

Wondering If It's Time To Give Up: A Case Example of the 7 by 7 Model for Spiritual Assessment¹

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Abstract This paper discusses spiritual assessment; what it is, why it is important, and how to include it in pastoral care. The case of a seriously ill, hospitalized older woman who is wondering whether it is alright to "give up" is presented. The 7 by 7 model is used to describe a spiritual assessment of this patient. The implications of the spiritual assessment for the chaplain's care plan and ministry in this case are discussed.

Introduction and Background

I first considered the subject of spiritual assessment over twenty-five years ago, during my pastoral care residency, when I was assigned as the chaplain in one of our hospital's psychiatric units. Like many beginning chaplains, I was searching for a way to describe my role, for a way to state how what I had to offer the patients was different from what they received from the social workers, nurses, and psychiatrists. As I remember it, my questions about all this were more forceful than any answers that I came up with.

My current work with spiritual assessment began about ten years ago. At that time, Julia Quiring Emblen, who was then a colleague on our nursing faculty, approached my fellow chaplain, Russ Burck. Julia wanted Russ' help to find a model for spiritual assessment which she could teach to her nursing students. Russ suggested Julia talk with me. Before long the three of us were joined by Carol Farran, another colleague on our nursing faculty, and we began meeting once or twice a month to discuss the strengths and weaknesses of different approaches to spiritual assessment. We met together for two years, critically reviewing the literature on spiritual assessment, and eventually developing our own model, which we called the 7 by 7 model for spiritual assessment. Working intensively on this project with my gifted colleagues was an experience I will always be grateful for.

My discussion of spiritual assessment today will have four parts. First, I will describe spiritual assessment. I will talk about why it is important, and how we implement it in our ministry. Second I will share with you the case of Dorothy, a seriously ill, hospitalized older woman who is wondering whether it is alright to "give up." Third, I will introduce you to the 7 by 7 model for spiritual assessment, by using it to create a spiritual assessment for Dorothy. Finally, I will discuss the implications of the spiritual assessment for the chaplain's care plan and ministry with Dorothy.

What is spiritual assessment? While our 7 by 7 model for spiritual assessment is relatively new, spiritual assessment is not a new activity for caregivers. When we provide care we usually think about the needs of the person with whom we are working. Spiritual assessment is the process of discerning the spiritual needs and resources of the person with whom we are working. Note that I include an assessment of spiritual resources as well as needs here. Unlike diagnostic models in some medical fields, in spiritual care our assessment model should not simply focus on problems, but also include the resources people bring to help them cope with those problems.

There are many useful ways to define spirituality. I think of spirituality as the way in which we find meaning and purpose in life, and the way we relate to the transcendent dimension of life. Some

¹ This paper is based on a May, 1995, College of Chaplains Care Cassette, "Spiritual Assessment: A Case Example of the 7 by 7 Model."

people make a distinction between spirituality and religion. They see spirituality as a more personal search for meaning and purpose, and religion as what we do in relation to organized groups of beliefs and practices, such as churches or synagogues. I think spiritual assessment should include both of these. I tend to use the two terms interchangeably.

Many chaplains become interested in spiritual assessment because their institution has developed a protocol requiring the chaplain to document a spiritual assessment on all new patients, clients, or residents. Usually these chaplains are looking for a set of categories which will permit them to write a brief note about a few key features of the spiritual needs and resources of many patients. I call that spiritual screening or triage.

Like physicians, nurses, and psychologists, we can perform a quick screening to determine if a person is experiencing a crisis, in our case a serious spiritual crisis. But again, like our colleagues in other health professions, a full diagnostic work-up, a full spiritual assessment is not a quick or simple process. There is a place for spiritual screening, but it is important to remember that it is different from spiritual assessment. This presentation is about spiritual assessment.

Why is spiritual assessment important? Spiritual assessment is important because it improves our ability to be accountable for our spiritual care. What are the goals of our ministry with a particular person? How do we know if the care we are providing is the care the person needs? What can help us guard against projecting our needs and assumptions onto the person we are caring for? In order to answer these important questions we require a way to describe the spiritual care we think a person needs. We can then provide that ministry and see if it has the effect we expected.

Our spiritual assessment gives us a way to state the goals of our ministry as we enter into a new pastoral relationship. It gives us a way we can talk with the patient, or other person with whom we are working, to see if they share our understanding of their spiritual needs and agree with the kind of spiritual care we are suggesting. Our spiritual assessment also gives us a better way to talk with staff colleagues about our understanding of a patient's needs and our goals for our ministry with them.

How do we do spiritual assessment? Many chaplains welcome the idea of being more explicit about the spiritual dimension of their work. They also welcome being more accountable for the goals of their ministry, but they don't like the idea of spiritual assessment. As I have heard them, chaplains seem to have two problems with spiritual assessment.

Some chaplains object because they believe that conducting a spiritual assessment means entering a patient's room with a clip board and a questionnaire, and asking the patient a list of questions. There are some models for spiritual screening and spiritual assessment that use such questionnaires, and I would argue there is a place for that approach to assessment.

However, the method for implementing spiritual assessment that I would recommend is much different. A central theme in our approach to pastoral ministry during the past fifty years has been our emphasis on the importance of the pastoral relationship. Our concept of a theology of presence is one way we express our belief that empathic, caring relationships with people in need can be expressions of divine care. Doing spiritual assessment should not alter our use of open-ended pastoral conversations in which we respond sensitively and empathically to the needs and feelings of the person with whom we are working. Nor should our interest in assessment compromise the importance of building trusting pastoral relationships with those to whom we offer our ministry.

What has changed in my ministry as a result of doing spiritual assessment is not what happens when I am visiting with a patient, client or resident. It is what happens after my first visit. After that visit I use the categories in our 7 by 7 model to think about the conversation I have just had and what I have learned about the spiritual needs and resources of the person I was with. This helps me think about the goals of my ministry and my care plan. I may then summarize the key points of my assessment and care plan in the patient's chart.

The second problem with spiritual assessment is raised by chaplains who describe their approach to assessment as highly intuitive. These chaplains report that their response to their patients is based on strong gut feelings or intuitions about what will best meet a patient's needs. They think doing spiritual assessment will interfere with their familiar pastoral style.

Assessment is a process of gathering information and interpreting the implications of that information. I assume that part of what happens when we respond to a patient's story with a strong intuition is that we have gathered a lot of information about the patient both very rapidly, and perhaps not all consciously. The work of spiritual assessment is not designed to block our use of our intuition or strong gut feelings. Rather, it asks only that we sometimes slow down and work to be more explicit about the information we have gathered and the way we are interpreting it, so that we can be accountable for the ministry we are providing.

Key Features of the 7 by 7 Model Before we turn to Dorothy's story let me describe a few of the key features of our 7 by 7 model for spiritual assessment. A central feature is that our model places the spiritual assessment in the context of a holistic assessment of the person we are working with. Chaplains in health care settings especially need no reminder that a person's medical or psychological status can have a profound impact on their spirituality. But the same is true for the psychosocial and racial/ethnic dimensions of life, so we feel it is important for spiritual assessment to include a holistic assessment.

A second important feature of our model is our functional approach to spirituality. Working in a large urban medical center, we need a model for spiritual assessment that will be useful across a wide spectrum of religious beliefs and practices, including people who wrestle with spiritual issues while having no specific religious affiliation. We find that using a functional approach to spirituality, that is, focusing on how a person makes meaning in life, is the best way to achieve this goal.

Finally, we feel that the spiritual dimension of life is complex, and that we need to be attentive to a number of dimensions of spirituality, including beliefs, rituals, and relationships in order to have a comprehensive approach to spiritual assessment. With this background let's get acquainted with Dorothy.

Dorothy: Wondering If It's Time to Give Up

I learned about Dorothy from a pastoral care resident at another medical center whom I will call Amy. Amy presented a verbatim of her ministry with Dorothy at a spiritual assessment seminar which I attended. I subsequently spoke with Amy to obtain her permission to use this case in this presentation and to learn more about Dorothy. I want to express my appreciation for Amy's generous permission to share this case with you.

Dorothy is not the patient's real name. I have changed her name, and some other facts in her case to protect her confidentiality. Dorothy is a Caucasian woman in her mid-70s who was admitted to the hospital for an exacerbation of asthma. She is a widow and a Roman Catholic. Amy's verbatim of her first visit with Dorothy will help us get to know more about Dorothy. Let me read that verbatim to you.

Known Facts and Background: The only information I had about Dorothy came from the admit slip. She was admitted to the hospital on August 10th, lived in a local suburb, and had Advance Directives. Father Henry had visited Dorothy on August 11th. She apparently had been very receptive to his visit and had expressed concern about not being able to attend church. Due to medical problems, Dorothy was homebound. Father Henry had anointed Dorothy and had administered communion.

Let me interrupt Amy's report for a minute here to add that the hospital to which Dorothy was admitted is run by a Roman Catholic community. One of the policies at that hospital is to offer the sacraments to all newly admitted patients who are 70 years old or older.

Amy continued, my visit on August 20th was prompted by a conversation with the Charge Nurse. I routinely check in with the Charge Nurse when I make rounds to see if anyone in particular might benefit from a visit. On August 20th the Charge Nurse suggested that I see Dorothy because "she had been in the hospital for a long time and seemed depressed."

Preparations and Plans. My own preparation, Amy writes, was the discussion with the Charge Nurse prior to seeing Dorothy. I didn't really have a plan for inviting Dorothy to talk about what was bothering her other than to provide an opportunity through my presence.

Observations: Dorothy was sitting up in bed breathing with obvious difficulty when I entered. She was receiving oxygen. A grey hand knit sweater was draped over her shoulders. The hospital tray was

to her right and it was covered with a variety of items. To her left was a portable toilet. On the window sill was a plant and a card. On the night table next to the bed were two flower arrangements.

Interview:

- C 1. (I stood at the end of the bed as I introduced myself) Mrs. Haines?
P 1. Yes?
C 2. My name is Amy and I'm a Chaplain. 6 West is a part of the hospital where I routinely visit patients. I'm here to say hello and to see how you are doing.
P 2. I'm not doing very well. I have emphysema, diabetes, and a heart condition. I can't breathe. I can't even get from here (her bed) to there (the portable toilet that was next to her bed) without help.
C 3. It must be very frustrating for you.
P 3. Yes it is. I am not able to care for myself. You must see a lot of people who never leave here. Most people who come here die. I'm not going to leave here. I have to use the toilet. Will you wait while I use it? I would really like you to stay for awhile. (She buzzed the nurse.)
C 4. I'll be happy to wait. (The nurse came in to help her.) I'll be back when you are finished. (I left for a brief period of time and returned.)
P 4. Thank you for coming back.
C 5. Would you like to talk about why you feel you are not going to leave here?
P 5. I can't breathe. I have so many health problems and they seem to be getting worse. My doctor said that he doesn't know what else to do for me. I need full time care now and my daughter and son-in-law both work.
C 6. Do you live with them?
P 6. Yes. They can't take care of me. I don't know what I'm going to do. I don't want to give up.
C 7. Is it possible to hire someone to help care for you?
P 7. I suppose, but I need someone all the time.
C 8. Could someone come in during the day and your daughter and son-in-law take over when they get home?
P 8. Yes. That would work, but I don't want to spend all of my daughter's inheritance on someone to care for me. I suppose I could do it for a year or so. I doubt if I'll live much longer than that. I need to talk to my daughter. Will you come back after I talk to her and help me decide what to do?
C 9. Yes. I will come back. I feel that you need to decide what is best for you but I will be more than happy to listen and help you figure it out.

Spiritual Assessment

Before we move on to develop a spiritual assessment for Dorothy, let's stop for a minute to think about our reactions to this visit. It is helpful to name our emotional response to the visit as a way to debrief from the encounter. This also helps us keep our feelings in perspective as we do the work of assessment.

Take a minute to think about any feelings you have about the people in this verbatim. How do you feel toward Dorothy? I like Dorothy. I like her straight-forwardness and her generosity. I am also anxious. Her story reminds me of other patients I have known with severe pulmonary diseases who required constant oxygen who were very anxious about getting enough air. I also feel sad. Dorothy seems worried and, as the nurse says, depressed. I am concerned about her. What are your feelings?

Do you have any feelings toward the other people in this case? One chaplain who heard the case reacted strongly toward Dorothy's daughter. This chaplain thought the daughter was selfish and neglectful. How do you feel toward her? or toward the chaplain?

Let's shift our focus now and begin work on our spiritual assessment of Dorothy. Some of you may object that we don't have enough information yet to do a spiritual assessment on this case. But isn't that part of what makes this case so realistic? We often have a brief visit with a patient who is in a crisis and we have to begin to find a helpful and caring way to respond before we have had an opportunity to gather all the facts about the person. It is also important to remember that as we get to know Dorothy better we can revise and supplement our assessment of her.

Before you hear my assessment of Dorothy, some of you may wish to stop the tape and make some notes about the spiritual needs and resources you hear in the verbatim, to make your own spiritual assessment which you can compare with the one that I have developed.

Holistic Assessment As I mentioned earlier, the 7 by 7 model places spiritual assessment in a holistic context. So as we begin we first look at the seven dimensions of our holistic assessment. The first dimension that we review is the medical dimension. What are the important features of Dorothy's medical situation? In Dorothy's case her medical condition is a central feature in understanding her spiritual needs. She is so weak she can no longer care for herself independently, and she is concerned that her death is near. At the beginning of the verbatim she tells the chaplain that she has emphysema, diabetes, and a heart condition. By itself, any one of these diseases could be a problem. The presence of all three conditions together is a cause for concern. Dorothy expresses her awareness of the gravity of her condition when she says to the chaplain, "I'm not going to leave here. . . I have so many health problems and they seem to be getting worse." Her doctor, she says, doesn't know what else to do for her. Dorothy reports that she has difficulty breathing and is so weak that she's not able to use the bedside commode by herself. As she thinks about the future she is aware she cannot be alone and that she needs assistance with her activities of daily living. The spiritual issues Dorothy seems to be wrestling are directly related to these significant changes in her medical condition.

Psychological dimension Let's turn to the psychological dimension. When she made the referral to the chaplain, the nurse described Dorothy as depressed. That seems to be accurate and perhaps appropriate given her situation. Dorothy also appears to be anxious. She is worried that she may not leave the hospital and needs to talk with the chaplain about this right away, even though she has just met the chaplain.

Family Systems dimension What can we say about Dorothy from a family systems perspective? At this point we have very little information about this aspect of her life and there is little we can say about it. We know that she lives with her daughter and is concerned about not being a burden to her, but we really can't judge how close or distant that relationship may be.

Psychosocial dimension What do we know about Dorothy from a psychosocial perspective? While we know a few things, there are many things we don't know about Dorothy. We know she is a widow, but we don't know how long ago her husband died, or what it has been like for her to be without him. She lives with her daughter and son-in-law, but we don't know how long she has lived there, or what that arrangement is like for them. She has three arrangement of flowers in her room, and so may have other family or friends who are also concerned about her. The hand knit sweater around her shoulders suggests that either she has an interest in needlework, or someone close to her does. Her concern about her daughter's inheritance suggests she has some financial resources at her disposal. Unfortunately beyond this we don't know anything about Dorothy's family of origin, childhood, education, work history, if any, hobbies or avocational interests.

Racial/Ethnic dimension What is Dorothy's racial/ethnic background and what implication may that have for our spiritual assessment? Dorothy is Caucasian, but Amy reported she never mentioned anything that identified any specific ethnic origin.

Social Issues dimension The social issues dimension may be less familiar than the five dimensions we have just discussed. It is the place in our model where we reflect on the impact of our social institutions and policies on Dorothy and her problems. Most approaches to diagnosis or assessment focus on the individual, or perhaps the individual in her or his family system. We include this dimension to remind us that we all exist in a social context and sometimes features of that social context make things easier or harder for the people we are working with.

Do you see any important social issues in Dorothy's case? One social issue that stands out in this case for me is how the organization of health care resources in our society limits the options available for Dorothy and other people in her situation. The way our system is organized, in-patient hospital care is readily available for Dorothy. But as she looks toward discharge she sees fewer good choices. While she lives with a daughter who appears to be concerned about her, Dorothy's daughter is working and is not available to be her full-time, primary caretaker. Additionally, Dorothy isn't sure she can afford the cost of having full-time care at home. These social issues seem to play an important role, limiting her options, in Dorothy's case.

Spiritual Assessment The seventh and last dimension in our holistic assessment is the spiritual dimension. There are seven specific sub-dimensions in the spiritual dimension which we will examine. The first of these we call belief and meaning. What are Dorothy's key beliefs and what gives her life meaning and purpose? Our knowledge of Dorothy is limited, but even with this limited information we can sketch some initial thoughts about beliefs and meaning in her life. We know that Dorothy is Roman Catholic and was receptive to the visit from the hospital's priest and the sacraments he administered to her. We don't know about any of Dorothy's specific beliefs. What, for example, is her understanding of God? Does her understanding of God emphasize God's loving mercy or stern justice? What does she believe about life after death? These may become important beliefs to be attentive to as we try to help Dorothy.

Beyond her beliefs, what appears to give Dorothy meaning and purpose in life? I believe this is the central issue for Dorothy right now. As I review her conversation with the chaplain I hear four inter-related ways in which Dorothy is talking about being in the midst of a profound change, a crisis of meaning and purpose in her life. The first way I hear Dorothy expressing this is in her relation with her daughter. She has an inheritance which she looks forward to giving to her daughter. She finds meaning in making sacrifices in her life in order to be able to give her daughter this gift. But her situation confronts her with the possibility that she may have to spend that money for her own care and not be able to give it to her daughter. Further, not only is she facing a situation in which she may not be able to care for her daughter, to give her a gift, she may have to ask her daughter to make sacrifices in her life in order to help care for Dorothy.

Second, Dorothy is dealing with the fact that since she entered the hospital she has gotten considerably weaker and is no longer able to care for herself as she was just a few weeks ago. She has lost a considerable degree of her independence and has become much more dependent on others for assistance with her daily needs. This change is permanent and it may be progressive. What does it mean for Dorothy's understanding of herself and her purpose in living to suddenly be so dependent on others? A number of Dorothy's comments to the chaplain point to the way in which this change has created a crisis for Dorothy. For example, Dorothy says, "They [her daughter and her son-in-law] can't take care of me. I don't know what I am going to do. I don't want to give up."

Third, Dorothy is aware that her death may be near. Her shortest estimate is that she will die during this hospitalization. Her longest estimate is that she will die in a year. In this conversation is Dorothy beginning to try on a new identity, that of dying person? What does it mean for her sense of meaning and purpose in life to think of herself as a dying person? Can she find meaning in this new role?

Fourth, and related to the three themes I just mentioned, is the way in which Dorothy isn't sure where her next home will be. Should she prepare herself to move back to her daughter's home and arrange to get some additional help with her activities of daily living? Should she prepare herself to move into a nursing home, a common solution for people in her situation, but one which may be out of the question, unmentionable, for Dorothy. Or, should she prepare herself for her death?

The more I went over Dorothy's words in this brief verbatim, the more I was struck when she said, "I don't know what I'm going to do. I don't want to give up." Dorothy is a woman who doesn't want to give up. But give up what? Dorothy's sentence, "I don't want to give up," strikes me as unfinished. What is it she doesn't want to give up? Don't we usually say, "I don't want to give up hope?" I wonder if Dorothy is facing a crisis of hope. She hopes she can get well and return to her daughter's home, but she's also not sure if she will leave the hospital alive. Does Dorothy's awareness that she may be dying make it

hard for her to be hopeful? Is there anything to hope for when we are dying? Can there be meaning and purpose in the process of dying for Dorothy? How can she know what to hope for if she isn't sure whether she will live or die? These are some of the questions about meaning and purpose in life that I hear Dorothy laboring with as she speaks to the chaplain.

The second dimension we look at in the specifically spiritual half of our assessment is one we call vocation and obligations. What duties and norms does Dorothy feel obligated to fulfill in light of her beliefs and meaning and purpose in life? Since we began doing assessments with this model, we have found that people's sense of their duties and obligations is so closely connected to their beliefs and meaning that it is often impossible to make a distinction between them. To a great extent that seems to be the case for Dorothy. It is important to her to be a good Catholic, to receive the sacraments and to attend Mass. It is important to her to be a good mother and provide for and not burden her daughter. It is important to Dorothy have advance directives, to take the responsibility to inform others about her preferences for her care should she become unable to express them directly. We also see that it is important for Dorothy not to make unilateral decisions about care arrangements should she be discharged, but rather to include her daughter in that process.

All of these are ways in which Dorothy's value commitments, her sense of duties and obligations, are evident in her brief conversation with the chaplain. But there is one additional place in which Dorothy expresses her values which I think is the most crucial for our assessment of her. It is when she says, "I don't want to give up." My impression is that this statement expresses Dorothy's belief in the moral significance of hard work. It is as if she were saying, "God helps those who help themselves." If she is to expect divine assistance in this crisis, Dorothy feels a moral obligation to shoulder her portion of the burden.

More importantly, I believe her statement, "I don't want to give up," also expresses Dorothy's sense of a duty to be hopeful, a belief that to give up hope in her recovery too soon is morally wrong. I think that Dorothy's statement may really be an indirect question, a request for consultation about her moral obligations in light of her changing health situation. It is as if she is saying, "I don't want to give up hope, but I'm feeling weaker and I'm doubtful that I will get better this time. May I be released from the duty to hope for and work for my recovery?" My impression is that Dorothy is addressing significant moral questions at this point in her illness.

The third dimension we consider in this part of our spiritual assessment is called experience and emotion. This is where we consider whether the person reports any direct spiritual experiences and if so, what impact they have had upon them. In this brief visit, Dorothy doesn't report any direct spiritual experiences, but it would be good to keep open to the possibility that she has had such experiences. People often need to develop some trust in us before they are comfortable sharing such experiences.

In this part of the assessment we also try to find one word which will capture the overall tone, sometimes we say emotional tone, of the person's spirituality. If you had one word to describe Dorothy's spirituality what would it be? I am still trying to find the word that seems to fit Dorothy the best. Tired, fearful, and anxious come to mind, but they feel like better labels of her emotional state than her spiritual state. Maybe a good word to describe her spiritual state will come to us when we visit her again and get to know her better.

The fourth dimension in our model is called courage and growth. This is the place in the model where we look at whether there has been or appears likely to be any change in the way the person makes meaning and finds purpose in life. For example, has Dorothy had an experience of radical doubt, an experience of the dark night of the soul, in which there was a profound change in her faith. What we know about Dorothy does not indicate she has had or is having such an experience, but we must keep in mind how brief this first visit was and the possibility that as we come to know her better we may learn something significant about this aspect of her spirituality.

The fifth dimension which we review is called rituals and practices. What rituals and practices express Dorothy's key beliefs and her sense of meaning and purpose in life? It appears that the rituals of her Catholic faith are quite important to her. She told Father Henry that before her admission to the hospital when she was home bound she missed attending Mass. She welcomed his visit and the

opportunity to receive the sacraments of anointing and communion from him. We don't know if she has any personal devotional practices in addition to these public ritual practices.

Beyond these religious rituals are there any other ritual activities that are important in Dorothy's life? I wonder about the impact of the loss of independence in her activities of daily living. Pointing to the commode at her bedside, Dorothy tells the chaplain she is too weak to even use it by herself. Every time Dorothy needs to use the toilet she is now involved in a ritual which reminds her of her weakness and need for help. What impact is the ritual reinforcement of this truth having on her spirit? It seems to me that the rituals of her dependence are reminding her of her weakness and the crisis she is in and they contribute to her depressed spirit. In this context the rituals of her Catholic faith, which can remind her of her worth as a child of God regardless of her level of independence, may take on new importance.

The sixth dimension in our model is called community. Who are the people with whom Dorothy shares her beliefs and her sense of meaning and purpose in life? With whom does she share her sense of duties and obligations? With whom does she share the rituals that are important expressions of her central values? Dorothy's daughter appears to be a key figure in her community. Dorothy does not want to make any important decisions without consulting her. But who else is there in Dorothy's community. The urgent way in which she welcomes the new chaplain into a key role in consulting with her about her future gives the impression that her community has become small and that she has few people to help her with important matters such as this.

If I am correct in my assessment that Dorothy is wondering and asking if she can be released from the moral duty of working and hoping to get better, then she needs a community to address this question with her. She needs her physician to help her interpret the implications of her growing weakness. She needs her daughter to help release her from the burden of a futile struggle to recover, and she needs the chaplain to release her from the duty to hope for an unlikely recovery and help her focus her sense of hope and meaning in new directions.

The final dimension we consider in our model is called authority and guidance. In times of crisis and doubt to whom does Dorothy turn for support and direction? It is difficult to get a clear picture about this aspect of Dorothy's spirituality at this point. Her initial engagement with the chaplain has considerable authority, both in her assessment of her condition, "I'm not going to leave here," and in her request for the chaplain to wait while she uses the toilet, "I would really like you to stay for awhile." She seems able to draw the chaplain into dialogue with her about her situation drawing on the chaplain's judgment without relinquishing her own. Her relationship with her daughter seems to have a similar mixture of consultation and inner authority. Dorothy may have a mature level of inner authority which enables her to speak her mind while at the same time seeking assistance from others. We can be more sure about this portion of our assessment as we spend more time with her.

Summary As you have seen, the process of developing a spiritual assessment using the 7 by 7 model is lengthy and complex. Here is my summary of our spiritual assessment of Dorothy.

Since entering the hospital Dorothy has become weaker. She realizes that if she leaves the hospital at all she will require full-time care at home. Up until this point Dorothy appears not to have seen herself as either an invalid or a dying person. She now is faced with the prospect that she is one or the other. This change is creating a crisis in her sense of purpose and meaning in life. As she tries to sort out what is happening to her she wonders what she can hope for and whether it would be alright for her to give up. She appears to need the assistance of her physician, daughter, and chaplain in helping her consider what she should hope for. Dorothy appears to be a devout Catholic and her faith should be an important resource in helping her as she reconsiders the object of her hopes.

A summary like this could be used in a chart note to share our spiritual assessment with other members of the care team.

Discussion

What are the implications of this spiritual assessment for the chaplain's care plan and ministry with Dorothy? There are a lot of connections that we could make between this assessment and the chaplain's ministry with Dorothy. Our time today will only permit me to focus on a few highlights. Based on this assessment, my care plan with Dorothy would focus on four things. First, the marked change in her health and strength since her admission has come as a surprise to Dorothy, a depressing surprise. I think she needs to have an opportunity to express the feelings which accompany this realization, her sense of shock, sadness, and perhaps anger about the significant losses she is experiencing. The chaplain can help with this by spending time with Dorothy and facilitating her expression of those feelings.

Second, Dorothy needs help in deciding whether it is ok to give up and whether she wants to give up. She needs to talk with her physician and her daughter about this. The chaplain can help with this by reflecting back to Dorothy that she seems to be trying to decide something important, by encouraging her to talk with her physician and daughter to get their input, and by helping Dorothy weigh her own values as she makes her decision about what she hopes for and whether it is ok to give up now.

Third, the chaplain can offer Dorothy some other options as she considers whether or not to give up. The chaplain might suggest to Dorothy that she is entering a process not of giving up but of letting go and saying good-bye, a process in which she has an important role and important work to do.

Fourth and finally, The chaplain can help Dorothy draw on her Roman Catholic beliefs and practices to find support and resources for each aspect of the process I have identified here. In the process of reflecting on her losses and letting go in light of her faith, she might also find comfort in the knowledge that her death will also be a time of saying hello, of being welcomed into the eternal presence of God.

As we come to the conclusion of this program and look at all the hard work we have done in developing this spiritual assessment of Dorothy, and a care plan based on that assessment, it is important to remain modest. The next time we visit Dorothy we might learn something that will require us to completely alter our assessment of her and our care plan. Our assessments must not keep us from openness and presence to meet our patients at their point of need. They can help us be more effective and accountable for the ministry we provide to meet those needs.

When I spend a lot of time doing an assessment of a person like Dorothy, I find I get attached to them. Some of you may have become attached to Dorothy and wonder how things turned out for her. Amy told me that Dorothy died in the hospital about three weeks after this visit took place. She had several cardiac episodes during that time and was in and out of the intensive care unit twice. She remained depressed about her poor health, but was comforted by the presence of her loving daughter and a caring chaplain. I'm grateful to both Amy and Dorothy for letting us learn from their stories. I wish you the best in your work with spiritual assessment. I hope that you find it enriches your ministry.

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