Key Concepts in Spiritual Care for Hospice Social Workers: How an Interdisciplinary Perspective Can Inform Spiritual Competence

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It is important for hospice social workers to understand research on spiritual care, particularly when hospice patients rely on spirituality and/or religion to cope. Spiritual competence is essential for hospice social workers to be sensitive to a patient's spiritual worldview. Research across disciplines provides guidance in defining what it means for hospice social workers to be spiritually competent. As such, the following article describes research that defines spiritual care, spiritual needs, spiritual pain, spiritual wellbeing and other concepts related to hospice social work. Examples are provided to help consider one's level of spiritual competence and ways to address patient spiritual needs. It is this type of information that empowers Christian social workers to integrate faith in practice and, ultimately, advance an interdisciplinary dialogue on spiritual care to ensure patient spiritual needs are met.

Professional expertise in hospice social work requires an understanding of theories, research, and practice specific to palliative and hospice care. In the process, hospice social workers draw from the knowledge and services of multiple disciplines to assist their patients. Hospice social workers participate on interdisciplinary teams as well as facilitate transactions between patients and other professionals to achieve treatment goals. Likewise, an interdisciplinary approach can be used to build on advancements made by related fields. This is particularly important when more resources are needed to understand an area that is new.

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Within the past several decades, research on patient spirituality has grown substantially across disciplines. Professionals in the fields of nursing and palliative medicine have largely shaped research on spirituality and hospice care. As a result, key terminology may be less familiar to hospice social workers. It is important, however, for social workers to understand key concepts associated with spiritual care to better assist patients who rely on spirituality and/or religion to cope. This is consistent with the value of cultural diversity, including religious diversity, which distinguishes social work practice (Nelson-Becker & Canda, 2008).

Spiritual competence enables sensitivity to patients with different religious and/or spiritual views (Hodge, 2011; Hodge, Baughman & Cummings, 2006; Gilligan & Furness, 2006). The Council on Social Work Education (n.d) and National Association of Social Workers (2007) both recognize the importance of being spiritually competent. There are employers, specifically in hospice, that require spiritual competence. There are also patients who need help to address their spiritual needs. Thankfully, spiritual competence can be developed over time (Hodge, 2011), provided one is intentional about exploring current research on the topic.

Drawing from interdisciplinary research not only increases the potential effectiveness of hospice social work, but it also enables hospice social workers to participate in an interdisciplinary dialogue about practices that convey spiritual competence. This further allows hospice social workers to advocate for patients to ensure their spiritual needs are met. This article describes the concepts of *spiritual care* along with *spiritual needs*, *spiritual pain*, and *spiritual wellbeing* based on nursing and palliative care research. Additional references from pastoral care, psychology, and social work research will be included for a thorough review.

Spirituality and Religion

Defining spirituality can be difficult given how abstract the concept is and the various ways spirituality may be experienced and, potentially, manifest (Gause & Coholic, 2007; Tucker, 2010). The most common definitions in interdisciplinary research suggest that the experience of spirituality is reflected by an awareness of being an essential part of the world. This awareness can emerge through, for example, a search for existential meaning, life purpose, and morally satisfying connection beyond the self and in relationship with others, higher power, and/or the cosmos (Puchalski, 2008a; Canda & Furman, 2009; Canda, 1999).

Religion involves beliefs, traditions, and rituals used to worship one (monotheistic) or more (polytheistic) deities. A deity is a god or goddess that is believed to have the power to influence the material and nonmaterial world. Religion may inform life choices to help one grow spiritually. Therefore, for some people, spirituality may be experienced through the

practice of religion. Spirituality may also be experienced through an existential connection with nature, relationships, and creative/intellectual endeavors (Canda & Furman, 2009, Canda, 1999).

Religious Diversity

There is significant diversity within and across religious traditions (Pew Research Center, 2008). Even though patients may identify as Catholic or Protestant, religious views can vary widely within each tradition. For example, Protestants as a whole may be more accepting of divorce, birth control, and ministers who marry, but differ denominationally on the role of women in the pastorate (Mead, 1995). There are also Protestants who may not identify with a particular denomination's theology, but choose to affiliate with a church in that denomination due to the worship style, membership, or programs (Van Hook, Hugen, & Aguilar, 2001).

Beyond personal preferences, a patient's spiritual worldview can vary based on socioeconomic factors. Women, those who are separated/divorced/widowed, have lower income, have less education, and live in the South tend to have a stronger religious commitment (Gallup, 2012; 2003). Religious commitment also increases with age (Gallup, 2012). Others may have felt marginalized due to discrimination based on gender, sexual orientation, or disability. There are more people with no religious affiliation, including atheists, however, many still identify as being religious or spiritual (Pew Research Center, 2013.

A patient's spiritual worldview is further informed by race and ethnicity. Some minority groups, like African Americans, have traditionally relied on the Protestant Baptist "Black Church" movement for personal and social empowerment (Canda & Furman, 2009; Hodge, 2003; Reese, 2013). Latin Americans have melded indigenous beliefs into their practice of Catholicism (Canda & Furman, 2009). Even when Asian Americans identify as Christian, Eastern religious beliefs may influence one's personal preferences (Reese, Chan, Chan, & Wiersgalla, 2010; Takahashi & Ide, 2003).

Personal preferences and demographic differences that shape a patient's spiritual worldview can shape beliefs about hospice care as well. For example, it is not unusual for African Americans to rely on familial support and prayer to sustain hope in a miracle rather than choose hospice care. They are more likely to tolerate pain given the value placed on the acceptance of suffering, but African Americans are also likely to accept death as God's will and use funeral rites to celebrate new life in heaven (Reese et al., 2010). Therefore, factors that inform a patient's spiritual worldview are complex and require special consideration by hospice social workers.

Spiritual Competence

To be spiritually competent, the provision of hospice social work must be consistent with a patient's spiritual worldview (Briggs & Rayle, 2005a, 2005b; Gumz, Wall, & Grossman, 2003; Hodge, Baughman & Cummings, 2006; Fukuyama & Sevig, 1997; Gilligan & Furness, 2006). This requires an understanding of how religion and/or spirituality contributed to a patient's development and continues to influence current functioning. Spiritual competence further requires social worker self-awareness and empathic communication of respect for religious diversity (Briggs & Rayle, 2005a, 2005b; Leseho, 2007; Hodge et al., 2006).

The absence of religious beliefs can be significant as well (Furness & Gilligan, 2010). For patients who do not identify as being religious, Furness & Gilligan (2010) suggest that it may be more appropriate to address with them existential meaning, life purpose, and/or a transpersonal connection, which, by definition, denotes the experience of spirituality. Regardless, based on Callahan's (2013a) model of spiritually-sensitive hospice social work, it is important for hospice social workers to be sensitive to a patient's spiritual needs to support the patient's experience of spiritual wellbeing.

Social work and related professions promote spiritual competence relative to discipline-specific practice guidelines. For hospice social workers, spiritual competence has been associated with culturally competent care by the National Association of Social Workers (2007, 2004) and the Council on Social Work Education (2012, n.d.). Additional organizational guidelines have been established by professional bodies like the Joint Commission on the Accreditation of Healthcare Organizations (2008, 2005) that require specific expertise in, for example, spiritual assessment by hospice staff.

There are models across disciplines that delineate levels of spiritual competence. Gordon & Mitchell (2004) developed a competency framework based on the work of an interdisciplinary group of health care providers associated with Marie Curie Hospices. The model is organized in order of progressive application of spiritually competent practice knowledge and skills. As seen in Appendix A, this model suggests that individuals with different levels of competence can provide some form of spiritual care if the intervention falls within one's level of expertise, otherwise, a referral would be in order.

Canda and Furman (2009) provide a detailed description of social work knowledge, attitudes, and behaviors associated with spiritual sensitivity, a concept that seems closely related to, if not the same as spiritual competence. As previously mentioned, Callahan (2013a, 2012, 2009a) applied the concept of spiritual sensitivity to hospice social work. Spiritually-sensitive hospice social work is described as the cultivation of a life enhancing therapeutic relationship. Callahan suggests that it is the patient's experience of this meaningful relationship that transforms a social work intervention into a form of spiritual care.

According to Callahan (2012, 2009a), hospice social workers can provide spiritually-sensitive hospice care both directly and indirectly, depending on patient needs and worker expertise. Spiritual support may be provided indirectly through the expression of unconditional positive regard, engagement in active listening, and empathic compassionate connection with the patient. The skills required for this type of intervention would be generalist in nature. Social workers with advanced generalist or clinical expertise may address spiritual issues directly with interventions such as spiritual assessment and spiritually oriented psychotherapy detailed later.

Spiritual Needs and Spiritual Pain

A patient's experience of spiritual needs and spiritual pain requires the provision of spiritually competent hospice care. Spiritual needs are associated with the desire "to integrate goals, values, and experiences in search of meaning and sense of purpose" (Millison, 1988, pp. 37-38). By making these connections, patients are better able to understand their place in the world and the implications of death. As such, having a terminal illness can evoke spiritual needs (Belcher & Griffiths, 2005; Nelson-Becker & Canda, 2008; Puchalski, 2001; Hodge & Horwath, 2011; Miller, Chibnall, Videen, & Duckro, 2005; Harrington, 2004).

When patients have difficulty integrating life events and experiences in a manner that supports life satisfaction, spiritual pain can result (Millison, 1988). The concept of spiritual pain has also been described as spiritual distress that sometimes requires clinical intervention to address. Spiritual pain represents a deep and profound experience of existential suffering. The experience of spiritual pain can be difficult to discern, thus appropriate intervention is likely to require an interdisciplinary approach. As such, a patient's biopsychosocial needs should be met to ensure they are not contributing to the experience of spiritual pain (Appendix B).

Spiritual pain can manifest through a change in psychosocial functioning that includes meaninglessness, anguish, isolation, alienation, and emptiness. Patients in spiritual pain may detach from others and express confusion or hopelessness. They may ask questions like "Why is this happening to me," "What is the meaning of my life," and "Do others value me and see me as a person of worth?" Patients who are religious may believe God abandoned them, begin questioning their religious beliefs, and refuse to engage in religious practices (Puchalski, 2008b, 2007; McCormick, 2007; Bratton, 2005; Knight & von Gunten, 2004a; Wintz & Cooper, 2003).

Based on psychology research, questions about one's faith can severely strain coping skills that lead to a spiritual crisis or spiritual emergency (Sperry & Miller, 2010). The *Diagnostic and Statistical Manual of Mental Disorders V* (American Psychiatric Association, 2013) has a V code for

religious or spiritual problems. Such problems can likewise evoke anxiety, confusion, and functional impairment. A differential diagnosis is required to ensure the problem is spiritual in nature rather than a symptom of a psychiatric disorder like religious delusions due to major depression (Hodge, 2005, Sperry & Miller, 2010).

Spiritual Coping and Spiritual Wellbeing

It is natural to consider spiritual and/or religious issues when faced with the end of life (Nelson-Becker & Canda, 2008). Despite a decline in religious affiliation, there remains a critical mass of people who are religious as well as those who are spiritual (Chaves, 2011; Gallup, 2012; Pew Research Center, 2013, 2012). Spirituality can be a significant resource for these people as patients (Koenig, 2005; Collins, Furman, Hackman, Bender, & Bruce, 2007). According to Puchalski (2008a), spirituality can help patients "move from hopelessness to wholeness, from despair to peace, and from meaningless to purpose and dignity" (p. 114).

Spiritual coping is rooted in the expression of spiritual and/or religious beliefs. Spiritual practices facilitate a connection with God, higher power, or some other source that nurtures a sense of wholeness known as spiritual wellbeing (Carpenito-Moyet, 2006). For some, spiritual practices are also considered religious practices. Examples of spiritual and/or religious practices include visiting with religious clergy/church/community members, reading inspirational literature, prayer/mediation, listening to inspirational music, and participating in worship services/religious rites/sacraments (Kellehear, 2000).

There are many indicators of spiritual wellbeing that have been cited across disciplines (Leseho, 2007). To help narrow the scope, based on in-depth interviews with 149 patients with terminal cancer, Murray, Kendall, Boyd, Worth, & Benton (2004) found that spiritual wellbeing was related to:

1. Inner peace and harmony
2. Having hope, goals, and ambitions
3. Social life and place in community retained
4. Feeling of uniqueness and individuality, dignity
5. Feeling valued
6. Coping with and sharing emotions
7. Ability to communicate with truth and honesty
8. Being able to practice religion
9. Finding meaning

Based on these results, it seems as though spiritual wellbeing involves the meeting of psychosocial and spiritual needs through related coping practices. What informs an individual's spiritual wellbeing requires further exploration, though, given potential implications for hospice social work.

Callahan (2013a) conjectured that spiritually-sensitive hospice social work could enable the experience of relational spirituality. Relational spirituality is described as the experience of enhanced life meaning through a morally fulfilling relationship with the self, someone/something else, or higher power. Here the caregiving relationship becomes a resource for coping that contributes to the patient's spiritual wellbeing. In theory, both patient and hospice worker could experience relational spirituality, but additional research is needed to test this model.

Spiritual Assessment

A spiritual assessment may be conducted to determine if a patient has spiritual needs, is in spiritual pain, or has spiritual resources. Such information may be collected in different ways throughout the treatment process. In fact, the Joint Commission (2008, 2005) requires a spiritual assessment with all hospice patients, although does not specify a particular hospice professional or specific questions to ask to conduct this assessment. A spiritual assessment is particularly important when a patient has a spiritual and/or religious worldview, expresses spiritual pain, and medical status suggests decline (Knight & von Gunten, 2004b).

A spiritual assessment can be conducted in a variety of ways (Dameron, 2005; Hodge, 2005, 2003, 2001). Some are identified by acronyms such as FICA (Faith, Importance/Influence, Community, and Address/Action) (Puchalski & Romer, 2000) and HOPE (Hope inspiring resources/Organized religious affiliation/Personal spirituality and practices/Effects on care) (Anandarajah & Hight, 2001). However, hospice social workers may conduct a spiritual history, which is another type of spiritual assessment. A spiritual history involves asking a series of open-ended questions about a patient's religious and/or spiritual background.

For example, as part of a spiritual history, hospice social workers may visually depict current spiritual resources in the patient's environment (spiritual ecomap), key moments in one's spiritual journey (spiritual lifemap), and intergenerational spiritual and religious trends (spiritual genogram) (Hodge, 2005, 2003; Gause & Coholic, 2007). As described by Hodge (2005, 2003), a spiritual ecomap depicts the strength of a patient's current connection with, for example, religious rituals, God/transcendent, religious community, spiritual leadership, parents' spiritual tradition, and transpersonal beings (e.g., angels or deceased loved ones) like in Appendix C.

Therefore, conducting a spiritual assessment provides essential information for spiritually competent hospice social work. This information facilitates a multifaceted understanding of the patient's religious and/or spiritual beliefs, provides an opportunity to communicate respect for the patient's spiritual worldview, and clarifies potential religious and/or spiritual resources that may be used throughout the intervention process

(Bratton, 2005; Puchalski, 2001; Puchalski, Lunsford, Harris, & Miller, 2006). These results may further highlight the need for the intervention of a board certified chaplain or other expert in spiritual care that requires a coordinated referral.

Spiritual Care

A variety of spiritual care models have emerged across disciplines (Holloway, Adamson, McSherry, & Swinton, 2011), with the majority coming from nursing and palliative care literature. One model that may be used to inform social work is by Puchalski (2008a, 2008b, 2007, 2006, 2001) and associates (Puchalski, Ferrel, Virani, Otis-Green, Baird, Bull, Chochinov, Handzo, Nelson-Becker, PrincePaul, Pugliese, & Sulmasy, 2009; Puchalski et al., 2006). These authors suggest that spiritual care requires interdisciplinary collaboration based on the biopsychosocial and spiritual model. Spiritual care is thus considered a component of holistic care that is patient-centered. It is also inclusive of spiritual care interventions that can be seamlessly infused into treatment.

Puchalski and associates (2009) suggest that illness challenges active engagement in activities and relationships that preserve life quality. Thus, the goal of spiritual care is to help patients experience a renewed sense of life meaning, purpose and connection with self, others, and the sacred. This spiritual care model provides a reference point for spiritual competence that is compatible with hospice social work in that it is congruent with the professional value of human diversity, including respect for the dignity and worth of all people. The delivery of spiritual care is associated with intrinsic and extrinsic practices that are also familiar to hospice social workers and can be integrated into the standard provision of care (Puchalski, 2008b; Puchalski, 2007).

The intrinsic components of spiritual care define the quality of engagement in the therapeutic relationship. Examples include the communication of compassion, unconditional positive regard, instillation of hope, and cultivation of a meaningful connection (Puchalski et al., 2009; Puchalski, 2008b); variations of such components are included in Appendix D. Hence, based on psychology and social work research, intrinsic components of spiritual care would require the application of spiritually sensitive, generalist practice skills (Briggs & Rayle, 2005b; Canda, 2005, 1999; Canda & Furman, 2009; Yardley, Walshe, & Parr, 2009; Callahan, 2013a, 2012, 2009a).

Extrinsic components of spiritual care are task-oriented. This includes the collection of patient information through the conduct of a spiritual assessment (Puchalski et al., 2009) and other interventions that are advanced generalist in nature (Appendix D). These extrinsic components of spiritual care would further require clinical skills to deliver spiritually oriented,

integrated, or modified psychotherapy as seen in Appendix E. Hospice social workers may draw from advanced generalist or clinical skills to help patients engage in faith sharing (Appendix F).

It is important to recognize when the provision of spiritual care is not appropriate. As previously suggested, a hospice social worker may not have the training, comfort level, or time to engage adequately in spiritual care. Knight & von Gunten (2004b) posed the following questions to assess a practitioner's personal readiness to provide spiritual care:

1. Do I have time to explore in further depth the impact of this person's religious beliefs upon their treatment decisions?
2. Do I know how to assess whether this patient's "pain" is physical or spiritual in origin?
3. Am I comfortable talking with this family about their religious beliefs and practices?
4. Am I likely to impose my own set of values or beliefs upon them in the process of assessing their needs?
5. Will I be comfortable in the face of strong emotions that may arise in the process of a more in-depth assessment of spiritual suffering?
6. Will I have the time and skills to provide comfort if my questions evoke great sadness or distress?
7. Who could best meet the needs of this patient and family at this time?

When additional help is needed, hospice social workers may seek the help of professionals with more expertise on the patient's interdisciplinary team such as a board certified chaplain or patient clergy in the community (Sperry & Miller, 2010).

Conclusion

This article highlights key constructs in spiritual care for hospice social workers. Even though these concepts span across disciplines, there is enough uniformity to clarify what defines spiritually competent care for hospice social workers. At times, the provision of spiritual care may stretch the boundaries of hospice social work, so coordination with other professionals may be the best expression of spiritual competence. It is important, however, for hospice social workers to build spiritual competence by seeking additional education and skilled supervision.

Implications for Christians in Social Work

Spiritual competence is essential for Christian social workers to manifest God through their work, but also to be sensitive to the fact that

not all patients are Christian. The practice of social work allows one the opportunity to express Christian virtues like faith, hope, and love (e.g., 1 Corinthians 13). Religious practices such as prayer can help one cope with compassion fatigue or inspire advocacy efforts to combat moral distress. Information relative to spiritual competence is particularly important for Christians in hospice social work. Christians in hospice social work may encounter patients with spiritual and religious struggles they identify with, such as why they are suffering, how to seek forgiveness, and how to sustain hope in eternal life. Hence, the potential for difficulty as well as the many opportunities for spiritual growth requires Christian social workers to learn more about how faith informs practice and how practice informs faith.

Future Research

This review suggests many directions for future research. Directions for future research include the need for more work to validate key constructs, which includes the development of measures to begin quantifying and testing potential relationships between factors that are believed to be associated with spiritually competent care. This trajectory will certainly involve research on specific treatment areas and patients in effort to determine the circumstances under which particular factors influence the *spiritual* quality of care.

It is also important to test training programs designed to help social workers develop spiritual competence. There is a substantial body of research about course curriculum related to spirituality and religion in university settings. This body of research needs closer examination to determine best teaching practices as well as factors associated with learning retention and application. Such research is essential for social work educators to use evidence-based teaching practices to cultivate spiritual competence in social work students and professionals.

Professional Responsibility

Spiritual competence has been established as a priority by professional and regulatory bodies across disciplines. New research and educational opportunities have emerged with implications for spiritually competent care by hospice social workers. It is appropriate to take a moment to marvel at these advancements and consider new directions in research, education, and practice. One important step is for hospice social workers to build spiritual competence so they may become active members on interdisciplinary teams that share in responsibility for spiritual care. To engage in such dialogue, hospice social workers must take time to learn the language that has emerged in research on spiritual care. ❖

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Appendix A: Spiritual Competency Framework

This competency framework is based on the work of Gordon & Mitchell (2004) with some modification to clarify further the differences between each level of competence:

Level 1 – This level applies to hospice staff and volunteers who have any casual contact with patients and their families/carers. To operate at this level, staff and volunteers must have self-awareness, understand that all people have spiritual and/or religious needs, have the ability to build relationships, identify potential unmet spiritual and/or religious needs, and refer to members of the interdisciplinary team for these needs to be met.

Level 2 – This level applies to hospice staff and volunteers who have formal contact with patients and families/carers. To operate at this level, staff and volunteers are able to build upon the competences expected of level 1 with increased self-awareness, ability to identify the presence of spiritual and/or religious needs, ability to recognize how spiritual and/or religious needs may be met, collaborate with the interdisciplinary team to ensure these needs are met, and seek additional training to build spiritual competence.

Level 3 – This level applies to hospice staff and volunteers who are members of the patient's interdisciplinary team. To operate at this level, staff and volunteers are able to build upon the competences expected of level 1 and level 2 with the ability to conduct formal spiritual assessments, develop a care plan inclusive of spiritual and/or religious needs, recognize potential ethical issues, sensitive handling of related patient information, and seek additional training to build spiritual competence particularly in areas of weakness.

Level 4 – This level applies to hospice staff and volunteers who are primarily responsible for the spiritual care of hospice patients. To operate at this level, staff are expected to have extensive professional training, authority, and expertise to manage and facilitate complex spiritual and/or religious needs of those associated with the patient's care. These individuals are likely to be board certified hospice chaplains or volunteer clergy. Examples of these needs involve existential needs associated with addressing end of life issues.

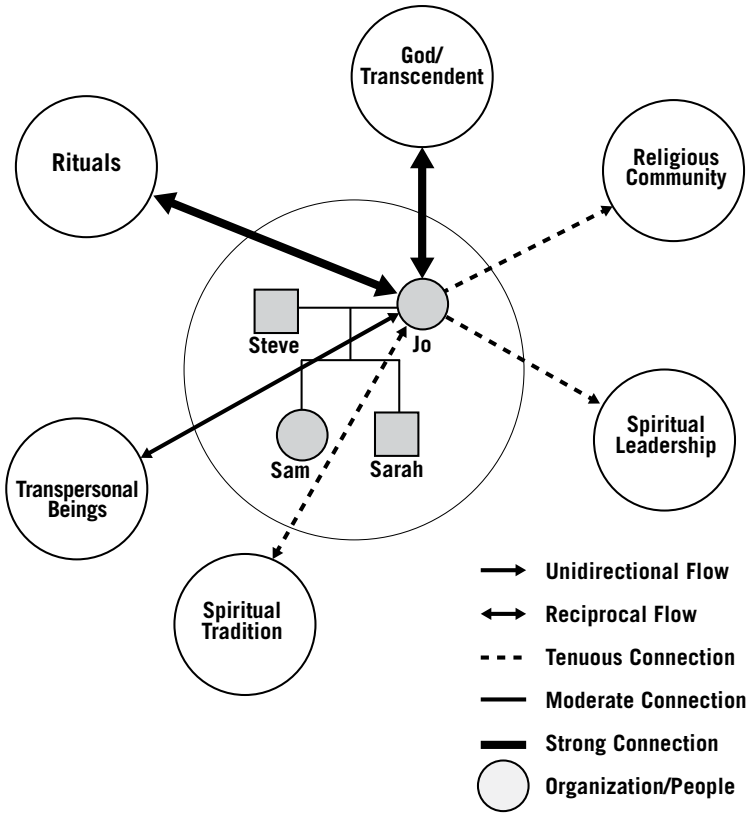
Appendix B: Biopsychosocial and Spiritual Needs

This review of biopsychosocial and spiritual needs is based on the work of Callahan (2009a). The close convergence of these needs demonstrates the importance of spiritual assessment:

Biological	Psychological	Social	Spiritual
Adequate treatment and care	Hope	Closure, finish business, and goodbye	Experience of nature
Caring health providers	Authenticity	Forgiveness and reconciliation	Divine forgiveness and support
Prudent medical management	Positive outlook	Legacy	Discussion about God and eternal life
Symptom control	Respect	Presence of loved ones	Meaning, purpose, and value in life
Physical comfort	Life review	Reunion with others	Visits by clergy
	Reflection	Mutuality and connectedness	Religious literature, items, and music
	Control	Final arrangements	Religious services, rites, and sacraments
	Acceptance	Permission to die	Prayer
	Fulfillment	Open communication	Inner peace

Appendix C: Spiritual Ecomap

There are a variety of ways to conduct and visually depict a spiritual history. Below is an example of a spiritual ecomap:



This ecomap depicts Jo's relationship with social systems associated with Jo's spiritual history and current functioning. Jo has a tenuous but reciprocal relationship with her spiritual tradition, based on her Catholic upbringing, as it continues to inform her spiritual worldview. Jo also has a tenuous relationship with her church and priest. Even though Jo has sought their spiritual support, she has been unable to maintain church participation due to being homebound. Jo has a strong, reciprocal relationship with God and relies heavily on religious rituals for spiritual coping. Jo has a moderate, reciprocal relationship with transpersonal beings identified as her guardian angel, Catholic saints, and Virgin Mary through prayer.

Appendix D: Spiritual Care Interventions

Based on research across disciplines[1], below are examples of interventions that hospice social workers may employ to provide spiritual care:

Generalist "Intrinsic" Interventions*:

1. Recognizing Personhood
2. Therapeutic Touch
3. Being Present
4. Listening
5. Reframing
6. Affirming
7. Self-disclosure
8. Normalization
9. Advocacy
10. Referral/Coordination

***Sources:** Callahan, 2009a, 2009b, 2010a, 2011b, 2012, 2013a, 2013b, 2013c; Canda, 1999; Briggs & Rayle, 2005b; Kaeton, 1998; Byock, 1996; Eilberg, 2006; Sheldon, 2000; Puchalski, 2001, 2006; Puchalski et al., 2009; Puchalski et al., 2006; Furness & Gilligan, 2010; Heyse-Moore, 1996; McCormick & Conley, 1995; Kubler-Ross, 1997; Mako, Galek, & Poppito, 2006; Cooper, 2005; Nelson-Becker, 2008; Sandage & Shults, 2007; Sperry & Miller, 2010; Stephenson, Draucker, & Martsolf, 2003; Watson, 2006; Eisenhandler, 2005; Tan, Grief, Couns, Braunack-Mayer, & Beilby, 2005; Miller et al., 2005; Rice & McAuliffe, 2009.

Advanced Generalist/Clinical "Extrinsic" Interventions*:

1. Visualization
2. Mindfulness
3. Bibliotherapy
4. Journaling
5. Reminiscence
6. Groupwork
7. Relaxation Response
8. Autobiographical Work
9. Guided Imagery
10. Focusing

***Sources:** Callahan, 2009a, 2009b, 2010a, 2010b, 2011b, 2012, 2013a, 2013b, 2013c; Bratton, 2005; Briggs & Rayle, 2005b; Staude, 2005; Miller, 2003; Kelly, 1995; Goldstein, 2007; Sheldon, 2000; Carson & Koenig, 2004; Furness & Gilligan, 2010; Puchalski, 2001, 2006; Puchalski et al., 2006; Puchalski et al, 2009; Hills, Paice, Cameron, & Shott, 2005; Sperry & Miller, 2010; Miller, Chibnall, Videen, & Duckro, 2005; Rice & McAuliffe, 2009.

Appendix E: Spiritually Modified Psychotherapy*

Traditional psychotherapeutic interventions may be adapted by a clinical social worker to address patient spiritual needs. Below are some examples:

1. Cognitive behavioral therapy – e.g., reframing self-defeating religious messages
2. Acceptance and commitment therapy – e.g., meditating to accept self/others
3. Existential therapy – e.g., creating sense of meaning to motivate life purpose
4. Psychodynamic therapy – e.g., transferring religious conflicts for resolution
5. Family therapy – e.g., building meaningful connections between family members

***Sources:** Callahan, 2010b, 2010c, 2011a, 2011b, 2013b; Sperry & Miller, 2010

Appendix F: Patient-Assisted Faith Sharing

In patient-assisted faith sharing, the patient elicits the help of the hospice social worker to engage in spiritual and/or religious practices. Below are some examples:

1. Verbal support and encouragement of spiritual beliefs
2. Read scripture or religious material for/with patient upon request
3. Share faith-related affirmations based on patient example
4. Prayer led by patient
5. Religious rituals arranged upon patient request

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