spirituwell

SpirituWell's Approach to Spiritual Screening, Assessment, and Care Planning

An evidenced-based approach to spiritual care practice.

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Screening for Spiritual Care Referrals in Serious Illness Care

Background

Spiritual and existential distress are common yet frequently under-recognized dimensions of suffering among individuals living with serious illness. While board-certified chaplains are the specialists trained to assess and respond to these concerns, integration of spiritual care into healthcare delivery relies on a generalist–specialist model.

Within this framework, social workers, nurses, and other interdisciplinary team members—who are specialists in psychosocial and clinical domains—serve as generalists in identifying patients who may benefit from chaplaincy support.

Validated screening tools have shown promise in enabling non-chaplain clinicians to identify spiritual distress efficiently and equitably. Importantly, these tools are designed to recognize not only religious distress, but also the broader existential suffering experienced by many patients, regardless of their spiritual or religious orientation.

While much of the validation research originates from oncology populations, comparable unmet spiritual needs—such as loss of meaning, identity disruption, and difficulty coping—are well documented across a wide range of serious illnesses, including end-stage renal disease, heart failure, and chronic obstructive pulmonary disease.

Screening Methodology

We use a brief, two-item screening tool administered by a nurse, social worker, or other care team member during routine patient intake or psychosocial assessment. This tool adapts the 'King 2-Question Screener,'[1] replacing one item with a more sensitive and specific question identified by Labuschagne et al[2].

Screening	Referral Criteria
Screening Questions: 1. Do you struggle with the loss of meaning and joy in your life? 2. Does your religion/spirituality provide you all the strength and comfort you need from it right now? **Response Options**: • Not applicable • Not at all • Somewhat • Quite a bit • A great deal	**Referral Threshold**: A response to either question with any of the following should prompt referral to chaplain for spiritual care: • Somewhat • Quite a bit • A great deal

This screening approach is designed to be inclusive. The first question addresses existential domains—meaning, joy, and psychological-spiritual well-being—using secular language. The second question includes religious/spiritual language but frames it around support needs, allowing patients to respond based on personal beliefs, traditions, or philosophies. This pairing ensures that patients with religious affiliations and those who do not identify as religious can both be meaningfully assessed and referred.

Discussion

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[1] King, Stephen DW, et al. "Determining best methods to screen for religious/spiritual distress." Supportive Care in Cancer 25.2 (2017): 471-479.

[2] Labuschagne, Dirk, et al. "Testing items to screen for religious or spiritual distress in adult outpatient cancer care." *Supportive Care in Cancer* 33.3 (2025): 1-9.

1. Recognition of Distress Across Worldviews

Jang et al.[3] found that patients with non-cancer serious illnesses (e.g. chronic heart failure, stroke, end-stage renal disease, or end-stage liver disease) report moderate to high unmet needs in the psychological and spiritual domains—including loss of meaning, difficulty coping, and identity-related distress. These needs were not limited to religious individuals, underscoring the importance of using language and measures that detect a range of spiritual-existential experiences, including those not tied to formal faith traditions.

2. Alignment with the Generalist–Specialist Model

The generalist–specialist model designates non-chaplain team members as screeners (generalists) and chaplains as responders (specialists). This approach equips social workers and nurses—who already address quality-of-life domains—to identify when a deeper spiritual care need is present. The screening tool supports this model by using inclusive language and clear thresholds for referral, streamlining decision-making without requiring deep theological interpretation.

3. Inclusion Through Language and Structure

The pairing of questions intentionally balances existential and spiritual domains. The first question—"Do you struggle with the loss of meaning and joy in your life?"—is secular and accessible to patients regardless of belief system. It centers the patient's internal experience of meaning, a universal aspect of serious illness.

The second question—"Does your religion/spirituality provide you all the strength and comfort you need from it right now?"—is phrased to allow diverse interpretation. It neither presumes religiosity nor excludes it, offering room for belief, doubt, and spiritual longing.

This structure maximizes the tool's ability to capture a wide spectrum of distress while remaining concise and actionable.

4. Complementary to Spiritual History Taking

It is important to distinguish spiritual screening from spiritual history-taking. Many interdisciplinary teams already use tools such as FICA, HOPE, or institution-specific questions like "Is spirituality an important part of the patient's life?" or "Is the patient part of a spiritual community?" These yes/no questions are valuable for understanding a patient's background, beliefs, and spiritual identity. However, they are not designed to assess whether a patient is currently experiencing distress.

In contrast, spiritual screening—like the tool proposed here—is designed specifically to identify current unmet needs, including existential suffering, spiritual struggle, and disruption in sources of meaning or connection.

A patient may report that spirituality is important or that they belong to a community, yet still be in deep distress. Conversely, a patient who does not identify as religious may still benefit from spiritual care when facing profound questions of suffering, purpose, or loss.

For this reason, spiritual screening and spiritual history are best understood as complementary practices: history gathering helps build rapport and context, while screening helps triage patients who may need immediate support from chaplaincy.

5. Integration with Spiritual Care Assessment

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[3] Jang, Hyoeun, et al. "Unmet needs in palliative care for patients with common non-cancer diseases: a cross-sectional study." *BMC Palliative Care* 21.1 (2022): 151.

Patients who screen positive are referred to a professional chaplain for full assessment using the PC-7 framework. This validated model evaluates seven domains of spiritual need, supporting the development of personalized care plans and enabling coordinated documentation and response. The screening tool thus serves not as a diagnostic instrument but as a triage mechanism, efficiently connecting patients with the specialist support most appropriate to their situation.

Spiritual Assessment & Care Planning

Palliative Care

Background

Patients facing serious illness frequently experience complex spiritual and existential concerns, which range from questions of meaning and legacy to fears about death, relational strain, and religious or spiritual struggle. These concerns impact quality of life, emotional wellbeing, decision-making, and engagement with care, regardless of a patient's religious or spiritual identity. National palliative care guidelines emphasize the need for **comprehensive spiritual assessment** as part of a palliative care plan.

As part of an interdisciplinary palliative care team, a professional healthcare chaplain is equipped to assess and respond to spiritual and existential distress. To perform spiritual assessments, SpirituWell chaplains us the **PC-7 Spiritual Assessment**, an evidence-based framework designed specifically for use in serious illness and end-of-life care. The PC-7 enables chaplains to conduct open-ended yet structured spiritual assessments across seven domains.

SpirituWell chaplains use the PC-7 as part of a conversational assessment, not a checklist, guided by patient cues and clinical context. Following the assessment, the chaplain documents findings using standard terminology, creates a spiritual care plan aligned with the patient's needs and values, and communicates findings to the broader team to support coordinated, patient-centered care. This framework ensures that spiritual care is not only person-centered but also evidence-informed, accountable, and integrative.

Spiritual Assessment Methodology: Palliative Care – 7 (PC-7)

Description: The PC-7 is an evidence-based, quantifiable model for the assessment of unmet spiritual concerns of palliative care patients near the end of life.

The assessment is designed to be used by a chaplain as follows:

- The spiritual assessment is a structured, yet conversational format

- Chaplain will explore seven key domains, which include:

Assessment Method: Open-ended patient interview; intended to be an open-ended conversation, not a structured discussion. When the themes in the PC-7 have not been mentioned by the patient, chaplains might comment on the theme and inquire whether they are a concern for the patient being interviewed.

Key Domains Summary

- Need for meaning in the face of suffering
- Need for integrity, a legacy, generativity
- Concerns about relationships: family and/or significant others
- Concern or fear about dying or death
- Issues related to making decisions about treatment
- Religious/Spiritual struggle
- Other dimensions

Scoring: For each domain, a chaplain may assign a score based on the chaplain's determination of the patient's level of unmet spiritual needs at the end of the visit. Scoring is as follows:

- 0 = no evidence of unmet need
- 0* = no explicit evidence of R/S concern, but the chaplain feels further assessment is needed to confirm this
- 1 = some evidence of unmet need
- 2 = substantial evidence of unmet need
- 3 = evidence of severe unmet need

Appendix I: PC-7 Indicators of Unmet Spiritual Needs

Adapted from Table 1 from Fitchett et. al

Theme	Indicators (these indicators are meant to be suggestive, not exhaustive of the associated themes)
Need for meaning in the face of suffering	The patient is having difficulty coming to terms with changes in things that gave meaning to life (e.g., grief related to key relationships, illness, frailty, dependency). The patient expresses despair or hopelessness about these changes. (The focus here is on coming to terms with illness, loss, diminished quality of life, or other diminishment. If the issue is about the meaning of their life, then score under Legacy.)
Need for integrity, a legacy, generativity	The patient questions the meaning of life—whether the life he or she has lived has meaning. Patient has painful regret about some or all of life lived. (If the regret is about a relationship where reconciliation is possible, then score under Concerns about relationships.) The patient questions whether he or she has made a positive contribution to loved ones, others, or society. The patient has tasks that must be completed before he or she is ready to die. (If the tasks are interpersonal, score under Concerns about relationships.) Reminiscing about their life is painful for the patient. The patient is distressed about having lived an imperfect life. (If the regret, conflict, or discomfort focuses on current illness, score under Need for meaning in the face of suffering.)
Concerns about relationships: family	The patient has unfinished business with significant others (e.g., need to overcome estrangement, need to express forgiveness, need for reconciliation, and unfulfilled expectations about others). (Regrets about relationships where reconciliation is unlikely should only be

Theme	Indicators (these indicators are meant to be suggestive, not exhaustive of the associated themes)
and/or significant others	scored under legacy.) The patient has concerns about the family's ability to cope without him or her. The patient has concerns that he or she is a burden to family/friends. The patient expresses isolation or loneliness.
Concern or fear about dying or death	The patient has concerns about dying or being unready for death. This may include explicit hesitation, reluctance, or avoidance to consider or discuss mortality, or associated issues. (This refers to a general sense of unreadiness. If the unreadiness is expressed in terms of specific tasks, score under Need for integrity. If the unreadiness is expressed in terms of unfinished interpersonal tasks, score under Concerns about relationships.) The patient is impatient for death. The patient is concerned to participate in important events before death; the patient is concerned that illness or death will prevent participation in important events. The patient is torn between letting go and fighting on. The patient has uncertainty or fear about life after death (afraid of damnation; concerned about reunion with loved ones). The patient has fear of pain or of pain in dying.
Issues related to making decisions about treatment	The patient needs assistance with value-based advance care planning. The patient is confused or distressed about end-of-life treatment or about making choices about end-of-life treatment.
R/S struggle	The patient wonders whether he or she is being abandoned or punished by God. The patient is concerned about God's judgment, forgiveness, and/or love. The patient questions God's love for him or her. The patient feels God is not answering prayers (e.g., asking to die soon). The patient expresses anger with God. The patient is alienated from formerly meaningful connections with religious institutions or leaders.
Other dimensions	The patient identifies a need for assistance to perform important rituals, religious or otherwise. Other spiritual concerns.