The Chaplain and the Hospital Patient:
A Typical Pattern for the Beginning of an Initial Visit

John Ehman 1/02, rev. 9/04 and 7/09

A hospital chaplain often makes patient visits that are neither requested nor scheduled. The patient is suddenly met by an unknown person in a role that may be seen to have *something* to do with religion. In the first minutes of a pastoral visit, a great deal happens involving first impressions, expectations, explanations, and the establishment of potential relationship. Every initial pastoral visit is different, but many begin along similar lines, influenced by hospital culture, social convention, and the general experience of illness and institutionalization. The following table "walks through" a common pattern for just the first minute or so of a visit and indicates how much can happen very quickly.

—Notes pertinent to *assessment* issues/dynamics are marked with a dotted underline.

	Action of the Chaplain	Nature of the Chaplain's Action	Action of the Patient	Nature of the Patient's Action
1.	The chaplain knocks on the usually open door before entering the room. (Also, from the doorway, it is often possible to look around the room and see the patient.)	Knocking on the door acknowledges that the chaplain is entering the *patient's* space and is *initiating* an interaction. (Also, in observing the room and the patient, initial impressions are formed. These first impressions may be insightful, but they can also be misleading.)	Typically, the patient invites in the as-yet-unknown visitor. (Patients, too, are usually keen observers of visitors, noting how they look and sound as much as what they say. Patients also form first impressions.)	The patient has probably had many hospital personnel come into the room, and this is another instance. There is likely an assumption that the person is approved by the hospital and the visit will be of a professional nature, starting with an appropriate explanation of the person's identity and intention.
2.	The chaplain states clearly his/her title, the reason for the visit, and inquires (usually informally) whether the patient would like to proceed. The chaplain acts in a friendly and non-anxious manner.	As the initiator of the visit, it is the chaplain's responsibility to proceed only with the patient's *informed consent*. Providing clear information also reduces confusion and anxiety about a visitor.	The patient often welcomes the visit and sometimes asks for further clarification of the chaplain's role. However, the patient may ask to be visited later or may decline the visit altogether.*	The patient acts on his/her right *as a patient* to give informed consent. (However, in the context of institutionalization, the patient may be hesitant not to give consent.)
3.	The chaplain may offer more Pastoral Care information and explain a bit more about his/her role, especially as someone who is primarily *interested in hearing* the patient's concerns and experiences. The chaplain works to *invite the patient to take the lead* in the conversation.	The chaplain invites the patient to begin taking the initiative. This is a demonstration of the chaplain's actual role as a *listener*, but inviting the patient to take the lead in the conversation amounts to a kind of "role reversal" at this early stage.	The patient typically responds positively to the caring, open, and non-anxious demeanor of the chaplain and ventures some comment. Initial comments are often of a polite/social nature (e.g., "I'm fine"), but some patients may right away seize the initiative and offer rich content.	The patient's initial comments may indicate personal concerns, but they often serve to "feel out" or test the chaplain's capacity as a *responder*. Also, two common worries are that a pastoral visit portends bad news or that a pastoral visitor intends to proselytize.
4.	The chaplain responds to the patient in a way that implies personal concern and attentiveness to the patient's situation. If practical, the chaplain asks if he/she may sit down. Thus begins the pastoral conversation.	The chaplain tries to convey a desire to be *open but not intrusive*. He/she works to *follow the patient's lead*. (Sitting facilitates a more informal atmosphere, but the patient should not have to strain from the bed or a chair in order to see the chaplain.)	If the patient is interested in pursuing a conversation, he/she will likely venture increasingly personal content (though "small talk" may itself serve a purpose for the patient). Also, issues of religious diversity often arise at the outset.	The patient continues to "feel out" the new *relationship* with the chaplain and the *role* and the *practical value* of the chaplain for the patient's present situation (which often involves issues from the patient's past). A chaplain may be seen to fill a non-religious need.

* If a patient declines a visit, the chaplain may state *very briefly* that the hospital is concerned about everyone's spiritual needs and how anyone may contact Pastoral Care if there is interest in doing so. Wish the patient farewell, but do not continue to engage the patient when a visit is declined.

TYPES OF *LEADING* IN PASTORAL INTERACTIONS*

One way of looking at a pastoral visit with a patient is with an eye to how much the chaplain may be leading or directing the course of the interaction. The more directive the chaplain, the less likely the conversation will be driven by the patient's expression of his or her needs. The following characterizations of interventions by chaplains are listed in order of the *degree of leading* involved.

Least Directive

1. Listening in attentive *silence*

2. *Simple indication* of understanding or acceptance (e.g., nod or "m-hum")

3. *Brief restatement* of the other person's exact own words

4. *Clarification* of a particular word or phrase

5. *Simple summary acknowledgement* of a patient's expression of thought or feeling

Moderately Directive

6. *Explicit approval* of what has been expressed (e.g., "Yes, I agree.")

7. *General leading* based upon what has been said (e.g., "Will you tell me more about that?"†)

Strongly Directive

8. *Tentative analysis* of what has been expressed

9. *Explicit interpretation* of what has been expressed or inferred

10. *Urging* or suggesting solutions to problems (e.g., "Do you think it would be helpful to...")

Most Directive

11. *Depth interpretation*

12. *Rejection* of expressed ideas or feelings

13. *Reassurance* against worries

14. *Changing the subject*

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* John W. Ehman. Based upon lectures by CPE Supervisor Allan W. Reed (St. Luke's Hospital, New York, 1993), drawing on *Principles and Procedures in Student Counseling* by Francis P. Robinson (New York: Harpers, 1950), pp. 82-95.

† Any question, even one intended to be *inviting*, may be experienced as significantly directive.

Three Popular Spiritual Assessment Instruments in Health Care/Research

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1) FICA (general assessment for use by clinicians)

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 health care provider 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 like-minded 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?"

2) Brief RCOPE (research measure of spiritual well-being, with potential clinical applications)

Positive Religious Coping	1) Looked for a stronger connection with God 2) Sought God's love and care 3) Sought help from God in letting go of my anger 4) Tried to put my plans into action together with God 5) Tried to see how God might be trying to strengthen me in this situation 6) Asked forgiveness of my sins 7) Focused on religion to stop worrying about my problems
Negative Religious Coping	8) Wondered whether God had abandoned me 9) Felt punished by God for my lack of devotion 10) Wondered what I did for God to punish me 11) Questioned God's love for me 12) Wondered whether my church had abandoned me 13) Decided the devil made this happen 14) Questioned the power of God

3) FACIT-Sp (research measure of spiritual well-being, with potential clinical applications)

Meaning & Peace	1) I feel peaceful. 2) I have a reason for living. 3) My life has been productive. 4) I have trouble feeling peace of mind. 5) I feel a sense of purpose in my life. 6) I am able to reach down deep into myself for comfort. 7) I feel a sense of harmony within myself. 8) My life lacks meaning and purpose.
Faith	9) I find comfort in my faith or spiritual beliefs. 10) I find strength in my faith or spiritual beliefs. 11) My illness has strengthened my faith or spiritual beliefs. 12) I know that whatever happens with my illness, things will be OK.

Items from two spiritual assessment instruments, based on dimensions of spirituality identified in the recent health care literature. —J.E., 6/3/05

The [Delaney] Spirituality Scale (2003/2005)

DIMENSION	ASSESSMENT ITEMS
Self-Discovery	- I find meaning in my life experiences. - I have a sense of purpose. - I am happy about the person I have become. - I see the sacredness in everyday life.
Relationships	- I believe that all living creatures deserve respect. - I value maintaining and nurturing my relationships with others. - I believe that nature should be respected. - I am able to receive love from others. - I strive to correct the excesses in my own lifestyle patterns/practices. - I respect the diversity of people.
Eco-Awareness (including Higher Power/ Universal Awareness)	- I meditate to gain access to my inner spirit. - I live in harmony with nature. - I believe there is a connection between all things that I cannot see but can sense. - My life is a process of becoming. - I believe in a Higher Power/Universal Intelligence. - The earth is sacred. - I use silence to get in touch with myself. - I have a relationship with a Higher Power/Universal Intelligence. - My spirituality gives me inner strength. - My faith in a Higher Power/Universal Intelligence helps me cope during challenges in my life. - Prayer is an integral part of my spiritual nature. - I often take time to assess my life choices as a way of living my spirituality. - At times, I feel at one with the universe.

—from Delaney, C., "The Spirituality Scale: development and psychometric testing of a holistic instrument to assess the human spiritual dimension," *Journal of Holistic Nursing* 23, no. 2 (June 2005): 145-167.

The [Galek, et al.] Spiritual Needs Assessment (2005)

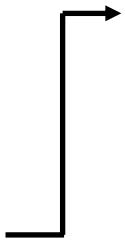
DIMENSION	ASSESSMENT ITEMS ("At any time while you were in the hospital did you have a need:")
Love/ Belonging/ Respect	- To be accepted as a person - To give/receive love - To feel a sense of connection with the world - For companionship - For compassion and kindness - For respectful care of your bodily needs
Divine	- To participate in religious or spiritual services - To have someone pray with or for you - To perform religious or spiritual rituals - To read spiritual or religious material - For guidance from a higher power
Positivity/ Gratitude/ Hope/ Peace	- To feel hopeful - To feel a sense of peace and contentment - To keep a positive outlook - To have a quiet space to meditate or reflect - To be thankful or grateful - To experience laughter and a sense of humor
Meaning and Purpose	- To find meaning in suffering - To find meaning and purpose in life - To understand why you have a medical problem
Morality and Ethics	- To live an ethical and moral life
Appreciation of Beauty	- To experience or appreciate beauty - To experience or appreciate music - To experience or appreciate nature
Resolution/ Death	- To address unmet issues before death - To address concerns about life after death - To have a deeper understanding of death and dying - To forgive yourself and others - To review your life

—from Galek, K., Flannelly, K. J., Vane, A. and Galek, R. M., "Assessing a patient's spiritual needs: a comprehensive instrument," *Holistic Nursing Practice* 19, no. 2 (March-April 2005): 62-69.

The 7 x 7 Model for Spiritual Assessment

—adapted from "The 7 x 7 Model for Spiritual Assessment: A Brief Introduction and Bibliography," by George Fitchett, (available via www.rushu.rush.edu/rhhv)

HOLISTIC ASSESSMENT:
- Medical (Biological) Dimension
- Psychological Dimension
- Family Systems Dimension
- Psycho-Social Dimension
- Ethnic, Racial, Cultural Dimension
- Social Issues Dimension
- Spiritual Dimension



SPIRITUAL ASSESSMENT:
- Beliefs and Meaning
- Vocation and Obligations
- Experience and Emotions
- Courage and Growth
- Rituals and Practice
- Community
- Authority and Guidance

HOLISTIC ASSESSMENT: The holistic assessment looks at six dimensions of a person's life.

Medical Dimension — What significant medical problems has the person had in the past? What problems do they have now? What treatment is the person receiving?

Psychological Dimension — Are there any significant psychological problems? Are they being treated? If so, how?

Family Systems Dimension — Are there at present, or have there been in the past, patterns within the person's relationships with other family members which have contributed to or perpetuated present problems?

Psycho-Social Dimension — What is the history of the person's life, including, place of birth and childhood home, family of origin, education, work history and other important activities and relationships. What is the person's present living situation and what are their financial resources?

Ethnic, Racial or Cultural Dimension — What is the person's racial, ethnic or cultural background. How does it contribute to the person's way of addressing any current concerns?

Social Issues Dimension — Are the present problems of the person created by or compounded by larger social problems?

Spiritual Dimension 

SPIRITUAL ASSESSMENT: The spiritual assessment looks at seven dimensions of a person's spiritual life.

Belief and Meaning — What beliefs does the person have which give meaning and purpose to their life? What major symbols reflect or express meaning for this person? What is the person's story? Do any current problems have a specific meaning or alter established meaning? Is the person presently or have they in the past been affiliated with a formal system of belief (e.g., church)?

Vocation and Obligations — Do the persons' beliefs and sense of meaning in life create a sense of duty, vocation, calling or moral obligation? Will any current problems cause conflict or compromise in their perception of their ability to fulfill these duties? Are any current problems viewed as a sacrifice or atonement or otherwise essential to this person's sense of duty?

Experience and Emotion — What direct contacts with the sacred, divine, or demonic has the person had? What emotions or moods are predominantly associated with these contacts and with the person's beliefs, meaning in life and associated sense of vocation?

Courage and Growth — Must the meaning of new experiences, including any current problems, be fit into existing beliefs and symbols? Can the person let go of existing beliefs and symbols in order to allow new ones to emerge?

Ritual and Practice — What are the rituals and practices associated with the person's beliefs and meaning in life? Will current problems, if any, cause a change in the rituals or practices they feel they require or in their ability to perform or participate in those which are important to them?

Community — Is the person part of one or more, formal or informal, communities of shared belief, meaning in life, ritual or practice? What is the style of the person's participation in these communities?

Authority and Guidance — Where does the person find the authority for their beliefs, meaning in life, for their vocation, their rituals and practices? When faced with doubt, confusion, tragedy or conflict where do they look for guidance? To what extent does the person look within or without for guidance?

A PERSONAL PRACTICE OF PASTORAL ASSESSMENT

John Ehman, 6/15/05

My primary assessment in pastoral visitation is simply whether the patient seems interested and able to use a chaplain to help meet his/her needs, and whether those needs seem appropriate for my involvement (or whether some referral is in order). The process of gathering information and making particular assessments can easily get in the way of patient-led pastoral care, but I recognize that I regularly keep the following concerns in mind. Items 1-4 and 11 are basic to virtually every visit.

1) Is the patient open to a chaplain's visit?
   - Has the visit been requested by the patient?
   - Is the patient interested in an explicitly religious encounter?
2) Is the patient in an immediate crisis?
   - Is the patient in shock?
   - Is the patient very sad, angry, or anxious?
3) Are there practical issues affecting interaction?
   - Are there privacy concerns for the visit?
   - Can the patient physically speak easily?
   - Is the patient tired or drowsy?
   - Are there language or cultural diversity issues?
   - Are there psychological impairments to consider?
   - How formal or intellectual is the patient's style?
4) Is the patient able to engage the chaplain as a resource?
   - Does the patient have a need or agenda in mind?
   - Is the patient able to talk freely about religious and/or personal issues?
   - How does the patient test the chaplain?
   - Are there particular role expectations of the chaplain?
5) Does the patient have an adequate social support system?
   - Does the patient feel alone in his/her problems?
   - Does the patient have a congregational connection?
   - Does the patient feel constrained by his/her religious social support system?
6) Does the patient have an active and helpful spiritual life?
   - Does the patient have developed resources for spiritual strength?
   - Is the patient able to draw on sources of spiritual strength while in the hospital?
   - Does the patient feel that God is near?
   - Is religion in some way a problem?
   - What is the patient's religious coping style (e.g., deferring or collaborative)?
7) How is loss a part of the patient's needs?
   - What past losses are salient for the patient?
   - What is the patient presently losing, or what does the patient think he/she is in the process of losing?
   - Has any religious practice been interrupted by this illness/hospitalization?
8) What is the patient's sense of the immediate future?
   - Is there a major event pending for the patient?
   - Is the patient hopeful, and does the patient give indication of brittle "wishing"?
   - Does the patient have a sense of progress in these days?
9) Does the patient have a sense of meaning and purpose in his/her life in general and in present events?
   - Is there a sense of God's providential involvement in the world?
   - How much chaos is the patient experiencing?
   - Does the patient feel that (his/her) life is unfair?
10) Are there special issues?
   - Is fear (especially in relation to faith) an issue?
   - Is death/dying an issue?
   - Is guilt/regret an issue?
11) What is the patient's expectation for pastoral follow-up?