ADVANCING THE INTEGRATION OF SPIRITUAL CARE IN HEALTH CARE

Caring for the Human Spirit® magazine

FALL/WINTER 2018

CRISIS & TRAUMA CHAPLAINCY

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HealthCare Chaplaincy Network™

A HEALTHCARE CHAPLAINCY NETWORK™ PUBLICATION

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HealthCare Chaplaincy Network™ is a global health care nonprofit organization that offers spiritual-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Our mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve the 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*. We have been caring for the human spirit since 1961.

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A LETTER FROM REV. ERIC J. HALL

Rev. Eric J. Hall
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Dear Healthcare Professionals,

We know that the qualifications and certifications of the chaplains who care for your patients are important to you. We at Healthcare Chaplaincy and the Spiritual Care Association have spent our existence educating chaplains, conducting research on spiritual care in health care, and developing and providing clinical spiritual care.

We want to ensure that you have the correct information regarding chaplains who are either already certified, or in the process of becoming certified, by the Spiritual Care Association (SCA). Many chaplains are being told that their institutions do not accept SCA certification. In some cases, we have found that chaplains of other certifying bodies are providing inaccurate information when asked by institutional leadership to prevent SCA certification from being accepted. This exclusion is not, and cannot, be supported by any evidence related to the ability of SCA certified chaplains to meet the chaplain's job requirements or performance standards. In fact, we excel at it.

The Spiritual Care Association, in 2016, responded to many calls from within professional chaplaincy and health care leadership from other disciplines for a more objective and evidence-based certification system. The Spiritual Care Association is the only chaplaincy certification process that objectively tests for achievement of core knowledge tied to quality indicators and uses direct observation of chaplain visits to test clinical competence. Hundreds of chaplains and institutions have embraced this new system as a step forward in the integration of spiritual care in health care. They have found our extensive standardized education and training to more closely align with the institution's need to provide quality care with identifiable outcomes and contributing benefits.

Institutions from coast to coast, and now all around the world, are working with us to enhance the care their patients, caregivers, and healthcare professionals receive. We can help you raise the bar and increase the benefit of your patients' experience. One starting point is accepting SCA certified chaplains, but HCCN and SCA have so much more to offer your organization and the people it serves, their families, as well as your staff who provide the care.

The Spiritual Care Association is happy to answer any questions and concerns about its certification process and/or assist you in determining the needs of your organization and the chaplains you hire to provide competent, compassionate care to your patients, families, and staff based on its current needs and relevant research and practice. We stand ready to work with you and your team to get the most out of evidence-based spiritual care.

The POWER of Holding Faith

By **Lee Woodruff**

"Who's going to want to dance with me now?" His face clouded over as he looked down at his legs. I could feel the anger rolling off of him.

The soldier was young. Early twenties if I had to guess. One foot, shattered by a roadside bomb in Iraq, was raised in traction, a halo contraption holding the bones in place.

I sat on the end of his bed in the Traumatic Brain Injury (TBI) unit of the VA hospital as he described how much he loved to dance. He told me he had the kinds of moves that drew the ladies' eyes.

"Who's going to want to dance with me now?" His face clouded over as he looked down at his legs. I could feel the anger rolling off of him.

I had earned the right to ask about his injury. My own husband had been seriously wounded by a roadside bomb just a few years earlier. In an instant, my world had turned upside down, and I was caregiving a husband at 46 with four young children.

The door to Jason's room opened suddenly and a nurse bustled in, checking his chart and monitors. She was older, cheery and chirpy. "How ya doin,' Jason?" she boomed with a voice full of personality. He mumbled a response.

"Did you talk to God today, Jason?"

"You know I don't believe in God," he scoffed, working to keep his face stony.

"Well, that's okay, Jason, I talked to him this morning and he says to tell you he's got your back." Her gaze never left the blood pressure cuff as she spoke.

The barest trace of a smile flickered across Jason's face and, suddenly, I understood. This was a familiar exchange, a dance they had both created, where only they knew the steps.

I learned an invaluable lesson that day, witnessing the interaction between the nurse and the young man who was coming to terms with a different set of dreams.

Jason may not have believed in God, or maybe he was too angry to begin a conversation, but that nurse worked her own small miracle as she tended to his medical needs. It was the kind of spiritual healing that didn't come in cc's or with a prescription. It required no extra time or effort from her duties. Including Jason in her prayers, whether he wanted her to or not, had a quietly powerful effect. As she

checked his IV lines and examined his chart, that nurse was holding the faith for him.

My own journey with resilience and testing my faith began on January 29th, 2006. My husband, Bob Woodruff, had just been named the anchor of ABC World News Tonight. Just six weeks into the job, he was reporting from inside a tank from Iraq when a roadside bomb exploded 20 feet away. Bob's skull was shattered. Rocks and shrapnel penetrated his head and neck. The incredible work of the military medics and so many others in his continuum of care is the reason he made a miraculous recovery and is back at work reporting the news.

During his 36 days in a coma, and the painstaking months of rehab beyond, I would come to understand that what had gotten me through this ordeal was a stool with four legs, each of them beginning with the letter F. Family, friends, faith and funny. In different measures and different degrees, each of these four F's had held me up and sustained me.

I had to trust in God and believe that, perhaps, our family could experience a miracle of any size and form. I was not going to let anyone rob me of that hope until Bob woke up from his coma and we could understand how much of him was left after the explosion.

At the very lowest moments in the journey—and there were many—my faith functioned like a trampoline that prevented me from sinking lower and boosted me back up with renewed hope.

Faith was the thing that gave me the conviction to tell my children that I believed God would help their father heal. Faith became the quilt that covered and comforted us as we lived, suspended between despair and hope, knowing that friends around the world were praying for us in their places of worship.

Too much information, negativity, too many facts, would have drowned me in those early days, for my husband's prognosis was not good. And yet the doctors and nurses in the hospital were able to keep the door open for me to believe. They were willing to negotiate with my psyche, to meet me in the darkened room I was in, and allow my brain to catch up with the reality of the situation.

In the journey our family has made since Bob's injury, establishing the Bob Woodruff Foundation (bobwoodrufffoundation.org) and working with injured veterans and their families, I have learned that there is hope in almost every situation. Even at the end of life, we can hope to have a "good" death. Hope can help a person move from diagnosis to treatment to palliative care and hospice. Words and the way we say them matter so much.

I don't know what happened to Jason after I left his room in the VA hospital. And I wish I'd asked that nurse's name, although I can still picture her smile. I will never forget the lesson she taught me that day about the transformative power of faith, and the life-changing ability to carry it for someone else on the days it may feel too heavy for them to bear.

Lee Woodruff *is a writer, media trainer and co-founder of the Bob Woodruff Foundation, which helps veterans and their families as they transition back to the homefront. Her favorite job is being a mother to four mostly grown and flown kids.*

CRISIS AND TRAUMA

The King and the Ant

By **Rev. Marcos A. Miranda, MDiv., BCC**

One of my life dreams is to climb Mount Katahdin in Maine. It is not the tallest mountain in the northeast—that honor goes to Mount Washington—nor is the ascent as steep as the fabled Priest trail in central Virginia. What makes Katahdin such a challenge, though, is a 1.1-mile trail known as the Knife Edge. You can see it in numerous GoPro videos on YouTube. It's a rocky scramble between two peaks, in some places as narrow as two feet, with deadly plunges on both sides. Forty-four people have died on Katahdin in the past 90 years, and the Knife Edge has claimed some of them. Yet, I want to cross it…after I get myself back into better physical shape.

When I think of the Knife Edge, I think of a young man named Hector. Hector was no kind of mountain climber, not in the conventional sense. However, he had scaled peaks of his own. Neither of his parents had finished high school, but Hector attended services at his local church and was an academic star by the time he was in second grade. He was also a fine athlete, playing baseball, basketball, and football. He was kind, thoughtful, and wise beyond his years. In short, he was one of those kids who, if he could just stay out of trouble, has a future that is assured.

For the longest time, Hector did fine. Then came adolescence, and a slow decline. His grades slipped. His performance on the court and field wasn't up to his regular standard. He began to withdraw, socially. It wasn't so much as to be a crisis, but enough to notice. During this time, he insisted he was fine. His parents did, too.

When I was first contacted by his parents via our crisis hotline, Hector was in a serious depression. His lethargy, according to his parents, had worsened. After my initial home visit and assessment, I recommended to his parents that he see a psychiatrist, thinking that there was something biochemical going on in his brain. Teens can develop severe depression too, and their likelihood of suicide is higher than that of adults. I did not want Hector to become a statistic. With his parent's permission and a release, the psychiatrist called me. I shared as much as I could to be helpful.

The psychiatrist was excellent, someone who believed both in talk therapy and pharmacology. He was Spanish-speaking, so he could talk to the parents as well as to me. He shared with me that Hector had lost interest in all the things that had once mattered to him because he didn't understand how, in a world so filled with suffering, there was any point in his expending energy. The doctor was skeptical of this explanation. He thought it was a cover story for something deeper, psychological or biochemical.

He tried Hector on various anti-depressants. Nothing seemed to work. The next step would be electroshock therapy, which has surprising clinical success despite the impressions that many have about it. Hector's parents recoiled from this possibility. Before they would do that, they wanted Hector to do some pastoral counseling with me. I agreed, though I made it clear my perspective would be religious, spiritual, ethical, and Biblical.

Within ten minutes of my next home visit with Hector, I realized that he had been telling the truth all along. He was frozen on the ledge of the Knife Edge of life, with a scary and narrow path ahead of him, the abyss of his ultimate death on one side, and of the guaranteed losses of life on the other. Hector was not in a psychological crisis, or a biochemical crisis. His crisis was spiritual, and I defy anyone to say that for at least a few moments, they have not experienced one like it.

I know it myself, that experience of being frozen on Hector's Knife Edge. In his case, he was overwhelmed by the future.

In mine, it was the present. I was teetering on that thread-thin path, staring down into the abyss of loss and death that was, in the moment, too much to bear. I had responded to a residential fire only to witness the unfair and tragic death of a child. Just reading about it in the news made me weep for the fate

of an innocent. In such a case, who among us has not just wanted to stay in bed, pull up the covers, and say to heck with it all?

Rather than make a futile attempt to talk Hector out of feelings that were all too real, I shared one of my favorite stories from the tradition of our Jewish friends, inspired by the words of Proverbs chapter 6, verses 6-8, about a wise king and a man also overwhelmed on the Knife Edge.

It is said that King Solomon, so wise and knowing, was traveling with his retinue in Jerusalem when he came upon a healthy young man prone in the dust of the road. The king asked, "Young man? Why do you lie there like a stone? Are you ill?"

The man answered, "No, I am healthy. But I have no strength for the day."

"Did you work all night?" the king queried.

The man shook his head. "No. I am depressed. Life is too much with me."

"The world can be depressing," agreed the king. "And then, the sun still rises."

"You are the wisest of men, offer me advice," the young man implored.

The king pointed to a busy anthill at the man's feet. "Learn from the lowliest of creatures. An ant lives less than half a year. In all that time, she is so small she can't eat more than a single grain of wheat. Yet she works without rest, gathering enough to sustain her body for many years."

At this point, Hector broke into the story. "That's crazy. What's the point? Why should an ant collect food for years when it's only going to live for a few months? Why should anyone?"

I smiled. "You should have written the story," I told Hector. "Because that's pretty much what the man said to King Solomon. Do you want to know what the king said back to him?"

Hector managed a grin. "Do I have choice?"

I nodded. "We all do. Solomon told the man that the ant thinks, 'Well, maybe I'll be granted an exceptionally long life. So I'd better gather a lot of food, in case the Creator gives me miraculous longevity."

"Ants don't get longevity," Hector argued.

"True," I told him. "But the grain it gathers doesn't go to waste. The ant has a mission, and even if the ant dies, the colony will use it. I'd say that in those circumstances, it's a waste for the ant to sit around and play some ant version of Fortnite. She gets out there and gathers food, even though animals might eat her, people might step on her, and if things go exceptionally well, she's only going to live for a few more months, anyway."

"But ants don't think."

"But we humans do," I told him. "When you asked me a second ago, 'Do I have a choice?' my answer was, 'We all do.' And we have a choice about whether to lie in the road and watch the ants or get up and use our gifts to help our families, our communities, and ourselves lead better lives. It's scary as crap out there. There's death on the left, and tragedy on the right. That's our reality."

Hector nodded grimly. "I feel like I'm walking high up on a ledge all the time, but I'm not sure where I'm headed. It's easier sometimes just to stop."

"Even an ant stops, sometimes," I reminded him. "There were a lot of things I have heard you speak about that made you happy, Hector. I think God wants us to be our best selves. And we can't be our best frozen on the Knife Edge of life." I took a chance with my next sentence. "I'm not a psychiatrist, Hector, but I think there's a reason those antidepressants didn't help you. Your problem isn't brain chemistry. I think the solution to your problem lies in finding a reason to take the next step."

"Maybe I should think of the ant," Hector joked.

"Now you're thinking like a King," I joked back.

Hector came back slowly. He returned to the basketball court first, and then to the other playing fields. He found more happiness in moving his body than in intellectual pursuits, though he went on to finish high school and go on to college. He's studying occupational therapy, another body-centered endeavor. I think maybe he's protecting himself from thinking too much, which is something for which I give him credit.

Most of all, I give him credit for finding a way to get out of the road and start putting one foot ahead of the other on this Knife Edge of a trail that we call life. We may not reap the fruit of our labors, but like those of the ant, they will never be in vain.

Rev. Marcos A. Miranda, MDiv, BCC *is the Founder and President of New York State Chaplain Task Force, an affiliate of United States Chaplain Task Force, and the Senior Pastor at Action In Christ International in Brooklyn, NY. He also serves as a chaplain with the New York State Fraternal Order of Police and recently completed the Doctor of Ministry program at Hebrew Union College-Jewish Institute of Religion.*

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CPE.org is provided by HealthCare Chaplaincy Network (HCCN), through its educational partner, the Institute for Clinical Pastoral Training (ICPT). HCCN has been providing CPE over 40 years and has educated thousands of CPE students. ICPT offers the only CPE evidence-based curriculum and objective testing.

During times of patient crisis, both health and spiritual care workers are on hand to comfort, educate and guide the sick. But who takes care of the caretakers? In this special section, we examine issues and challenges surrounding staff care and resiliency.

On The Evolution (Or Devolution) of Clinical Pastoral Training

BY RAYMOND J. LAWRENCE, D.MIN. DIPLOMATE SUPERVISOR AND PSYCHOTHERAPIST, CPSP

PERRY N. MILLER, D.MIN. DIPLOMATE SUPERVISOR AND PSYCHOTHERAPIST, CPSP

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Anton T. Boisen, the most unlikely of all persons to have created a revolutionary movement of any kind, spawned the clinical pastoral training movement in 1925. Boisen drew from the findings of Sigmund Freud. He trained clergy to be listeners, and to be listeners especially to the unconscious. In Boisen's view, the incorporation of such psychoanalytic principles into the practice of clinical pastoral training, and therefore pastoral care and counseling, was essential. This approach, in a few words, was the road to healing not only for patients but also most critically of all, for the trainee.

Both Freud and Boisen were adherents to the tradition of Socrates and his injunction that it is essential 'to know oneself.' Thus, the mission of the pastoral clinician is to assist the patient or parishioner in that task. However, there is a hidden agenda here too. To assist another 'to know the self,' the pastoral clinician must also be engaged personally in that task. The latter is the real sticking point, the place where resistance kicks in, the point at which clinical pastoral training becomes a fearful threat to all of us well-defended persons. To attend to a patient's unconscious is one thing, but to attend to one's own is another matter. Many a clinical pastoral trainee has foundered on the rocks of his or her own unconscious.

Thus, the authentic clinical pastoral training movement has always had a threatening edge to it. No one comes to know the self without some degree of serious uneasiness. Rural Howe put it well:

I want students "dunked" — plunged deeply into life, brought up gasping and dripping, and returned to us humble and ready to learn. I want my students to lose, as soon as possible, their easy faith, their ready answers; and I want them to lose any hope of ever again having an easy faith or a ready answer. I want them to lose their personal conceits and their illusions about themselves, their illusions about their fellow men and their illusions about God. I want their assumptions about ministry and their assumptions about how they are going to conduct their ministry completely destroyed.

Through the decades since Boisen, the clinical pastoral training movement has morphed into something less threatening. A part of this transformation has been the elimination of the threatening requirement of self-knowledge and a reversion to educational theory. Malcolm Knowles supplanted Sigmund Freud as the principle extra-theological theorist among many pastoral clinicians. Clinical training has been supplanted by clinical education. If we can assume the task of passing on information, we can thereby bypass the burden of knowing ourselves. We can then put Socrates, Freud and Boisen back into their graves, and relax.

Boisen' s movement was quickly and almost universally embraced by the Protestant churches by the mid-1930s, and from then on virtually every Protestant minister had at least a single unit of clinical pastoral training, often to very positive effect. Boisen's vision reinvigorated Protestantism in the U.S. between 1930 and 1960.

As the decades rolled on, Boisen's vision has been eclipsed. The organizations that have purported to carry forth the mission of Boisen reverted to alternative and less frightening views of life and healing. Today one would be hard pressed to find any significant number of so-called pastoral clinicians who have even read any of Boisen's works. If Boisen could be resurrected from his grave, he would not likely want to have anything to do with the clear majority of the programs that purport to be clinical pastoral training, or more lately clinical pastoral education.

In the current environment, Boisen is little more than an empty and forlorn figurehead. His clinical training is no longer 'training.' It is now 'education.' His 'pastoral' training is no longer pastoral. It's 'spiritual.' Few in the field bother to read Sigmund Freud and the works that inspired Boisen to create clinical pastoral training. They prefer to read Carl Jung because Jung believed in god, or in fact many gods.

The College of Pastoral Supervision and Psychotherapy (CPSP) is no perfect vessel. However its central mission is to return the clinical pastoral movement to its historic, redemptive and transformative mission, that of training religious leaders in the task of pastoral care and counseling. The CPSP assertion that it is committed to "Recovery of Soul in the clinical pastoral movement" takes on rich meaning for the CPSP community.

Creative movements in history invariably change through time. The salient question is whether the changes are for better or for worse. It is now past time for a critical assessment of the changes that have taken place in the clinical pastoral movement over the past century. Have they been for good or for ill? Every responsible pastoral clinician is obliged to weigh in on this question.

Raymond J Lawrence, D.Min. *is General Secretary, College of Pastoral Supervision and Psychotherapy. Diplomate in Pastoral Psychotherapy and Pastoral Supervision and author most recently of Recovery of Soul: A History and memoir of the Clinical Pastoral Movement (Amazon).*

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Brian H. Childs, Ph.D. *is Professor of Bioethics and Professionalism at the Mercer University School of Medicine, is past President of CPSP and a Diplomate Supervisor and Psychotherapist. He is also on the Board of Trustees of the Commission for the Accreditation of Pastoral and Psychotherapy Training.*

The Role of Self-Care in Establishing the First Outpatient Chaplaincy at Memorial Sloan Kettering Cancer Center

By **Clio Pavlantos, B.C.C., M.Div., M.A., C.M.A**

I am a staff chaplain at Memorial Sloan Kettering Cancer Center (MSK) in New York City, one of the first outpatient chaplains the hospital has ever had in its long history. I began at Sloan Kettering as an intern. When I became provisionally certified, the director of Chaplaincy Services, Reverend Jill Bowden asked me to participate in a pilot study to determine the need for outpatient chaplaincy at the Evelyn Lauder Breast and Imaging Center (known at MSK as "BAIC"). The project was a response to repeated requests for chaplaincy coverage from the Breast Service. The requests came from the BAIC's director, Dr. Larry Norton, a medical oncologist whose pioneering research has dramatically improved the treatment of breast cancer.

The BAIC is housed in its own building near the inpatient hospital. BAIC treats patients from all over the world while continuing its traditions of research, teaching fellows, training research and nursing staff. As at every MSK facility, all those who work there — from environmental services, to food services, administrative and security staff, research and clinical staff, to medical and surgical staff — see their work as vital to the best possible care of the patients they serve.

When I arrived, the outpatient Breast Service had no tradition of chaplaincy. Most of the staff at BAIC had never worked beside a chaplain, and many had no idea what chaplains did. I was starting from scratch, facing confusion and outright skepticism from some staff. Our Lead Nurse welcomed me to the facility and encouraged me to begin in the chemotherapy suites where patients were treated individually. Chemo nursing staff were curious, and many were interested in having me work with them in their unit. Watching me visit patients as they administered treatment led to my first nursing referrals. I made an educational presentation to a few nursing meetings, describing chaplaincy and identifying spiritual distress in patients. I left my card. Patient volume built slowly. Some younger nurses began to pull me into rooms to talk with patients who were anxious, upset or afraid.

I was feeling impatient to move the process along and help the nurses feel more comfortable with making referrals. I decided to make my presentation more experiential by ending it with a mock chaplaincy visit to the whole meeting. My presentation had always been as concrete and specific as I knew how to be in describing chaplaincy. In addition to speaking about spiritual distress and the National Comprehensive Cancer Network (NCCN) Spiritual Distress Guidelines that are standard practice for charting chaplaincy visits at MSK, I spoke about the kinds of statements patients make and behavior they exhibit, and the kinds of circumstances that trigger spiritual distress. This time, when I reached the end of the presentation, I gave them a typical blessing and ended with a short silence, asking all to focus on their breath. This is how I introduce patients to meditation and contemplation. The breath is an introduction to sitting in silence in many cultures and religions, and it has no associations for most of the patients that I see. As I let the nurses sit in silence, the quiet in the room deepened. I kept it short and asked them to briefly focus on what brought them into nursing and what they hoped to accomplish that day. Afterwards, the nurses reacted positively. Many said they wished they could have more meditative experiences themselves, and I offered to lead quiet time with them whenever they made a request.

In the months that followed, nurse managers came to me and asked me to begin meetings with quiet time.

Chemo nurses asked me to lead contemplative time at their morning briefings. I was asked to present to administrative staff, and a few of them spoke about how much they wanted to begin every day with a silent time. Our conversation led to a meditation group run by administrative staff that met for several months. Many administrative staff began sitting in silence on their own, some with the aid of phone apps. Staff began to see how self-care in turn improves patient care and began to understand that they need to care for themselves as they provide care for patients. Learning about self-care led to better understanding of how chaplaincy affects patients. Experiential education that evolved into self-care carried deep information about chaplaincy to many levels of management throughout BAIC. Staff wanted to pass on to patients what they had experienced. Staff became more open to making referrals. Ministry to staff led to better ministry to patients. I've recently been asked to make several presentations to one department at the BAIC, introducing several levels of administrative and clinical staff to chaplaincy and contemplation. The Lead Attending came to me to say that she had received positive comments from staff. She attended a subsequent presentation and has asked that fellows learn about chaplaincy.

Questioning the role of chaplaincy in outpatient care has stopped. Nursing referrals from those who've experienced chaplaincy are more focused, leading to visits concentrated more clearly on spiritual concerns. This has led to more positive patient experiences focused more clearly on spiritual care: I've been approached by medical oncologists whose patients have spoken about the efficacy of spiritual care in response to chaplaincy consults. I've been approached by all levels of staff about meditation/contemplation. These days, more people know who I am and what I do, even if I've never met them.

As I reflect on my experiences in the early phases of bringing chaplaincy to BAIC at MSK, I am struck by the bond between healthcare providers and patients. Both groups have a need for spiritual care and both have a need to learn spiritual self-care. The experience of being visited by a chaplain or experiencing chaplaincy as part of staff education can become templates for individuals discovering their own means of spiritual self-care. Being present to the creation of sacred time and space can be educational as well as experiential. Experienced transcendence is a guide in finding a personal relationship with the sacred. Whether I consult with a patient or lead staff meditation, I am showing providers and patients how to take care of themselves. This may be the most satisfying aspect of my chaplaincy at BAIC.

In my CPE training, I'd heard about "elevator speeches" and looked at organizational charts. I've never come up with an elevator speech or a strategy for speaking with the physicians in my facility. Providing self-care ministry as part of an educational presentation on chaplaincy was the way I found to establish Chaplaincy at BAIC, building a culture of referring patients to the chaplain. My continuing open-door policy for staff and constant focus on staff care is an important part of continuing education on chaplaincy, expanding from meditation to consults for staff in spiritual distress. Staff referrals for chaplaincy continue to become more focused on spiritual and religious concerns as staff experience the wider range of spiritual issues covered by the chaplain's ministry.

Person-to-person experience has been instrumental in establishing chaplaincy in a facility without any tradition of spiritual care. Staff and patients have found a shared need for chaplaincy. The experience of spiritual care has been the most effective way for me to generate interest in chaplaincy on the part of staff and patients. One meaningful self-care experience may be worth many elevator speeches and a few hundred PowerPoint slides.

Clio Pavlantos *is currently Staff Chaplain serving at the Evelyn H. Lauder Breast and Imaging Center, Memorial Sloan Kettering Cancer Center. She comes to Chaplaincy from the arts, notably as instructor at The Laban/Bartenieff Institute of Movement Studies, where she was a member of the Certificate Faculty.*

Chaplaincy: Self-Care for the One Who Cares for Others

By **Elaine Chan, B.C.C., M.Div., M.S.W.**

While walking in Chinatown one day after work, I stopped by a Chinese bakery to pick up rolls for my mother and sister. It was the end of the day and the trays on the shelves looked bare. A disappointed Caucasian patron told me that the bakery didn't have anything fancy, like chocolate or fruit fillings, only plain buns. But this was just fine with my mother and sister are Chinese-Americans, they prefer the traditional baked buns, whether roasted pork, custard filled or sweet bun.

The bakery wasn't busy. There was only one other customer, and the bakery worker was helping him. I asked her if she had roast pork buns but didn't catch her answer. Impatient, I turned to leave when she asked what my hurry was. Her question made me stop and think. Why am I always in a hurry? Since that day, I have asked myself that whenever I do feel hurried.

As a lay Roman Catholic chaplain who ministers to individuals of various faiths as well as to those who don't profess a faith, I am often on the go. I minister to patients in the pre-operative unit, which has a revolving door of patients. In addition, I visit patients in three other units, striving to see as many patients on my floors as I can, not relying solely on referrals. When I am with patients, I give them my full attention and time. In addition, I participate in interdisciplinary rounds, attend staff and other meetings, as well as periodically offer religious services. I also try to keep up with work emails and readings. I often eat lunch at my desk. I don't often leave work on time, though I usually do when I plan to visit my mom or sister, who need care. By the time I get to my home and do a few things, it's time to go to bed and wake up the next morning to start the whole process again.

Self-care is a necessity for chaplains, but it is something we often fail at. Chaplains often put their own needs last in order to attend to the needs of others. I feel the profession tends to draws individuals who are caregivers. Chaplaincy allows us to care for others as part of what we do. Our need to do for others may be seen as a dysfunction in another discipline, but doing for others is my modus operandi. I am the oldest of seven and care for my mother, sister, and others. But who cares for the chaplain when we are caring for so many others? Colleagues and our families can sometimes be good supports. But caring begins with us, with ourselves.

A spiritual director reminded me of the Christian commandment "You shall love your neighbor as yourself." Matthew included it in the Book that bears his name (Matthew 22:39), but he knew it originated in Leviticus (ch19:v18), where it is the great underlying precept of the Torah. As Rabbi Akiva (50-135AD) taught in the Talmud: "This is a fundamental principle of the Torah."

Mindful of this doctrine, once a week I try to attend a job-organized meditation session. The group that facilitates the session has an app, Journey. Journey closes their meditation by saying that our practice benefits us and those around us. A meditation would have helped me before I rushed in and out

of the bakery! I have also used other apps (e.g. Headspace, Calm and Smiling Mind).

I recently started a meditation practice every night before bed. I am still new to the process but find it helpful in relaxing me so I can rest. Sometimes different thoughts arise, for example, I remember I need to follow up with a patient the next day, or that I want to pray for a particular patient. I don't judge the thoughts. I take note of them and let them go. Doing the meditation has given me confidence to meditate with patients. Patients who are spiritual but not religious, or those who are not, may be open to meditation but not prayer. Some already have a meditation practice.

When I can, I take a walk to the local church for noontime Mass. Just being outside is lovely. There's a calming peace, especially during the spring when different trees and flowers are in bloom. I sometimes stop to take pictures. I tell God how beautiful the flowers are, complimenting God on their creation.

Taking time for prayer is a form of self-care as I stop to be present to myself. I tell God about what is happening with me. Perhaps I am feeling tired, not having slept well the night before. Or perhaps I am stressed by something that is happening at work, with family, or friends. I am aware of God's presence and love for me. At times, I may hear God's gentle reminder to care for myself and not overdo, or give me direction on something I am struggling with.

Periodically, I go on a long weekend retreat or even a weeklong one. At one retreat house, I joined a group that did Qi Gong, a Chinese breathing and movement practice, at sunset by the river. It was picturesque and relaxing.

My first Clinical Pastoral Education supervisor, a rabbi, noted that Catholic religious sisters tend to have difficulty having fun. I find that fun needs to be programmed into my life. I tell myself I am going to have fun whether I like it or not! I enjoy watching comedies, cartoons or children movies. I also just set aside time not to do anything, sitting in a park and people watching.

I enjoy spending time with children and pets as they're all about fun. A friend's son loves to play soccer. He loves chasing the ball with me, even though I am not a good player. Thank God there are usually other children in the park who want to play with him so I can take a break! It's fun to watch him play. My cats, too, love to play and to be petted. I feel that God gave them to me to teach me to be present to the moment.

Self-care is about being gentle with myself. I don't "should" or judge myself. I know I am human and can make mistakes. While there are things I have no control over--like the number of patients and the speed of turnovers in pre-op--there are things I can control, so when I am stressed or tired, I can take a break, meditate, go to church, have lunch, or try to leave on time. Like everything else, self-care takes practice.

The next time I go to the bakery, I will try not to be hurried.

Elaine Chan *is a staff chaplain at Hospital for Special Surgery in New York. She has been a chaplain for over 15 years. She has a M.Div. from New York Theological Seminary. Prior to serving as a chaplain, she worked for 20 years in community organization and development.*

SPIRITUAL CARE ASSOCIATION

Over the two years that the Spiritual Care Association (SCA) has been certifying health care chaplains, we have made numerous attempts to help chaplains and health care administrators understand the major differences between the SCA system and others with some success, but there is continuing misunderstanding on some major points.

The basic distinction between the SCA process and others in the field is that the traditional chaplain certification process focuses on how much training a candidate has and who that chaplain trained with, followed by a highly subjective and unstandardized review. The SCA process, while not unmindful of training, focuses on whether the candidate can demonstrate command of core knowledge linked to evidence-based spiritual care quality measures and direct observation of the chaplain's interaction with a simulated patient. In other words, can the chaplain deliver quality spiritual care?

The core knowledge test is the only one of its kind in the industry. Candidates for SCA certification are the only ones in the industry who have had to demonstrate knowledge of the major content areas related to chaplaincy practice. This test is completely objective and periodically updated to reflect new knowledge and research in the field.

In a traditional chaplaincy certification process, clinical competence is evaluated by the chaplain's self-report of a clinical encounter presented in writing and augmented by discussion with several peers. This self-report is generally incomplete, subject to the chaplain's memory of what actually happened, and cannot show the reviewers the non-verbals including tone of voice and pastoral presence that everyone agrees are central to the chaplain encounter. Often the encounter is with a patient the chaplain knows well and thus knows how to approach successfully. In short, the process tests what the chaplain thinks they did or what they would like to have done. In the SCA process, the chaplain engages in an encounter with a live, simulated patient. The chaplain has only a brief referral shown to them about a minute before the encounter as a preparation. Thus the chaplain's assessment and relationship building skills are fully tested along with their non-verbal skills such as eye contact, pace and tone of voice. Within 30 minutes of the conclusion of the visit, the chaplain must submit a written chart note, thus demonstrating their writing ability in the context of the job-related task of communicating with the clinical team. In short, the process evaluates what the chaplain actually does do under conditions that closely approximate their actual work situation.

We believe that these innovations merit inclusion of SCA certification as an allowable option for all health care chaplaincy positions. It is important to note that SCA has offered both of these innovations to the other chaplaincy certifying bodies. We continue in discussion with several of them on these topics but most of the major associations have declined this offer. We believe these methods are significant improvements on existing processes and would welcome other that want to adapt or adopt them.

The Rev. George Handzo, BCC, CSSBB
Director, Health Services Research & Quality
HealthCare Chaplaincy Network

SPECIAL SUPPLEMENT

SPIRITUAL CARE ASSOCIATION

The interdisciplinary, international professional membership association for spiritual care providers that has created the first comprehensive evidence-based model to define, deliver, train and test for the provision of high-quality spiritual/chaplaincy care

WELCOMING as members all individuals and organizations committed to the delivery of optimal spiritual care as a vital component of whole-person care and the overall patient experience

EDUCATING chaplains, physicians, nurses, social workers, other health care professionals, and clergy via a robust Learning Center

ENGAGING all interdisciplinary team members, recognizing that the delivery of spiritual care requires both generalists and specialists

OFFERING new pathways for chaplain credentialing and board certification to ensure demonstration of clinical competencies

ADVOCATING to advance the integration of spiritual care in health care around the world

From a chaplain:

> **"I feel like I'm finally being recognized that what I do matters. I'm finding a home where I can have community and learn more."**

MAKING SPIRITUAL CARE **A PRIORITY**

SCA, an affiliate of the 57-year-old HealthCare Chaplaincy Network, marks the culmination of decades of **experience, research, discussion**, and **insight** from respected leaders, daily providers, and others interested in spiritual care and chaplaincy.

OUR EVIDENCE-BASED MODEL

18 Quality Indicators define the key aspects of successful spiritual care, provide metrics, and suggest tools to measure that quality	**Scope of Practice** establishes what chaplains need to do to meet those indicators, and effectively and reliably produce quality spiritual care	**Knowledge Base** identifies the standardized training and experience necessary to meet the Scope of Practice	**Objective Testing** assesses the chaplain's knowledge (Standardized Knowledge Test) and demonstrated clinical competencies (Standardized Patient Exam/Simulated Patient Encounter)

OUR STANDARDIZED KNOWLEDGE TEST AND SIMULATED PATIENT EXAM:

- Bring to the profession of health care chaplaincy the same rigor in education, training and testing demanded by other health care disciplines
- Establish the framework for an ongoing process of implementation, research, and quality improvement

OUR STANDARDIZED KNOWLEDGE TEST AND SIMULATED PATIENT EXAM:

Currently, more than a dozen chaplaincy groups within the U.S. offer varying education/training, however, no other organization that trains and certifies chaplains can demonstrate the use of a standardized, evidence-based curriculum nor the scoring of knowledge and competency tests. **This is the SCA difference, and represents a higher bar than any other chaplain certification processes.**

From a chaplain:

> **"Boldly taking the leadership in areas of direct interest to me and our profession … The upgrade of standards for a 'new age' is very welcome."**

USING THIS GROUNDBREAKING AND TRANSFORMING EVIDENCE-BASED MODEL, SCA OFFERS CHAPLAIN CREDENTIALING AND ADVANCED PRACTICE BOARD CERTIFICATION

Advanced Practice Board Certified Chaplain (APBCC) is a chaplain who has demonstrated advanced skills in the provision of and leadership in spiritual and chaplaincy care by successfully completing a test of core knowledge derived from evidence-based quality indicators for spiritual care as well as a simulated patient exam that evaluates competency in direct patient care. Advanced Practice Board Certified Chaplains (APBCC) have been trained and tested in standardized curriculum based on the latest evidence in areas including department management; HIPAA regulations; the assessment, diagnosis, and treatment of spiritual distress; cultural competency; advance care directives; patient clinical care; staff support; grief; and bereavement among other essential topics.

From a chaplain:

> **"It's about time! Thank you for putting this together. It really is the future of chaplaincy at stake."**

Board Certified Chaplain (BCC): The designation of Board Certified Chaplain will continue to be maintained by the SCA. Current BCCs will have to take the core knowledge test around the time of their 5-year anniversary to maintain their BCC. At any time, BCC chaplains may choose to apply and test for APBCC designation.

Chaplain Credentialing is for those working as chaplains who are not board certified, and meet SCA's requirements, which include a Bachelor's degree in a content area relevant to chaplaincy, at least 400 hours of clinical pastoral education, and successful objective testing.

SCA's innovative approach to chaplain training, credentialing, certification, and continued education incorporates the desires and issues raised by those in the field, administrators, researchers, and thought leaders over decades. The Spiritual Care Association:

- Provides education: clinical training for students, continuing education for chaplains and specialized education for other health care disciplines based on a knowledge base founded in the latest research and updated as new evidence and needs appear.
- Brings chaplaincy to the level of training and demonstrated clinical competencies required by other professional disciplines, including doctors, nurses, social workers and therapists, responding to the need for training to be tested, and relies on standardized testing and a simulated patient experience to demonstrate clinical competency, knowledge base, and best practices.
- Opens professional chaplaincy to capable and competent individuals, who can now enter the field through various pathways while ultimately demonstrating the required degree of knowledge and competency. By providing pathways for credentialing and certification that focus on knowledge and demonstration of skills, many who have been unable to meet the requirements that do not consider culture, belief tradition, geographical location, age, and financial resources will now be able to be trained, credentialed or certified, and continually educated to provide the best care for those whom they serve in their care systems.

It's All About WHOLE-PERSON CARE

Social Workers:

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Online Spiritual Care Generalist Courses for Social Workers

Learn more about effective communication techniques, counseling skills, grief/loss/bereavement, cultural competence/inclusion/vulnerable populations.
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www.spiritualcareeducationsocialworkers.org

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Read this bi-annual publication, with content-rich articles for multiple disciplines. For a free subscription:
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Spiritual Care Grand Rounds Webinars

Hear experts present on a wide range of spiritual care topics every month. CEs/certificate of completion.
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www.healthcarechaplaincy.org/education

Caring for the Human Spirit Conference

May 20-22, 2019, Myrtle Beach, South Carolina

Social workers should include training in spirituality as part of their ongoing education, specifically their role as spiritual care generalists and the use of appropriate and effective spiritual care screens and interventions. Effective training will include the concepts of the generalist/spiritualist model of multidisciplinary spiritual care as described in *Making Health Care Whole.*

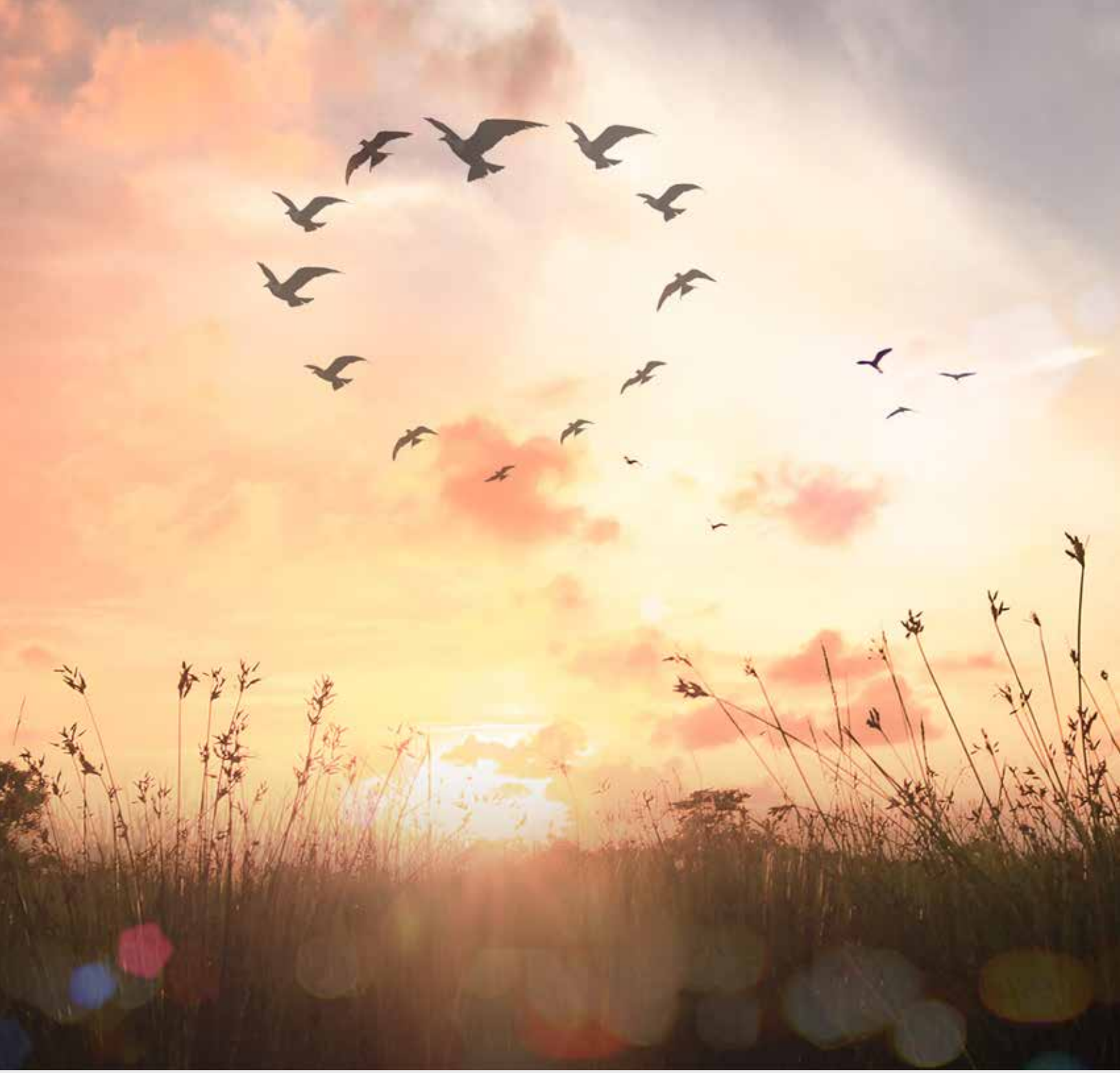
(Pulchalski and Ferrell. 2010)

SPIRITUAL CARE ASSOCIATION

HealthCare Chaplaincy Network™

We're the experts in clinical care, education and research related to spiritual care in health care.

FOR ADDITIONAL RESOURCES:
www.spiritualcareassociation.org • www.healthcarechaplaincy.org



Spiritual Care and Social Work: Integration into Practice

HealthCare Chaplaincy Network™

SPIRITUAL CARE ASSOCIATION
Making Spiritual Care a Priority

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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.

www.healthcarechaplaincy.org
www.spiritualcareassociation.org
212-644-1111

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 Medicine[2] 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]

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.
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]

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 plan[39] 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 professionals[45] 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.

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]

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 emotional, physical or spiritual pain might be understood as a spiritual test[104] 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 values[126] 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]

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 patients[131] 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.

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 Competency[137], 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.

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To learn more, contact Rev. Bran P. Hughes, Programs and Services at HCCN, at bhughes@healthcarechaplaincy.org, 212-644-1111 x261

Inspiration ... Pass it on!

Editor's note: This column is all about inspiration—to pass along to your patients and colleagues.

Beyond the Body: Relieving Existential Suffering

By **Torrie Fields, MPH**

Goal-concordant care: it is the notion that we can measure how well clinicians are able to match a treatment with the goals of a patient and their family. When facing a serious illness, patients and families can have myriad symptoms, ranging from pain and discomfort to anxiety to financial distress, and focusing on patient-directed goals of care can help palliative care teams and other providers customize services to their needs.

But what happens when someone with a serious illness chooses treatment that does not align with their own goals for care? This form of self-sabotage can be distressing not only for the healthcare team but for loved ones supporting a struggling patient. But to the well-trained eyes and ears of a healthcare chaplain, it simply indicates that a patient is experiencing existential suffering. I know this from personal experience.

In 2015, I was diagnosed for the second time with cervical cancer, after almost 10 years in recovery. I was avoidant and despondent, and I struggled to keep appointments and even to tell my loved ones about my diagnosis. I was ashamed of myself and felt betrayed by my body. I thought my diagnosis of cancer was my fault, my punishment for sexual abuse many years prior, which resulted in a positive diagnosis of high-risk Human Papilloma Virus (HPV), a virus known for causing cervical cancer in women. I had grown up in a community where sexual purity was required and, after my assault, I didn't report it. I internalized my shame, repressing my feelings until I was diagnosed with cancer.

Prior to starting treatment, I requested a palliative care consultation to ensure that my goals and values were considered as part of my treatment plan. Though my oncologist was reluctant at first to make the referral because of my favorable prognosis, I was scheduled to meet with a palliative care social worker. She walked me through my goals of care and helped me revise my advance directive so that it reflected my values. With those goals in mind, I met with my clinical team to evaluate the treatment options available for my stage and type of cancer. After reviewing all the options, I made a decision that would not allow me to meet my goals of care. My social worker recommended I speak with a chaplain on the palliative care team. In fact, she demanded it. Documented in my chart, she recorded for my chaplain's review:

"Patient reports: 'I must have been an awful person in a past life for me to be experiencing this now.' "

With great hesitance, I met with a healthcare chaplain for the first time. I had not been seeking religion or spirituality in my life, and I wrongly believed that chaplains on palliative care teams were there to bring me "back to the fold." After two visits with a palliative care chaplain, we resolved my existential suffering enough to choose the treatment option that would achieve the goals that would give me the best quality of life after cancer. After three months with him, I was on the road to healing the pain that drove many of my decisions. He provided me with bereavement tools and ways to gently engage with my spirit. By paying attention to my suffering, and by walking alongside me in unpacking its origins, my

chaplain connected me to a part of myself where love remained.

My chaplain was the most important part of my cancer journey. He treated me with patience and respect and was the catalyst to providing me goal-concordant care. His impact was immeasurable.

When we address our feelings of existential suffering with intention and guidance, we can find true metamorphosis. I know I did.

Torrie Fields, MPH, is the Senior Manager, Advanced Illness and Palliative Care at Blue Shield of California. She leads the development and implementation of programs and policies at Blue Shield of California that work to improve the quality of life for individuals with serious illness and their families.

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