostician,* Elizabeth McSherry's work at the Veterans Administration, and the model of the North American Nursing Diagnostic Association. This book addresses many of the questions pastoral caregivers have raised about this timely and enduring topic and provides an informed and balanced approach for making decisions about spiritual assessment models and tools.

Comment

Good assessment needs to be the cornerstone on which all of pastoral care delivery is built. It drives the plan of care, interventions, and outcomes. It surfaces the facts that communicate to other disciplines what chaplaincy does. As a side note, it is important to distinguish spiritual screening, which any staff person can do, and spiritual assessment, which should be the prerogative of the professional chaplain. Many chaplains have avoided doing assessment because professional pastoral care does not have a standard method. All chaplains need to realize that what is most important is to have a system that becomes standard for them and for their colleagues in a given institution so that other disciplines come to understand what they are doing.

Fitchett, G., & Risk, J. Screening for Spiritual Risk. *Journal of Pastoral Care & Counseling. In Press.*

Summary

For years George Fitchett has been the leading authority on spiritual assessment and screening. The article describes a brief screening protocol for use identifying patients who may be experiencing religious/spiritual struggle, as well as patients who would like a visit from a chaplain. They describe the results of a pilot study in which non-chaplain healthcare colleagues administered the screening protocol to patients on admission. The protocol identified 7% of the patients as possibly experiencing struggle. The protocol generated a very low rate of false positives and a somewhat higher rate of false negatives.

Comment

Increasingly, pastoral care in healthcare settings is focused on need for care rather than desire for care. For chaplains to demonstrate outcomes that contribute to healing, they have to demonstrate need. Until now, there has been no screening protocol for pastoral care. The screening protocol from Fitchett and colleagues provides an extremely simple, effective and easily taught method to identify patients with religious struggle. It can easily be inserted into any nursing or admitting assessment.

Ledbetter, Timothy J. (2008). Screening for pastoral visitations using the Clinical + Coping Score. *The Journal of Pastoral Care and Counseling, 62 (4)*, 367-373.

Abstract

Hospital chaplains struggle to know which patients most likely need pastoral care and why. The author presents a computerized model to screen and document indicated patients. A new screening tool is introduced, the Clinical + Coping Score, which can check with greater precision for patients who show evidence of insufficient coping. This screening model informs the subsequent assessment and intervention opportunities, though they are not discussed. The model's format enables chaplains to efficiently and effectively document pastoral screening using the hospital's electronic charting program. Two levels of visitation priority are suggested. In so doing, the chaplains are able to identify the indicators for pastoral care contacts and interventions, as well as the number of patients whose recognized needs have yet to be addressed (Ledbetter, 2008, p. 367).

Comment

This is a practical, applied article that describes a model for assisting hospital chaplains in deciding which patient are in greatest need of pastoral care. The model is simple, and yet practical, and provides a framework in which chaplains consider patients' medical status (stable, serious, or critical) and coping resources (full, adequate, marginal, and deficient) as they screen patients for potential pastoral visits. Chaplains in training would benefit from reading and discussing this article before their first hospital placement.

Kristeller, J. L., & Hummel, L. M. (2006). Spiritual engagement and transformation in cancer patients: The experience of the patient, the role of the physician. In Joan Koss-Chioino and Philip Hefner (eds.), *Spiritual Transformation and Healing: Anthropological, Theological, Neuroscientific, and Clinical Perspectives*, Lanham, MD: Rowan and Littlefield Press.

Summary

This chapter addresses the general question of the quality of the spiritual experience of the patient and the related question of how such issues might be appropriately explored within the medical setting by the physician. It also addresses the question of whether there is an appropriate and effective way for oncologists to explore the issue of spiritual or religious concerns with their patients, and it explores how patients may experience both that type of inquiry and their own experiences in drawing on spiritual or religious resources. The authors describe a brief, patient centered approach that oncologists can use in assessing and addressing patients' spiritual concerns, which they call the OASIS inquiry (Oncologist Assisted Spirituality Intervention Study). The authors' research suggests that not only does a brief, patient-centered inquiry, such as the OASIS approach, appear to be acceptable to most patients and relatively comfortable for physicians, but there is an increase in patients' satisfaction with care and at least preliminary evidence of improved quality of life for some patients. Whether it is appropriate for physicians to explore the spiritual or religious concerns of their patients remains a matter of legitimate debate and physician choice.

Comment

This book chapter explores many issues that are important for health care professionals, including chaplains who work in health care settings. It builds a strong rationale for why it is important for physicians to assess and address patients' spiritual needs during medical treatment, particularly oncology patients. The authors respectfully acknowledge both philosophical and practical reasons why physicians might resist doing any sort of a spiritual assessment of their patients. However, they argue effectively that a brief, patient-centered assessment is both possible and desirable. One of the outstanding things about this chapter is that it reports the findings of two research studies which provide empirical support for the hypothesis that a brief, patient-centered spiritual assessment approach can be effectively used by physicians and benefits patients. Thus, this chapter not only provides a spiritual assessment approach for physicians, but it also models how health care professionals, including chaplains, can empirically evaluate spiritual assessment approaches for health care settings. The authors' OASIS spiritual assessment approach is one of the very few that has been empirically evaluated and supported. Hopefully, chaplains and other health care professionals will "go and do likewise" with spiritual assessment approaches they may develop. This chapter may also help chaplains more fully understand spiritual assessment from the perspective of physicians and increase their ability to collaborate effectively with physicians in patient care.

Puchalski, C. (2006). Spiritual assessment in clinical practice. Psychiatric Annals, 36 (3), 150-155.

Summary

Spiritual needs are important to many patients. There is institutional support for the inclusion of spiritual care in the holistic care of patients. There is also data that patients want their spiritual beliefs integrated into the care of their patients and that spiritual beliefs may benefit patients in some healthcare outcomes, resiliency to stress and adverse situations, and coping with suffering. A spiritual history provides an opportunity in the clinical encounter for the patient to share spiritual beliefs if that is what he or she chooses to do. It also helps the clinician to identify spiritual distress, as well as spiritual resources of strength, and to provide the appropriate therapy and referrals needed to give the patient the best care from a bio-psycho-social-spiritual framework (Puchalski, 2006, pp. 154-155). The author describes her spiritual history "FICA" model as follows (Puchalski, 2006, p. 153):

F — Faith and Belief

"Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds "no," the physician might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

I — 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?"

C — Community

"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?" Communities such as churches, temples, and mosques, or a group of likeminded friends, can serve as strong support systems for some patients.

A — Address in Care

"How would you like me, your healthcare provider, to address these issues in your healthcare?" Often it is not necessary to ask this question but to think about what spiritual issues need to be addressed in the treatment plan. Examples include referral to chaplains, pastoral counselors, or spiritual directors, journaling, and music or art therapy. Sometimes the plan may be simply to listen and support the person in their journey.

Comment

This article provides a strong rationale for why it is important to assess spiritual issues in health care settings. It offers suggestions to help health care professionals recognize spiritual issues in the clinical setting. It provides concrete suggestions about how to take a spiritual history in medical settings. Although the article is directed primarily to physicians, chaplains may also find the rationale and spiritual history approach useful for their own practices. When chaplains are given opportunities to provide training about spirituality to physicians, nurses, psychologists, and social workers, this article may be useful for helping these members of the health care team more fully understand the importance of conducting spiritual assessments.

II.   Five to Ten other Books or Articles

A number of the articles and book chapters in this section were written by psychologists or social workers for mental health professionals, but are included because they have considerable relevance to the work of health care chaplains. Several of the articles in this section were written by chaplains and provide valuable perspectives, but in my view did not fall into the category of the "five best" on the topic of spiritual assessment.

Hodge, David R. (2006). A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. Social Work, 51(4), 317-326.

Abstract

Growing consensus exists regarding the importance of spiritual assessment. For instance, the largest health care accrediting body in the United States, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), now requires the administration of a spiritual assessment. Although most practitioners endorse the concept of spiritual assessment, studies suggest that social workers have received little training in spiritual assessment. To address this gap, the current article reviews the JCAHO requirements for conducting a spiritual assessment and provides practitioners with guidelines for its proper implementation. In addition to helping equip practitioners in JCAHO-accredited settings who may be required to perform such an assessment, the spiritual assessment template profiled in this article may also be of use to practitioners in other settings (Hodge, 2006, p. 317).

Comment

The target audience for this article is social workers and treatment facilities, but chaplains working in health care settings may find the discussion of JCAHO recommendations about spiritual assessment very relevant. The author offers his views about how the JCAHO recommendations can be effectively implemented in clinical practice. For example, he recommends fewer assessment questions, but questions that are more open-ended in nature. He also suggests that a brief spiritual assessment may reveal the need to transition into a deeper second level assessment. The author's discussion of cautions and caveats about performing more in-depth spiritual assessments are valuable, but will hopefully not discourage social workers and other clinicians to perform more in-depth spiritual assessments when indicated.

Hathaway, William L. (2003). Clinically significant religious impairment. Mental Health, Religion and Culture, 6 (2), 113- 129.

Abstract

Recent psychodiagnostic practice, as embodied in the DSM IV, requires that psychopathological features result in a ''clinically significant impairment'' to qualify as a ''mental disorder'' in many cases. The impairment must be in social, occupational, or other

important areas of functioning. The current proposal is that clinicians should consider the potential impairment in religious functioning arising from mental disorders in diagnostic process. It is suggested that psychopathology may result in a clinically significant religious impairment that is defined as a reduced ability to perform religious activities, achieve religious goals, or to experience religious states, due to a psychological disorder. Various existing approaches to studying the relationship between religious functioning and psychopathology are briefly reviewed and roughly categorized as either focused on 'symptomatic religiosity' or reflecting a 'religiously sympathetic' posture. Yet, in both of these approaches, religion has predominantly been construed as an exogenous variable contributing to mental health in some fashion (for good, for ill, or for both). The current proposal suggests that clinicians should also consider religion in endogenous perspective. So construed, religion is a significant domain of adaptive functioning, which may be adversely impacted by psychopathology. A discussion of various clinical, research and ethical issues involved in realizing the proposal is provided (Hathaway, 2003, p. 113).

Comment

This article explores the idea that mental disorders can cause impairment in religious functioning, or in other words, result in a reduced ability for patients to perform religious activities, achieve religious goals, and to experience religious states, due to a psychological disorder. Chaplains in medical settings may frequently observe situations where patients' physical disorders are causing impairment in their religious functioning. The author's article provides a rationale for the importance of chaplaincy services in the sense that when religion and spirituality are viewed as adaptive areas of human functioning that can be impaired by psychological or physical disorders the need to intervene pastorally to help patients who are in spiritual distress may be more readily understood by all members of the health care team.

Richards, P. Scott, & Bergin, A. E. (2005). Religious and spiritual assessment (pp. 219 – 247). In P. S. Richards & A. E. Bergin (Eds.), *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: American Psychological Association.

Summary

In this chapter, the authors' discuss a number of reasons why it is important for counselors and psychotherapists to assess clients' religious and spiritual backgrounds and status along with the other aspects of their lives. They identify and describe dimensions of religiosity and spirituality that are clinically relevant from a psychological perspective. They then describe a multilevel, multi-systemic psychological assessment strategy and discuss how a religious-

spiritual assessment fits into such a strategy. The authors also discuss how intake questionnaires, clinical interviews, and standardized tests can be used to facilitate a religious-spiritual assessment. They discuss meta-empathy, or the idea that psychotherapists may on occasion experience intuitive insights and inspiration that assist them in understanding their clients. They also discuss the importance of assessing the spiritual outcomes of treatment.

Comment

This book chapter was written by psychologists for psychologists and has received positive reviews within the mainstream psychology profession. Its primary value for chaplains may be in the psychological perspective it provides about religious and spiritual assessment and in the validation it gives concerning the importance of spirituality in a comprehensive treatment approach. Understanding why a religious and spiritual assessment is important from the perspective of psychologists and other mental health professionals may help chaplains more effectively interface with them on the health care team. This chapter may give chaplains some additional insight into dimensions of spirituality that may be important in clinical settings. Chaplains may also find that the authors' brief discussion of meta-empathy affirming of the non-quantifiable aspect of their role as spiritual caregivers and of the importance of the spiritual presence in chaplaincy care.

Gorsuch, Richard L., & Miller, William R. (1999). Assessing spirituality (pp. 47 – 64). In W. R. Miller (Ed.), Integrating spirituality into treatment: Resources for practitioners. Washington, DC: American Psychological Association.

Summary

This practically focused chapter begins with a brief consideration of why mental health professionals should assess clients' spirituality. The main body of the chapter is devoted to recommendations on how to assess spirituality in ways that are relevant to treatment. The authors start with broader approaches and proceed to more specific measures organized around the three broad assessment domains—cognitive, behavioral, and experiential. Finally, they offer a few general cautionary notes about this area of assessment.

Comment

This book chapter provides some strong rationales for why it is important for psychologists and other mental health professionals to assess the religious and spiritual dimensions of their clients' lives. It provides useful suggestions about assessing clients' religious beliefs,

behaviors, and experiences. Its primary value for chaplains may lie in helping broaden their understanding of religious and spiritual assessment from a psychological perspective.

Millspaugh, D. (2005). Assessment and response to spiritual pain: Part I. *Journal of Palliative Medicine, 8(5)*, 919-923.

Abstract

Spiritual pain or suffering is common. Cicely Saunders described persons with "total pain" including the physical, psychological, social, and spiritual dimensions. Yet, a construct for what it is, and how to respond, is not so common. In this paper, I hypothesize that the components of spiritual pain can be summarized in the following manner.

Spiritual pain or Suffering =
(Awareness of death + Loss of Relationships + Loss of Self) (Loss of Purpose + Loss of Control)/Life affirming and transcending Purpose + Internal Sense of Control

Thus, an assessment of spiritual pain or suffering should examine the degree to which the individual is experiencing each of these components and their relationship to each other. Further, each of these components is dynamic, always in process, both within and between the components. A second paper will examine the sufferer's religious responses and suggested pastoral responses (Millspaugh, 2005, p. 919).

Comment

This article provides a useful exploration of some potential causes of spiritual pain and suffering (e.g., awareness of death, loss of relationships, etc.). The article seems to derive primarily from the author's clinical experience as a chaplain and so it provides a valuable, but perhaps limited perspective in this regard. I did not find the author's algebraic formula of spiritual suffering helpful in the sense that I think it oversimplifies something that is much more complex. Simplifying complex ideas can often be helpful, but in this case I think the mathematical formula so distorts the relationships between various life experiences and personal characteristics that can cause and ameliorate spiritual pain and suffering that it is not helpful. Nevertheless, despite its limitations, I think this article provides some useful food for thought about the types and causes of spiritual pain and suffering patients may be experiencing. I think it may be especially useful for those who are early in their training as chaplains.

Millspaugh, D. (2005). Assessment and response to spiritual pain: Part II. *Journal of Palliative Medicine, 8(6)*, 1110-1117.

Abstract

In Part I of this article, published in October 2005, I hypothesized that the components of spiritual pain can be summarized in the following manner.

Spiritual pain or Suffering =
(Awareness of death + Loss of Relationships + Loss of Self) (Loss of Purpose + Loss of Control)/Life affirming and transcending Purpose + Internal Sense of Control

Thus, an assessment of spiritual pain or suffering should examine the degree to which the individual is experiencing each of these components and their relationship to each other. Now in Part II I examine the Christian sufferer's religious responses and suggest pastoral interventions (Millspaugh, 2005, p. 1110).

Comment

Millspaugh details several general categories of patient responses to spiritual pain—eight, to be specific. He then presents a section on "pastoral response" which discusses a number of issues, including self-assessment, pastoral presence, pastoral assessment, and spiritual care planning. Each of these provides detailed questions that chaplains may want to consider concerning the person suffering spiritual pain. I thought that this article had many helpful insights; however, in the latter half of the article was unfocused and suffered from repetitiveness and a lack of clarity and organization. There were various lists and the numbering was not consistent. One numbered list had a numbered list within it that was also numbered with plain, ordinal Arabic numerals. Later a different numbering structure was used. I once had a clinical supervisor who was fond of saying that when it comes to clinical practice, "It is better to be simple-minded than muddle-headed." I think this article may leave readers feeling muddle-headed because of its lack of clarity, conciseness, and organization. Nevertheless, I think this article has value if readers are willing to make the effort to sort through the muddle-headedness and find the gems of clinical insight offered within it.

Austin, Larry J. (2006). Spiritual assessment: A Chaplain's perspective. *Explore, 2(6)*, 540-542.

Summary

Austin's brief article identifies a lack of collaboration between healthcare professionals and a lack of understanding and specificity of professional functions and concepts. He provides a set of categories for spiritual assessment as a "starting place for dialogue and collaboration among disciplines; sense of the Holy, actions of the Holy, beliefs and practices, affective responses, personal responsibility, community, meaning, vocation, hope, grief, humor, forgiveness, courage, and virtue and beauty" (Austin, 2006, p. 540). He then briefly explains each category, implying that each of these categories may be important to assess with patients.

Comment

This is a brief and basic article and may be most useful to those early in their training as chaplains to stimulate their thinking about possible ways to think about patients' spirituality. To someone not yet familiar with chaplaincy or basic pastoral care, it may offer some new and helpful information.

Gordon, Tom, & Mitchell, David (2004). A competency model for the assessment and delivery of spiritual care. Palliative Medicine, 18, 646-651.

Abstract

The delivery of spiritual and religious care has received a high profile in national reports, guidelines and standards since the start of the millennium, yet there is, to date, no recognized definition of spirituality or spiritual care nor a validated assessment tool. This article suggests an alternative to the search for a definition and assessment tool, and seeks to set spiritual care in a practical context by offering a model for spiritual assessment and care based on the individual competence of all healthcare professionals to deliver spiritual and religious care. Through the evaluation of a pilot study to familiarize staff with the Spiritual and Religious Care Competencies for Specialist Palliative Care developed by Marie Curie Cancer Care, the authors conclude that competencies are a viable and crucial first step in 'earthing' spiritual care in practice, and evidencing this illusive area of care (Gordon & Mitchell, 2004, p. 646).

Comment

This article provides some valuable perspectives about the challenges of assessing patients' religious and spiritual beliefs and background in hospital settings. The four-level religious and spiritual competence model also provides a useful way to think about religious-spiritual competency expectations in health care settings. The authors' description of the pilot study they did among staff members in the Marie Curie Hospices was useful in the sense that it provides some food for thought about how religious-spiritual competencies might be encouraged among health care staff—and about the role chaplains might take in promoting such competencies. The weakness of the article may be that the authors remained rather vague about what specific religious-spiritual competencies they regard as important.

Scott, Stacey, Garver, Stacy, Richards, Julie, & Hathaway, William R. (2003). Religious issues in diagnosis: The V-Code and beyond. Mental Health, Religion and Culture, 6, 161-173.

Abstract

This paper addresses the issues around considering clients' religious and spiritual functioning as a matter of client diversity. Such issues may be under appreciated by many clinicians. The introduction of a religious and spiritual problem V-Code (V62.89) into the DSM-IV provided a significant accommodation of client religious and spiritual functioning in contemporary psychodiagnostics. The V-Code allows for explicit identification of a nonpathological religious or spiritual focus in treatment. The nature of and history of the V-Code's inclusion in DSM-IV is briefly reviewed. The strengths and limitations of the V-Code for raising clinician awareness of the religious and spiritual domain of client functioning is discussed and illustrated by a number of case examples. The V-Code approach is contrasted with Hathaway's (2003) clinically significant religious impairment concept. Both are viewed as making complementary contributions to a religiously and spiritually sensitive clinical practice (Scott et al., 2003, p. 161).

Comment

Perhaps the primary value of this article for chaplains is that it may raise their awareness about the potential influence of the American Psychiatric Association's Diagnostic and Statistical Manual's (DSM) religious and spiritual problem V-Code on how psychiatrists and other mental health professionals think about religious and spiritual diagnosis and assessment. Overall, the authors express concerns that the DSM V-Code is a poor tool in the assessment of religious and spiritual issues and that it needs to be revised to be more helpful to clinicians.

Gleason, John J. (1999). The four worlds of spiritual assessment and care. Journal of Religion and Health, 38(4), 305-317.

Abstract

From the dawn of human consciousness, religious and spiritual expressions have been inexorably intertwined with some degree of assessment toward more effective care—whether such care is offered by shaman, imam, rabbi, shirpa, prophet, priest, pastor, physician, nurse, or lay minister. Currently, two major forces have brought spiritual assessment and care into sharp focus regarding the delivery of health care in the U.S. The first is the advent of managed care. The shift in emphasis from sickness-based to wellness-based reimbursement, spurred by spiraling costs, has brought close scrutiny to provider effects on patient outcomes. The second major force, related to the first, has been increased attention to alternative medicine and to previously unacknowledged adjuncts to traditional health-care delivery, most often understood by the terms "holistic health" or "wellness." One of the sub-areas within holistic health is spiritual care. A measure of the increasing importance of spiritual care within the delivery of U.S. health care is the fact that the Joint Commission on Accreditation of Health Organizations (JCAHO) is gradually upgrading the place of chaplaincy services in the Standards. Thus, a clear, simple, user-friendly, inclusive, valid, reliable, useful diagnostic, care-anticipating, and outcomes-measurable spiritual-care model is becoming more a necessity in the increasingly demanding discipline of clinical chaplaincy (Gleason, 1999, p. 305).

Comment

This article describes a "four world" model for conceptualizing patients' spiritual development along literal-mythical and open-closed dimensions. It also presents case examples of people in these "four worlds" with implications for chaplains. Findings from a study where the reliability and validity of an assessment approach based on the four-world model are also presented. Although the practical value of this spiritual assessment approach for chaplains in healthcare settings can be questioned, the article provides food for thought and debate as chaplains in training seek to clarify their own views about how they can most effectively conduct spiritual assessments with their patients.

Flannelly, Kevin J., Galek, Kathleen, Tannenbaum, Helen P., Handzo, George F. (2007). A preliminary proposal for a scale to measure the effectiveness of pastoral care with family members of hospitalized patients. Journal of Pastoral Care and Counseling, 61, 19-29.

Abstract

The authors conducted an electronic search of the Medline database for articles measuring family satisfaction. Content analysis was then performed on the relevant studies to determine the types of themes included in scales measuring family satisfaction in healthcare settings. The authors used these themes to develop a scale for measuring the effectiveness of pastoral care with family members. A convenience sample of chaplains that was asked to judge the usefulness of each of the scale items, rated them all, on average, to be "somewhat useful" to "very useful" for evaluating chaplains' effectiveness. The value of the scale is discussed in terms of its being a more outcome-oriented measure of effectiveness compared to typical family satisfaction instruments (Flannelly et al, 2007, p. 19).

Comment

The focus of this article is not about assessing patients' religious-spiritual issues, but on describing the development of a scale for assessing the outcomes of the pastoral services chaplains provide to the family members of hospitalized patients. This article may be valuable for chaplains who are concerned about assessing the outcomes of their pastoral care for a couple of reasons. First, the process of scale development it describes may assist chaplains who wish to develop their own outcome assessment measures. Second, the scale the authors developed for measuring the effectiveness of pastoral care with family members may prove useful for chaplains who wish to assess the effectiveness of this aspect of their work.

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