

Debate & Analysis

Spiritual needs assessment:

the LOADS SHARED mnemonic

INTRODUCTION

It has been suggested that offering spiritual care may be one aspect of holistic patient management.¹ Most GPs acknowledge the central place that spirituality occupies in personhood, with the bi-directional relationship between spiritual wellbeing and physical health often being evident in our consultations.² Many patients are conscious of their spiritual needs and that these may require therapeutic input.³

Several spiritual care therapies have been developed to respond to these observations. Community Chaplaincy Listening (CCL) and Primary Care Chaplaincy (PCC) have been more recently described in the UK.⁴⁻⁶ PCC, for example, seeks to help patients address their deepest inner needs and find meaning, purpose, and orientation towards the transcendent. The emerging evidence base for PCC is gaining momentum, specifically in terms of its efficacy, relevance as a talking therapy, ability to respond to varied and complex presentations, and reduction in GP workload.^{4,5}

SPIRITUAL NEEDS ASSESSMENT

It seems then that there is a need for GPs to be able to assess the spiritual needs of their patients. Various tools (including FAITH, FICA, HOPE, and FACT) exist to facilitate the process of spiritual history taking.⁷ Do these tools, however, assess spiritual needs?

Each tool shares three basic elements: Does the patient have a belief system (spiritual or religious)? Does the patient have any personal spiritual practices? And are they part of a faith community? Each tool then addresses how the patient's spiritual views affect their medical care. The ultimate aim of these tools is to act as a conduit to accessing relevant spiritual care. Undoubtedly, they have their role in this function. But do they assess spiritual needs? It could be argued that these tools determine how the patient perceives or defines their spirituality rather than assessing their spiritual needs.

UNINTENDED CONSEQUENCES OF EXISTING TOOLS

It is possible that these existing tools are only helpful for those who identify as spiritual. However, spirituality may best be seen as a universal human experience, with patients having spiritual needs: a need for love, meaning, purpose, and

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connection, irrespective of their conscious or subconscious worldview.⁸

Although the current tools facilitate care and onwards referral for those patients who recognise their spirituality, they may hinder such input for those with spiritual needs who do not describe themselves as spiritual. We may therefore be at risk of failing to identify and care for the spiritual needs of many patients.

CUES TO A BETTER WAY

Perhaps a more person-centred approach may be useful? Perhaps a more inductive model that starts with themes emerging from the patient's narrative, as opposed to a deductive model that applies specific questions to each patient?

We teach our trainees to respond to 'cues' as part of good consulting and recognise the value of cues in our interactions with patients.⁹ Cues can be both verbal and non-verbal, and point towards issues of importance for the patient. Spiritual needs may be presented as cues within the consultation. If such cues are attributed to spiritual needs, this may facilitate ongoing spiritual care or referral regardless of the patient's predefined spirituality.

But what are these cues? Is there any theory or evidence supporting them and how can they be recognised?

MASLOW'S HIERARCHY AND HANLON'S MODERN MALADIES

Some expressions of PCC have been based on a fusion of Maslow's hierarchy of needs and Hanlon's modern maladies.^{4,5} Maslow describes a hierarchy of ascending needs: from the physiological to the transcendent.¹⁰ He suggests that those who are ultimately fulfilled move beyond their personal needs

for significance, security, and self-esteem towards transcendence. If this premise is accepted, it could be said that transcendent or spiritual needs may be more evident when these personal needs are either over-relied on or unmet. Hanlon's thesis is that we have moved through various phases of public health (commencing with great public works such as a clean water supply through to risk factor theory and control of disease) and the health crises we now face are: *loss of wellbeing, obesity, addictive behaviours, and depression/anxiety*.¹¹ These maladies, he argues, have arisen within the societal philosophical milieu of reductionism, individualism, and consumerism, which potentially weaken concepts such as spirituality and may in fact contribute to the conditions necessary for such ailments. Hanlon's suggested response includes a transition from a '... *mechanistic understanding ... to enabling the growth of what nourishes human life and spirit ...*'. If he is correct it may be justifiable to see the above maladies as potential cues, associated in some patients with unmet spiritual needs, arising from a breakdown in Maslow's hierarchy.¹⁰

REASONS FOR REFERRAL TO PRIMARY CARE CHAPLAINCY

Research into PCC and other similar iterations of chaplaincy including CCL have identified several recurring presenting symptoms or reasons for referral.⁴⁻⁶ Presenting symptoms include the expected issues of *bereavement, relationships, and negative life events*. Issues of *guilt, shame, regret, self-image, social isolation, and employment* were also common presentations. Given the frequency of these issues across the research, it is

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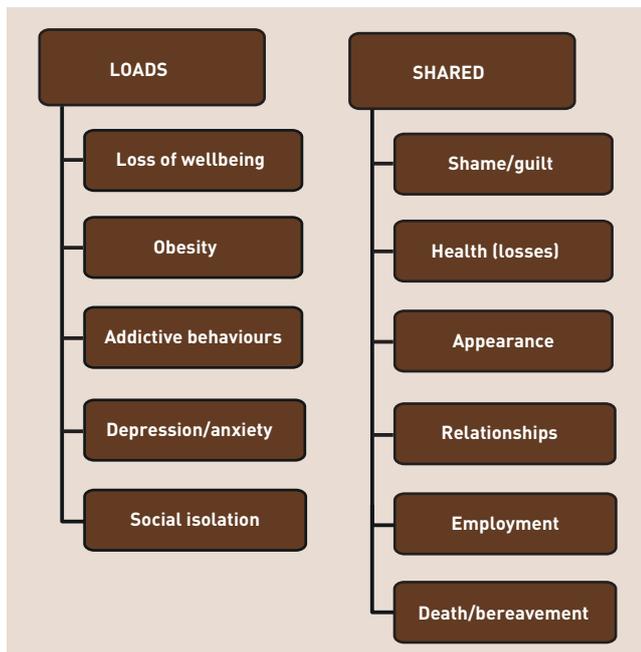


Figure 1. LOADS SHARED mnemonic.

suggested that these symptoms may also act as cues highlighting in some patients a potential association with an underlying spiritual need, again possibly arising from an interruption of Maslow's hierarchy.

BENEFITS OF SHARING LOADS

The cues recognised from research can be combined with Hanlon's maladies and may usefully generate the following mnemonic: LOADS SHARED (Figure 1).

As with any mnemonic it is easy to remember and, in this case, also hints at the purpose of assessing spiritual needs.

More importantly, though, this model allows clinicians to naturally respond to these spiritual cues as part of their normal consultation. This approach avoids the more tick-box questionnaire approach of some of the existing tools and remains a clinical skill within the realms of most consultation models.¹² This seems to sit well within the primary care context as with time and continuity we gain insights into the patient's psychosocial-spiritual context and can afford to rely less on the above (more direct) tools that may lend themselves more to a secondary care environment.

This cues-based model is also more accessible for patients and their doctors. Patients defined as non-spiritual by the

existing questionnaires will still be able to have their spiritual needs assessed. GPs may feel constrained by time or unprepared to take a spiritual history using the existing questionnaires, but most would feel able to respond to cues and signpost to PCC or equivalents.

POTENTIAL CHALLENGES

It is possible that utilising this tool may identify spiritual needs in patients who initially neither identify as spiritual nor desire spiritual care.

It is however possible that, having tested patient understanding and acceptance of concept, spiritual care could be shared as one management option. This may then be viewed as a similar approach to the other lifestyle interventions we suggest in our consultations.

CONCLUSION

LOADS SHARED may be a useful cues-based spiritual needs assessment mnemonic for GPs. It has a number of advantages over existing questionnaires and may provide a realistic approach that is already embedded within good consulting.

If this model is to gain traction and consequently maximise patient benefit it will require education at both undergraduate and postgraduate level. Finally, as utilisation of this mnemonic may result in increased signposting to spiritual care therapies such as PCC, there is a need to increase the provision of such services.

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Provenance

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