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Spiritual AIM and the work of the chaplain: A model for assessing spiritual needs and outcomes in relationship

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ABSTRACT

Objective: Distinguishing the unique contributions and roles of chaplains as members of healthcare teams requires the fundamental step of articulating and critically evaluating conceptual models that guide practice. However, there is a paucity of well-described spiritual assessment models. Even fewer of the extant models prescribe interventions and describe desired outcomes corresponding to spiritual assessments.

Method: This article describes the development, theoretical underpinnings, and key components of one model, called the Spiritual Assessment and Intervention Model (Spiritual AIM). Three cases are presented that illustrate Spiritual AIM in practice. Spiritual AIM was developed over the past 20 years to address the limitations of existing models. The model evolved based in part on observing how different people respond to a health crisis and what kinds of spiritual needs appear to emerge most prominently during a health crisis.

Results: Spiritual AIM provides a conceptual framework for the chaplain to diagnose an individual's primary unmet spiritual need, devise and implement a plan for addressing this need through embodiment/relationship, and articulate and evaluate the desired and actual outcome of the intervention. Spiritual AIM's multidisciplinary theory is consistent with the goals of professional chaplaincy training and practice, which emphasize the integration of theology, recognition of interpersonal dynamics, cultural humility and competence, ethics, and theories of human development.

Significance of Results: Further conceptual and empirical work is needed to systematically refine, evaluate, and disseminate well-articulated spiritual assessment models such as Spiritual AIM. This foundational work is vital to advancing chaplaincy as a theoretically grounded and empirically rigorous healthcare profession.

KEYWORDS: Chaplaincy, Spiritual assessment, Spiritual care, Conceptual model, Palliative care

INTRODUCTION

In primitive times, the healer cared for mind and body, and also, importantly, spirit (Sigerist, 1951, p. 136). As medicine evolved, the role of spiritual healer diverged from that of medical practitioner (Temkin & Temkin, 1967, p. 207). Although spiritual

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leaders (e.g., clergy, teachers) have provided spiritual healing for the physically and mentally ill for centuries, the field of professional chaplaincy has emerged largely during the last century (Cadge, 2012, p. 24). Board certification in chaplaincy is an even more recent development, beginning in the 1940s (Cadge, 2012, p. 24).

As with any practice that matures into a "profession," the process of professionalization brings benefits, challenges, and obligations. Professions strive to enhance the quality and consistency of care provided by their practitioners, guided by standards of practice and ethical principles. In the case of chaplaincy, benefits of professionalization should accrue to patients and their loved ones, as consistent standards of chaplaincy permeate healthcare settings and practices. A number of studies have shown that chaplain visits have a positive impact on patient satisfaction (Gibbons et al., 1991; Jankowski et al., 2011). Benefits also accrue to professional chaplains, who may experience greater professional gratification, recognition, and opportunities (VandeCreek & Burton, 2001).

Challenges for the field of chaplaincy include the need to distinguish the unique contributions and roles of chaplains as members of healthcare teams (VandeCreek & Burton, 2001; VandeCreek, 1999; Jankowski et al., 2011; Cadge, 2012). In addition, concerns about the costs of healthcare increasingly challenge chaplains to justify their cost effectiveness and clearly articulate their added value. Another challenge for chaplaincy is the basic work of agreeing upon definitions, goals, outcomes, credentialing, and other directions for the field (Lucas, 2001; Ellison & Benjamins, 2013; Krause, 2011).

As a profession, chaplaincy also must meet its obligations to adhere to the highest possible standards in training, to articulate required competencies for certification, as well as to assure ongoing quality of practice (e.g., through peer review, continuing education, and regular consultation with colleagues). In addition, chaplains must adhere to a code of ethics that guides their practice. Furthermore, procedures must be in place for addressing complaints from colleagues and recipients of care when chaplains do not adhere to ethical principles (Spiritual Care Collaborative, 2004; Association of Professional Chaplains, 2009).

A critical obligation of chaplaincy is to articulate and critically evaluate theoretical models, to disseminate these models, and to educate chaplains in their appropriate use (Fitchett, 2002; Jankowski et al., 2011). Models provide the framework for professional clinical application and are the common language that professionals employ to communicate their ideas and assessments within the field and beyond. For example, the biopsychosocial model is a conceptual framework of health and illness that gained traction as a way to teach doctors in training that patients are more than their disease or symptoms (Engel, 1979).

Training and board certification in professional chaplaincy require that chaplains utilize spiritual assessments to guide their care (Spiritual Care Collaborative, 2004; Association of Professional Chaplains, 2009). The Joint Commission requires only that spiritual assessments be conducted (Joint Commission, 2010). Recent literature pertaining to the professionalization of chaplaincy advocates for greater articulation of interventions and outcomes that correspond to spiritual assessments (Handzo, 2012; Peery, 2012). However, it is unclear to what extent professional chaplains formulate, utilize, and articulate spiritual assessment and the theoretical models from which they emanate (O'Connor et al., 2005). Further, there remains a relative paucity of published, well-described spiritual assessment models (HealthCare Chaplaincy, 2011; Jankowski et al., 2011).

Therefore, the purpose of the present paper is to describe one clinically implemented spiritual assessment model, called the Spiritual Assessment and Intervention Model (Spiritual AIM). Spiritual AIM is based on more than 20 years of chaplaincy experience and teaching, is currently taught to chaplain trainees, and has been disseminated to multiple clinical disciplines. After describing the development and theoretical underpinnings of Spiritual AIM, three cases illustrating its use will be presented, the model critiqued, and areas in need of further study discussed.

SPIRITUAL ASSESSMENT VS. SPIRITUAL SCREENING

At the outset, a fundamental distinction must be made between *spiritual assessment* and *spiritual screening* or *spiritual history* (LaRocca-Pitts, 2012). Spiritual screening and spiritual history have been more widely studied and purposefully designed to be conducted by clinicians from any discipline (Massey et al., 2004; Fitchett & Canada, 2010). These screens usually employ a limited set of questions designed to gather data about a patient's faith, the importance of their faith and/or faith community, and their need for assistance or resources in having their spiritual needs addressed. Spiritual *screening* therefore connotes the essential, but necessarily circumscribed, goal of screening for spiritual needs and resources. However, even tools with "assessment" in their name may be more appropriately termed spiritual *screening* tools (Borneman et al., 2010). Such screens do help identify the need for a professional

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chaplain and can lead to appropriate referrals from other healthcare providers (Jankowski et al., 2011).

Spiritual *assessment*, in contrast, should only be completed by a professionally trained chaplain (Handzo et al., 2012). Spiritual assessment is not a scripted or generic set of questions asked in the same way of each patient. Spiritual assessment is an evolving dialogue, established within a compassionate encounter with the patient, regarding those issues that most concern that 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.

DEVELOPMENT OF SPIRITUAL AIM: ROOTS IN CHAPLAINCY MENTORSHIP

One of us (MS) developed the theoretical model of Spiritual AIM over the past 20 years to address these limitations. Initially, the first author was part of a small group of chaplains mentored by the Reverend Dr. Dennis Kenny as part of their supervisory training. For two years (1991–1993), the first author was part of this working group. At the outset, the work primarily drew from a Lutheran-based perspective regarding what people needed spiritually and how people grew spiritually. The group met weekly to discuss, question, and comment; dialogue and disagreement were welcomed and helped develop the first author's ideas about the model. A primary focus of this group involved observing how different people responded to health crises. The constellation of core needs and the idea of interventions designed to address those needs emerged from this dialogue and supervision.

During that time, MS began observing what occurred in the relationship between the patient and the chaplain, which led her to read and draw from the field of object relations psychology. It also caused her to reflect more deeply on her own theology, which describes healthy relationships between individuals, and between individuals/communities and the Divine or Ultimate Reality. These relationships demonstrate both autonomy and connection, as well as love toward the self in balance with love toward others and the Divine or Ultimate Reality.

Over the next 18 years, the model gained greater specificity in interventions. During that time, the model's language has been modified to be more inclusive of other faiths. In addition, substantial efforts were made to "translate" the model more effectively to other disciplines within the hospital setting. Additionally, the model had been extensively utilized in clinical work with patients and in supervisory work with chaplaincy students. It should be noted that some aspects of the model were described in previously published work by a non-chaplaincy scholar (specific attribution to MS was not made, however, as the scholar was describing clinical pastoral education as an ethnographer) (Lee, 2002). Finally, the interdisciplinary work of our Spiritual AIM research team (see the Acknowledgments section) 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.

"Being in Relationship": Fundamental to Spiritual AIM

Relationships are the context for spiritual development. Object relations psychology provides an important framework for understanding this assumption about the spiritual nature and potential for healing (Rizzuto, 1981). As noted by other authors, spiritual development, and therefore spiritual care, cannot be seen as separate from relationships (Clinebell, 1984). Personality takes shape through people's experiences of relationships and social context, specifically how a child appropriates, internalizes, and organizes early experiences in the family (Chodorow, 1978). Spiritual AIM posits that spiritual dynamics and core needs are shaped in a similar manner.

As the individual grows, she carries the internal drama of childhood experiences within her memory. Individuals assimilate new experiences with old dramas, rather than experiencing the new in its contemporary form (Pine, 1990). This living out of personal history in relation to others is termed "transference." A person develops compelling beliefs acquired by inference from experience. These beliefs are largely unconscious and guide a person's behavior and form a spiritual life script about how the person needs to relate to God and others in order to be loved and accepted (Kenny, 1980). Patients often transfer their experience with their parents onto their assumptions about God, their relationship and experience with God, and the way they speak about God (Rizzuto, 1981). For example, one of us (MS) visited a hospital patient who, based on experiences in childhood with alcoholic parents who were emotionally distant, expressed a spiritual perspective in which God was remote, detached, and, theologically speaking, transcendent (i.e., outside the patient's world or experience). This detachment also played out in relationship with the chaplain, who struggled to

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establish rapport with the patient. The patient was initially skeptical that the chaplain would be interested in her as an individual. Using a poem, "God Says Yes to Me" by Kaylin Haught (Kowit, 1995), the chaplain helped the patient connect with a warm and loving experience of God. The chaplain also asked the patient to reflect on her most loving relationship. The patient described her childhood nanny. When the chaplain asked the patient, "What if God were named [the nanny's name]?" the patient began to cry. Over the course of a several-week hospital stay, this brief intervention helped the patient cultivate a relationship with God (whom she now called by the nanny's name). God had become—theologically speaking—immanent (i.e., fully present to her in an immediate way). From the chaplain's perspective, the care shown by the chaplain to a patient as an individual was representative of God's love and care for her individually as well. As this case illustrates, patients **may** view the chaplain as an extension, conduit, or representative of God—or of another dimension greater than oneself.

Therefore, the process of spiritual healing entails exploring how patients relate to others, why they relate in these ways (i.e., what patterns of object relations guide his/her behaviors), and how the patient may benefit from modifying these dynamics. The goal of the chaplain is to assist in the patient's healing. The process of raising the spiritual life script to consciousness, testing and disconfirming it, largely in relationship with the chaplain, often frees the patient from her spiritual life script or primary dynamic of relationship developed in childhood. She has greater freedom and is then brought back into the balance of loving self, God, and others equally. This spiritual life script may need to be disconfirmed many times in many different ways for lasting integration to occur.

As Spiritual AIM draws upon object relations for its foundation, it also has roots in foundational ethical and theological themes, namely, the ethic of reciprocity, more widely known as the Golden Rule—"Treat others as you wish to be treated" (Flew, 1979, p. 134). This theme is prominent in Jewish and Christian teachings and scripture ("Love your neighbor as yourself," Leviticus 18:18, Matthew 22:37–40), and is expressed in some similar fashion in all ethical and faith traditions (Flew, 1979, p. 134). For example, it is expressed in the negative in Confucianism—i.e., "What you do not wish for yourself, do not impose on others" (Huang, 1997, p. 14). Spiritual healing is a process in which people live in balance with what is considered in one author's theology (MS) the "Greatest Commandment," and, in rabbinic literature, the "greatest principle in the law"—that is, "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 6.5; Leviticus 19:18; Luke 10:27) (Levine & Brettler, 2011). 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.

Thus, central to Spiritual AIM is our understanding of spirituality as expressed through relationships. Spirituality addresses relationality in four dimensions: the individual's relationship with himself, with his community, with nature, and with the divine or that which transcends the self. Furthermore, extensive experience with asking care providers what they believe to be core spiritual needs of human beings—regardless of culture, origins, religion—revealed consistent responses, including: connection, community, self-worth, self-esteem, hope, peace, meaning, to love, to be loved, reconciliation, and forgiveness. Regardless of the length of this list of needs, the following three core spiritual needs seemed to encompass the majority of responses: (1) meaning and direction, (2) self-worth/belonging to community, and (3) to love and be loved/reconciliation.

Definition of Spirituality in Spiritual AIM

Thus, **we came to define spirituality 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**. This definition seeks to recognize each patient's individuality in terms of their deepest need and evaluate where the patient is located along the path toward healing and wholeness. In addition, Spiritual AIM uniquely posits that, when individuals face any crisis, one of the three primary spiritual needs surfaces in a clear and immediate manner.

DESCRIPTION OF SPIRITUAL AIM

As described in further detail in Table 1, Spiritual AIM provides a conceptual framework for the chaplain to: (1) diagnose an individual's primary unmet spiritual need—through observing the patient's words and behavior in relationship with the chaplain, as well as through the chaplain's self-awareness of the interpersonal dynamic with the patient; (2) devise and implement a plan for addressing this need through embodiment/relationship; and (3) articulate and evaluate the desired and actual outcomes of the intervention. Analogous to medical diagnosis

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

Meaning & Direction	**Primary Identified Spiritual Need** 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). • Patients 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 Truthteller**
	Intervention—"to Do"	
• Name and 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 along side patient on a path.	• 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. • Listen attentively while valuing patient's story. • Empower patient to identify what is loveable about them.	• 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.

Continued

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Table 1. *Continued*

Meaning & Direction	**Primary Identified Spiritual Need** Self-Worth & Belonging to Community	Reconciliation/to Love and Be Loved
	Plan for Embodiment of the Chaplain—"to Be" (continued)	
• 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).	• 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.	• 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 his/her behavior has an impact on other people. • 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 and God. • Patient experiences reconciliation.

and treatment, we assert that, when chaplains utilize a systematic framework for spiritual assessment of the patient's primary need, and when they select appropriate interventions (from their armamentarium of tools) to address this need, the patient is much more likely to experience healing in the spiritual domain. Further, Spiritual AIM's multidisciplinary theory is consistent with the goals of professional chaplaincy training and practice, which emphasize the integration of theology, recognition of interpersonal dynamics, cultural humility and competence, ethics, and theories of human development.

Primary Identified Spiritual Need and Spiritual Task

Patients with a core spiritual need of reconciliation tend to love self more than others and come from a place of egocentric, distorted self-love. Their concern for themselves is out of proportion with respect to loving God or others. In working with a patient whose core need is reconciliation, the task involves helping the patient not only to love herself, but also to love and humble herself in relationship to God and others. Patients with a core need of self-worth demonstrate the opposite dynamic, wherein they love God and others but tend to exclude themselves. The primary spiritual task in working with a patient with this core spiritual need involves helping the patient feel worthy of self-love. Patients with a core need of meaning and direction may be out of touch with self and others, and be out of touch with their own desires. They may be overly focused on the mind (e.g., intellectualizing, asking questions, searching, wondering). The primary spiritual task in working with a patient with this core spiritual need involves helping

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the patient get in touch with their own sense of purpose, meaning, direction in life, and desires.

Assessment: Observing the Patient

The chaplain identifies the core need through their personal interactions and experiences with the patient, rather than the mask or persona that the patient presents to the world. While experiencing a health crisis, most people cannot hide their primary spiritual need. The veil is thinner—the need surfaces and is much more present and obvious, much like an open wound. It becomes the dominant topic in the conversation with the chaplain. The patient's normal defenses and coping mechanisms are challenged. The patient may discuss how support systems may not be working, or may have been fragmented or weak to begin with. This provides the chaplain with an opportunity to make an assessment about where the patient places themselves in relationships with others. The patient may also consider their concerns about mortality in the midst of a medical crisis. The chaplain may also make an assessment based on the way the patient expresses their concerns about the end of their life.

When in crisis, the patient's primary spiritual need manifests through their comments and behavior, through where they attribute blame, the questions they ask, and the concerns they raise (Shields & Joseph, 2010). 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. 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 that personify certain characteristics: **guide**, **valuer**, or **truthteller**.

It should be noted that patients may describe themselves in a certain way, but this description may be dissonant with the way the chaplain and others observe the patient's behavior. This patient's self-description or self-explanation is described in Spiritual AIM as "persona" (see Figure 1)—or the way the patient wishes to appear. Similar to the key relevance of collateral information, awareness of transference and countertransference, and the mental status examination in psychiatric assessment, Spiritual AIM does not take the patient's self-description at face value. Instead, the assessment is based in part on observing the patient's behavior, noting what occurs between the patient and chaplain, and observing or assessing the relationships the patient has with others. For example, a patient may say, "I don't ask for much," and yet the chaplain observes the patient behaving in a demanding way with nurses and aides. When behavior and self-description conflict, the chaplain bases an assessment on behavior. Behavior serves as a more reliable indicator for assessment than what the patient says about himself, when there is a conflict between behavior and self-description.

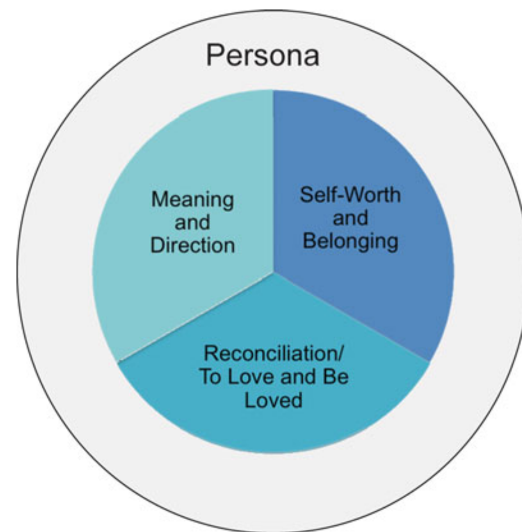

Fig. 1. Spiritual AIM conceptual model.

Assessment: Chaplain's Self-Awareness

Core to Spiritual AIM is the chaplain's use of herself and the relationship with the patient to make a spiritual assessment and facilitate healing. The chaplain makes her assessment through hearing certain phrases or comments made by the patient, observing the patient's behavior, and noting the chaplain's awareness of her own tendency to react in the presence of each of the primary needs. Depending on the chaplain's individual characteristics (e.g., temperament, culture, family history, and past experiences), each chaplain will likely react differently from other chaplains to each of the core needs. Each chaplain is encouraged to become familiar with their personal reaction to each of the primary spiritual needs, to help them make future assessments. For example, some chaplains enjoy the energy of verbally wrestling with a patient with a primary need of reconciliation. Another chaplain may feel exhausted and afraid of the anger expressed by patients with a primary need of reconciliation.

Chaplain's Embodiment

Once the chaplain has made an assessment, it is our view that Spiritual AIM guides the chaplain in conceptualizing an intention (Breitman, 2005), embodiment (what "to be"), or pastoral stance (Clark,

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2006). Spiritual AIM uses the term "embodiment" to refer to this aspect of the chaplain's role, but we acknowledge that different terms for this concept are used and may resonate differently in diverse disciplines and faith traditions. For example, Christians may use the term "incarnation" to refer to embodiment. What the chaplain embodies is *who the chaplain is* for the patient. "To be" in relationship with the patient is as important as "to do" something in relationship to the patient.

Central to the idea of embodiment in Spiritual AIM, the chaplain's embodiment—or "being in relationship"—can help the patient heal according to their primary spiritual need and task. Specifically, for the patient whose primary spiritual need is meaning and direction, the chaplain's embodiment ("guide") can facilitate the patient achieving greater clarity (e.g., making a decision about goals of care, or gaining clarity about the meaning of one's life). For the patient whose primary spiritual need is self-worth and belonging, the chaplain's embodiment ("valuer") can help the patient feel more worthy and learn to advocate more for their needs to be met. For the patient whose primary spiritual need is reconciliation, the chaplain's embodiment ("truthteller") holds the patient accountable for greater responsibility and humility.

Furthermore, through one's embodiment, the chaplain serves as a representative or reminder of the divine in such a way that healing takes place in the relationship (Kushner, 1981, p. 151). The chaplain becomes aware that "something more" than just the person and the chaplain is present in the room when a spiritual care encounter is taking place. The "something more" can even be surprising to the chaplain—and, frequently, to staff who may be present when healing interactions take place. The depth of intimacy of these powerful grace-filled moments of forgiveness, trustful surrender to the hands of mystery, and epiphany may be totally unforeseen and powerfully move us and transform our lives in the midst of a very clinical environment, such as a common hospital room. In the first author's (MS's) theology, these touching and surprising moments are possible because of God's presence, uniquely born in the midst of the chaplain and the patient, in their coming together—i.e., "For where two or three gather in my name, there am I with them" (Matthew 18:20) (Holy Bible (New International Version), 1978).

Chaplain's Intervention

The chaplain needs a plan (i.e., what "to do") (Handzo et al., 2012; Doehring, 2006). If the chaplain does not have a plan, the encounter may meander or stay within the realm of a social visit. Spiritual AIM articulates interventions that are intended to move patients along a path of healing. Analogous to readiness for behavioral change, the patient must be willing to travel together with the chaplain along this path. The interventions of Spiritual AIM guide the chaplain but are never spoken aloud to the patient. This may seem like an obvious point, but one author (MS), in teaching the model for many years, has found that this needs to be explicitly stated. The interventions in Table 1 describe what can best be understood as a pathway to healing; fundamental to devising an intervention. The chaplain first needs to assess where the patient is along this pathway. Drawing on this image, the chaplain attempts to walk alongside the patient, working with the patient toward an outcome related to achieving greater wholeness to meet their core spiritual need. This does not mean that the chaplain describes their assessment or intervention to the patient; rather, the chaplain keeps these in mind as she walks with the patient.

Furthermore, the patient's responses to the chaplain's interventions can be employed by the chaplain to assess whether the intervention is facilitating healing for the patient. The chaplain may use this as informative feedback (similar to narrowing one's differential diagnosis based on additional information), and may even choose another course of action (intervention), or even reformulate the chaplain's assessment of the patient's core spiritual need. Analogous to differential diagnosis and empirical treatment in medicine, Spiritual AIM provides the framework for reaching an initial diagnosis (through assessment), devising a treatment (intervention), and assessing the outcome in order to confirm or disconfirm a diagnosis.

It may seem unusual to include ritual as an intervention; however, it is integral to Spiritual AIM. Rituals are one way by which humans mark life transitions (Shields, 2009). Spiritual AIM thus takes into account spiritual care interventions that offer religious and nonreligious/poetic rituals for patients to mark their movement along the pathway toward meeting their core spiritual need. Rituals and ceremonies at the bedside are unique to the domain of spiritual care (Shields, 2009). For thousands of years, healers and spiritual leaders have performed ceremonies and healing rituals to observe important occasions and to mark life events. Not only is the professional chaplain's clinical expertise recognized by their professional certification, but their spiritual expertise is also validated through their ordination/authority within a lineage that often goes back thousands of years in a specific faith tradition. Through providing ritual as an intervention, chaplains tap into a heritage of healing (VandeCreek & Burton, 2001). The chaplain is uniquely positioned to bring these spiritual interventions into the realm of the

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clinical. No other professional caregiver is trained to provide the full spectrum of rituals from the world's diverse faith traditions at the bedside. In addition, chaplains are specifically trained to understand the nuances of providing ritual—including when to refer to other spiritual caregivers or faith leaders. Chaplains also create rituals for nonreligious patients, family, and staff who need to mark profound occasions and times of transition (e.g., birth and death) using nonreligious materials such as poetry and music.

Analogous to physicians identifying improved function in an organic system or in a given set of laboratory parameters, chaplains who employ Spiritual AIM identify what improvements along the path of spiritual health and wholeness would look like. Based on each patient's identified core spiritual need, the chaplain strategically intervenes to walk with the patient toward greater wholeness and health.

While the desired outcomes described in Table 1 may appear ambitious, clinical experience provides many examples of patients who have achieved significant healing of their spiritual needs. For example, a dying 70-year-old mother, after talking with the chaplain, was able to express to her children her conclusion about the meaning of her life: "The best thing I ever did was having you two kids." In another case, a chaplain was working with a patient with a history of childhood trauma who was now coping with advanced cancer. The chaplain assessed the patient's core spiritual need as reconciliation. Although this patient did not believe in God (but attended a church for many years), the chaplain's embodiment as truth-teller helped the patient, through their relationship, to learn to look at her part in relationships, to be more vulnerable with her husband, and to take responsibility for what she could do to heal relationships. Interestingly, she described an epiphany—which occurred in church at Christmas—involving a release of shame and misery and the adoption of a new sense of enjoyment of life.

As illustrated by the above examples, Spiritual AIM seeks attainable outcomes that are observable or reportable by chaplain or patient (Lucas, 2001). As Peery stated, "Outcomes are simply the observable results of our care" (2012, p. 351). Outcomes-oriented models, such as Spiritual AIM, have several research implications, addressed further in the Discussion section. With regard to outcomes, Spiritual AIM postulates that core spiritual needs are universal; Spiritual AIM does not presuppose belief in God or any other religious belief. Thus, Table 1 identifies seeking and experiencing "forgiveness from others and God" as one *possible* desired or proposed outcome, but other outcomes involving reconciliation are equally desirable.

CASE EXAMPLES

To illustrate the clinical application of Spiritual AIM, three cases based on actual patient encounters are described below. Based on the assessment of the patient's primary identified core spiritual need, the chaplain sought to intervene to help the patient move further along the path toward spiritual health, with desired outcomes conceptualized and evaluated in relation to the identified core spiritual need.

Meaning and Direction

Background

Mr. X, a 70-year-old man, is suffering from significant complications from a gastrointestinal cancer. He is in a loving, supportive relationship with his partner. Although he does not affiliate with any particular religious practice, he was raised Mormon and has a very positive relationship with family members who still practice this religion. He was referred to the chaplain by his primary care physician to discuss some of the patient's questions about the end of life.

Assessment

The patient tells the chaplain that, due to his illness, he can no longer work at his job in the hospitality industry. The patient tells the chaplain that he had previously felt a great sense of meaning and purpose in his employment. He is wrestling with two questions related to meaning and purpose. Since his work had been a big part of his identity and he could no longer work, he tells the chaplain that he wonders about the meaning of his life and what his legacy will be. Additionally, he tells the chaplain that he is afraid of facing the finality of the end of his life because, having left the Mormon faith, he has no belief in an afterlife. The patient is also agonizing about the right time of year to visit his family and friends. On the one hand, he knows that his death is drawing near and wants to have quality time with them; on the other, he wants to do this during spring or summer, when the weather is nicer.

Chaplain's Awareness

The chaplain is puzzled by the patient's feeling stuck and the lack of action about when to visit his beloved friends and family, especially given his lucid understanding of his prognosis.

Plan For Embodiment

The chaplain seeks to embody a guide for the patient.

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Intervention

The chaplain reflects back to the patient her observation that the patient is struggling with the decision about when to take a final trip to the community where he grew up to say his goodbyes. She asks the patient, "When was a previous time or place in your life when you sought an answer and you came to some certitude about a decision you needed to make? How did you decide?" This reminds the patient of his own inner wisdom and ability to make a good decision. The patient commits to living one day, having made the decision to visit immediately, and the next day imagining he has made the decision to wait until the spring to visit his birthplace. The chaplain also names for the patient that he is wondering about his legacy and the meaning of his life, particularly given his ambivalence about there being some kind of existence after death. The chaplain guides the patient as he articulates a strengthening belief that his loving and long-lasting relationships are his legacy and will continue in some form after he dies. The chaplain names, and helps the patient process, his sadness related to the loss of these relationships.

Outcomes

The patient decides to wait until the spring to visit his hometown and expresses feelings of serenity and acceptance that he may die before he can take the trip. The patient enrolls in hospice, and, at the request of the patient, the chaplain marks this decision with a blessing. While he is in hospice, the patient and chaplain speak regularly. Even as the patient becomes more somnolent and quiet, he affirms his legacy as an excellent and loyal friend.

Self-Worth and Belonging to Community

Background

Ms. Y is a woman in her sixties with a life-threatening cancer. She is in a loving and supportive relationship with her husband. She was raised as a Catholic and currently worships at a nondenominational Christian church. Her palliative care nurse practitioner referred her to the chaplain.

Assessment

The patient reveals that she has been keeping herself on a strict diet and has been using an enormous amount of supplements and vitamins because she wants to stay alive as long as possible for her husband. She expresses worry about her husband's well-being after she dies. She focuses on an arduous dieting regimen to the neglect of her own pleasurable activities, such as gardening and camping. She worries about whether she is following the diet correctly. She also misses her friends.

Chaplain's Awareness

The chaplain notices that the patient seems very interested in the chaplain's personal life. He feels sadness about the patient's extreme behavior to please her husband and thinks that it detracts from her doing what she enjoys.

Plan for Embodiment

The chaplain seeks to embody a valuer and community with the patient.

Interventions

The chaplain begins by attentively listening to the patient and affirming her desire and efforts to stay well. He acknowledges the patient's loneliness and her worry about the diet regimen. He surfaces her old belief that she must take a lot of vitamins and be strict with herself to be worthy in her husband's eyes. The chaplain's interventions are informed by the theology that he and the patient share in common—that the patient is a beloved child of God and that God is calling her to recognize this. Her old belief is that she needs to be engaged in this challenging regimen to be in community with her husband. In reality, she is inherently deserving of nurturing at this point in her life. The chaplain explores her anger with God, indicating to her that she is worthy and allowed to feel anger. He also explores the multiple facets of the patient's grief—at feeling lonely, at letting go of her old beliefs and practices, at her sadness that her life is coming to an end. The chaplain affirms and coaches the patient in self-advocacy, and in doing so the patient finds her voice to express her true feelings to her husband.

Outcomes

The patient acknowledges that she is feeling angry with God. This anger energizes her to claim her voice. She makes a decision for a new life, where she will ask for what she needs and do things she enjoys, such as spending time in the garden, with friends, and camping. She begins to feel more able to advocate for herself in relationships and treatment decisions.

Reconciliation and the Need to Love/Be Loved

Background

Mr. Z, a 58-year-old man, is brought to the emergency department with acute chest pain and is diagnosed with a myocardial infarction. The chaplain is called

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into the emergency department to meet with the patient. When the chaplain arrives, the patient is working on his laptop, is on his cellphone, and has an assistant by his side. The nurse enters, tells the patient to "stop all of that" and announces that the chaplain is here to see him.

Assessment

The patient almost immediately, and with minimal prompting, confesses to the chaplain that he is currently having an affair. He says that he believes that the affair is a great cause of stress and, ultimately, the cause of his heart attack. He expresses guilt and a desire to end the affair and repair his marriage. The patient expresses anger at the nurse for taking away his laptop and cellphone and sending his assistant out. Prior to this medical event, the patient was not taking responsibility for his part in the brokenness of his marriage.

Chaplain's Awareness

The chaplain notes her internal trepidation (her "gut reaction") that the patient might be challenging to create rapport with, based on the observed interaction with the nurse as well as his appearance of wanting to remain in control, even during a health crisis. Therefore, the chaplain is relieved when the patient readily acknowledges his stress and his part in his broken relationship with his wife.

Plan for Embodiment

The chaplain seeks to act as a "truthteller" by reflecting back the patient's honesty about his feelings of guilt, the stress this has created for him, and his need for forgiveness and reconciliation.

Interventions

The chaplain asks questions to encourage the patient to confess his part in creating brokenness in his life and marriage. The chaplain asks the patient to acknowledge his impact on others. The chaplain also assesses whether the patient is contrite. The chaplain acknowledges the patient's guilt and asks him to talk more about it, which encourages him to express contrition and remorse. Once the patient expresses true regret, the chaplain holds the patient accountable to identify and commit to new behaviors and make amends to his wife. She asks the patient to state how he will end the affair and what he will do to take specific responsibility for the brokenness in the marriage.

Outcomes

The patient expresses his emotions and sheds tears. The patient makes a commitment to make meaningful changes in his life. After several weeks and months of changed behavior, the patient is able to access self-forgiveness and receives forgiveness from his wife for his part in their estrangement.

DISCUSSION

Spiritual AIM is one of the few well-articulated spiritual assessment and intervention models to describe not only assessment, but also corresponding interventions and desired outcomes. Moreover, unlike the vast majority of existing models, it clearly articulates its underlying psychological and theological underpinnings.

Although there is no established, widely-agreed-upon standard for evaluating spiritual assessment models, Fitchett's framework is the most comprehensive for this purpose (Fitchett, 2002). Spiritual AIM does address the various criteria of this framework. For example, Spiritual AIM operates from a "holistic context"—that is, it recognizes the relationship between religion and other aspects of human life assumed and expressed in the model—for example, culture, personality, family, and health—rather than just focusing narrowly on religion.

Spiritual AIM is characterized by a number of unique features. First, it is based on a definition of spirituality that includes—yet is broader than—questions of meaning. This is important because we have discovered through clinical practice that many individuals define spirituality through other terms—including love, relationships, community, and belonging. While some might argue that these terms are in themselves dimensions of meaning, Spiritual AIM 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.

Furthermore, Spiritual AIM was developed as a **process** to occur in the context of the **relationship** between the chaplain and patient, a criterion also suggested by Lewis (2002). In addition, through its use of commonly used language (rather than restricting the model to theological language), Spiritual AIM translates effectively to the interdisciplinary team. In contrast, some models use exclusively theological language (LaRocca-Pitts, 2012; Pruyser, 1976), which may be challenging for healthcare professionals from other disciplines to relate to. Nevertheless, Spiritual AIM is grounded in a specific theological perspective that is inclusive of several faith traditions and based on commonly held values.

Few models identify desired outcomes of spiritual care interventions (Lucas, 2001; Peery, 2012). Art Lucas, Sue Wintz, and Brent Peery have been

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teaching outcome-oriented chaplaincy for years. Yet, the use of this type of chaplaincy has not been widely adopted by professional chaplains. However, in our view, just as every field of medicine must identify targets of interventions in order to measure effectiveness, chaplaincy needs to identify specific outcomes that can be assessed. The next steps for chaplaincy are therefore to develop reliable and valid assessment tools, to define and implement specific interventions targeted at specific spiritual needs, and to evaluate the outcomes of these interventions systematically.

It is important to note a number of critiques of Spiritual AIM. First, some chaplains—as well as other healthcare professionals—may react to the model's assessment of one "core spiritual need" as "labeling" or "putting people in a box." At least two responses can be made to this critique. To begin with, the model emphasizes the importance of making an assessment of one primary spiritual need in the service of designing and implementing specific interventions. In other disciplines, this is analogous to the importance of making a presumptive diagnosis or case formulation in order to design and implement a treatment plan. In plain terms, one must "put one's nickel down" in order to try to make progress in meeting the patient's needs. As noted previously, the patient's responses to the initial assessment and intervention may lead to a reassessment and new intervention based on a different core spiritual need. This is part of the process, just as other disciplines must remain open to new information that may shift the clinician's diagnostic thinking and illuminate other potential treatment options. Second, all healthcare disciplines categorize patients; this is nothing new. What may appear novel is the notion that even chaplains categorize patients. The model proposes a parsimonious categorization scheme based not only on years of experience working with this model and noting its utility, but also on the practical need to get to work in helping patients, rather than spinning one's wheels in making an assessment. Indeed, one strength of the model is the straightforward classification into three core spiritual needs; experienced chaplains can often make an initial assessment within minutes of meeting a patient.

A second criticism of the model has been leveled on the basis of its apparent reference to primarily Judeo-Christian or Western faith traditions. Some chaplains may not wish to "translate" the model into their own faith tradition. However, chaplains should be encouraged to claim their experience, theology, and spiritual practice, and to apply the model through that lens, with a critical eye. Chaplains can adopt the model's categories and interventions and yet have a different theological basis for doing so. The key point, however, is that chaplains should be able to articulate a spiritual assessment model, apply it appropriately in the clinical setting with the full range of patients, and communicate it effectively to the interdisciplinary teams with whom they work.

A related criticism is that Spiritual AIM's Christian origin may limit its effectiveness and adaptability with patients of certain non-Christian religious backgrounds, or with patients with no faith/religious background or practice. However, in several places, Spiritual AIM offers an open template that can be filled in according to a patient's background. For example, a patient with a core spiritual need for self-worth may demonstrate the outcome of "reports greater sense of belonging to community" (see Table 1) by joining a completely secular illness-related support group, or a spiritually focused, though not religious, mindfulness or guided meditation group. Or a chaplain may make an intervention marking an important decision made by a patient with a core spiritual need of meaning and direction by offering a blessing or ritual that is appropriate to that patient's religious background (Table 1). Moreover, it is our belief that chaplains can be grounded in their own philosophical and/or theological framework and yet also learn and use frameworks and methods that originate from different belief systems or philosophies. For example, chaplains already do this when they utilize a *psychological* theory or tactic adapted to their specific role. In addition, chaplains regularly, and often with great skill, enter into patients' unique worldviews and belief systems, including when those views or beliefs differ significantly from those of the chaplain. This is akin to physicians learning the "biomedical model" for providing care, while still needing to respect patients' individual beliefs about health and medicine. We encourage chaplains encountering Spiritual AIM, or any spiritual assessment model that is new to them and emanates from a theological framework different from their own, to draw on these aspects of their professional training.

Another criticism is related to the lack of systematic evaluation of Spiritual AIM against extant theories and frameworks for providing culturally competent pastoral and clinical care. Spiritual AIM was developed while ministering in multiple geographic areas and to diverse populations with regard to race, ethnicity, religion, culture, sexual orientation, religion, etc. (11 years in North Carolina, 3 years in Southern California, 18 years in San Francisco). However, it has not yet been evaluated in terms of frameworks and best practices for cultural humility in pastoral care and counseling (Visions Inc., 2013; Augsberger, 1986; Sue & David,

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2013). An important next step is to evaluate Spiritual AIM's viewpoint of patients' behaviors and chaplains' assessments and interventions through the rubric of several well-articulated and respected theories about culturally competent pastoral counseling (Bennett & Bennett, 1993; Warwick-Booth et al., 2012). This work would explore cultural nuances in Spiritual AIM—such as variations in communication styles and patterns, and how culture shapes patients' responses to illness (Bennett & Bennett, 1993; Warwick-Booth et al., 2012). It would also be useful to evaluate Spiritual AIM by replicating the above-mentioned study in a variety of settings and recruiting only for patients with a particular or no faith background.

An important next step is to articulate Spiritual AIM's viewpoint of patients' behaviors and chaplains' assessments and interventions with more detailed exploration of cultural nuances—such as variations in communication styles and patterns, and in how culture shapes how patients respond to illness (Bennett & Bennett, 1993; Warwick-Booth et al., 2012).

Despite these critiques, Spiritual AIM provides a foundation for further conceptual and empirical work. Additional conceptual work is needed to describe the similarities and differences between Spiritual AIM and other models used in healthcare settings, such as the biopsychosocial and biopsychosocial–spiritual models. How do assessments of patients' "core" needs differ across disciplines, for example, in the palliative care setting? Do professionals with different types of training and experience (e.g., physicians, chaplains, nurses, mental health providers) focus on different parts of the same patient's narrative, and can Spiritual AIM help focus the team on the most critical "core need" for a given patient? At the end of life, can Spiritual AIM be utilized by chaplains to provide brief interventions that improve the dying patient's final days and, in turn, help the patients' loved ones in their bereavement?

Empirical study of Spiritual AIM is also required in order to more explicitly describe the specific subjective and objective bases for assessment of the different core spiritual needs, as well as to identify which interventions are most effective, in what contexts, and for which patients. For instance, our research team is currently conducting a mixed-methods study to describe the content and processes of spiritual assessments and interventions conducted by chaplains among palliative care outpatients with advanced cancer.

Further work is also needed to evaluate the effective "dose" of spiritual intervention for given patients. In current clinical settings, the dose of spiritual care that each patient receives is more likely to depend on the patient's length of stay than on the patient's identified core spiritual need. While it is often thought that the process of transformation is a lengthy and difficult one, it is also possible that such change may occur even with one or several relatively brief interactions, such as was the case with Mr. Z described above.

CONCLUSION

In summary, some aspects of Spiritual AIM may appear bold—the specificity of making assessments, prescribing matching interventions, and delineating desired outcomes that describe healthy spirituality. In addition, **Spiritual AIM defines healthy spirituality as getting a person's core spiritual needs for meaning and direction, for self-worth and community, and to love and be loved all met**. Chaplains' sense of humility may constrain them from asserting that they can achieve such outcomes. In addition, some chaplains may prefer to remain "agenda-free" in their interactions with patients. Even the use of a model itself may be experienced as a potential threat to personal freedom, in that some chaplains prefer to "follow their pastoral intuition." While we recognize these concerns and agree that intuition can be a useful tool in the chaplain's toolkit, it is nevertheless crucial for chaplaincy to take on the obligations of a profession. As a profession, chaplaincy requires the use of a spiritual assessment model. Furthermore, like every healthcare profession, chaplains must formulate plans, communicate with the other members of the healthcare team, and strive to meet those desired outcomes. Spiritual AIM, like any model developed to guide health interventions, deserves scrutiny and empirical study. Moreover, chaplaincy will grow stronger as a profession by detailing its unique conceptual models, critically evaluating and refining these models, and designing and conducting model-based, hypothesis-driven research using rigorous methods.

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