Spiritual AIM

SPIRITUAL ASSESSMENT AND INTERVENTION MODEL (AIM)

MANUAL

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Chapter 1. Introduction

The Spiritual Assessment and Intervention Model (Spiritual AIM) focuses on the initial assessment of a patient during a spiritual care encounter and provides concrete interventions based on that assessment. This unique, evidence-based model has been under development since 2011 and has been continually refined since then.

This manual provides background on Spiritual AIM, step-by-step guidance for using the model, exercises to promote confidence in using the techniques and interventions taught, and material for further education as desired.

How to Use this Manual

Development and pilot testing[1] of this manual conducted by the Spiritual AIM team demonstrates that chaplains can make reliable Spiritual AIM assessments, interventions, and care plans if they:

1. Read the Spiritual AIM manual & complete all of the exercises included.

2. Read "Spiritual AIM and the work of the chaplain: A model for assessing spiritual needs and outcomes in relationship."[2]

3. **Optional:** Seek additional education and technical support from the Spiritual AIM team (e.g., writing verbatim, practicing documentation, engaging in patient simulation activities).

If you plan to use this manual to teach others about spiritual assessment, **we strongly recommend** that you contact the authors for additional training and technical support, as well as customized tools and activities.

Please note: Spiritual AIM is one of the few evidence-based spiritual assessment models that has shown promise for positive impact on spiritual healing.[3] However, Spiritual AIM is a spiritual assessment model and not a comprehensive pastoral education program or care modality.

Spiritual assessment is best conducted by a professionally trained chaplain who, through credentialing, has demonstrated the skills described in the Standards for Professional Certification by the Association for Professional Chaplains and Strategic Partners for Spiritual Care.[4]

As will be described throughout this manual, spiritual assessment is dynamic and relies on the interpersonal interactions between spiritual care providers and recipients. It is not a prescribed set of interventions or a structured interview protocol. Professional chaplains draw on various theories and tools to meet the spiritual needs of those in their care—spiritual assessment is one important tool in the toolbox of professional spiritual care and creating and communicating care plans.

If you are not a chaplain: Non-chaplain medical providers (e.g., nurses, doctors), community clergy and psycho-social practitioners—and likely anyone who interacts with people in crisis—may benefit from this manual. We encourage you to partner and regularly consult with professional chaplains in your institution and community as you address spiritual needs.

If you are a chaplain working outside of a healthcare setting: For the purposes of consistency, we refer to care recipients as "patients" throughout this manual. Although the manual has been tested only in healthcare settings, Spiritual AIM has been taught and used in various settings, including higher education, prison/re-entry, and military.

Generalizability and Social Location of Manual Development Team

The manual was developed by spiritual care educators/practitioners and medical professionals affiliated with academic medical centers in large cities, including San Francisco, CA; Palo Alto, CA; Washington, DC; and San Diego, CA; as well as a Middle States Commission on Higher Education accredited religious seminary in New York City. Those who worked on the development of the manual include the following representation: White, African American, Native American, Christian, Jewish, and Queer. The manual was developed by women, in their 30's-60's, all with high levels of education, all born in the United States with English as their native language.

Manual testing, which included pre/post knowledge tests and live education, occurred with ~120 professional chaplains and Clinical Pastoral Education (CPE) trainees working in healthcare, long-term care, and palliative care/hospice settings. Thorough description and analysis about manual testing will be described in a forthcoming manuscript.

Given the fact that the manual was largely developed in academic medical centers in urban settings and tested primarily on White Christian spiritual caregivers, the manual may require adaptation for other cultures/communities.

Manual Testing: Demographics[5]

- Religion:
  - 81% Christian; 5% Jewish; 4% Muslim; 3% Buddhist; 3% Catholic; 1% Interfaith; 1% Inter-spiritual; 5% Declined to answer

- 35% Board Certified with APC, NAJC, NACC or CASC

- Years of Experience
  - 0-10 Years = 58%
  - 16-20 Years = 7%
  - 21-30 Years = 10%
  - 31-40 Years = 2%
  - Declined to answer = 23%

- Race –
  - Asian – 9%
  - Black – 12%
  - Caucasian – 50%
  - Hispanic – 10%
  - Other:
    - Jewish Ashkenazi – 12%
    - Middle Eastern – 1%
  - Declined to answer – 6%

- 53% of participants work in Hospital/Acute Care/Academic Medical Center/VA. Other settings included:
  - Recovery
  - Palliative Care
  - Manager/Educator
  - Congregation
  - University
  - Long-Term Care
  - Geriatric Care
  - Hospice
  - Pediatrics

Are We There Yet?

When we embarked on this journey—first, describing and evaluating the Spiritual Assessment and Intervention Model ("Spiritual AIM") in an initial research study; and second, developing this manual for use in training chaplains in the use of Spiritual AIM—we needed to ask ourselves some important questions: Why study Spiritual AIM? Why describe it in detail? Was there really a need for us to put this model out there in the public domain? Why not just keep teaching Spiritual AIM to chaplains who happened to train with those clinical pastoral educators familiar with Spiritual AIM? How was this *particular model* different from others already described? Was another model needed? How were chaplains being trained? Didn't they already have a method for assessing and intervening with patients?

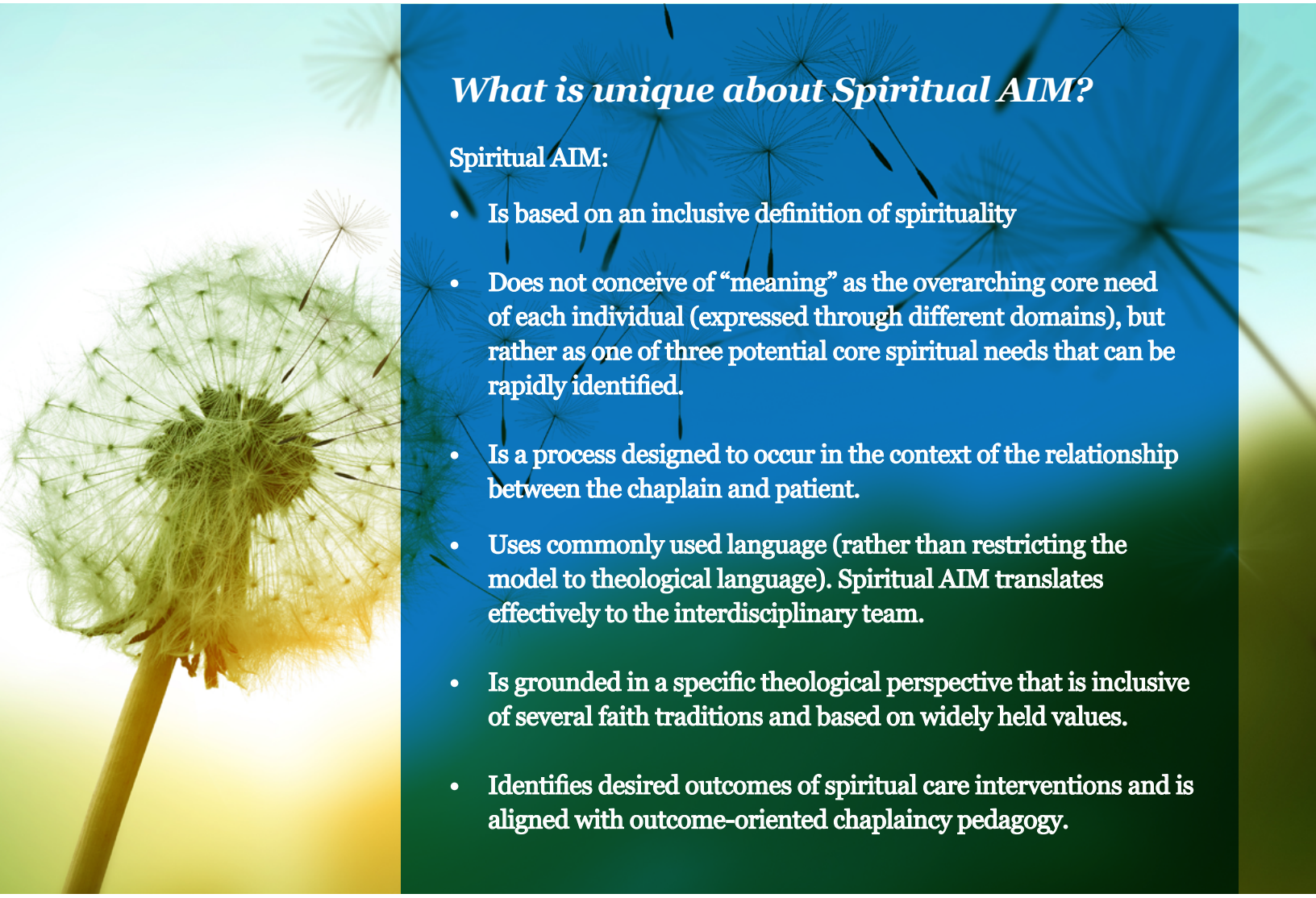
Luckily, we had extremely curious and skeptical non-chaplains as our research partners. They kept asking these kinds of questions, and we had to keep justifying, explaining, and explaining again. Gradually, for ourselves as chaplains and for our non-chaplain colleagues, the answers started to form. New questions arose. But we grew more comfortable with asking these questions. We learned it was all part of the process.

Real Stories Bring Spiritual AIM to Life

The research study also yielded something novel in spiritual assessment and care—transcribed conversations with real patients and chaplains using Spiritual AIM. As we worked to further describe Spiritual AIM, it became apparent that the real-life examples from the study of evidence of a patient's spiritual assessment, the interventions of the chaplain, and the outcomes described by the patient themselves was precious material for use in a manual that could educate chaplains about how to effectively use Spiritual AIM.

A model for use with real people—whether it is intended to describe, to instruct, to challenge, or to treat—needs to be developed and described in ever-increasing detail, so that new viewers can truly see what is there. Like a photograph being developed in a darkroom, the goal is for dim and blurry forms to emerge as distinct shapes with edges and unique colors. Similarly, we could talk vaguely about Spiritual AIM among ourselves, convincing ourselves that the model was well-formed and useful. But until we forced ourselves to elaborate it, write it down, describe it to others, study it, and now, provide an in-depth training manual, we remained in the darkroom, alone, with the light out.

This model is one of many that chaplains may encounter in their training and careers. In describing Spiritual AIM, we are not asserting that Spiritual AIM is better than other models. However, it is unique in several ways, which are detailed further in the callout on the next page and in Chapter 2. By describing Spiritual AIM in detail in this manual, we are trying to empower chaplains and their educators to develop an approach, a plan, and a strategy when encountering a patient.



What is unique about Spiritual AIM?

Spiritual AIM:

- Is based on an inclusive definition of spirituality
- Does not conceive of "meaning" as the overarching core need of each individual (expressed through different domains), but rather as one of three potential core spiritual needs that can be rapidly identified.
- Is a process designed to occur in the context of the relationship between the chaplain and patient.
- Uses commonly used language (rather than restricting the model to theological language). Spiritual AIM translates effectively to the interdisciplinary team.
- Is grounded in a specific theological perspective that is inclusive of several faith traditions and based on widely held values.
- Identifies desired outcomes of spiritual care interventions and is aligned with outcome-oriented chaplaincy pedagogy.

The chaplain who steps into a patient's world without a plan may tell themselves that they are being genuine or organic, meeting the patient where they are. These are internal justifications. Without a plan, the chaplain risks turning the pastoral encounter into a meandering, formless waste of both their time and the patient's time. While it may feel like a lovely, "friendly visit" from the chaplain's perspective, this is not truly pastoral care. The chaplain, at some level, is aware of this and may feel unsatisfied or even unimportant. The patient is left wondering what the visit was meant to accomplish, or worse—the patient may be annoyed or angry at the intrusion.

Beyond the immediate chaplain-patient encounter, there are other reasons why it is important for the chaplain to have a thorough understanding of and ability to use a well-described model. Without these, the spiritual care provider is unable to explain her work or the patient's needs in terms that other healthcare professionals and team members can grasp, and in ways that are ultimately useful to the care of the patient. In today's healthcare environment—fast-paced, increasingly high-tech, and short on patience for vaguely described interventions—chaplains need to describe their work in

understandable terms. Chaplains need to be vocal about their contributions and have the cases and data to back up these claims.

We hope that a full description of Spiritual AIM, and training in its use, will help chaplains avoid the meandering visit, stake their claim more effectively in healthcare systems, and provide more effective pastoral care to their patients.

Purpose of the Spiritual AIM Manual and Training

For years, those learning about Spiritual AIM asked for a comprehensive written description of the model, with specific details to guide their assessments, interventions, and outcomes. Since the publication of "Spiritual AIM and the work of the chaplain: A model for assessing spiritual needs and outcomes in relationship"[2], dozens of CPE learners and professional chaplains have sought out more guidance and practice in using the model. While we are thrilled at the enthusiasm and interest, as with any endeavor involving humans, interpretation and evolution is inevitable. This manual and training were developed to standardize how spiritual care providers use Spiritual AIM, as well as to maintain fidelity in the way that the model is taught. This manual has been revised, piloted, and tested over eight years, with more than 120 individuals around the United States. Users have included chaplain interns in their first unit of CPE as well as chaplains in their 40th year of professional spiritual care practice. The pilot is detailed in a forthcoming manuscript, and it is noteworthy to share that participating in the Spiritual AIM Training as outlined in this manual results in users making consistent and reliable spiritual assessments, according to the model. At a recent virtual Professional Development Intensive hosted by the Association of Professional Chaplains, participants were correctly assessing spiritual needs over 90% of the time, after engaging in this training.

Notice that at no point do we refer to Spiritual AIM as a structured intervention or interview. Spiritual Assessment is most effective when it is used by a spiritual care provider who has significant reflective practice, self-awareness, and pastoral skill to establish a spiritual treatment plan, while engaging authentically with the person in their care. Our hope is that this training will provide you with the confidence to integrate Spiritual AIM into the Standards for Professional Spiritual Care, so that you can provide excellent spiritual care and communicate efficiently about your work to interprofessional colleagues.

> "Spiritual assessment is an evolving dialogue, established within a compassionate encounter with the patient, regarding those issues that most concern the individual patient. Spiritual assessment involves diagnosing an individual's primary unmet spiritual need and devising a plan about how to address that need through a process of particular interventions aimed at healing outcomes.

Spiritual Stance

In order to avoid the cautionary scenario of the meandering pastoral care visit already described, Spiritual AIM provides guidance about a spiritual stance, or embodiment, for the chaplain. Even if you are still learning the interventions for each spiritual need, you can remember the general pastoral stance to guide your responses and interactions with patients.

Meaning & Direction = Chaplain is a guide.
Reconciliation/To Love and Be Loved = Chaplain is a truth-teller.
Self-worth & Community Belonging = Chaplain is a valuer.

Spiritual AIM offers specific interventions to try based on the assessment made. As chaplains, we seek to practice ethically and to do no harm. Yet chaplains who are learning spiritual assessment will need to risk making an assessment and trying out corresponding interventions, as described by Spiritual AIM [Table 1, page 19]. Fortunately, we do not practice spiritual care with a scalpel; so if an intervention is not effective, try interventions from one of the other two Spiritual AIM core needs.

Imagine you are on a road trip. Spiritual AIM is like a map, not a GPS. Spiritual AIM does not tell you what to do every step of the way. It provides you with options for possible route and guideposts. If you get stuck, you can "pick up the paper map" of Spiritual AIM to chart out a new route. View this video for more information about Spiritual AIM as a map. [https://youtu.be/xCPfw4VCugw]

By now you have read "Spiritual AIM and the work of the chaplain: A model for assessing spiritual needs and outcomes in relationship."[2] Let's test your knowledge of key points about the background and conceptual framework of Spiritual AIM:

QUIZ

1. ***As a practice matures into a "profession," the process of professionalization brings:***
   - ☐ a. Obligation to enhance quality and consistency of care, guided by professional standards and ethics
   - ☐ b. Benefits to patients and their loved ones
   - ☐ c. Benefits to chaplains who may experience greater professional satisfaction, recognition and opportunities
   - ☐ d. None of the above.
   - ☐ e. All of the above.

2. ***True or False: Board Certifications with one of the Strategic Partners for Spiritual Care requires that candidates can offer a clear description of spiritual assessment.***

3. ***Spiritual Assessment models are:***
   - ☐ a. Required for the daily hospice reimbursement rate
   - ☐ b. A common language that professionals use to communicate clinical observations and actions in the field and beyond
   - ☐ c. Required by the Center for Medicare Services
   - ☐ d. A way to show doctors that patients should just be seen for their illness
   - ☐ e. A pain and waste of time

What spiritual assessment is NOT and why that's important

Spiritual assessment is related to, but not synonymous with:

Spiritual Screening
Validated Spiritual Measures
Spiritual History

This is important because chaplains have a unique role on the interprofessional care team. Any member of the team can conduct a spiritual screening, take a spiritual

history, or use validated spiritual measures to explore and document more about a patient's spiritual needs and resources. However, chaplains are spiritual care specialists, meaning that they have the training and skills to actively address spiritual suffering through dynamic, clinical interventions and a spiritual care plan.

QUIZ

1. Which of the following is a spiritual history tool and not a spiritual assessment model?

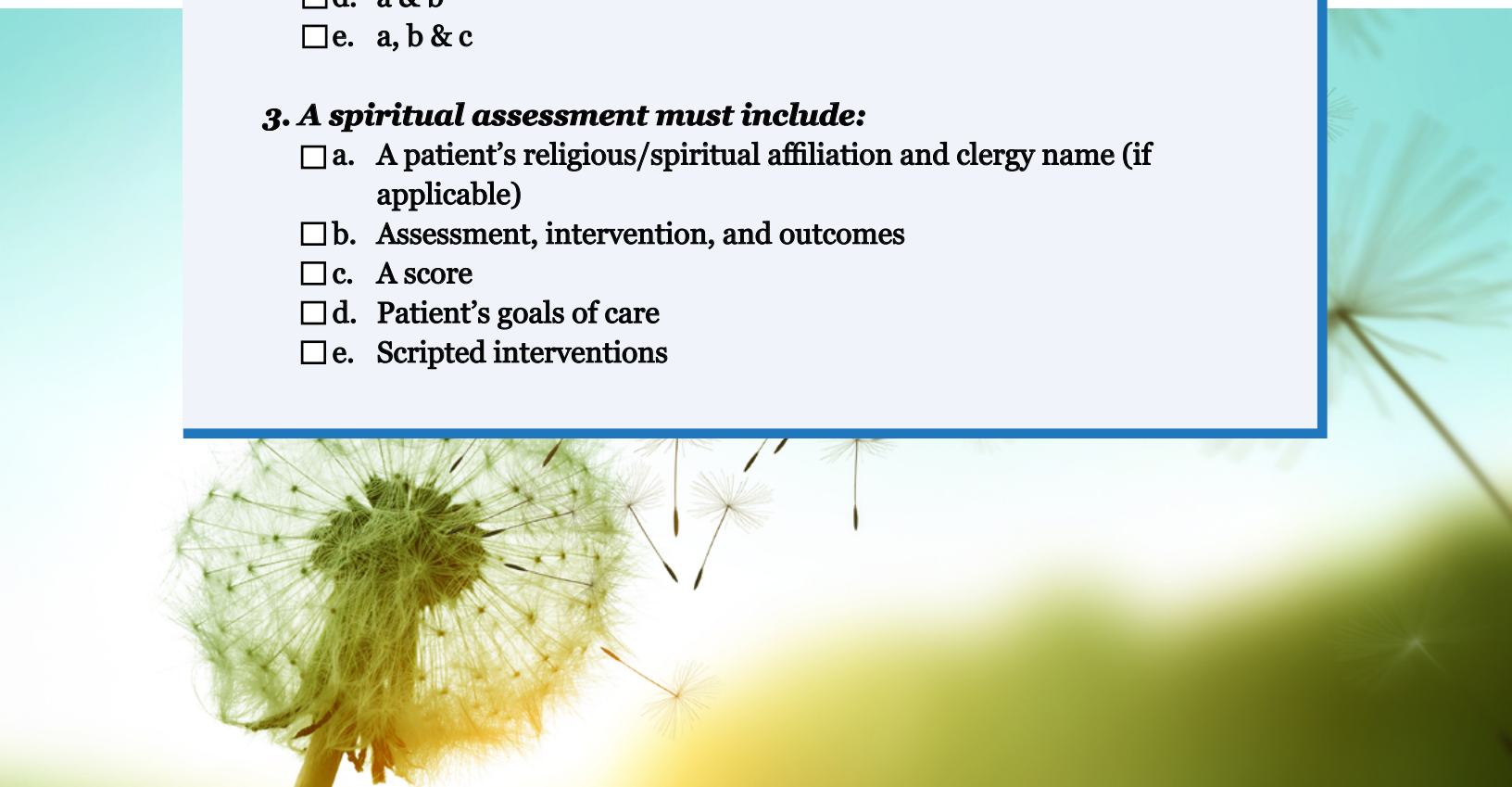
- ☐ a. SDAT
- ☐ b. 7x7
- ☐ c. FICA
- ☐ d. Peery's Approach
- ☐ e. The Discipline

2. Spiritual screening and history generally entails:

- ☐ a. A limited set of questions designed to gather data about the patient's faith, the importance of their faith and/or faith community
- ☐ b. Information about a patient's need for assistance or resources in having their spiritual needs addressed
- ☐ c. Inventory of spiritual strengths and weaknesses that can trigger a referral to a chaplain, but lack suggested interventions to inform a pastoral plan
- ☐ d. a & b
- ☐ e. a, b & c

3. A spiritual assessment must include:

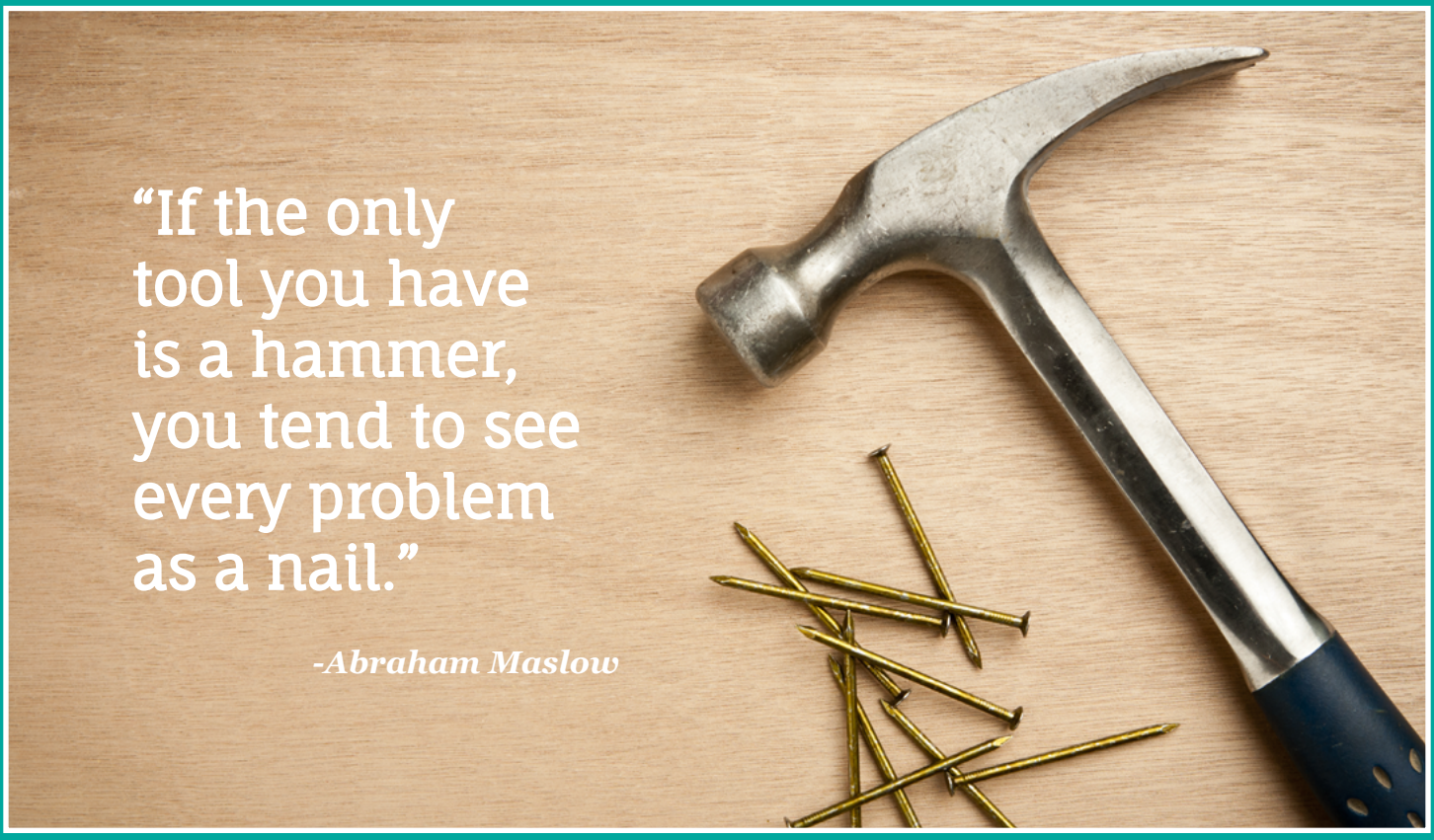
- ☐ a. A patient's religious/spiritual affiliation and clergy name (if applicable)
- ☐ b. Assessment, intervention, and outcomes
- ☐ c. A score
- ☐ d. Patient's goals of care
- ☐ e. Scripted interventions



A Litany of Biases

"The other is no way another myself, participating with me in a common existence. The relationship with the other is not an idyllic and harmonious relationship of communion or a sympathy through which we put ourselves in the other's place; we recognize the other as resembling us, but exterior to us; the relationship with the other is a relationship with Mystery."

-Emmanuel Levinas, Time and the Other



"We don't see things as they are, we see them as we are."

-Anaïs Nin

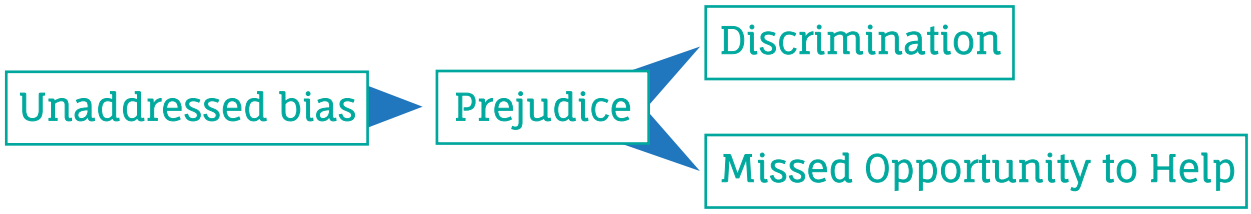
"R. Samuel b. Nahmani said in the name of R. Jonathan: A man is shown in a dream only what is suggested by his own thoughts..."

-Babylonian Talmud, Berkhot 55b

All medical providers carry biases and assumptions about those in their care. Spiritual and emotional care is especially susceptible to biases. By cultivating self-awareness, empathy, and assessment skills, providers of all disciplines can more humbly meet holistic needs of patients and their loved ones. Spiritual assessment is an example of a diagnostic tool that can be used to acknowledge and overcome biases about a subjective topic.

WHAT IS BIAS?

Definition - Merriam Webster
a. An inclination of temperament or outlook
especially; a personal and sometimes unreasoned judgment
b. An instance of such prejudice



- The Intuition Bias: "I just follow my intuition; I can read people"
- The Hammer and Nail Bias: "I need to know my legacy is secure, so I focus primarily on that when providing spiritual care." Or "I have found a spiritual practice that has helped me so I'm going to offer it to every patient."
- The Loving (and Listening) Presence Bias: "There is no room for confrontation or challenge in spiritual care."
- The Cheerleader Bias: "People who are suffering need constant encouragement; my job as a chaplain is to find the right scripture or prayer to lift their spirits."
- The Intellectual/Meaning Bias: "Spiritual care is only about meaning making — I don't focus on relationships and community."

Reflection Break

Write down your answers to these questions.

Which of these biases do you relate to?

Why do you think you hold these particular biases?

What other biases can you think of?

Evaluating Spiritual Assessment Models

INTEGRATIVE EXERCISE 1:

List four spiritual assessment models that you are aware of:

1.

2.

3.

4.

Now select one of the models and use the following rubric to evaluate the model.[6]

Articulates theological underpinnings (a.k.a. goal for spiritual healing)	
Includes a theory about human personality/ development	
Inclusive of people who belong to a faith tradition as well as those who do not. (e.g., model is not theocentric)	
Suggests modalities/vehicles (i.e. dialogue with patient)	
Guidance on how to make assessment (suggests there is more than one assessment that can be made)	
Offers corresponding interventions	
Suggests possible outcomes	
Acknowledges its own limitations (e.g., limited use with non-verbal patients)	

Reflection Break

Brainstorm at least 12 spiritual needs that you have observed in yourself and others.

1. 7.
2. 8.
3. 9.
4. 10.
5. 11.
6. 12.

Now group these in the following categories:

Self-Worth & Community Belonging

Reconciliation/To Love & Be Loved

Meaning & Direction

> Spirituality is defined as encompassing the dimension of life that reflects the needs to seek meaning and direction, to find self-worth and to belong to community, and to love and be loved, often facilitated through seeking reconciliation when relationships are broken.

Chapter 2. Overview of Spiritual Assessment and Intervention Model (AIM)

Development of Spiritual AIM: Roots in chaplaincy mentorship

As you have read in "Spiritual AIM and the work of the chaplain: A model for assessing spiritual needs and outcomes in relationship,"[2] Spiritual AIM is a model developed over two decades by Rev. Dr. Michele Shields, BCC, ACPE, inspired at the outset by a mentoring group with Rev. Dr. Dennis Kenny. It was nurtured over the years based on Michele's encountering hundreds of patients, family members, and professional caregivers and supervising more than a dozen clinical pastoral education supervisory students and observing how different people responded to a health crisis. Since 2011, the work of an interdisciplinary research team led by Rev. Dr. Michele Shields, Allison Kestenbaum, BCC-PCHAC, ACPE, and Laura Dunn, MD, has helped refine the model even further through conceptual and empirical discussions occurring during team meetings. These meetings included in-depth discussions of transcripts of chaplain sessions (conducted with outpatients receiving palliative care for advanced cancer), critical inquiry into the origin and meaning of specific language used in the model, and exploration of novel concepts and themes emerging from the evidence.

QUIZ

1. Which psychological theory informs Spiritual AIM?

- ☐ a. Acceptance and Commitment Therapy
- ☐ b. Cognitive Behavioral Therapy
- ☐ c. Psychoanalysis
- ☐ d. Sociocultural theory
- ☐ e. Object Relations Theory

QUIZ CONTINUED

2. ***According to the theological underpinnings of Spiritual AIM, healthy relationships between individuals and communities and the Divine/Ultimate reality demonstrate:***
   - ☐ a. Autonomy
   - ☐ b. Connection
   - ☐ c. Love toward the self in balance with love toward others, the Divine and Ultimate Reality
   - ☐ d. None of the above
   - ☐ e. a, b & c

3. ***True or False: The work of Rizzuto and Chodorow heavily influence Spiritual AIM, particularly the theory that spiritual dynamics and needs, just like personality, are shaped in relationship.***

Reflection Break

Review the excerpt on page 77 of "Spiritual AIM and the work of the chaplain: A model for assessing spiritual needs and outcomes in relationship."[2]

1. What parts of this theory do you agree with?

2. How would you critique this theory?

3. What contemporary theories, such as trauma-informed care, might influence how you conduct spiritual assessment?

4. Write about a recent encounter as a chaplain that informs your answers to the above questions.

"You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbor as yourself."

(Deuteronomy 6.5p; Leviticus 19.18; Luke 10:27) .

Spiritual AIM was developed with these fundamental themes in mind as the standard for spiritual maturity and healing. Healing requires both autonomy and connection. One must be autonomous enough to love oneself and value connection to achieve fairness in balancing love for oneself, others, and God.

Do you agree or disagree with this statement? Does it align with your theology? Explain.

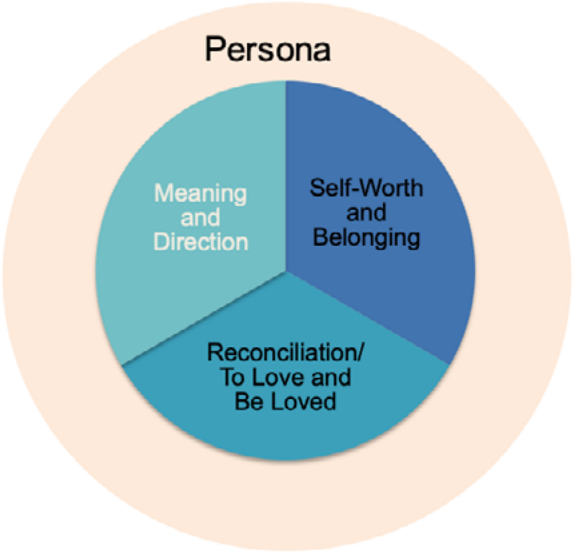
Making Assessments

The chaplain assesses the primary spiritual need, the level of acuity of the need, and how far along the patient is on the path toward healing and integration, defined by Spiritual AIM.

What helps us make an assessment? What information do you use?

- ***Comments***
- ***Behavior***
- ***Attribution of blame***
- ***Questions***
- ***Concerns***
- ***Chaplain's own internal response to person***
- ***Assessment of where person is along path to healing***

Persona and Spiritual AIM: Sometimes, a patient will describe themselves in ways that conflict with how they behave and how others see them. For example, a patient may tell you they are easy to get along with, but you come to learn they have alienated the entire nursing staff. Or they say that they make decisions easily because they try not to live in their head, but you find out from their physician that the patient is asking the same questions over and over about a potential procedure. In Spiritual AIM, persona refers to this tendency to depict oneself in a way that may contradict their core spiritual need.



Reflection Break

How do you feel about each spiritual need? Use yourself and your reaction.

Which spiritual need are you most drawn to?

What spiritual need are you least drawn to?

Making Interventions

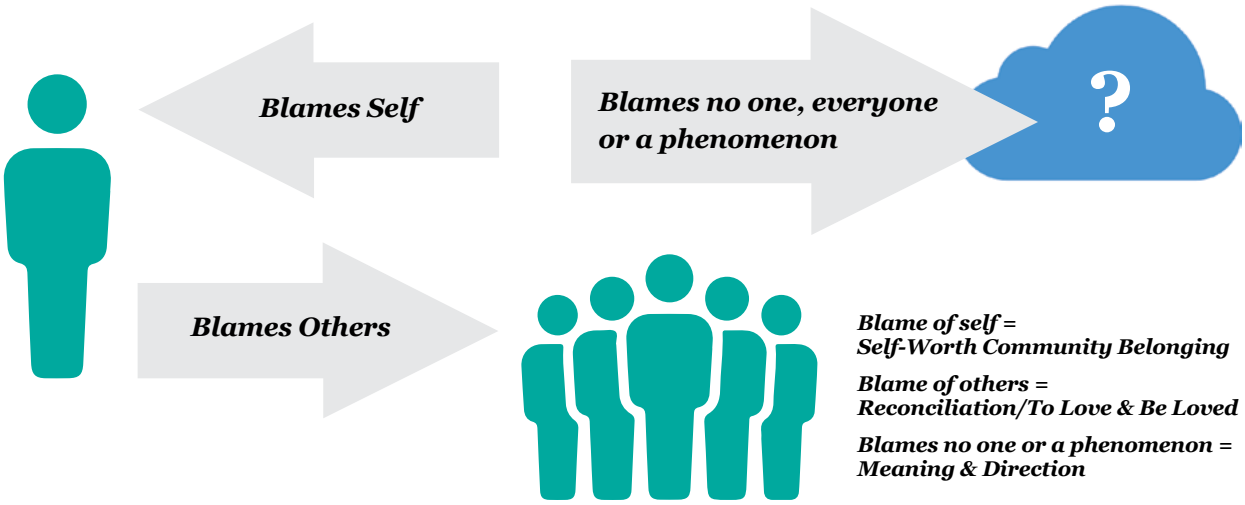
The chaplain leads the patient through a process of healing using specific interventions that correspond to the primary spiritual need. The chaplain does this through embodiment. The chaplain makes a choice to step into a role and stance and personify certain characteristics: **guide, valuer, or truth-teller.**

Basic Spiritual AIM Matrix (See Table 1 for greater detail)

	Meaning and Direction	**Self-Worth and Belonging to Community**	**Reconciliation/ To Love and Be Loved**
Assess-ment	Patient tends not to place blame; intellectualizes and asks questions/ wonders.	Patient tends to blame self; prioritizes caring for others.	Patient blames others; may complain, and present with strong or/angry judgments and assumptions re: others
Inter-vention	Chaplain serves as a guide; surfaces questions and helps patient claim resources for making decisions.	Chaplain affirms patient and offers community by listening to his/her story.	Chaplain observes the impact of patient's behavior on others, noting broken relationships. Holds patient accountable.
Out-Come	Patient experiences greater clarity/makes decision.	Patient prioritizes their needs and desires.	Patient takes responsibility for brokenness; changes behavior.

VECTORS OF BLAME

One quick way to make a spiritual assessment is to observe where the patient is placing blame. Some chaplains find it useful to visualize where the blame is being directed, whether it be internal or external, and attempt corresponding interventions based on this observation. If you try the interventions and don't see the related outcomes, you can try another core spiritual need.



Anger and Socially Just Spiritual Care

"Anger" is a word and emotion that should trigger curiosity and humility when providing socially just spiritual care. There is a history of pejorative racial and gender stereotypes related to anger and aggression. Spiritual assessment at its best should be a tool that empowers caregivers to confront and address their personal bias and those of the systems within which they work.

Spiritual AIM speaks a lot about anger, and even suggests that one can make a spiritual assessment on the "direction" and "function" of anger being expressed by a patient. Is the anger directed at self? Is the anger directed at others? When the patient experiences their anger, does it allow them to connect with their sense of self-worth or clarify? Or does it pull the patient away from their accountability, into a spiral of rage and isolation?

While these questions can be helpful in making an assessment, we see empathy as the first appropriate response to anger. As with so much in chaplaincy, our care is strengthened when we start with connecting through self-awareness and connection through the heart, i.e. our emotions. Only once we determine that we feel safe to stay physically present and connect emotionally with a patient, can we then use tools, such as spiritual assessment.

Table 1. Spiritual Assessment and Intervention Model (Spiritual AIM)©

Note: Referred to as "the model" throughout this manual.

PRIMARY IDENTIFIED SPIRITUAL NEED		
MEANING & DIRECTION	SELF-WORTH & BELONGING TO COMMUNITY	RECONCILIATION/TO LOVE AND BE LOVED
PRIMARY SPIRITUAL TASK		
Learn to be in relation to self and therefore others (God)	Learn to love self	Learn to love others (God)
ASSESSMENT - OBSERVING THE PATIENT		
• Patient does not place blame. • Patient tends to intellectualize circumstances. • Patient sees and articulates both sides of most situations. • Patient is concerned about the meaning of own life/identity and making sense of his/her illness. • Patient has difficulty focusing and making decisions. • Patient employs several metaphors, images, or analogies in conversation. • Patient asks questions and demonstrates curiosity (e.g., about illness, the nature of God or religion). • Patient feels enticed, yet encumbered by exploring infinite possibilities.	• Patient blames self, not others. • Patient does not complain. • Patient accepts current reality without questioning or evaluation. • Patient expresses concern for others and fears burdening them. • Patient prioritizes caring for others and may minimize their own needs, healing, and/or self-care. • Patient shows deep appreciation for social support and opportunities to tell their story.	• Patient blames and mistrusts others. • Patient complains (e.g., about food, staff). • Patient expresses unrealistic expectations that others should know patient's needs. • Patient does not take responsibility for own healing or choices. • Patient presents with combative energy and angry affect early in process. • Patient's comments focus on their assumptions about other's flawed actions and inner lives, rather than their own. • Patient discusses strained, broken, or estranged relationships, need to forgive or be forgiven, inability to grieve losses, or unwillingness/ inability to say goodbyes.
ASSESSMENT - CHAPLAIN'S SELF-AWARENESS		
• Chaplain may feel in a fog or have difficulty following what patient is saying.	• Chaplain may feel that patient attempts to serve as a caregiver for the chaplain. • Chaplain may feel that patient puts chaplain up on pedestal.	• Chaplain may feel him/herself being drawn into a triangle. Chaplain feels at risk of alienating patient easily.
PLAN FOR EMBODIMENT OF THE CHAPLAIN - "TO BE"		
Guide	Valuer and Community	Prophet and Truth-teller

INTERVENTION - "TO DO"		
• Name & reflect back emotions (especially anger) as a source of clarity. • Surface what decisions need to be made or questions need to be answered. • Ask patient how he/she has coped with similar crises and circumstances or made decisions in the past. • Help patient to name resources to help make decisions, answer questions, or achieve clarity about their heart's desire. • Demonstrate support and guidance, as if walking alongside patient on a path. • Honor when patient makes important decision (e.g., regarding treatment, to enroll in hospice, to take an important trip) • Honor when patient arrives at a new meaning (e.g., deciding upon a legacy project like a video, letter for child). • Commission the patient for this decision/work/meaning with a blessing or ritual (religious or non-religious/poetic).	• Surface anger as source of energy; accompany him/her as they feel it. • Surface old, unhealthy, unkind beliefs about self. • Create a "community of two" by keeping patient company and listening to his/her story of illness/suffering. • Make specific, genuine statements of affirmation about attributes, role, and behavior of patient. • Ask the patient for their opinion on a subject about which they know more than you. • Listen attentively while valuing patient's story. • Empower patient to identify what is lovable about them. • Make referrals to spiritual communities, classes ,and illness-specific support groups. • Regularly remind patient about loved ones and reference other caregivers on team to build support. • Use faith tradition to challenge old beliefs; create and offer new cleansing belief and ritual.	• Demonstrate ability to tolerate patient's anger. • Surface and explore sadness, fear, grief, loss of sense of control beneath the anger. • Acknowledge brokenness, tension or estrangement in the relationships patient discusses. • Remind patient of own internal resources/abilities to advocate appropriately for self. • Hold patient accountable for creating safety for self, and choosing to trust others. • Remind patient to say what they need rather than expect others to intuit it. • Ask patient about their part in estrangement and conflict. Call them to confess fully. • State impact of patient's behavior on you/others. Observe whether contrite/sorry. • Patient takes responsibility to apologize and for behavioral changes/acting differently. • After patient has behaved differently, discuss forgiveness from others, self-forgiveness, and forgiveness in their faith tradition; offer ritual.
DESIRED OR PROPOSED OUTCOME/HEALING/ WHOLENESS		
• Patient learns and trusts that whatever decision they make will be congruent with own values. • Patient identifies own primary/ prominent heart's desire. • Patient attains greater clarity regarding meaning or purpose of his/her life. • Patient reports less angst and more support about making a particular decision.	• Patient reports greater sense of belonging to community. • Patient names how he/she is addressing his/her needs. • Patient prioritizes self-concern in equal balance with concern for others. • Patient's actions/behavior suggest enhanced self-worth.	• Patient realizes that their behavior has an impact on other people. • Patient expresses vulnerability and feelings, instead of resorting to anger and blaming others. • Patient confesses part in conflict and broken relationships. • Patient expresses true remorse through feelings. • Patient commits to new behavior and forgives self. • Patient may seek and may experience forgiveness from others & God. • Patient experiences reconciliation.

Chapter 3. Assessments

I. Meaning and Direction

As described in "Spiritual AIM and the work of the chaplain: A model for assessing spiritual needs and outcomes in relationship,"[2] patients with a core spiritual need of Meaning and Direction may be asking many questions (e.g., about the meaning of their life, existential questions). Or, they may be in a situation where they need to make a decision and are finding it very difficult to do so. Decision making is difficult because they struggle with narrowing their choices to only one possibility and letting go of others. They like to keep all of their options open and entertain many possibilities. Yet it is difficult to commit to only one and let go of all the rest. To use a metaphor, these patients want to be able to choose from the entire buffet, and do not want to choose just one item from the menu.

Patients who seem to be searching—whether in terms of faith, vocation, relationships (e.g., trying to find the "ideal mate")—likely have a core spiritual need of Meaning and Direction. These patients ask questions to make sense of why something is happening. They may seem to be "lost" and be more outer-directed than inner-directed. In other words, rather than having an internal compass or map, they are more driven by circumstances. They may seem out of touch with their own heart's desire.

This person does not know whom to blame in the midst of conflicts, or for circumstances that occur. For instance, they might say, "On the one hand, my boss put me on probation for something I didn't do. On the other hand, I was hanging around with colleagues who showed some questionable judgment, so it was my fault too, and I see that now." They may have a foot in both camps at the same time—both accepting blame at the same time as blaming others, so they end up blaming no one. Their thinking may be tangential or circular, and not easy to follow. The chaplain may feel lost in conversation with these patients. The conversation may go off on numerous tangents, unless the chaplain works to help the conversation stay on track.

Different chaplains may respond differently to these kinds of patients. Some chaplains may find these patients fascinating—given their creativity and openness to new ideas.

Other chaplains may find these patients frustrating and feel like they are lost in a "fog." Recognizing how you respond to these kinds of patients is a critical part of your assessment of the patient.

Example from the study

A woman in her 60s, who had cancer for 25 years, wondered why she was such an unusual survivor, when so many younger women had died. She worried, "Do I have a purpose in my life? Is my life worthwhile? I think this slow ebbing of capacity eats away at these feelings that I'm here for a reason, you know?"

II. Self-Worth and Community Belonging

This person tends to minimize their needs. They fear burdening others. They may not feel worthy of the communities in which they are a member, (e.g., family, religious congregation). They often defer to the judgment of others. When there is conflict in a relationship, this person blames themself. They deeply appreciate the presence of visitors, family, and social support. They tend to regard others more highly than themselves.

Examples from the study

1. A woman in her 40s who is the mother of 10 children, all of whom she home schooled, is dying of cancer. All of the children were the "apple of her eye" and it was very hard for her to assert her choices and preferences over anyone else's in the family. For example, the family liked to watch movies in the evening. When the chaplain asked the patient what kind of movies she liked, she said she enjoys romantic comedies. However, she would not select such a movie because she worried her husband and younger children would not enjoy it. She put everyone else above her.

2. A woman in her early 30s, dying of cancer and living with her mother, struggled with declining energy and her desire to tackle her medical and insurance paperwork. She did not want to burden her mother with it. She already felt like she was imposing on her mother by not being able to do chores around the house.

III. Reconciliation

This person demonstrates a tendency to blame others and shows evidence of broken or estranged relationships. They may express a need to forgive or be forgiven, but usually get stuck because they avoid seeing their own part in causing the brokenness. There may be resistance to grieving losses and/or an unwillingness to say goodbye. If there is a full confession with true remorse, there can be a change of behavior. Forgiveness of others and self, and even reconciliation, is possible.

Example from the study

A woman with cancer sits in her bedroom upstairs and feels lonely. Her husband is on his computer downstairs. She blames him for ignoring her. "I could be dead up here, for all he knows!" she fumes. She has not told him that she is lonely and wants his company. She also complains that her friends do not call her. She refuses to initiate calls to them. She expects them to know when to call her, like mind-readers. She does not take responsibility to get her own needs met.

SAMPLE EXERCISE

"Something was going astray. And so we went to marital counseling. I thought, 'Well, this is the best we can do to try to analyze or objectify whatever the imbalance was.'"

- Name the patient's core spiritual need and provide a rationale for your choice (include language from the model on pages 19-20):
- **Sample answer:** The patient's core spiritual need is Meaning & Direction.

The patient indicates that "something" was going "astray," but does not assign blame to self or others ("Patient does not place blame"). The patient's comment about marital counseling is intellectual. He uses the word "thought" and relies on "analysis" to identify and address the problem ("Patient tends to intellectualize circumstances").

EXERCISE

1. "I've found the support group helpful because I'm not as bad off as a lot of people there. In a way, that's a terrible way to feel, but I think, 'Oh my goodness, I don't have any problems compared to this person.'"

Question: Name the patient's core spiritual need and provide a rationale for your choice.

Core Need:

Rationale/language from the model:

EXERCISE CONTINUED

2. Mr. Y is a man in his 60s. He practices Buddhism and references certain concepts from Buddhist philosophy at several points during your visits with him. He received his cancer diagnosis two years ago and has received treatment off and on since that time. The patient tells you on multiple occasions that he works as a nature tour leader and he is often proud of himself for being more physically fit than most of his 25-year-old colleagues. He also tells you about his resentment toward friends who say they want to help him, but that they are doing so "just to make themselves feel good." He encourages you to take his side and validate his resentment.

Question: Name the patient's core spiritual need and provide a rationale for your choice.

Core Need:

Rationale/language from the model:

3. "She was just this stranger who comes across kind of harsh, who's been hurting her father for years and years and years. She just disappears for two, three years at a time and then will call him up when she needs money or something."

Question: Name the patient's core spiritual need and provide a rationale for your choice.

Core Need:

Rationale/language from the model:

4. Mr. Z is a man in his 70s. He was diagnosed with liver cancer after having a knee replacement that did not heal as expected. He owns several horses and indicates that he has always found riding and caring for horses with his wife to be a kind of spiritual practice. Mr. Z is ambulatory, but frail. Yet he tells you on several occasions that he is eager to get back to horseback riding. He states that it is his fault that he

EXERCISE CONTINUED

is not healing more quickly. He wants to please his wife, who is eager to begin riding with him again.

Question: Name the patient's core spiritual need and provide a rationale for your choice.

Core Need:

Rationale/language from the model:

5. "I'm back at the starting point. I've trudged out and trudged back—I grew up in the Midwest and my field was hard, it's been plowed under and it's going out in those fields during winter and it's usually been rainy and it's just pretty bloody mucky. It's not easy walking and you sort of walk several yards and your boots are full of mud and you go back. So it's tiring. And that's how I've been feeling, I think, this last year—more so than I had before."

Question: Name the patient's core spiritual need and provide a rationale for your choice.

Core Need:

Rationale/language from the model:

ANSWER KEY

#1

Core Need: Self-worth

From the model: "Patient expresses concern for others and fears burdening them"

#2

Core Need: Reconciliation

From the model: "Chaplain may feel him/herself being drawn into a triangle. Chaplain feels at risk of alienating patient easily"
"Patient's comments focus on their assumptions about other's flawed actions and inner lives, rather than their own."

#3

Core Need: Reconciliation

From the model: "Patient blames and mistrusts others"

#4

Core Need: Self-worth & Belonging

From the model: "Patient prioritizes caring for others and may minimize their own needs, healing, and/or self-care"; "Patient blames self, not others"

#5

Core Need: Meaning & Direction

From the model: "Patient employs several metaphors, images, or analogies in conversation"

Chapter 4. Intervention/Embodiment

I. Meaning and Direction

For the person with a spiritual need of meaning and direction, you will embody a guide. This person needs accompaniment, someone who will shine a light on the path for them to find their own meaning and see which direction is best for them to take. To be a guide, you can name and reflect back emotions as sources of clarity. Anger works particularly well for this.

You can also surface what decisions need to be made and/or what questions need to be answered. Asking the patient how they have coped with similar crises or made decisions in the past allows them to be empowered to apply the same means and methods to the present. For instance, if they made a decision in the past by going out into nature, you can lead them in a guided meditation of going out into nature or to a calm place. If they have prayed in the past with their pastor, they could pray with you and/or their pastor now.

Ask the patient to name resources to help make decisions and answer important questions. The goal is to help them achieve clarity about their "heart's desire." Heart's desire is what they want most. It is their "true north" and the goal that is most important to them at this moment in their life. Listen closely to the metaphors and images that a person with a spiritual need for meaning and direction uses. Ask them how the metaphor relates to their current situation. For example, if a patient says that the current situation reminds them of a garden that needs to be pruned, ask them what in their current situation requires "pruning."

Demonstrate support and guidance to the patient as if you were walking with the person along a path. It is important to acknowledge and honor the occasions when the person makes an important decision (e.g., regarding treatment, enrolling in hospice, taking a trip).

The chaplain should also recognize when the patient arrives at new or renewed understanding about the meaning of their life (e.g., creates a legacy video, writes an

ethical will, resolves a faith issue). You can celebrate and commend the person for this decision/work/meaning with a blessing or ritual (religious or non-religious/poetic). Rituals are part of how we honor patients' transitions. They symbolize important passages in people's lives. Religious, spiritual, and non-religious rituals are all important ways of honoring transitions.

Although chaplains often explore sadness and deeper emotions, we must remember that celebration is an important part of spiritual care. At times, patients will benefit from a chaplain who can advocate and make space for the need for celebration with the interprofessional team.

Example from the study

In speaking with a patient in her 60s, it became apparent to the chaplain that writing was important to the patient. The patient considered herself a poet and was part of a writing group. The chaplain observed that the patient became more energetic and animated when she spoke about writing. The chaplain noted this vitality and enthusiasm (interestingly, a word that means "alive within God") when she spoke about writing. Writing was her heart's desire. The chaplain invited the patient to read a poem she had written about her treatment and anger she felt toward some of the doctors on the interdisciplinary care team.

The chaplain noticed the anger in the poem and "surfaced this" by verbally acknowledging it and reflecting this observation back to that patient. This helped the patient acquire greater clarity about how she felt the doctors were not listening. She was frustrated and felt a loss of identity, as she perceived that they cared only about her body and not her soul. The patient felt she was treated like a specimen, an outlier. She stated that they treated her as a curiosity because she had survived longer than expected.

The chaplain celebrated the reading of the poem with the patient and framed it as ritual and a milestone worthy of celebration. The chaplain also affirmed that this patient's occasional asking of "What the f--- , God?" was, in fact, a prayer, in that it came from her heart and she was addressing it to God.

II. Self-worth and Community Belonging

For a person with a core need of self-worth, you will embody a valuer. You may also embody community, even if it is a community of two. It may be a community of three, if the patient believes in the presence of God or some other constant spiritual companion. By embodying a valuer/community, surfacing anger is a source of energy that helps patients stand up for themselves and find their voice. The chaplain as valuer also encourages the patient to express old, unhealthy, unkind beliefs about themself so that they can be empowered to find what is false in these. Patients can decide what

beliefs, possibly theological, are and are not serving them. You can help them with this discernment. The chaplain can empower the patient to identify what is lovable about themself by keeping the person company, while listening to their story. This is particularly effective with patients who have a story to tell about the trajectory of their illness or health crisis. A key intervention for self-worth and belonging is to make specific, genuine affirmations about the attributes, roles, and behavior of your patient. This does not mean a generic affirmation, like, "You're great!" but rather what you genuinely find great about them. For example, "You are so giving and generous to your family!" Authentic affirmations are about being in the context of relationship and saying what you genuinely enjoy about the person. This person soaks up other people's enjoyment of them like a sponge because they are affirmation-deprived. They are sensitive to and can detect disingenuousness. They tend to be discerning about the use of sarcasm/angry wit so it is important that the embodiment of affirmation be real.

Another way to embody affirmation is to ask for the patient's opinion on a subject about which they know more than you. Invite them to be the expert and humble yourself to learn from them. To extend the patient's experience of community, the chaplain can make referrals to spiritual communities, classes, and illness-specific support groups to foster a greater sense of belonging. Regularly remind the patient about loved ones and reference other supportive caregivers on the team to build a conscious sense of support. Use the person's faith tradition to challenge old beliefs and build new healthier ones about themself. For example, if the patient creates a new, cleansing belief, the chaplain can offer a ritual to bless this, provided that the patient would like this.

Example from the study

With the same woman described in the Assessment chapter (page 23), the chaplain encouraged the patient to choose a movie that she would like to watch, especially after the younger children went to sleep. The chaplain also encouraged her to go outside and to cherish her devotional time in a garden in the neighborhood, as the patient had indicated this was something she could do for herself to nurture her quiet time and "community" with God. It was a time where she was not having to/or feeling compelled to take care of others over herself.

The chaplain's embodiment of a valuer was to help the patient value herself—her care, her interests, and her desires. The chaplain worked to value her as a person by affirming all that she has done for others, especially her children. The chaplain also affirmed the patient's hopes and prayers for miraculous healing. At the same time, the chaplain supported the patient in her desire to say goodbye to her family, if the miraculous healing were to not happen. This demonstrates a way of valuing herself, her relationships, and her identity as a wife and a mother.

In addition, the chaplain embodied a pastor for this deeply religious woman. She was part of a home church and did not have a leader of a church to call upon, so no clergy was making home visits, bringing her communion, or pastoring to her individual concerns. The chaplain embodied the authority of someone who could pray with and for her. This is especially important for someone with a tenuous sense of self-worth.

III. Reconciliation/To Love and Be Loved

For the patient with a core spiritual need of reconciliation, the chaplain will embody a truth-teller who holds up a mirror, reflecting the patient's relationships to others and calling them to their better nature. The truth-teller holds the patient accountable for their part in tense or broken relationships, asking them to take responsibility and to assume greater humility. The patient may easily express anger, and the chaplain works to explore the sadness and fear beneath the antagonistic exterior.

The chaplain may guide the patient through the reconciliation process several times, in order for the patient to come to full awareness of these dynamics and stop the cycle of blaming others. The chaplain helps the patient to acknowledge brokenness in one particular relationship at a time (rather than global grievances with groups or institutions). It is important to break down and go through each part of the reconciliation process. It is not just a single confrontation, but rather drawing the person through this process.

Reconciliation Process

The chaplain calls the patient to confess and acknowledge their part in creating the brokenness so that they can express their contrition and acknowledge their impact on others. Contrition refers to a state of feeling truly remorseful. It includes allowing oneself to truly feel and empathize with the pain that they have caused another through their actions. Many patients get stuck at the confession because feeling true contrition can be very painful, and patients with a core need of reconciliation will attempt to avoid pain, as they fear it will amplify loss of control. In reality, feeling and expressing sadness or fear is often extremely empowering.

The challenge for the chaplain is to stay with the patient and not alienate them while they articulate the impact on other people of what they are confessing. This requires diligence, skill, and patience on the part of the chaplain. The chaplain should be vigilant for ways in which the patient may try to continually focus on the fault with others and cautious about not getting hooked and joining the person in their other-blaming. The chaplain may also start to lose their own motivation in working with the person and may need to overcome this.

The chaplain should be aware of the fact that there are instances where people have been genuinely victimized and wounded, where the patient is not at fault. In those cases, the chaplain should not call the patient to confession or contrition, but rather

be a supportive presence and support them in seeking appropriate mental health or other support. But in routine broken relationships, it is healing for the patient to be held accountable to reconcile the brokenness. The chaplain can celebrate forgiveness and hard work at the end, once the reconciliation has occurred (whether it be from self-forgiveness, forgiveness from God, forgiveness from others). Being a truth-teller is telling the "truth" about a person's forgiveness and the renewed intimacy, trust, and love that can come with it.

Example from the study

With the patient described in the previous chapter on Assessment (page 23) who was angry with her husband, the chaplain embodied a challenging stance, using humor. "So, he's a mind reader? Without you telling him, he can telepathically understand that you want him to come upstairs?" Similarly, the chaplain challenged the patient about her resentment toward friends who were not calling her. "How could your friends know when a good time to call would be, especially when you are not feeling well at certain points during the day?" The chaplain also explored the patient's relationship with her estranged sister. She encouraged the patient to acknowledge and own her part in the estrangement through a letter. The chaplain also worked with the patient to take ownership of her responsibility to make herself more comfortable in the hospital for a procedure for which she was very anxious, especially because of triggers related to past experiences of abuse.

Spiritual AIM–Assessment Integrative Exercise SAMPLE EXERCISE

Patient: "Christmas was rather interesting because I had decided I wasn't sending my sister a Christmas present. I had called her before I went in the hospital and she didn't call me back because she didn't want to hear the gory details. That was her excuse for not calling me back and I was really pissed off at her for that. So I just thought … she's very selfish and she's very controlling, or I should say self-centered and controlling…"

Interventions: "Are there any relationships that you look at and you think, 'That's a relationship that I'd like to work on or that's a relationship that causes friction, it's not in the shape that I would like to have it. Or, it causes me some discomfort?'"

"So what kind of relationship do you envision having with her? What kind of relationship would you like to have with her?"

SAMPLE EXERCISE CONTINUED

Sample Answer: The patient's core spiritual need is reconciliation/to love and be loved. The patient expresses anger about her sister not calling her back. ["Patient presents with combative energy and angry affect early in process."]

She makes strong judgments about her sister being "selfish, self-centered and controlling." ["Patient's comments focus on their assumptions about other's flawed actions and inner lives, rather than their own."]

The patient's description of her relationship with her sister demonstrates strain, brokenness, but also the possibility of reconciliation and forgiveness. ["Patient discusses strained, broken, or estranged relationships, need to forgive or be forgiven."]

It is also unclear if the patient indicated to her sister that she expected a call back before her visit to the hospital. ["Patient expresses unrealistic expectations that others should know patient's needs."]

The chaplain's interventions include inviting the patient to acknowledge brokenness in her relationship with her sister. ["Acknowledge brokenness, tension, or estrangement in the relationships patient discusses."]

Once the patient acknowledges the tense relationship that she has with her sister, the chaplain asks the patient to describe what a more ideal relationship would look like. By doing so, the chaplain is inviting the patient to articulate her needs rather than expect her sister to read her mind and predict her feelings. ["Remind patient to say what they need rather than expect others to intuit it."]

EXERCISE

1. ***Patient:*** "Yeah, so that's kind of where my despair is. I've done a lot of other alternative things, changes in my lifestyle and eating. I'm not very good at exercise, but I changed my diet a lot. I've been juicing. I went to a 10-day detox treatment center, just trying to cleanse my body of all the chemo and radiation. It's like nothing's working."

EXERCISE CONTINUED

Intervention: "I heard you say, 'I've made all these changes, and this is my despair.' It sounds like part of what's going on for you now is that you're trying all these things to get back to health, and it sounds like *you're feeling out of control. No matter what you do, from what you're telling me, the cancer seems to advance."*

Assess the patient's core spiritual need and name the chaplain's intervention using the model.

Core Need:

Rationale/language from the model:

2. ***Patient:*** "So the chemo's changed as well as the protocols to combat the side effects. They said, 'If you don't want to do chemo, we have a pill form kind of chemo.' And then, 'Oh my goodness, that was such a hard decision. Church members came to pray in the hospital with us and we did a lot of praying and I just felt so overwhelmed."

   Intervention: "Tell me why you had decided against the chemo. Was it your expectations about chemo? What else led you against chemo?"

Assess the patient's core spiritual need and name the chaplain's intervention using the model.

Core Need:

Rationale/language from the model:

3. ***Patient:*** "... Without the chemo, it seems like it's just going to grow back ... I think this is common among cancer patients because I've done a lot of reading—I've read dozens of books. People tend to find comfort in it—even though the chemo isn't pleasant, you feel like something's being done ..."

EXERCISE CONTINUED

Intervention: "So it sounds like a scary moment, actually."

Assess the patient's core spiritual need and name the chaplain's intervention using the model.

Core Need:

Rationale/language from the model:

4. ***Patient:*** "And [regarding the cause of the cancer] the thing that I know for sure is that I have been pumping cortisol into my body for so long because I'm an anxious personality. My mother has told me this story that when I was a baby at one of my first well-baby visits, the doctor put his hand on the table next to mine. I jumped up and he said to my mother that, 'This is a child you're going to have to do things slowly and calmly around,' sort of hyper-reactive."

   Intervention: "What a big story … that happened so early in your life and she carried that. And she told you and you've carried that story."

Assess the patient's core spiritual need and name the chaplain's intervention using the model.

Core Need:

Rationale/language from the model:

5. ***Patient:*** "I had a surprise hospitalization this summer. I had a blocked bowel. Terrible, terrible painful experience and I was hospitalized for a week … I was raised Catholic, but I don't do that anymore. And I almost fainted. In walked a chaplain, but he was a monk so he was in a full brown monk robe with a big giant crucifix hanging off him. And it was like uhhhh, 'What do you want?'"

EXERCISE CONTINUED

Intervention: "I appreciate you saying that you have a sense of what's helpful to you from a chaplain and what's not so helpful. That's good for me to hear. And it sounds like you have some concern about me as a chaplain, maybe judging you or trying to push stuff on you."

Assess the patient's core spiritual need and name the chaplain's intervention using the model.

Core Need:

Rationale/language from the model:

6. Patient: "I feel that my anxiety and discomfort lately have put a barrier between my partner and me. He's just gone through back surgery a week and a half ago. I've been sort of resentful about having to take care of him during his recovery."

Intervention: "Why do you suppose there's that resentment? Why do you suppose it's there?"
"So you find him needy?"
"So you might be increasingly needy in the future and you'll have to depend on him."

Assess the patient's core spiritual need and name the chaplain's intervention using the model.

Core Need:

Rationale/language from the model:

ANSWER KEY

#1

Core Need: Self-worth & Belonging to Community –
"Patient blames self, not others."

Chaplain's intervention(s) from the model: "Surface anger as source of energy; accompany him/her as they feel it."
"Create a "community of two" by keeping patient company and listening to his/her story of illness/suffering."

#2

Core Need: Meaning & Direction -
"Patient has difficulty focusing and making decisions."

Chaplain's intervention(s) from the model: "Surface what decisions need to be made or questions need to be answered."

#3

Core Need: Meaning & Direction -
"Patient tends to intellectualize circumstances."

Chaplain's intervention(s) from the model: "Name & reflect back emotions (especially anger [in this case fear]) as a source of clarity."

#4

Core Need: Self-worth & Belonging to Community –
"Patient blames self, not others."

Chaplain's intervention(s) from the model: "Surface old, unhealthy, unkind beliefs about self."
"Create a 'community of two' by keeping patient company and listening to his/her story of illness/suffering."

#5

Core Need: Reconciliation/To love and be loved –
"Patient blames and mistrusts others."
"Patient presents with combative energy and angry affect early in process."

ANSWER KEY CONTINUED

Chaplain's intervention(s) from the model: "Demonstrate ability to tolerate patient's anger."
"Hold patient accountable for creating safety for self, and choosing to trust others."
"Acknowledge brokenness, tension, or estrangement in the relationships patient discusses."

#6

Core Need: Reconciliation/To love and be loved –
"Patient's comments focus on their assumptions about other's flawed actions and inner lives, rather than their own." "Patient discusses strained, broken, or estranged relationships, need to forgive or be forgiven, inability to grieve losses, or unwillingness/ inability to say goodbyes."

Chaplain's intervention(s) from the model: "Surface and explore sadness, fear, grief, loss of sense of control beneath the anger."
"Acknowledge brokenness, tension, or estrangement in the relationships patient discusses."
"Ask patient about their part in estrangement and conflict. Call them to confess fully."

Chapter 5. Outcomes

I. Meaning and Direction

For the meaning and direction patient, outcomes include making a decision, restoring identity, and/or finding purpose. They may make a big decision and demonstrate a new-found trust that whatever decision they make will be congruent with their most deeply held values. The person may report less angst and greater support about making their decision as a result of working through this process with you. If you worked on finding meaning, another desired outcome is that they identify their own primary heart's desire, that which is most important to them at this time. They can return to this touchstone when needed. You may help them to identify a more realistic hope, if their heart's desire is not possible (e.g., an actively dying person who wants to take a trip to Europe, but is physically unable).

The chaplain can acknowledge the grief about them not attaining what would be ideal. But it is possible for the patient to cultivate more flexibility. The intent is for them to attain greater clarity about the meaning or purpose of their lives.

Example from the study

The same patient described in the previous chapters in Assessment and Intervention (pages 22 and 28, respectively) reported to the chaplain that she found meaning through a renewed understanding of God. She realized that she had, in fact, been praying all the time because she talks to God and often is able to say, "Wow God, thank you" when she is feeling grateful. She expresses anger to God and now sees this as a legitimate prayer. She also came to understand God from a feminine perspective, which resonated with her. She realized that the poetry she was writing was an outlet for prayer. The patient did not strongly identify with any particular theology or practice, yet she came to understand that, "If God is really God, then God is everywhere." She had previously thought of God as an entity that you asked things of. Her perception changed to seeing God as a guide she talked with in her kitchen or when she would see a sunset. She also made arrangements with a community chaplain to continue to receive spiritual guidance, once her time with the study concluded.

II. Self-worth and Belonging

One outcome is that the patient reports a greater sense of belonging to community. This could be in relationship to the chaplain and/or to their various other communities, such as the community of "family." The patient can give specific examples about how they are addressing their needs. They prioritize their self-care more than before, with the support and encouragement of the chaplain or other "champions." Their self-concern is increased and comes into greater balance with their concern for others. It may not be in total balance, but there will be a marked improvement. Their behavior suggests enhanced self-worth because they are prioritizing their own concerns to a greater extent.

Example from the study

Returning to the patient from the Assessment and Intervention chapters (pages 23 and 29), although the patient did not address her needs exactly how the chaplain suggested, she did start taking better care of herself. For example, she prioritized her need for rest. As her energy was waning, she was increasingly able to tell her kids that she was tired and could not do home schooling, so that she could preserve her energy for other quality time. She was very pleased and proud of how accommodating they were to her when she made this request. She reported that they said, "Yes, mommy, get your rest." They were quiet and the older children looked after the younger ones in age-appropriate ways. Also, when she did not have the energy to have her prayer time in nature, the patient implemented conversations she had with the chaplain about wordless prayer and the image of resting in God's hands. She quoted scripture to validate this practice for herself: "The Spirit will pray for us in groans too deep for words." She realized that she didn't have to use words and owned being in bed as a cozy place where she could warm herself by the warmth of God, as a metaphor for sitting near a cozy fireplace. This was an image presented to her by the chaplain borrowing from Archbishop Desmond Tutu.

The patient also came to see how she could align her prayers with her beliefs and her decline due to her illness. She followed through on speaking with her husband and children about her death, acknowledging her ambivalence that "the Lord is healing me, yet I have doubts." The patient stated that she believed she was already healed, but that healing had not manifested itself physically yet. She and her husband decided that even if "one of us passes away, God is still good. We have no guarantees in life about how long we live".

These profound conversations with her family allowed her and them to hold their great faith alongside acknowledgment of her illness. The patient was able to tell her husband what a good father and husband he had been. She expressed gratitude for the time they had, if they could not have more time together. The patient also experienced a greater sense of belonging to her faith community because she had the chaplain lifting up her concerns, representing all of that community.

III. Reconciliation/To Love and Be Loved

The outcomes for each stage look like the following: The patient realizes that their behavior is at least partially responsible for the brokenness in relationships with other people. The chaplain uses empathy to articulate how the patient's behavior has had a negative impact on others. Rather than indulge in false contrition or shame, the patient mourns their actions that have contributed to brokenness. They acknowledge their own insensitivity to the impact of their behavior. And they commit to breaking this pattern of behavior in order to make a lasting, meaningful change.

Reconciliation Process

They are able to name their part in the broken relationship with specific examples. The person expresses true remorse about these behaviors. Behavior may be an action or could also be holding some kind of unrealistic expectations of others. The patient will take new action to relate to others differently (e.g., being more active rather than passive, calling others to say what they need, having clearer/flexible emotional boundaries, rather than rigid or overly permeable ones). Finally, the patient will seek forgiveness from people with whom relationships were broken (if possible) and with a higher power (if applicable). They will seek self-forgiveness. Through this, the patient experiences reconciliation with others and with God. Patient will experience empowerment and self-agency, acknowledging that it is not worth carrying around extra resentments.

Example from the study

The patient from the previous chapters (pages 23 and 31) wrote a letter to her estranged sister acknowledging her responsibility for their broken relationship. The patient showed her vulnerability and told her sister how sick she really was; this opened up the door to healing. This patient reported that during Christmas at church, she was overcome with an epiphany to let go of all of her resentments toward others. She let go of judgment toward herself for her shame about agoraphobia and previous abuse. She took responsibility to enjoy the time she had left. "I'm going to take a Xanax and leave the house." She went dancing on New York's Eve with her husband and friends and reported "finding more intimacy with him" in their relationship. She also found a new way of approaching her hospitalizations, and in being more trusting and open about herself to others, she found that people were "so much nicer" to her. She brought some personal items that brought her comfort, including a picture of herself when she was well. The risk she took to show her vulnerability endeared her to the staff, who were curious and talked with her about these items, building a relationship with her.

IV. Integrative Exercise

Example: A patient whose core spiritual need is self-worth says, "I went and spent some time in the garden just because I felt like it." In this instance, the patient expressed how she prioritized meeting her own needs rather than taking care of others.

EXERCISE

1. ***Vignette and related patient quote***
   A man in his 30s is married with a two-year-old son. He was a PhD candidate and received his diagnosis soon before moving to this new city with his family. Despite receiving treatment, his health is declining. He speaks about his concern for his wife and son, but also his own rapidly waning energy.

   "I mean, my priorities for a while have been healing and then other stuff, healing then family, and it's been really weird. It's not a priority, a hierarchy I enjoy. It doesn't make me feel good but, you know, if my body says sleep and rest, that's what I'm going to do. Yeah, I'm not trying to push it."

Question: Name the patient's core spiritual need and how the patient quote illustrates the desired outcome (using the model).

Core Need:

Outcome/language from the model:

2. ***Vignette and related patient quote***
   A woman in her early 30s, dying of cancer and living with her mother, struggled with declining energy and need to tackle her medical and insurance paperwork. She did not want to burden her mother with it. She already felt like she was imposing on her mother by not being able to do chores around the house.

   "I asked my sister to come and help last year. It was like, 'I have not been able to see my desk for like two-and-a-half years now. Could you

EXERCISE CONTINUED

come and help me?', 'cause she loves cleaning and rearranging furniture and stuff like that."

Question: Name the patient's core spiritual need and how the patient quote illustrates the desired outcome (using the model).

Core Need:

Outcome/language from the model:

3. Vignette and related patient quote

A woman in her 50s is married to a man and has two teenage children. She underwent several experimental treatments for her cancer at multiple medical facilities, which have been very successful. She is now energetic and involved in several activities and support groups. She has talked with the chaplain about survivor's guilt and rituals to help her to celebrate her healing and life's purpose.

"I went on vacation and wanted to make sure I got in the water. You and I had talked a lot about water. I love both looking at the water and also being in the water, feeling the water. I wanted to make sure I had that experience and I did. That got me to focus in a little bit."

Question: Name the patient's core spiritual need and how the patient quote illustrates the desired outcome (using the model).

Core Need:

Outcome/language from the model:

4. Vignette and related patient quote

A man in his 60s is married to his wife and has children and grandchildren. He worked as a teacher prior to becoming ill. He has a squamous cell carcinoma. He has a close though conflicted relationship with his wife and is angry at several of his doctors for various reasons.

EXERCISE CONTINUED

"My big fear is that I'm not going to feel better. This is just the course of the disease. That's another huge fear is this—that I'm not going to feel better. This is just the way the disease goes. That's what I fear most of all. And get worse. Yeah, less energy, more depressed, and I feel like that's just the course I'm on. That's what scares me."

Question: Name the patient's core spiritual need and how the patient quote illustrates the desired outcome (using the model).

Core Need:

Outcome/language from the model:

5. Vignette and related patient quote

A man in his 50s worked as a pilot, but is now retired. He discovered he had metastasized cancer through a routine health screening.

"To find out what my spirituality is, I needed a guide to show me where it is. So that I know better how I feel about things. You know, some people find spirituality in the beauty of the outdoors and some people find it in music or some people find it elsewhere, in books. I found it in talking with people. Seems to be my place where I find my joy, the strength, the everything. And I thought that was really interesting because I have been doing that, but I didn't know I was doing that."

Question: Name the patient's core spiritual need and how the patient quote illustrates the desired outcome (using the model).

Assess the patient's core spiritual need and name the chaplain's intervention using the model.

Core Need:

Outcome/language from the model:

EXERCISE CONTINUED

6. Vignette and related patient quote

A woman in her 50s has had breast cancer for over 20 years. She has been in and out of hospitals and rehab over the years. She used to be a Zen practitioner, but is no longer. She had a long-term partner, but recently broke up with her and now lives alone.

"The language that a radiologist uses is only for radiologists. Even the symptom management doctor couldn't figure out too much. But it's mildly disturbing to me that this has been going on since 2009. Hasn't grown very much during that time so if it is cancer, that's a good thing, but nobody has called it out. So from now on, I said, 'Can I just have you look at all my scans from now on?' And she said, 'Absolutely. Just request me.'"

Question: Name the patient's core spiritual need and how the patient quote illustrates the desired outcome (using the model).

Assess the patient's core spiritual need and name the chaplain's intervention using the model.

Core Need:

Outcome/language from the model:

ANSWER KEY

#1

Core Need: Self-Worth and Community
Outcome/language from the model: "Patient names how he/she is addressing his/her needs."
"Patient prioritizes self-concern in equal balance with concern for others."
"Patient's actions/behavior suggest enhanced self-worth."

#2

Core Need: Self-Worth and Community
Outcome/language from the model: "Patient names how he/she is addressing his/her needs."

#3

Core Need: Meaning & Direction
Outcome/language from the model: "Patient identifies own primary/prominent heart's desire."
"Patient attains greater clarity regarding meaning or purpose of his/her life."

#4

Core Need: Reconciliation/To Love and be Loved
Outcome/language from the model: "Patient expresses/owns vulnerability and feelings, instead of resorting to anger and blaming."

#5

Core Need: Meaning & Direction
Outcome/language from the model: "Patient identifies own primary/prominent heart's desire."
"Patient attains greater clarity regarding meaning or purpose of his/her life."
"Patient reports less angst and more support about making a particular decision."

#6

Core Need: Reconciliation
Outcome/language from the model: "Patient confesses part in conflict and broken relationships."
"Patient commits to new behavior and forgives self."

Chapter 6. Communicating with Chaplains and Other Professionals

It is important for chaplains to communicate using language that other disciplines can understand. Christocentric or any purely theological terminology is not easily understood by all. Spiritual AIM was consciously developed using language that is applicable to the spiritual realm, but is described through everyday language that people are more likely to use. For example, the terminology about meaning and direction makes just as much sense to those who have a strong theological world view as it does those who do not. Although a patient may resonate with language about rituals, sacraments, etc., it may alienate or confuse medical caregivers. Likewise, belonging to community and the need for self-worth is also common language. Part of what the chaplain is doing is embodying a place of worship that offers community and belonging. Many faith traditions have a sacrament or practice of reconciliation, but it is useful to summarize this for caregivers through more accessible language.

Chaplains have a unique lens through which we operate. We have our own models for working with patients. We make spiritual assessments based on our own criteria for understanding the spiritual needs of people. We have a way of being in relationship with the patient that is useful and a pathway of interventions that are efficacious, as well as outcomes that we believe reflect spiritual healing. Yet it is a missed opportunity to advocate for holistic care of patients when we fail to interpret this information in a way that is easily understood by caregivers of diverse backgrounds.

Part of what makes Spiritual AIM an effective tool for communication is that it parallels other disciplines. Using Spiritual AIM core needs to describe assessment, intervention, and outcomes works well in verbal interactions with interprofessional team members. It also lends itself easily to documentation in the medical record.

For example, you can use this simple acronym as a Spiritual AIM Charting Template.

A: Assessment
E: Embodiment
I: Intervention
O: Outcome
U: Update/Follow-up

This is an example of a more detailed documentation template that includes Spiritual AIM.

Recommendations for the Team:
1)
2)

Patient was (un)accompanied for this visit. [Include name]

Basic Spiritual Screening Conducted? YES/NO - DATE
Do you have any spiritual or religious beliefs or practices that are important to you? YES/NO [free text]
Faith Community Affiliation or Clergy Connection? YES/NO) [free text]

Spiritual Assessment, Interventions & Outcomes:

	Meaning and Direction	**Self-Worth and Belonging to Community**	**Reconciliation/ To Love and Be Loved**	**Pain and Suffering**
Assessment	Patient tends not to place blame; intellectualizes and asks questions/ wonders.	Patient tends to blame self; prioritizes caring for others.	Patient blames others; may complain, and present with strong or angry judgments and assumptions re: others	
Intervention	Chaplain serves as a guide; surfaces questions and helps patient claim resources for making decisions.	Chaplain affirms patient and offers community by listening to his/her story.	Chaplain observes the impact of patient's behavior on others, noting broken relationships. Holds patient accountable.	
Out-Come	Patient experiences greater clarity/makes decision.	Patient prioritizes their needs and desires.	Patient takes responsibility for brokenness; changes behavior.	

Advance Care Planning:

Family/Relational Resources or Concerns:

Follow up:

Integrative exercise
Use the templates above to practice writing a Spiritual AIM informed note in the medical record.

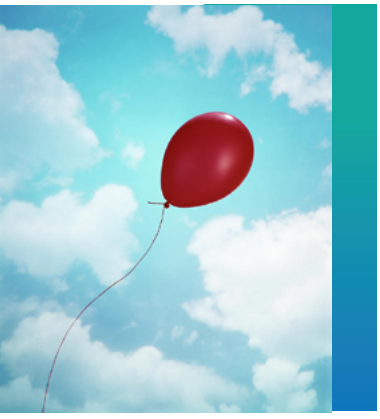
Chapter 7. Clinical Issues

I. Pediatrics

Children tend to be able to "imagine" freely, and this can provide insight into their experience, and opportunity to heal in relationship with you.

Pediatrics is a unique clinical specialty and chaplains working in this setting benefit form specialized training and mentorship. We also recommend collaborating closely with Child Life Specialists. In general, chaplain interactions with children should be guided by the self-worth and community belonging core spiritual need. Affirmation and focusing on building rapport are essential. At the same time, if the child is clearly expressing anger, the chaplain can help them express their frustration as a way to connect with their power in a situation where they feel powerless. For example, with whom are they angry? If they are questioning their situation, the chaplain should embody the guide. But all this should be done with the self-worth interventions in mind.

For example, a child in the ICU expressed feeling powerless to impact what was going on in her life. The chaplain encouraged the patient to express her anger by giving her a squirt gun. The patient led with intense anger, so a chaplain might assume that reconciliation is her spiritual need. But in fact, she had not contributed to any brokenness in relationship. She was legitimately angry about her situation. A chaplain can support a young patient by reminding and reinforcing boundaries. For example, asking, "Do you think it is helping when you throw food on the floor? Why are you doing that?" can remind the patient that their actions do impact others, even the powerful adults around them. The hope is that if the chaplain embodies and demonstrates boundaries, this may serve as modeling to the patient, who can internalize and apply this.



If the child is questioning, the chaplain should resist the urge to give answers, which can be especially tempting with small children. Wade through the questions with them; advocate for physicians to explain to

them what is going on in factual and age-appropriate ways. Chaplains should always leave medical explanations to medical providers, but the chaplain can advocate. For example, "Dr., the patient has some questions about why he is taking this medication, and how it will help him heal." Medical providers may look to the chaplain to address existential issues in pediatrics. If a patient brings up questions or fears about themselves or a loved one dying, the chaplain can explore their precise concerns."What are you most concerned about? What are you afraid of? What would you miss?" The chaplain can also offer mentoring and support to parents who are not sure how to engage on this topic with their children. The chaplain can help facilitate these conversations, especially when there are explicit theological concerns, such as questions and beliefs about heaven.

Metaphor is common with the meaning and direction core spiritual need, but many children draw upon images to express themselves. For example, a child might reference a storm outside. The chaplain can explore what they are "storming about." "Does it feel stormy inside too? Do you feel tossed around on the inside?" If kids are able to talk about feelings, they will. However, if you can identify metaphors that allow children to speak imaginatively, they can express themselves quite fully. Children tend to be able to "imagine" freely, and this can provide insight into their experience, and opportunity to heal in relationship with you.

Reflection Break

The child of an adult patient meets you and instantly tells you about a balloon they saw, floating away in the sky. Thinking about Spiritual AIM, how would you respond?

A pediatric patient looks out the window and shows you a cloud they believe is shaped like a horse. How would you respond?

II. Dementia

Chaplains can provide these individuals with a sense of community by demonstrating that they value their memories and that their life has been and is meaningful.

Chaplains should consult with those who specialize in caring for patients with dementia to inform their care. However, there are some helpful generalizations that align with

aspects of Spiritual AIM. It is now common knowledge that playing familiar or favorite music for patients with dementia, particularly music from their youth, can have a calming impact. One wonders if the music connects them to some sense of their identity.

Using metaphorical language can also be helpful. If a patient is telling a story about being in a boat tossing in the ocean, or stating that they are a child needing to get home, the chaplain can tune into the meaning behind the content of what they are discussing. "What would make you feel like you were home? What would make you feel safe and secure? What is home like?" For example, every evening an elderly woman with dementia insisted on having all of the family photographs she displayed in her room packed up in a bag and "ready to go." The chaplain can advocate for this kind of simple comfort. Chaplains can provide these individuals with a sense of community by demonstrating that they value their memories and that their life has been and is meaningful.

Reconciliation is also possible for individuals with dementia. They may perceive a caregiver as being someone with whom they have a broken relationship. Rabbi Michael Goldman, the founder of Seivah: Life Beyond Memory tells a story about a patient in a long-term care facility who confused him with the "bad person" from the town where she grew up. Rabbi Goldman recognized the spiritual distress related to this tension and embodied the "bad person." He said "I'm sorry for all the things that I did. Can you forgive me?" allowing the person the opportunity to experience reconciliation.

Whatever the projection you receive as the chaplain, remain attentive to the Spiritual AIM core needs and see if there may be an opportunity for healing. Do your best to meet whatever spiritual need is in the moment. When we think of Spiritual AIM Outcomes with this population, it is primarily to provide dignity through your care and presence. What does a healing relationship look like in that moment? Consider which of the Spiritual AIM incarnations you can take on. If you are mindful and awake to the person in your care, you can establish rapport.

III. Psychiatric Care

"...In psychiatry, you are on spiritual ground already. Take off your shoes..." - Michele Shields

This section assumes that professional chaplains possess basic knowledge and skills to provide spiritual care that is congruent with care for mental health and psychiatric conditions. As with any spiritual care, it is crucial for chaplains to observe and address the mental state of a patient in their care and refer and consult with a mental health

professional accordingly. Mental health considerations may also overlap with any of the other special considerations described in this manual. Providing sensitive and effective care to patients in an acute psychiatric event or with a history of mental illness entails reviewing the patient's medical record, if possible, so that the chaplain can align the psychosocial information with the spiritual care plan. As with all specialties, there is a vast array of skill that mental health providers have in screening and addressing spiritual needs. When collaborating with a non-chaplain provider, we recommend that chaplains set aside their assumptions about what the provider may or may not know and be prepared to provide collegial education about professional spiritual care.

Clinicians who work in mental health and psychiatric settings develop best practices and helpful generalizations about spiritual needs in psychiatric care. This manual will not focus on this information. Rather, this section of the manual will provide a generic, introductory overview of the intersection of spiritual and psychiatric care, using examples from the Spiritual AIM study referenced above. The concept of Embodiment, which has been described above and detailed in Table 1 (beginning on page 19), can be a helpful way for chaplains to anchor their approach when providing spiritual care in a mental health or psychiatric context. Here are three case studies that describe the embodiment and interventions of chaplains using Spiritual AIM:

I. Self-Worth and Belonging

As we have learned, the need for self-worth and belonging to community may be indicated by the patient's self-blaming as well as deep appreciation for the presence of visitors, family, and other social support.

Mr. A, a Jewish man in his 60's, was admitted to the inpatient psychiatric unit for a second hospitalization in six months suffering from clinical depression. In the previous year, Mr. A. had lost his job, and his 30-year-old daughter had died suddenly. Mr. A. felt unresolved grief about both these events and a deep sense of shame for not being able to protect his family either financially or from unexpected illness. Mr. A. experienced his own depressive illness as a sign of weakness and selfishness, and repeatedly told the chaplain that he felt useless. Seeing himself as not useful was a lifelong pattern for Mr. A. that predated his recent losses and his illness. Mr. A. highly valued being in community and benefited from peer and staff interaction. He also possessed a speech impediment that further isolated him from others.

The spiritual caregiver embodied valuing and community.

Mr. A. did not consider himself religious. However, he was deeply connected to cultural values. The chaplain shared the same cultural background and embodied community by connecting him with his Jewish cultural tradition through exchanging stories about his ancestry that illustrated his "deep belonging" in a community and

a collective history. He was greatly helped by humor. Sharing jokes made him feel connected and useful to others. The chaplain also affirmed his value through the use of cultural stories that dealt with the dignity of each human being. Since community and a sense of "usefulness" was so pivotal for Mr. A, the chaplain, with Mr. A's permission, contacted the leader of a local cultural community center and asked her to be in touch to affirm his place in that community and the value of his participation. The chaplain also helped to connect him as a volunteer to the community center to use his skills as a chef cooking for holiday celebrations. After this intervention, he reported an increased sense of feeling like he "belonged" and was "useful" on the psychiatric unit and within his community center after returning home.

II. Meaning and Direction

The need for meaning and direction may be indicated by the patient's difficulty in making decisions, seeking the larger meaning in their life, and questioning why this is happening in order to make sense of this stage of life.

Mrs. B is a transgender woman in her 40's with a Christian upbringing who presented with Bipolar Disorder. She had successfully managed her illness as an outpatient for the past 20 years. This latest hospitalization led to a sense of hopelessness and a loss of meaning for her. She had made it through many struggles successfully in her life. At this time, she reported feeling lost and unsure what should come next.

The spiritual caregiver embodied or incarnates a guide.

The chaplain used discussion and guided visualization to guide Mrs. A. toward times in her past when she felt "on track" and a sense of meaning and purpose. She reported experiencing spirituality most keenly when she was on a ship in the vastness of the ocean, as a young oceanography researcher, looking up at the night sky. She reported feeling more hopeful whenever she felt connected to a "bigger reality." Through telling the story of previous struggles with mental illness, she was able to see her current hospitalization as part of a larger narrative that connected her to a sense of meaning and hope. The chaplain and Mrs. A. created a ritual to mark the end of this hospitalization.

III. To Love and Be Loved

The need to love and be loved in reconciled/completed relationships may be indicated by the patient's other-blaming, broken or estranged relationships, the need to forgive and be forgiven, and the inability to grieve losses and say good-bye.

Mr. C was a 30-year-old man who was hospitalized due to clinical depression. Mr C. had a strong desire for love, but felt "doomed" because he thought he would never have a meaningful relationship. He blamed this on the "superficial" nature of dating

apps and did not see his own responsibility in maintaining relationships. He had been excommunicated by his religious community of origin. He felt a lot of unresolved grief and shame in relationship with his church and a lack of forgiveness for himself.

The spiritual caregiver embodies or incarnates a truth-teller.

The chaplain visited with Mr. C to listen to his story. The chaplain's truth-telling involved gently directing Mr. C. to examine his own role in maintaining sustainable relationships and pointing out the ways that internalized shame was keeping him from reaching out toward love. Upon Mr. C's discharge, he wrote a letter to the chaplain, reporting that the intervention had given him "belief in the possibility of companionship and love" in his life.

The chaplain contacted the leader of a local cultural community center and asked her to be in touch to affirm his place in that community and the value of his participation. The chaplain also helped to connect him as a volunteer to the community center to use his skills as a chef cooking for holiday celebrations. After this intervention, he reported an increased sense of feeling like he "belonged" and was "useful" on the psychiatric unit and within his community center after returning home.

IV. Addiction

Although we do not wish suffering on anyone, pain can be a great spiritual teacher for folks with a core spiritual need of Reconciliation and provides the motivation to recover.

If a patient is not ready to address their addiction, then reconciliation with others will not be possible. However, the chaplain can put the focus on the immediate needs related to addiction (i.e., accountability regarding pain medication, housing).

Putting aside the debate about the efficacy of various treatments for addiction, the 12 Steps of Alcoholics Anonymous are also the steps of the Spiritual AIM reconciliation process. As you may know, these steps have been applied to 12 Step programs for various addictions. Whenever dealing with someone with an alcohol or substance use disorder, a chaplain must remember to take the stance of the truth-teller and work through the reconciliation process, empowering the patient to take responsibility for their actions before any further spiritual healing can be done. Chaplains may find it useful to be familiar with the 12 Steps so that if they are caring for a patient walking that spiritual path, they can be supportive. For example, if they observe that a person is not being fully contrite, they can advise them to return to the appropriate step.

Addiction is a disease marked by denial. People who are addicted will often be adamant that they are not addicted, which aligns with the other-blaming and lack of personal responsibility that we see in the Spiritual AIM Reconciliation dynamic. For example, they might say, "It was all their fault. If you had my problems you would drink, too!" In addiction, a patient who has not healed through the Reconciliation/Love and Be Loved process can benefit from being held accountable for the negative impact they have had on others. Evidence of how much their actions have hurt other people can help them to understand the consequences of their addiction. Addiction often includes numbing of emotions and recovery includes waking up to oneself and taking responsibility through expressing vulnerability and true feelings. This will include pain they feel about hurting others. Although we do not wish suffering on anyone, pain can be a great spiritual teacher for folks with a core spiritual need of Reconciliation and provides the motivation to recover.

When a person has fully "cleaned house" and begun the process of confessing their mistakes to another person, such as the chaplain, they can then move forward with the steps to address their character defects. The person may start to feel relief and hopefulness that they are now on a healing path. They continue to take positive action and can address broken relationships they have created.

It can be easy to wrongly assess a person with addiction as having a core need of Self-Worth and Community Belonging because they appear hard on themselves. The "egomaniac with an inferiority complex" is expressing a dramatic, false contrition and being overly judgmental of themselves. Although we often think of arrogance as being about superiority, being overly critical of oneself is another kind of arrogance.

Chapter 8. Spiritual AIM Standardized Patient Materials

Medical simulation provides real world situations that allow healthcare professionals and those in training to learn critical skills while receiving feedback from faculty and peers. Spiritual Assessment is a skill that we believe can be practiced through patient simulation. In conjunction with the Simulation Training Center at UC San Diego School of Medicine and thanks to the support of the Cambia Health Foundation, standardized patient materials have been developed for each of the three Spiritual AIM core spiritual needs.

Full cases with background, instruction/training for actors and faculty scoring sheets are available by contacting the authors of the manual via the Spiritual AIM website. The cases are not currently published so that future students will have the opportunity to participate without having had access to background information that might compromise their learning experience.

www.SpiritualAIM.org

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