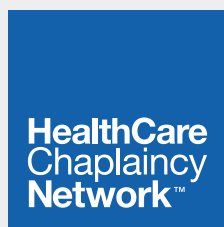


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Spiritual Care and Social Work: Integration into Practice



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HealthCare Chaplaincy Network™ (HCCN), founded in 1961, is a global health care nonprofit organization that offers spiritual care-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Its mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve patient experience and satisfaction and to help people faced with illness and grief find comfort and meaning--whoever they are, whatever they believe, wherever they are.

The Spiritual Care Association (SCA) is the first multidisciplinary, international professional membership association for spiritual care providers that includes a comprehensive evidence-based model that defines, delivers, trains and tests for the provision of high-quality spiritual care. Membership is open to health care professionals, including chaplains, social workers, nurses and doctors; clergy and religious leaders; and organizations. SCA, with offices in New York and Los Angeles, is a nonprofit affiliate of HealthCare Chaplaincy Network.

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INTRODUCTION

Whole-person healthcare requires attention to more than the strictly medical aspects of care. Quality clinical care includes expert attention to all of a patient's quality of life, including the biological, psychosocial, social, and spiritual domains, referred to in social work as the biopsychosocial spiritual domains of assessment that often includes an affective or emotional component.¹ Historically, the focus on the medical model of care has led to an almost exclusive focus on the physiological aspects of care. For the multidimensional aspects of the patient experience to be addressed, the approach must broaden and deepen, with healthcare providers possessing the training, skills, competency, and confidence necessary to recognize and attend to strengths, hopes, and distress within each domain.

In order to provide whole person care, or what the National Academy of Medicine² calls Family- and Patient-Engaged Care, healthcare providers must recognize that illness and injury, particularly when serious, impacts not just the body, but the quality of life of the entire person as well as that of their family. This is inherent in the work of the social worker who is trained to understand the person as being within their environment - of which family is an extension. This level of care is best delivered through an interprofessional, collaborative team approach, with all members of the healthcare team competent to screen for strengths, resources, history, beliefs, values, and distress across all of the quality of life domains.³

"If we [every professional caregiver] do not have an awareness of the person in all of his or her dimensions, we cannot effectively attend to and put in appropriate context the dimension for which we have special responsibility."⁴⁰

To do so, healthcare clinicians must receive the professional education necessary to incorporate whole person care into their practice. There is a growing recognition of the potential negative impact of ignoring the psycho-social-spiritual determinants of health - including spiritual, religious and existential beliefs, values, and practices. In 2016, HealthCare Chaplaincy Network™ (HCCN) released the white paper *SPIRITUAL CARE: What It Means, Why It Matters in Health Care*.⁴ This paper, a fundamental resource for healthcare clinicians of all disciplines, articulates the importance of identifying religious and spiritual strengths and resources and addressing religious and spiritual concerns.

Social Work has both historical and philosophical connections to spirituality since its inception.⁵ The Charity Organization Society, founded in 1869 in Britain, made a deep impact on social work through its focus on families and development of a codification of methods to determine the claims and needs of potential clients.⁶ Social Work pioneer Jane Addams founded Hull House in 1889 out of her humanitarian and religious beliefs, viewing it as a "cathedral of humanity" "capacious enough to house a fellowship of common purpose."⁷ Mary Richmond, viewed as a cornerstone in building the profession of social work, developed what she called "social diagnosis"⁸ and constructed the foundations for a more structured casework based on theoretical and practical applications within the profession. Social work and other religiously based social service organizations such as Catholic Social Services, Lutheran Social Services, and Jewish Social Services have long been united in their concern for and service provision to disenfranchised populations.

While social work began with an emphasis on spirituality, the field evolved to consistently ignore it throughout an extended period of its history, often as a way to advocate for professional legitimacy and acceptance.⁹ The current standards of the Council on Social Work Education include religion and spirituality as part of Competency 2: Engage Diversity and Difference in Practice.¹⁰

Specialized training regarding the integration of spirituality into social work practice has been somewhat limited and inconsistent. Recently, however a growing number of Master of Social Work programs, including all five of the top ranked graduate schools identified in a 2016 US News and World Report's assessment of MSW programs, include courses or workshops on spirituality.¹¹ Spirituality is now formally recognized as a core dimension of assessment and intervention in social work. Likewise, culturally competent social work practice includes the demonstration of knowledge, skills, and attitudes to address spirituality.^{12 13 14}

“Spirituality is now formally recognized as a core dimension of assessment and intervention in social work.”

This paper will provide social workers guidance in better understanding the importance of spirituality, how to integrate appropriate spiritual care into their clinical practice, and ways in which to work collaboratively with board certified chaplains. Social workers play a potentially significant role in addressing the spiritual needs of patients. The discussion that follows is applicable to all settings in which social workers practice, but is especially relevant for social workers in hospitals, primary care outpatient settings, psychiatric, rehabilitation or skilled nursing facilities, home healthcare, and both inpatient and home palliative care or hospice.

It is important as we begin this discussion to acknowledge that there is a certain lack of consensus in terms of definitions, professional scope of practice and role differentiation between the professional healthcare social worker and the professional healthcare chaplain. There are even functionally parallel bodies of research and subsequent terminology, paradigms, and self-understandings within each profession about spiritual care as a domain, and how concretely each profession seeks to address it in those they serve. In many ways, the research and discussions have occurred within profession-specific siloes, with social workers reading research and discussions about spirituality and spiritual care written and published by social workers, and chaplains doing the same with research and publications by chaplains. This has led to some confusion when each profession seeks to engage the other. Difference exists in terminology, as will be discussed regarding spiritual screens, spiritual histories, and spiritual assessments (all “chaplaincy” terms), and brief spiritual assessments and comprehensive spiritual assessments (social work terms) more the framework used within the social work literature on the topic.

Importantly, however, there are no fundamental or irreconcilable points of tension between social work and chaplaincy when it comes to the provision of spiritual care to patients, families, and staff. Clear communication, clarification of scope of practice (both as professions and in idiosyncratic clinical circumstances), and a collaborative sense of team work with an emphasis on spirituality as a vital domain of care can yield constructive dialogue between the chaplain and the social worker. This paper will not resolve all such issues to everyone's satisfaction. Rather, it does seek to offer a starting place for continued interprofessional dialogue around spirituality and spiritual care. The hope is to encourage cross-pollination, better understanding for both social workers and chaplains of the current state of the research from within both professions, and from that base to foster continued joint efforts to find common ground, common understanding, and common purpose from which chaplains and social workers can collaborate to effectively address spirituality and spiritual care within healthcare.

SPIRITUALITY AND RELIGION

The religious beliefs of the people in the United States are complex and multifaceted. A 2016 survey by the Gallup organization revealed that 89% of people believe in God,¹⁵ while 70.6% claim Christianity as their faith heritage.¹⁶ 5.9% are of non-Christian faiths (Jewish, Muslim, Buddhist, Hindu, and other world religions).

However, the share of U.S. adults who say they believe in God, while still remarkably high compared to other advanced industrial countries, has declined modestly in the past decade.¹⁷ A growing number of Americans, roughly 23 percent, are religiously unaffiliated, including some who self-identify as atheists or agnostics. Thirty-seven percent of the population describe their beliefs as “spiritual but not religious”. This should not, however, be interpreted as persons finding beliefs, values, and practices as unimportant or irrelevant. Rather, each person should be provided the opportunity to describe what is significant to them and how they experience it. Individuals who eschew religious or spiritual terms often identify as secular humanist, a term that many find preferable to identifying oneself by that which one is not, such as atheist or agnostic.¹⁸

Spirituality, while also complex and multi-faceted, provides people with guidance and support for approaching life’s joys and challenges through both personal and community experiences.¹⁹ It is experiential in nature, but can also include or be revealed in neurophysiological, cognitive, characterological and behavioral expressions. Key themes include the quest for meaning and purpose; the experience of amazement or awe, mystery, and transcendence; and the understanding of what it means to live in community. Other spiritual themes include the yearning to seek integration, integrity and connectedness, the inherent capacity for transformation, experiences of a transpersonal nature - including experiencing connections with deceased loved ones, transcending ordinary boundaries of self, space, and time, creating openness - and expanding awareness. Spirituality can include formal religion, embracing beliefs that are sacred to the individual, cultural values and practices, or a combination of each. There is a great deal of diversity in definitions of spirituality and religion. Within healthcare, a 2009 international panel of medical, psychological and spiritual care experts provided the following articulation of a consensus definition of spirituality that is widely accepted:

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices.²⁰

While spirituality is expressed through beliefs, values, and personal traditions and practices,²¹ religion, for the sake of this paper, will be defined as:

A subset of spirituality, encompassing a system of beliefs and practices observed by an individual within a community, supported by rituals that acknowledge, worship, communicate, or approach the Sacred, the Divine (in Western cultures), or Ultimate Truth, Reality, or nirvana (in Eastern cultures).²²

Like spirituality, religion is also multidimensional. While religion addresses existential concerns, it also provides personal as well as social identity within a communal expression that has had stability over time through its history and traditions. It specifies or requires certain behavioral patterns and encourages believers to practice specific forms of religious expressions, such as rituals, worldviews, and a set of moral and ethical beliefs and practices. Religion helps people make sense of their world and provides motivation, joining them together with a community of others who share a great proportion of their beliefs and values.

“Spirituality, while also complex and multi-faceted, provides people with guidance and support for approaching life’s joys and challenges through both personal and community experiences.”

Some readers may disagree with these definitions of spirituality and religion. This arena is somewhat controversial in the literature, and there is no universally-accepted and agreed-upon definition of either concept, including how they relate to one another. These two have been chosen because of their breadth, clarity, and reputation of their authors. Most importantly, clinicians should recognize the necessity to work within the context and with respect for those they serve in order to mirror the language by which persons choose to define their own experience, beliefs, values, and practices.

To summarize, according to the definitions above:

Spirituality refers to our inner belief system; the core of our being. It is a delicate 'spirit-to-spirit' relationship to oneself, and the God of one's understanding. Everyone is a spiritual being.

Religion refers to the externals of our belief system: community worship, prayers, traditions, rites, and rituals that point a person to an experience and relationship with the Divine, however the persons defines it. Not everyone is religious.^{23 24}

Patients and families “consistently voice a desire for basic spiritual care that includes active listening, empathic communicating, and expressing compassion.”

Viewing spirituality in this broader context allows the healthcare provider to also explore issues of culture and identity that are often synergistically impacted by the myriad of changes induced by illness or injury, and are accentuated even more as patients face serious illness, chronic life-transforming conditions, or end-of-life.^{25 26} Many people turn to and/or explore their spiritual and religious resources when faced with an illness or hospitalization.²⁷ It is important for healthcare providers to understand that as illnesses progress or complications occur, patients may find themselves contemplating their legacy and meaning or purpose with thoughts about transcendence and transformation becoming increasingly urgent.^{28 29} Family members and patients often also find themselves struggling with spiritual, religious and existential concerns from the time of diagnosis into anticipatory grief, and finally bereavement.³⁰ Lunn offers useful insight into various belief systems and how they might impact a person's journey in healthcare settings, and suggests that the common denominator among the various perspectives is that each one “helps to draw the adherent to their center or essence”³¹ even in the midst of disruption which leads to an existential quest and growth.^{32 33}

INTERPROFESSIONAL COLLABORATION

Interprofessional care models acknowledge that the sharing of roles is not unusual, particularly in healthcare.³⁴ There may be significant role overlap with collaborating team members who are expected to have some level of competence to address the numerous concerns of diverse patients. And the ability to provide expert, specialized services within one's own discipline's scope of practice is vital to optimal holistic care of patients.³⁵ It is important to function within one's scope of practice, professional role, and areas of competence, and to communicate and refer pro-actively when one's role overlaps with the expertise of another healthcare professional on one's team. It is essential for teams to practice reflection, clear and consistent communication, build respect within the team, and for professionals to remain fluid to meet patient needs.^{36 37}

While patients may not expect their physicians, nurses, social workers, therapists, and other clinicians to provide in-depth, specialized spiritual care, they do consistently voice a desire for basic spiritual care that includes active listening, empathic communicating, and expressing compassion.³⁸ Ideally, all members of the healthcare team can learn to screen for spiritual

strengths, hopes, needs, and practices, to incorporate basic spiritual resources and interventions into the patient care plan³⁹ that take into account the idiosyncratic ways the patient expresses needs and beliefs.⁴⁰ In addition, screening for spiritual distress, addressed later in this paper, is essential in order to determine what further interventions may be needed to support the patient by the chaplain, who is the spiritual care specialist on the team.

Studies have shown that attending to the spiritual needs of patients and their family members is an integral component of holistic care that directly facilitates positive outcomes.⁴¹ Further, patients may feel abandoned spiritually if the healthcare team does not address spiritual and religious concerns. This is often a result of the healthcare provider's assumption that spiritual care is not part of their job, that they do not have time to adequately address it, or that they do not feel sufficiently equipped to do so.^{42 43}

Social workers, as part of a healthcare team along with other health professionals, have a unique opportunity to collaborate with board certified chaplains to address the spiritual needs of patients and families, provide support, and relieve suffering, particularly in referring to the chaplain when spiritual distress is identified as being present. This highly integrated interprofessional level of care delivery empowers each discipline to clearly understand and respect the professional expertise of the other while fostering trust and mutual confidence in sharing sometimes overlapping roles.⁴⁴ Such collaboration leads to the shared goal of better outcomes for patients. Explicit communication between disciplines as well as clear definitions of professional roles can help this to work optimally throughout the care continuum.

ROLE OVERLAP AND ROLE DIFFERENTIATION

HealthCare Chaplaincy Network™ has expanded upon the terminology of spiritual care specialist and spiritual care generalist first developed by a 2009 consensus group of interdisciplinary professionals⁴⁵ and articulated in the book *Making Health Care Whole*.⁴⁶ This approach clarifies both role overlap and differentiation of various team members as they assume roles in the provision of spiritual care delivery. Hall et al. state that "Paralleling the medical model, the spiritual care generalist is responsible for screening for spiritual need and making referrals to the spiritual care specialist when more in-depth spiritual care is appropriate. For example, in many clinical contexts, the social worker or nurse might perform a brief spiritual screen, a physician might take a spiritual history, and the chaplain might conduct a more in-depth assessment and provide complex spiritual care in response to their referrals."⁴⁷ Thus, all team members serve a role in both identifying and addressing the spiritual needs of all patients yet work in a collaborative model to provide optimal spiritual care.

Patients often present spiritual needs and a readiness to share them with a healthcare provider spontaneously, without planning or anticipation of that moment. Any healthcare professional may be the recipient or listener to innermost spiritual doubts and inquiries at any given time. Some persons may feel more comfortable talking about deeply personal questions or doubts with someone outside their own specific religious, spiritual, existential, or cultural tradition or a person who they perceive not to be, or professes themselves not to be, religiously or spiritually affiliated when in a medical setting.^{48 49} Others may talk about their spiritual concerns with a person because the timing is right, or the interpersonal connection allows them to feel safe enough to discuss their concerns. Therefore, the interpersonal relationship and/or chemistry may determine the professional with whom a patient who feels vulnerable shares their spiritual concerns. This highlights the importance of interprofessional spiritual care training of all team members to contribute to meeting the spiritual needs of patients in those times of spiritual discussions.

“Patients who reported a high level of spiritual support were more likely to receive hospice care and less likely to die in an intensive care unit, which were in turn associated with significantly lower health care costs.”

SOCIAL WORKERS AS SPIRITUAL CARE GENERALISTS

Within medical settings, the specific role of a social worker varies widely, depending on the facility's size, staffing and role designation, mission and resources and also based on the training, expertise, and competence of the social workers themselves. The social worker's responsibilities may include advance care planning, permanency planning for dependents, working with families around practical, emotional, and/or psychological issues, discharge planning, assessment of neglect or abuse, or the treatment of psychiatric diagnoses. Other settings allow for more counseling and clinical intervention, focused on coping with illness and loss, and often involve deep explorations of the patient's inner experience and resources. According to the Congressional Research Service, social workers function as the largest providers of mental health services in the United States.⁵⁰

“When prepared with sufficient training and competency, professional social workers are well-positioned to collaboratively engage with patients as spiritual care generalists.”

Recent papers attempt to re-establish the spiritual dimension of social work practice, calling for reconsideration of the relationship between spirituality and the social work role at a theoretical and conceptual basis.^{51 52} When prepared with sufficient training and competency, professional social workers are well-positioned to collaboratively engage with patients as spiritual care generalists. Strengths-based and solutions-focused approaches - both rooted in the belief that capacity rather than pathology should be the primary focal point of the helping process - can, and should, also be applied to spirituality. This approach to spirituality, then, is also consistent with the ideological foundations of social work.^{53 54 55}

Exploring spiritual themes such as an individual's religious community support, spiritual beliefs, level of spiritual strengths and/or potential needs or areas of distress using evidence-based instruments and tools can be a relevant part of overall spiritual assessment within the patient's narrative. Engaging a patient's spiritual, religious, and/or existential beliefs can support healthy and constructive coping and may address any potential barriers to wellness or healing. For example, a social worker may work with patients nearing end of life to prioritize their psychological, philosophical and spiritual experiences over further medical interventions when treatment seems futile.⁵⁶ Addressing more practical adjustments patients are forced to make along the continuum of illness can spark existential questions about identity, role and purpose.^{57 58} Social workers are often called upon to engage these kinds of concerns.

Within their scope of practice, expertise, and competence, social workers can play a valuable role by screening and assessing for spirituality's broader experience and meaning in patients' lives. The skills and competencies in any given context among the members of the interprofessional team, balanced with the contextualized needs of the presenting patient, will help determine which member of the team is best to conduct an in-depth spiritual assessment. The assessment is then shared with the entire team so that the patient can receive truly coordinated holistic whole-person care. Within the profession there is currently a great deal of variation; while some social workers are well-trained and competent, not every social worker will be the best prepared team member to respond to particular spiritual needs. This is due to a range of factors, including: lack of training, personal comfort or interest or time constraints due to heavy caseloads, and institution-specific scope of practice.⁵⁹ All social workers should, at minimum, be able to identify spiritual needs that trigger appropriate referrals to a board certified healthcare chaplain who can connect the patient to their local faith community leader if they desire to be. Professional chaplains specialize in in-depth spiritual discussions and should be referred to patients who wish to develop or enrich their spiritual practice and expression while coping with illness.

SPIRITUAL SCREENING, SPIRITUAL HISTORY, AND SPIRITUAL ASSESSMENT

Best practice entails developing a proactive plan for attending to the spiritual needs of patients by the entire interdisciplinary team.⁶⁰ There has been some cross-professional confusion secondary to the definition and use of the term of “spiritual assessment.” A spiritual assessment can be a broad category of addressing spirituality and/or religion in any way, which is one use of the term. And a spiritual assessment tool or process also refers to a more specific, concrete approach, often used in chaplaincy alongside the spiritual screen and spiritual history. This has led to some unclear communication between the fields of chaplaincy and social work. Puchalski, et al. (2009) proposed a model of spiritual care in healthcare beginning with the spiritual screen, often called a brief spiritual assessment in the social work literature, close to the time of admission, followed by the more in-depth spiritual history taking, most often performed by a spiritual care generalist, and then a formal spiritual assessment, often called a comprehensive spiritual assessment in the social work literature, as needed by the spiritual care specialist. These distinct levels of evaluation of spiritual needs ultimately lead to specialized spiritual care interventions and outcomes. For the remainder of this paper, we will use the terms spiritual screen, history, and assessment when discussing the overall approach to assessing a person’s spirituality and/or religion.

Each tool – the spiritual screen, spiritual history, and spiritual assessment - has a variety of possible formats and instruments and can be integrated with electronic medical records. The “measuring what matters” movement,⁶¹ which seeks to ensure that interventions are addressing meaningful patient outcomes, has begun to focus on spiritual concerns. This reminds practitioners of the importance of clearly documenting the spiritual screenings, histories, assessments and ultimately spiritual care interventions provided, and the desired contributing outcomes for the person because of those interventions.⁶² While there may be some variance in which tool is used for which task, it can be helpful to involve a variety of team members in screening for spiritual concerns in order to increase the likelihood that patients who are experiencing spiritual distress are identified, and appropriately referred for further in-depth spiritual assessment and care.

The *spiritual screen* is an instrument intended to help identify and triage patients and families for points of contact between their spirituality and/or religion and the provision of their healthcare, and to refer for more in-depth spiritual care by the chaplain particularly if issues such as spiritual distress or struggle may have potential impact upon the provision or reception of services.⁶³ The screen usually requires a brief time commitment and can be potentially done by any team member – from admission staff to those on the interprofessional teams. The screen is often limited to a few key questions that focus on basic preferences and any obvious distress that needs further referral and follow up.⁶⁴ The most commonly used spiritual screening tools include the Rush Protocol,⁶⁵ and the NCCN Distress Thermometer.⁶⁶

The *spiritual history* involves a more detailed intervention of interviewing a patient in order to come to a better understanding of patients’ spiritual needs and resources and generally uses a lengthier and broader set of questions. A spiritual history is often done with a trained team member in the context of an assessment such as a History and Physical (H&P).⁶⁷ Several spiritual history instruments in use include FICA Spiritual History Tool (Faith, belief or meaning; Importance and Influence; Community; Action, Address),⁶⁸ SPIRIT (Spiritual belief system, Personal spirituality, Integration, Rituals/restrictions, Implications, and Terminal events),⁶⁹ HOPE (Hope, Organized religion, Personal spirituality, Effects of care and decisions),⁷⁰ and the social worker-developed Domains of Spirituality.^{71 72}

Once these areas of spiritual resources, beliefs, practices, and/or potential areas of distress or struggle are identified, healthcare teams are able to incorporate a patient's spiritual needs or requests into the overall care plan. This includes listening to the patient's expression of their individual spirituality, values, and related beliefs and practices. These often involve the patient's community of support, community spiritual or faith leader, incorporating practices and ritual items that may be of importance to the patient and family, or ongoing interventions and spiritual support provided.

As the spiritual care specialist, the chaplain is the member of the interdisciplinary team who is responsible for assessing and documenting the ways in which the patient's spirituality, including beliefs, values, practices, and rituals, are integrated into the care plan. Social workers in healthcare settings are often called upon to conduct an initial brief spiritual assessment, described above as a spiritual screen, as well as a more comprehensive assessment which may include a spiritual history. This view is supported by the NASW Standards for SW Practice in Healthcare settings (2016), which explicitly acknowledge that social workers conduct assessments to determine psychosocial-spiritual well-being.⁷³

Both social workers and chaplains focus on person-centered, family-focused, culturally-congruent models of care. Both utilize a process of gathering, analyzing, and synthesizing assessment information about the patient to understand mental health status, patient and family strengths and perceived needs, patient goals of care, resource availability, coping styles, barriers to care, and other issues which form the basis for goal planning and interventions. However, each discipline conducts an assessment differently within the context of their education, professional training, and scope of practice. A biopsychosocial-spiritual model for the care of patients^{74 75} can be incorporated into the social work assessment to help identify spiritual beliefs, practices, or spiritual community resources within in the context of the patient's larger psychosocial support system.^{76 77}

Board certified chaplains are most often the spiritual care specialists who complete the formal spiritual assessment, a more extensive and complex process, to identify a person's spiritual, religious, existential, cultural and emotional beliefs and values within their personal context and narrative. This includes ascertaining one's sources of meaning, hopes, strength and coping as well as any issues of spiritual pain, suffering or distress. From the assessment, the chaplain generates a spiritual care plan that describes the issues that have been addressed through their interventions and next steps to be taken throughout the patient's admission. All these elements are documented in the patient medical record and shared with other members of the healthcare interdisciplinary team.⁷⁸

Models for a professional chaplain's spiritual assessment include: Spiritual AIM, (Meaning and Direction, Self-Worth and Belonging to Community, and Reconciliation/to Love and Be Loved)⁷⁹ - which focuses on relationships as the context for spiritual development, source of needs and outcomes as a result of meeting those needs; the Spiritual Distress Assessment Tool (Meaning, Transcendence, Values, and Psycho-Social Identity)⁸⁰ - which identifies and scores unmet spiritual needs and spiritual distress; and the Discipline for Outcome-Oriented Chaplaincy - which conceptualizes a person's needs, hopes, and resources around four aspects of a spiritual profile (Concept of the Holy, Meaning, Hope, Community)⁸¹, develops a plan, and measures the outcomes. When a social worker provides the comprehensive spiritual assessment, they may well use the social-work-developed tools, such as: iCARING Brief Assessment (Importance of spirituality/religion, Community, Assets, Resources, Influence, Needs, Goals),⁸² a spiritual history,⁸³ spiritual lifemaps,⁸⁴ spiritual genograms,⁸⁵ spiritual eco-maps,⁸⁶ and spiritual ecograms.⁸⁷

Addressing patient spirituality is vital for successful advance care planning and medical decision-making within clinical contexts. Spiritual themes that impact such decision-making and planning may be frequently missed by busy providers despite the importance spirituality and religious beliefs and issues as revealed in research.^{88 89} Thus, every member of the team needs to have basic skills in identifying spiritual needs so they will not be missed and social workers will find that the inclusion of even a spiritual screen is quite consistent with the values and standards of their existing practice.

UNDERSTANDING SPIRITUAL DISTRESS

As chaplains work extensively with issues of spiritual distress, pain, and struggle, it is essential for social workers to be familiar with the concept so that when it appears a referral is made to the chaplain for specialist spiritual care. “There is recognition that spiritual or existential or religious questions can be triggered by the diagnosis of illness or experience of loss.”⁹⁰ When a person is confronted with a life-challenging or life-threatening illness, most people will try to understand why the illness has occurred and what it might mean on a deeper level. Humans are often inclined to interpret life events through a lens of meaning-making, in order to cope with, or even survive, the circumstances. Spiritual distress may occur in situations in which a patient is unable to ascribe meaning to the experience in a satisfying way, such as recognizing the illness as an opportunity to mature or see life with a different perspective. Illness may well appear to a patient to serve no purpose and may result in deep existential or spiritual pain or suffering, known as spiritual distress.^{91 92 93 94 95}

Spiritual distress is different from physical pain. It cannot be addressed or removed in the same way that physical pain can. Spiritual care, when provided competently, can reduce spiritual distress and ameliorate suffering.⁹⁶ Spiritual distress may arise when the meaning in life is challenged and in some instances shattered. For many, illness provides the ground for spiritual growth and the potential for new levels of self-awareness that often lead to a renewed sense of meaning and purpose in life.⁹⁷ One potential positive outcome of spiritual distress is the maturation of a person’s spirituality and the reframing of the medical journey, regardless of outcome. Many have shared that facing illness led to a spiritual rebirth resulting in a deepening of faith or spirituality. Subsequently, this deepened faith can provide much more meaningful and powerful spiritual resources, such as hope, peace, and a more authentic relationship with self, others, and the person’s individual understanding of the transcendent or “that which is outside of the self, and yet also within the self”⁹⁸ also known as God, Allah, HaShem, or a Higher Power in Western traditions and as the Ultimate Truth or Reality, Vishnu, Krishna, or Buddha in Eastern traditions. Some may refer to the transcendent as Nature or the Universe.

It is important to avoid assumptions about how certain religious groups engage their spirituality in the context of healthcare, particularly around issues of spiritual distress, pain, or struggle. Additionally, in recognizing the autonomy of each person, it is important to recognize that each individual has distinctive and personal beliefs, practices and values that may or may not be informed by religious affiliation or spiritual principles. Even within the same faith tradition and cultural upbringing, individuals may have different issues that create spiritual distress, especially as they approach end of life.^{99 100} If and how a patient chooses to address pain may well depend on the meaning that a specific patient ascribes to the suffering, regardless of the patient’s race, ethnicity, cultural, religious or spiritual affiliation. These beliefs may come from a past experience with a dying loved one rather than from religious dictates of a person’s specific faith tradition. For some, suffering may have a redemptive quality and seeking relief could be perceived as a sign of spiritual weakness.^{101 102 103} How one endures

“Addressing patient spirituality is vital for successful advance care planning and medical decision-making within clinical contexts.”

emotional, physical or spiritual pain might be understood as a spiritual test¹⁰⁴ or an opportunity to advance toward a more psycho-spiritually mature state of being. Sensitive and detailed spiritual assessment uncovers the spiritual and/or religious beliefs specific to the patient, and develops a strategy to address those in the plan of care.

The National Comprehensive Cancer Network has provided guidelines for spiritual distress management that may arise for patients during a health crisis.¹⁰⁵ All team members, particularly social workers,¹⁰⁶ should be alert to potential issues of spiritual distress when completing a spiritual screen or spiritual history or when in conversation with a patient during their course of treatment. These may include expressions of grief, concerns about death or the afterlife, conflicted or challenged belief systems, loss of faith, concerns about meaning/purpose of life, concerns about relationship with deity, concerns about isolation from religious community, guilt, hopelessness, conflict between beliefs and recommended medical care, and ritual needs.

SPIRITUAL CARE INTERVENTIONS AND THERAPEUTIC QUALITIES

There are many new counseling interventions that focus on such spirituality-oriented concepts such as meaning, dignity and peace.¹⁰⁷ Spiritual care “is about being present with someone in the midst of their life as they face new challenges and experiences. In chaplaincy this is referred to as the ministry of presence.”¹⁰⁸ In social work, it might be referred as staying in the here and now,¹⁰⁹ being mindfully present,¹¹⁰ or meeting patients where they are.¹¹¹

For example, research done with spiritual lifemaps illustrated the important therapeutic outcomes as a result of using this comprehensive assessment instrument with clients in a hospice setting.¹¹² Even those patients who do not identify themselves as spiritual will likely be able to reflect on the very human experiences of awe, interconnection, gratitude, transcendence and impermanence. These types of extraordinary experiences, often arising amid the ordinary, stand out above and beyond the usual ebb and flow of life, and can reasonably be understood as “spiritual” experiences. Patients learn to identify and strengthen their sense of purpose, provide hope, and inspire them to persevere.

Every person needs to be reassured that he or she is not alone in their experience, and “when speech is necessary, it is usually the person facing the new challenge...that needs to speak.”¹¹³ Even when a patient identifies as non-spiritual and/or non-religious, relationships to these domains are a potential area for important clinical exploration, provided the social worker or chaplain do so within the parameters of the patient’s definitional framework and with respect to their own articulation of their perspective.¹¹⁴ Given this, it can be “very difficult to speak generically about these resources as they vary so greatly from person to person.”¹¹⁵ Spiritual care is “meeting people where they are and assisting them in connecting or reconnecting to things, ideas and principles that are at their core of being—the breadth of their life, making a connection between yourself and that person.”¹¹⁶ It is a healthy goal for the patient to “come to some understanding on their own in the context of being heard.”^{117 118}

Social workers are also skilled at using behavioral techniques and teaching self-management skills.^{119 120} For example, in terms of meeting clients where they might be, the social worker might recommend some type of meditative practice as potentially helpful for anxiety created by a breathing disorder. In suggesting that, the social worker would want to take into account the patient’s own history with and belief about meditative techniques, perhaps having them utilize something from their own spiritual background to be culturally sensitive and consistent and to build upon their strengths.

Healthcare social workers may also use spiritually modified cognitive therapy as a therapeutic modality due to its effective and straightforward theoretical framework, its present-moment orientation and its compatibility with brief treatment models that focus on short term goals.¹²¹ Though to do so, the social worker would need to conduct a comprehensive spiritual assessment in order to effectively implement this intervention.

ETHICAL GUIDELINES IN SPIRITUAL CARE

There are also important ethical guidelines when providing spiritual care. When conducting any kind of spiritual intervention – a screen, history, or assessment – the social worker should be non-coercive and patient-centered. This is consistent with the NASW Code of Ethics standard 1.02 that deals with self-determination of those being served.¹²² Professional boundaries must always be maintained so that trust can be established. The social worker should approach the work respecting client autonomy by working within the definitional frameworks employed by patients, and avoid attempting to provide answers for the unanswerable existential questions such as “Why me?” or “Why now?” No social worker should proceed in a manner that goes beyond one’s level of expertise and training in spiritual care. Proselytizing is never acceptable. Finally, praying with patients is a controversial area and general guidelines recommend being respectful and mindful of both patients’ needs as well as appropriate training and boundary considerations.¹²³

Ethical considerations and challenges should be balanced by therapeutic humility, pacing and presence, as well as collegiality, and clear, open interprofessional communication. Additionally, cultural humility can help mitigate low levels of cultural competency as healthcare providers allow patients to teach them who they are by asking, listening fully, and hearing, all of which develop and contribute to a holistic healing context and encounter. Social workers lacking the knowledge to ethically and effectively conduct a comprehensive spiritual assessment with patients from religious tradition with which they are unfamiliar should approach patients and families from a place of curiosity, or refer to the chaplain. When conducting a brief assessment, it is common practice to inquire directly about patient spirituality or religion, for example the iCARING brief assessment tool.¹²⁴ If one asks only about someone’s cultural or religious tradition, then they risk missing those patients who self-identify as being spiritual but not religious. Consequently, it more inclusive to ask about a person’s sense of spirituality and/or religion in a more direct manner, a practice that helps to legitimize the topic in healthcare settings.¹²⁵

Spiritually-integrated care requires authentic connection, and the clinician’s self-awareness, grounded presence, and humility. It requires an honest examination of the social worker’s embedded values¹²⁶ and an in-depth understanding and acknowledgment “that the individualistic, secular value system in which Western cognitive therapy is wrapped often conflicts with the values in many spiritual traditions. Thus, the central issue is to address the value incongruence, while maintaining the therapeutic heart of the cognitive procedure.”¹²⁷ An example of this is when a faith tradition values spirituality and community as opposed to secularism and individualism.¹²⁸

“Spiritual distress may occur in situations in which a patient is unable to ascribe meaning to the experience in a satisfying way, such as recognizing the illness as an opportunity to mature or see life with a different perspective.”

OPPORTUNITIES FOR COLLABORATION WITH PROFESSIONAL CHAPLAINS

The family- and patient-engaged care approaches of chaplaincy, social work and other healthcare disciplines are highly congruent. Their mutual goals support identifying and mobilizing the patient and family to participate constructively in negotiating the complex healthcare system, solve problems in a crisis, and gain access to resources for support throughout the illness/injury and afterward.¹²⁹

Both social workers and chaplains are also often called upon to provide support to the rest of the team.¹³⁰ Chaplains are explicitly charged to bring spiritual care to healthcare providers as well as patients¹³¹ and can also provide training, modeling, and equipping of other team members to provide basic levels of empathic spiritual support.¹³² Professional resilience is not maintained without enriching learning and expansion of one's intellectual, interpersonal and spiritual life. Both social workers and chaplains help each other and other interdisciplinary team members engage in the process of self-exploration that serves them as professionals, which will invariably serve patients.

“Sensitive and detailed spiritual assessment uncovers the spiritual and/or religious beliefs specific to the patient, and develops a strategy to address those in the plan of care.”

Social workers, with their focus on person-in-environment as a theoretical perspective, are able to validate the experiences of other healthcare team members, who find that they are experiencing the cost of caring in the forms of burnout, secondary-traumatic stress, compassion fatigue, and second victim phenomena. Chaplains and social workers working together, ideally alongside wellness champions from other health disciplines, can effectively address both the promotion of resilience building activities as well as promote healing practices amongst healthcare team members who are facing adverse situations with their patient/family systems. Such care of the healthcare team translates into better care of the patient.

Social workers have consistently valued collaboration and building networks with board certified chaplains who are in a unique position as the spiritual care specialists to lead teams in addressing the spirituality of patients, and often collaborate in activities such as Schwartz Center Rounds,¹³³ co-facilitating patient and family support groups, bereavement care services, and planning patient focused activities, programs and educational events in patient care plans and family meetings.

Ideally, each member of the team will offer their specialized skills and talents to each patient and will work collaboratively with colleagues, sharing ideas and resources, in service of the patient. It is important that each discipline engage in open discussion, respecting collaboration and exploration of the potential overlap in roles, which are opportunities for further professional learning. Open communication and coordination among team members will lead to the optimal care of each patient, including the spiritual domain.

CONCLUSION

Spirituality is a fundamental aspect of our identity and our understanding of what it means to be “human.” The importance of spirituality is being embraced by the healthcare field as it gains recognition as an essential component of whole-person care. As each discipline acknowledges the importance of spirituality and addresses it in healthcare appropriately and competently, interventions will occur that improve the patient’s quality of life and experience. To accomplish this, each member of the team, including social workers, should, at a minimum, be able to conduct a spiritual care screen.

As valuable members of interdisciplinary healthcare teams, social workers use a variety of clinical skills ranging from brief assessments as well as comprehensive bio-psychosocial spiritual assessment, to identify the unique characteristics of a person’s personality, family dynamics, socio-economic standing, and culture, to name but several elements, that may interfere with healthy functioning and efficient participation in the services associated with their care. High levels of patients’ unmet spiritual needs are likely due to practitioner unfamiliarity with basic spiritual care concepts, but this can be improved when the entire healthcare team takes responsibility for screening for spiritual concerns and making referrals to the spiritual care specialists on the team.¹³⁴

Social workers may be called upon to identify the spiritual concerns of their patients in various health settings. A key function of social work practice is to empower patients by using a strengths-based model to address and adjust to challenges. Central to the social worker’s role in healthcare is the identification of internal and external strengths and resources that a patient can use deliberately to reduce obstacles to care and to enhance coping with illness, including their unique spiritual resources. Spirituality provides the guidance for how persons approach life.¹³⁵ Tapping into this pre-existing cognitive framework, building upon it when appropriate, referring patients to the spiritual care specialists, and helping patients recognize the aspects of their spiritual beliefs and the resources that support them through hard times is crucial during times of illness or injury.

Advanced training for any social worker who wishes to provide more in-depth spiritual care is a necessity. Spiritual care has been a significant part of social work practice and is addressed in The NASW Code of Ethics,¹³⁶ the NASW Standards and Indicators of Cultural Competency¹³⁷, and the Council for Social Work Education.¹³⁸ Trained and capable social workers often provide some level of spiritual care while also highly valuing communication, collaboration and appropriate referral to chaplaincy colleagues.¹³⁹ Strong partnerships between social workers and chaplains are critical to our mutual goal to serve and meet the spiritual needs of patients and families. Both disciplines are recognized as essential to the delivery of quality care. Together, chaplains and social workers can continue to form excellent partnerships that better serve patients, medical team members, and the larger healthcare system.

Every person needs to be reassured that he or she is not alone in their experience, and “when speech is necessary, it is usually the person facing the new challenge...that needs to speak.”

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