Spiritual Assessment, Pastoral Diagnosis, and Pastoral Prescription

Discerning, naming, and responding to spiritual need in pastoral care.

Assessment → Diagnosis → Prescription

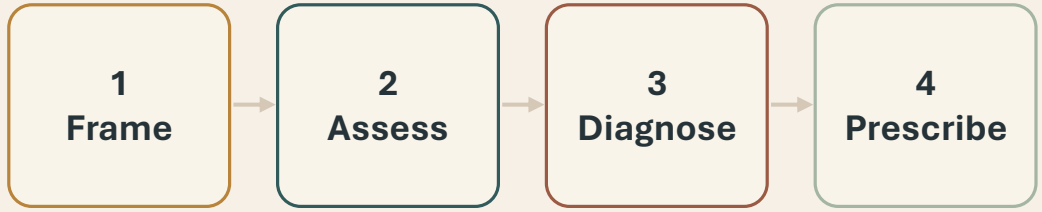
Learning objectives

What participants should be able to do by the end

LEARNING OUTCOMES

Distinguish spiritual assessment, pastoral diagnosis, and pastoral prescription.
Use a multidimensional assessment lens without reducing persons to instruments.
Formulate a theologically grounded, ethically bounded pastoral care plan.
Apply the model to a case while recognizing referral and collaboration needs.

30-MINUTE FLOW



The method is recursive: new information may revise diagnosis; new pastoral response becomes part of further assessment.

Core posture: listen before naming; name before intervening; intervene with humility and accountability.

Why this matters: spiritual care is never neutral

Pastoral care interprets suffering, hope, identity, and vocation

IN THE ROOM

People bring explicit and implicit theology: God-images, guilt, hope, lament, covenant, vocation, shame, forgiveness, belonging.
Caregivers also bring theology: assumptions about agency, suffering, healing, sin, grace, justice, and the good life.
Without disciplined reflection, pastoral care defaults to intuition, cliché, personal preference, or avoidance.

A graduate-level pastoral method makes the implicit explicit—so it can be examined, revised, and practiced responsibly.

The working model: discern, name, respond

A practical-theological cycle for pastoral care

The cycle remains accountable to the careseeker, community, tradition, and interdisciplinary standards of care.

Theological foundations: what kind of “seeing” is pastoral?

Diagnosis is shaped by doctrine, anthropology, and ecclesial practice

A THEOLOGICAL ANTHROPOLOGY FOR CARE

Imago Dei: the person is more than pathology, sin, role, or crisis.
Incarnation: care attends to embodied, social, and material realities.
Pneumatology: discernment expects divine agency without controlling it.
Ecclesiology: healing is often mediated through community, memory, ritual, and justice.

Pastoral diagnosis should never collapse mystery into mastery. Its purpose is faithful accompaniment, not spiritual control.

Spiritual assessment: disciplined listening for sacred meaning

Not a checklist, but an interpretive conversation

Spiritual assessment asks:

MEANING	What gives this life or crisis significance?
CONNECTION	Who or what holds the person in belonging?
IMAGE OF GOD	How is the Holy, ultimate, or sacred imagined?
PRACTICE	What rituals, prayers, texts, silences, and habits sustain or wound?
AGENCY	Where is there freedom, constraint, calling, or despair?

The goal is not to “extract data” but to hear how the careseeker narrates God, self, others, world, and future.

A multidimensional assessment map

Five domains for graduate-level pastoral listening

Narrative
dominant plot, rupture, lament

Relational
attachment, community, isolation

Careseeker story

Ritual-practical
prayer, sacraments, habits, symbols

Moral-vocational
guilt, shame, calling, repair

Theological
God-images, hope, providence, evil

Use the map flexibly. The same crisis may look different depending on which domain is foregrounded.

Assessment tools: useful scaffolds, not substitutes for wisdom

FICA, HOPE, 7×7, genograms, and narrative questions

RAPID SCREENS

FICA
Faith/belief · Importance · Community · Address in care

HOPE
Sources of hope · Organized religion · Personal practices · Effects on care

DEEPER MAPS

7×7
Seven holistic dimensions crossed with seven spiritual dimensions; especially helpful in chaplaincy documentation.

Spiritual genogram
Traces religious inheritance, ruptures, loyalties, conflicts, and resources across generations.

WISDOM QUESTIONS

What must not be misunderstood about your faith or spiritual life?
What language would feel respectful—or disrespectful—right now?
What has helped before, and what has harmed?

Graduate practice: choose the tool that fits the setting, culture, urgency, and consent of the careseeker.

Pastoral diagnosis: naming the spiritual pattern in care

Discernment that guides action without reducing mystery

A WORKING DEFINITION

Pastoral diagnosis is a tentative, theologically informed interpretation of the careseeker's spiritual condition, conflict, resource, or need—formed for the sake of faithful care.

IT IS NOT

a clinical DSM diagnosis
a moral verdict
a shortcut to advice
a claim of certainty

IT IS

an interpretive hypothesis
a theological lens
a guide for care
a focus for supervision

Differential discernment: similar presentations, different care

Avoid one-size-fits-all pastoral interpretations

Grief / lament

Anger, numbness, bargaining, ache for presence

Moral injury

Betrayal, complicity, shame, loss of moral coherence

Spiritual struggle

Alienation from God, religious doubt, conflict with community

Clinical depression

Anhedonia, sleep/appetite changes, hopelessness, suicidality risk

Trauma response

Hypervigilance, dissociation, embodied fear, control needs

Systemic harm

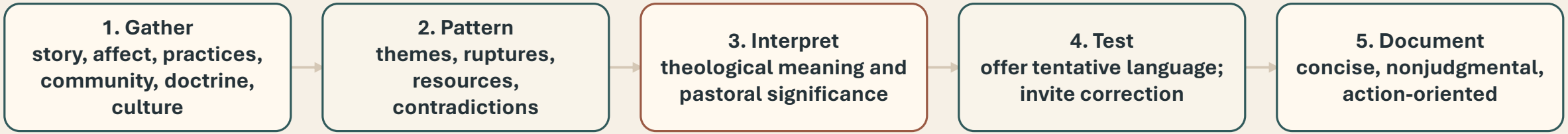
Racism, poverty, exclusion, abuse, religious trauma

The same sentence—“God has abandoned me”—may signal lament, depression, trauma, spiritual struggle, or inherited doctrine. Diagnosis requires careful differential listening.

Safety note: any indication of self-harm, abuse, psychosis, or severe impairment requires immediate protocol, consultation, and referral.

How to formulate a pastoral diagnosis

From data to interpretation to collaborative language



FORMULA

“In the context of [situation], the careseeker appears to be experiencing [spiritual pattern/need], marked by [evidence], with resources in [strengths], suggesting pastoral attention to [direction].”

Good diagnoses are: humble, revisable, specific, trauma-aware, culturally responsive, and linked to action.

Ethics: diagnosis and prescription require boundaries

Power, consent, confidentiality, competence, and collaboration

CONSENT	Ask permission before explicitly spiritual questions, prayer, touch, ritual, or contacting religious/community supports.
COMPETENCE	Stay within training; consult and refer for clinical, legal, medical, or safety issues.
POWER	Do not use doctrine, role, or sacramental authority to pressure compliance.
CULTURE	Avoid assuming Christianity, orthodoxy, family norms, or preferred religious language.
CONFIDENTIALITY	Know mandated reporting, institutional policy, documentation standards, and pastoral privilege limits.

Ethical pastoral prescription asks: “Would this response increase freedom, truthfulness, safety, and connection—or compliance and dependency?”

Pastoral prescription: a co-created, faithful next step

From diagnosis to practices, supports, and accountability

A pastoral prescription is not "what I would do."

It is a fitting pastoral response that emerges from assessment, diagnosis, tradition, context, consent, and capacity.

PRESCRIPTION MUST FIT

the spiritual diagnosis
the careseeker's tradition and agency
the level of crisis and safety
the community and system involved
the caregiver's role and competence

A menu of pastoral prescriptions

Match intervention to diagnosis, not anxiety

FOR LAMENT

psalms of lament · permission for anger · ritualized grief · companioned silence

FOR SHAME

grace-based reframing · confession without humiliation · embodied blessing · safe community

FOR MORAL INJURY

truth-telling · accountability · repair · lament · reconciliation only when safe

FOR ISOLATION

belonging plan · one trustworthy contact · worship re-entry · community mapping

FOR DISTORTED GOD-IMAGE

gentle theological exploration · counter-narratives · spiritual direction · careful scripture

FOR TRAUMA-RELATED DISTRESS

stabilization · choice · grounding · referral · avoid forced disclosure or spiritual bypass

Avoid “prescribing” practices that intensify scrupulosity, shame, dependency, or religious trauma.

Case study: Mara

A composite case for applying the model

Mara, 37, is caring for her father after a sudden stroke. She has stopped attending worship and says, “I know I should trust God, but I feel punished and angry. Prayer feels fake. My siblings say I’m bitter. I’m exhausted and ashamed that I resent him.”

She sleeps poorly, misses work, and has one trusted friend. She denies suicidal intent but says, “I don’t know how long I can do this.”

CLASS TASK

What would you assess first?
What might be spiritually at stake?
What diagnoses would you consider—and rule out?
What prescription would be faithful, ethical, and concrete?

Hold the tension: Mara’s anger may be a holy protest, a grief response, caregiver burnout, depression risk, or a shame-laden theology of punishment.

Mara: spiritual assessment map

What we know, what we need to ask, what must be held carefully

KNOWN DATA

anger at God
prayer feels fake
caregiver exhaustion
family criticism
shame and resentment
one trusted friend

ASK NEXT

safety and support
sleep/work impairment
prior losses and theology of suffering
history of prayer/worship
family system and resources
what “punished” means

HANDLE CAREFULLY

do not silence anger
do not rush forgiveness
assess depression/burnout
avoid blaming her faith
honor caregiving burden
collaborate/referral as needed

Assessment conclusion: Mara needs both spiritual permission for lament and practical/clinical support for caregiver strain.

Mara: diagnosis and prescription

A tentative pastoral formulation and care plan

TENTATIVE PASTORAL DIAGNOSIS

In the context of caregiving crisis and family criticism, Mara appears to be experiencing unresolved lament, shame-laden resentment, and a punitive God-image, marked by withdrawal from worship and prayer avoidance, with resources in honesty, moral concern, and one trusted friend.

INITIAL PRESCRIPTION

Stabilize
Assess risk, sleep, caregiving load; identify respite and referral options.

Authorize lament
Frame anger as a biblical form of truthful prayer, not faith failure.

Practice
Invite a brief non-performative prayer: "God, this is what is true today."

Community
With consent, help name one concrete support request to trusted friend or church.

Follow-up
Review whether the plan reduces isolation, shame, and burden within one week.

Referral threshold: worsening impairment, suicidal ideation, trauma activation, or major depression symptoms require coordinated clinical care.

Evaluation: how do we know the prescription is helping?

Pastoral care requires feedback, supervision, and revision

OBSERVE CHANGE IN

spiritual language: more truthful, less coercive, more hopeful?
practice: sustainable prayer, ritual, community, repair, or rest?
agency: increased choice, safety, clarity, and support?
relationships: less isolation, more appropriate boundaries?
risk: reduced distress—or need for higher level care?

Supervision question: “What in me wants this diagnosis or prescription to be true?”

Documentation: concise, observable, nonjudgmental, and linked to the stated plan.

Cultural humility and interfaith responsibility

Assessment and prescription must fit the person, not the caregiver

Three commitments

1. Ask before interpreting
Let the careseeker define sacred language, community, and what counts as help.

2. Locate power
Notice race, gender, class, sexuality, disability, colonial history, and institutional authority.

3. Prescribe within consent
Offer practices compatible with the careseeker's tradition, conscience, and desired level of spiritual engagement.

Pastoral care can be deeply confessional without being coercive: the caregiver's integrity and the careseeker's agency must both be honored.

Integrated workflow for practice

A repeatable structure for pastoral encounters

Attend

presence, safety, consent

Assess

story, theology, practice, community

Diagnose

tentative pattern and resources

Prescribe

fit response with consent

Evaluate

feedback, supervision, revise

Two checks must run throughout: safety/clinical referral and theological/ethical accountability.

Graduate habit: move slowly enough to know what you are doing—and why.

Graduate reflection exercise

Five minutes of synthesis or post-presentation discussion

PROMPT

Choose a real or imagined pastoral encounter. Write one sentence for each part of the triad:

Assessment: What is spiritually at stake?

Diagnosis: What tentative pattern names the need and resources?

Prescription: What one faithful next step fits consent, safety, tradition, and capacity?

Share in pairs: where might your formulation need more humility, evidence, or ethical restraint?

Selected sources for further study

Representative works behind the model

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