Universal Library of Arts and Humanities Original Article

ISSN: 3064-9943 | Volume 1, Issue 4

Open Access | PP: 17-18

DOI: https://doi.org/10.70315/uloap.ulahu.2024.0104005

Linguistic and Listening Dimensions of FACT as a Tool for Assessing Spiritual Needs in an Acute Care Setting

Jim Schnell, Ph.D.

Fulbright Scholar Association, USA.

Abstract

Our understanding of health care chaplaincy practices continue to evolve in matters having to do with spiritual screening, histories and assessments. FACT, an acronym titled spiritual assessment tool, has been designed for chaplaincy use in acute care settings. Within the aforenoted FACT dynamics there is room for emphasis on linguistic variables. Language frames thought and so the language we use serves to frame the thoughts we process. It is subtle but it is concretely vivid. It is helpful to consider this phenomenon within the context of the hospital setting.

It is important for expressions of caring to be offered in language which is understood by the patient. That is, the chaplain needs to gauge the level of understanding which the patient is capable of and converse with the patient in a manner that is easily understood by the patient. The chaplain needs to consistently consider if his/her language level is appropriate for the receiver.

The chaplain's communicative role involves a ministry of dialogue. This makes language usage especially relevant. If the receiver is not familiar with the terminology used by the sender he/she has little to rely on regarding the interpretation of meaning, except contextual cues. The accuracy of these contextual cues may or may not be reliable. Thus, chaplain sensitivity with patient language norms is pivotal to his/her success in providing counsel.

Keywords: *Spiritual Care; Chaplaincy; Spiritual Screening; Linguistic Patterns; Patient Care.*

INTRODUCTION

Health care chaplaincy practices continue to evolve in matters having to do with spiritual screening, histories and assessments. FACT, an acronym titled spiritual assessment tool, has been designed for chaplaincy use in acute care settings. It stresses Faith, being Active in one's faith, Coping and having a Treatment Plan (LaRocca-Pitts, 2012). This article is in response to "FACT, A Chaplain's Tool for Assessing Spiritual Needs in an Acute Care Setting," by Mark LaRocca-Pitts that was published in Chaplaincy Today, 2012 (Volume 28, Issue 1), pages 25-32. It is intended to highlight the relevance of linguistic and listening dimensions that exist within such spiritual screening, histories and assessments.

LaRocca-Pitts (2012) clarifies that Faith poses the questions "What is your faith or belief? Do you consider yourself a person of Faith or a spiritual person? What things do you believe that give your life meaning and purpose?" Being "Active in one's faith" asks the questions "Are you currently active in your faith community? Are you part of a religious or spiritual community?" Coping addresses the questions "How are you coping with your medical situation? Is your faith helping you cope?" Treatment plan focuses on offering encouragement when the patient is coping well or offering paths to improvement if there are challenges to coping.

MATERIALS AND METHODS

Within the aforenoted FACT dynamics there is room for emphasis on linguistic variables. Language frames thought and so the language we use serves to frame the thoughts we process. It is subtle but it is concretely vivid. It is helpful to consider this phenomenon within the context of the hospital setting.

Herman K. Knodt, former Director of Pastoral Care at Grant Hospital (Columbus, Ohio), emphasizes the chaplain should speak the "patient's language". It is important for expressions of caring to be offered in language which is understood by the patient. That is, the chaplain needs to gauge the level of understanding which the patient is capable of and converse with the patient in a manner that is easily understood by the patient. One idea can be expressed at a variety of language levels (Knodt, 1986). The chaplain needs to consistently consider if his/her language level is appropriate for the receiver.

RESULTS AND DISCUSSION

The chaplain's communicative role involves a ministry of dialogue. This makes language usage especially relevant. If the receiver is not familiar with the terminology used by the sender he/she has little to rely on regarding the interpretation of meaning, except contextual cues. The accuracy of these

contextual cues may or may not be reliable. Thus, chaplain sensitivity with patient language norms is pivotal to his/her success in providing counsel.

The stress on language is a building block for the emphasis on dialogue. "It is a ministry of conversation, of the mutual exchange of ideas and feelings, both verbally and nonverbally . . . . All professions in the hospital engage in dialogue with patients. But it is done in concert with other services and activities. Dialogue is the primary service and activity of chaplains. If not done with sensitivity and skill, it leaves the chaplain with little else to offer" (Arnold, 1986, p. 1). It is an essential tool for the chaplain.

The effective chaplain will consistently seek ways to develop communicative skills that enhance the work of the health care team. These skills can serve to enhance the patient orientation process. The communicative role of the chaplain within the patient orientation process draws considerably on chaplain listening skills. Listening skills are a primary factor in enabling the chaplain to empathize with the patient's situation (Becker, 1985, p. 33). Unfortunately, listening is a communication behavior that seems to be taken for granted (Spearritt, 1962).

As a listener, it is important for the chaplain to respond to feelings expressed, rather than to the intellectual content of patient messages. This can be difficult, as ministerial training emphasizes the intellectualization of beliefs and the importance of finding the "truth" in terms of intellectually formulated propositions (Wise, 1951, p. 71). Thus, the chaplain must be aware of dynamics that can enhance his/her understanding of the patient's perceptions and work to benefit the patient with this awareness.

The chaplain listens to patient views about the hospital environment and policies as he/she helps the patient become oriented. Based on what is understood, he/she can be instrumental in minimizing patient anxiety by providing additional information and guidance regarding what will be happening during the patient's visit. For instance, "they'll get you up at 7:30 a.m., you will take a shower, they will give you an injection, and about a half hour later roll you down a long hallway. I will be with you when they take you from your room" (Knodt, 1986).

CONCLUSIONS

The linguistic and listening dimensions of the FACT model offer elaboration of key dynamics that operate within the FACT model. This article is intended to provide increased awareness of matters having to do with language and listening processes, both in consideration and practice. It is through this consideration and practice that we can sharpen usage of the FACT model and derive more relevant benefits from it.

REFERENCES

1. Arnold, J.P. "Patient, Family, Staff Communication: A Chaplain's Perspective". Paper presented at the "Communicating With Patients" conference, University of South Florida, 1986.
2. Becker, A.H. The Compassionate Visitor. Minneapolis, Minnesota: Augsburg Publishing, 1985.
3. Knodt, H.K. Personal interview with Director of Pastoral Care, Grant Hospital (Columbus, Ohio), May 9, 1986.
4. LaRocca-Pitts, M. "FACT, A Chaplain's Tool for Assessing Spiritual Needs in an Acute Care Setting," Chaplaincy Today, 2012 (Volume 28, Issue 1), 25-32.
5. Spearritt, D. Listening Comprehension--A Factual Analysis. Melbourne, Australia: G.W. Sons, 1962.
6. Wise, C.A. Pastoral Care: It's Theory and Practice. New York, New York: Harper and Brothers, 1951.

Citation: Jim Schnell, "Linguistic and Listening Dimensions of FACT as a Tool for Assessing Spiritual Needs in an Acute Care Setting", Universal Library of Arts and Humanities, 2024; 1(4): 17-18. DOI: https://doi.org/10.70315/uloap.ulahu.2024.0104005.