

# Some differences between social work, spiritual care, and psychology: Content variance in end-of-life conversations

## Original Article

**Cite this article:** Schultz M, Baziliansky S, Mitnik I, Ulitzur N, Campisi-Pinto S, Givoli S, Bar-Sela G, Zalman D (2024). Some differences between social work, spiritual care, and psychology: Content variance in end-of-life conversations. *Palliative and Supportive Care* **22**, 306–313. <https://doi.org/10.1017/S1478951523000652>

Received: 26 February 2023



Accepted: 07 May 2023

### Keywords:

Cancer; Chaplaincy service; End-of-life care; Psychology; Social work

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### Abstract

**Objectives.** Within the multidisciplinary team, there can sometimes be lack of clarity as to the specific different contributions of each of the psycho-social-spiritual professionals: social workers, psychologist, and spiritual caregivers. This study examined the content of their end-of-life conversations with patients.

**Methods.** A total of 180 patients with terminal cancer received standard multidisciplinary care, including conversations with a social worker, psychologist, and spiritual caregiver. After each patient's death, these professionals reported using a structured tool which content areas had arisen in their conversations with that patient.

**Results.** Across all content areas, there were significant differences between social work and spiritual care. The difference between social work and psychology was slightly smaller but still quite large. Psychology and spiritual care were the most similar, though they still significantly differed in half the content areas. The differences persisted even among patients who spoke with more than 1 kind of professional. The 6 content areas examined proved to subdivide into 2 linked groups, where patients speaking about 1 were more likely to speak about the others. One group, “reflective” topics (inner and transpersonal resources, interpersonal relationships, one's past, and end of life), included all those topics which arose more often with spiritual caregivers or psychologists. The second group, “decision-making” topics (medical coping and life changes), was comprised of those topics which arose most commonly with social workers, bridging between the medical and personal aspects of care and helping patients navigate their new physical, psychological, and social worlds.

**Significance of results.** These findings help shed light on the differences, in practice, between patients' conversations with social workers, psychologists, and spiritual caregivers and the roles these professionals are playing; can aid in formulating individualized care plans; and strengthen the working assumption that all 3 professions contribute in unique, complementary ways to improving patients' and families' well-being.

### Introduction

The physical, psychological, social, and spiritual are all important dimensions of the patient's experience of illness, even more so at the end of life, and each plays a significant role in facilitating coping for the dying patients and their family (Corr and Corr 2012). As a result of this growing understanding, not only social work but also spiritual care and psychology have become integral parts of the multidisciplinary team across hospital departments and particularly in oncology and in palliative care (Ann-Yi et al. 2018; Kelley et al. 2015; National Consensus Project 2018).

Social workers in end-of-life care assist patients and family members in managing losses at every stage of the disease's trajectory, coping with the stresses and adjustments, assessing and intervening regarding a broad range of patient and family needs, tending to family dynamics and enhancing positive communication between its members, seeking to make use of their social resources, and facilitating communication around care planning (Bosma et al. 2010; Middleton et al. 2018; Thiel et al. 2021). A helpful, extensive list of social work palliative care competencies has been generated through a consensus process (Glajchen et al. 2018). Psychology contributes significantly to end-of-life care of patients with cancer, employing psychological assessment and evidence-based treatments for individuals, families, and groups aimed at strengthening

coping abilities, enhancing well-being and decreasing levels of distress (Ann-Yi et al. 2018; Kasl-Godley et al. 2014). Palliative spiritual care (sometimes called chaplaincy) can include preparing for the end of life, expressing fears and hopes surrounding death and what comes after, considering goals of care and improving communication with the medical care team, helping patients make use of their own spiritual resources, connecting to a sense of community and to the larger forces in the world (Jeuland et al. 2017).

Collaborative, interdisciplinary patient care planning improves when there is clear understanding among team members as to the contribution and areas of focus of each kind of professional on the team (Fitchett et al. 2009; Harr et al. 2010; Kao et al. 2017; Middleton et al. 2018). Additionally, in our world of limited funds, it only makes sense to include different professionals on the team if their contributions are sufficiently unique and complementary. Yet social workers, spiritual caregivers, and psychologists can sometimes seem confusingly similar to each other, at times leading to less effective collaborative patient care or even role conflict (O'Connor and Fisher 2011; Wittenberg-Lyles et al. 2008), with the work of the spiritual caregiver the least well understood (Cadge et al. 2011; Damen et al. 2019; Schultz et al. 2020; Wittenberg-Lyles et al. 2008). While some studies have helped to clarify the goals of these professional interventions (Jeuland et al. 2017; Massey et al. 2015), not many studies examined what patients actually speak about with each kind of professional, and very few studies have directly compared the social work, psychology, and spiritual care intervention with the same patients.

The current study, focused on the hospital setting, aims to observe possible differences between conversations that patients with terminal cancer and their family members have with social workers, psychologists, and spiritual caregivers.

## Methods

From November 2018 to March 2020, the directors of the oncology departments at Rambam Health Care Campus identified all those patients with a life expectancy of 6 months or less. Only those patients with the cognitive, physical, and language-based capacity to complete the entry questionnaire were included. Of these 363 patients, 231 (64%) agreed to enter the study, and the final study sample of 180 patients comprised those who had passed away before the end of the study period.

Of these patients, 154 (86%) had met with a social worker, 94 (52%) with a spiritual care provider, and 41 (23%) with a psychologist. It is worth noting that 1 of the departmental psychologist positions was unfilled for half the study period, leading to a smaller than expected percentage of patients getting to see a psychologist. Otherwise, all 3 professions were available as needed for all patients. After each patient's death, the primary social worker, spiritual caregiver, and psychologist for that patient (where relevant for each profession) conducted a retrospective medical record audit using their own notes to report which content areas had come up in at least 1 of their conversations with the patient. The study question that they answered, newly developed for this study, is presented in full in Table 1.

In the study site, the social workers, psychologists, and spiritual caregivers are not part of a separate palliative care team but rather work in both the inpatient departments and outpatient clinics, meeting patients and family members at all stages of their treatment. The multidisciplinary care plan provided to all patients and family members, whether enrolled in the study or not, included conversations with a social worker whenever possible. The decision

**Table 1.** Content areas item, for reporting by psycho-social-spiritual professional

Over the entire period of time in which you saw the patient, please indicate the content that arose in your conversations with the patient (you can select multiple content areas):

1. End of life (e.g. fears as death approaches, their legacy, putting things in order before dying, wishes regarding end-of-life care, saying goodbye, end-of-life rituals, will)
2. Inner resources or resources between the patients and that which is greater than them (e.g. faith, calmness, meaning of life, key values, hope, prayer)
3. Significant interpersonal relationships (e.g. expressing their love, wishing to ask forgiveness, current status of family relationships, disagreements within the family about what comes next)
4. Dealing with the medical system and the medical treatment (e.g. how to return home, difficulties in communication with the staff, uncertainties about continuing treatment)
5. Changes as a result of being sick (e.g. losses, clarifying what is important to them so long as they are still alive, anxiety, depression, despair)
6. Looking back over the past (e.g. memories, achievements, regrets, missed opportunities, secrets)

to add a psychologist or spiritual care provider to a given patient's care plan was generally made at the discretion of the multidisciplinary team in accordance with the perceived patient needs, and occasionally at the request of the patient or family members. As a general rule, the same psychologist or spiritual care provider saw a given patient throughout their care, whereas multiple social workers might see the same patient over the course of different inpatient stays and outpatient visits. Overall, 8 social workers, 4 psychologists, and 5 spiritual care providers were involved in this study. Their patient and family visits were all individual, rather than team conversations. In these visits, patients and family members were invited to spontaneously raise issues of importance to them, and the visits were not conducted according to a standardized tool or preset questions. Patients did, of course, also speak with palliative care physicians and nurses, but the content of those conversations was outside the scope of this study.

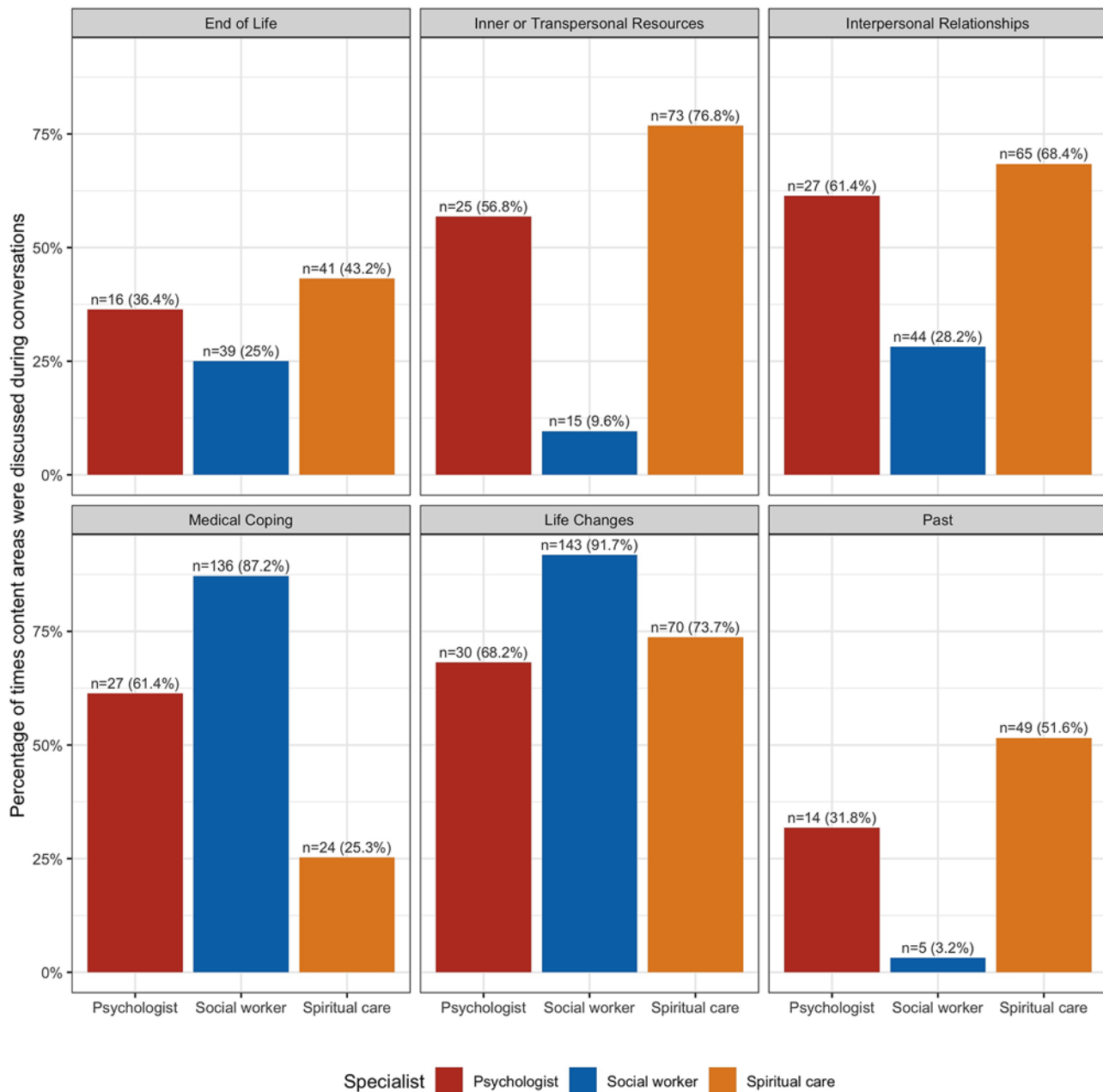
Patient data collected from a patient questionnaire and from the electronic health record included demographics, support from family and friends, religiosity, spirituality, country of birth, family Holocaust history, philosophical view of illness, Steinhauser calmness measure, % of time hospitalized, time before death of palliative care conversation with a physician (if any), rapidity of illness progression, general approach to aggressiveness of care, type of cancer, and cancer treatment.

## Statistical analysis

We tested differences between groups using standard Chi-square test of independence or Fisher's exact test depending on the type of variable and the corresponding metrics. The level of statistical significance (for the Type I error rate) was conventionally set to 5% (i.e.  $H_0$  rejection threshold set at  $p$ -value  $< 0.05$ ). The statistical analysis was conducted on R software (R Foundation Statistical Computing, Vienna, Austria. URL <https://www.R-project.org/>).

## Results

Study participants were 52% male, mean age 63 years, 72% were married, 72% Jewish and 16% Muslim, 37% received higher education, gastrointestinal (35%) and lung (27%) were the most common



**Figure 1.** Differences in frequency of content areas arising in conversations with different professionals (significance is shown in Table 2).

types of cancer, 30% were first- or second-generation Holocaust survivors, and 81% enjoyed a high level of support from family and friends.

The striking differences between professions regarding the conversations' content areas are summarized in Fig. 1, and the significance of the difference between each pair of professions is shown in Table 2. The difference between social workers and spiritual caregivers is very significant across all content areas, between social workers and psychologists in 5 of 6 areas, and is significant between spiritual caregivers and psychologists in 3 of 6 areas.

In order to see whether these results would persist within subsets of the sample, and in particular to see whether patients who speak with more than 1 kind of professional speak about the same topics with whomever they are speaking, we examined 3 subsets:

those patients who had spoken with both a social worker and a psychologist, with both a social worker and a spiritual caregiver, and with both a psychologist and a spiritual caregiver. The results are found in Fig. 2. By comparing Figs. 1 and 2, we can see that the content areas reported remain extremely consistent even when looking at subsets of the data where we might expect the differences to decrease or disappear.

Looking specifically at those patients who saw both a spiritual caregiver and psychologist ( $N = 30$ ), we also calculated how many patients spoke about a given content area with both of those professionals. These are the 2 professions that show the most content-based similarity, and this is a way to examine the extent to which they differ, even for the same patients. We calculated the expected values, using the content area frequencies from the whole

**Table 2.** Statistical significance of differences in content, whole sample, by pairs of professions (differences are shown in Fig. 1)

Content area	Social worker vs Psychologist	Social worker vs Spiritual caregiver	Psychologist vs Spiritual caregiver
End of life	$p = 0.19$	$p = 0.004$	$p = 0.57$
Inner or transpersonal resources	$p < 0.001$	$p < 0.001$	$p = 0.03$
Interpersonal relationships	$p < 0.001$	$p < 0.001$	$p = 0.53$
Medical coping	$p < 0.001$	$p < 0.001$	$p < 0.001$
Life changes because of illness	$p < 0.001$	$p < 0.001$	$p = 0.64$
Looking at the past	$p < 0.001$	$p < 0.001$	$p = 0.046$

study sample, were the content area frequencies for each of these professions to be entirely independent variables. In most content areas, the results were very similar to the expected values if these were entirely independent variables (Expected value | Actual value: End of life, 4.7 | 8; Resources, 13.1 | 16; Relationships, 12.6 | 14; Medical, 4.7 | 4; Life changes, 15.1 | 17; Past, 4.9 | 5).

Interestingly, we found that the content areas can be broken into 2 subgroups, or clusters. We examined whether patients who had spoken about one content area with any of these professionals were more likely to have also spoken about another content area. Specifically, we considered all pairs of content areas, testing the association between them, and the results are shown in Table 3, where each column shows what percentage of patients who spoke about the topic in the left-most column also spoke about that additional topic. Patients who spoke about end of life, inner or transpersonal resources, interpersonal relationships, or the past were significantly more likely to speak about each of the other one of those topics. Similarly, patients who spoke either about coping with the medical system or about life changes because of illness were more likely to speak about the other of those topics. But between those 2 subgroups, the content areas did not correlate. Significantly, referring back to Fig. 1, the 4 topics in the first subgroup are the content areas much more commonly reported in conversations with psychology and spiritual care, whereas the 2 topics in the second subgroup are the content areas that come up more often with social workers than with any other profession.

There were limited correlations between demographics and which professionals a patient saw or the number of conversations they held. Women had more sessions with a psychologist ( $p = 0.003$ ) and with a spiritual caregiver ( $p = 0.03$ ) than men did. The families of Jewish patients born in Israel were more likely to see a spiritual caregiver ( $p = 0.02$ ) than were other groups. Patients who self-reported less calm had more conversations with the social worker ( $p = 0.01$ ).

There were a small number of correlations between patient data, as found in the entry questionnaire and the electronic health record, and the content areas they raised with at least 1 of these professionals. Women spoke more than men about end of life ( $p = 0.02$ ) and medical coping ( $p = 0.03$ ). Holocaust survivors (first or second generation) spoke more about their past ( $p = 0.03$ ).

Patients with fewer children were more likely to speak about medical coping ( $p = 0.002$ ). Jewish patients spoke about end of life relatively more often ( $p = 0.04$ ). Less spiritual ( $p = 0.008$ ) and less religious ( $p = 0.01$ ) patients were more likely to speak about life changes, and less religious patients also spoke more about their past ( $p = 0.04$ ). Viewing illness as fate negatively correlated with speaking about relationships ( $p = 0.03$ ) and changes ( $p = 0.02$ ). Interestingly, having a palliative care conversation with the physician did not correlate with speaking about end of life with these professionals, though more rapid illness progression did ( $p = 0.045$ ). Patients who spent more time in the hospital (days hospitalized/days of life, from study enrollment) spoke more about relationships and their past ( $p = 0.02$ ). Patients who spoke with both a psychologist and spiritual caregiver tended to speak about more topics with each of those professionals than did patients who only saw 1 of them.

## Discussion

This study offers a window into the differences in content between conversations with social workers, psychologists, and spiritual caregivers in an inpatient setting with patients with terminal advanced cancer. The novel contributions of this preliminary study are in examining the prevalence of 6 key content areas and, in particular, in being able to compare across professions by gathering the data from all three professions regarding the same patients.

The differences between social work and spiritual care were the largest, and those between social work and psychology were still quite large, while those between spiritual care and psychology were smaller though still significant. This pairing, spiritual care and psychology on the one hand and social work on the other, was also reflected in the finding that the 4 areas which were more common in spiritual care and psychology conversations – speaking about end of life, inner or transpersonal resources, relationships, and one's past – clustered together in the results. Similarly, the 2 areas which were most common in social work conversations – medical coping and changes – were also linked together (Table 3). At least in our hospital setting, we can identify these groups with 2 distinct aspects of psycho-social-spiritual conversations, reflective and relating to decision-making, though of course the 2 substantially inform each other.

Given the study methodology, we cannot definitively conclude to what extent differences in the content of conversations derive from patients' conscious choices as to what to speak about with each kind of professional, or the kinds of topics that each professional is more listening for, i.e. conversational strands they are more likely to pick up on. In other words, the driver of the difference may be patients' perceptions of the role of these professions, or the professionals' own role identity. Finally, it is also possible that part of the difference derives from how they record visits in the medical file, i.e. what they see as worthy of being reported. Even given this caveat, the differences are so substantial that they seem to be a reliable indicator of real differences in the conversations taking place between patients with terminal cancer and these 3 kinds of professionals.

Furthermore, even looking at subsections of the study where we hypothesized the differences might vanish (patients who spoke with more than 1 professional), the differences remain highly persistent (Fig. 2). That result, combined with the fact that very few demographic variables correlated with seeing a particular kind of professional or talking about particular content areas,

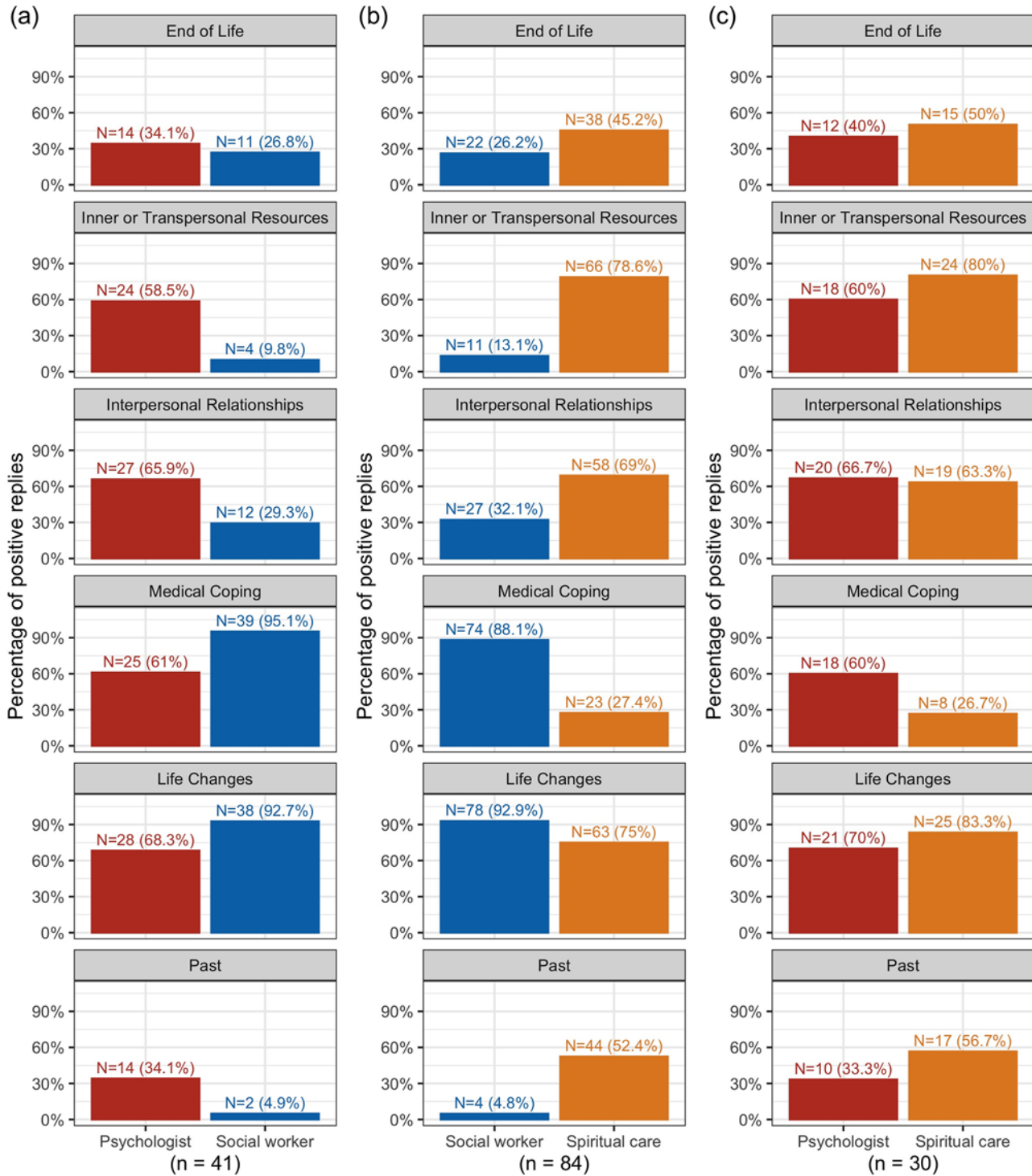


Figure 2. Content areas by subset of the study sample – only those patients who saw both of the 2 different kinds of professionals listed in each panel.

strengthen the reliability of these findings, regardless of which patients are involved.

Finally, the expected value analysis indicates that even between psychology and spiritual care, the pair of professions with the greatest similarity, the conversations look significantly different, even when those 2 professionals speak with the same patient. The fact that those patients spoke with both a psychologist and a spiritual

caregiver did not translate into the content areas converging substantially more than we would expect if 2 different patients had spoken with the same professionals.

We can now consider the findings regarding specific content areas. Medical coping, including thinking about discharge, talking about difficulties in patient–staff communication, and thinking through questions of continuing treatment came up very often with

**Table 3.** Correlations between speaking about a given content area with any of the psycho-social-spiritual professionals and speaking about any other given content area

Spoke about topic with any professional yes and no, N	Also spoke about... end of life N (%)	Resources	Relationships	Medical	Changes	Past
End of life Yes 75 No 93		$p = 0.001$ 50 (66.7) 37 (39.8)	$p < 0.001$ 61 (81.3) 37 (39.8)	$p = 0.11$ 68 (90.7) 75 (80.6)	$p = 0.26$ 72 (96.0) 84 (90.3)	$p < 0.001$ 42 (56.0) 17 (18.3)
Resources Yes 87 No 81	$p = 0.001$ 50 (57.5) 25 (30.9)		$p < 0.001$ 70 (80.5) 28 (34.6)	$p = 0.81$ 73 (83.9) 70 (86.4)	$p = 0.67$ 82 (94.3) 74 (91.4)	$p < 0.001$ 48 (55.2) 11 (13.6)
Relationships Yes 98 No 70	$p < 0.001$ 61 (62.2) 14 (20.0)	$p < 0.001$ 70 (71.4) 17 (24.3)		$p = 0.40$ 81 (82.7) 62 (88.6)	$p = 0.13$ 94 (95.9) 62 (88.6)	$p < 0.001$ 50 (51.0) 9 (12.9)
Medical Yes 143 No 25	$p = 0.11$ 68 (47.6) 7 (28.0)	$p = 0.81$ 73 (51.0) 14 (56.0)	$p = 0.40$ 81 (56.6) 17 (68.0)		$p = 0.02$ 136 (95.1) 20 (80.0)	$p = 0.56$ 52 (36.4) 7 (28.0)
Changes Yes 156 No 12	$p = 0.26$ 72 (46.2) 3 (25.0)	$p = 0.67$ 82 (52.6) 5 (41.7)	$p = 0.13$ 94 (60.3) 4 (33.3)	$p = 0.02$ 136 (87.2) 7 (58.3)		$p = 0.28$ 57 (36.5) 2 (16.7)
Past Yes 59 No 109	$p < 0.001$ 42 (71.2) 33 (30.3)	$p < 0.001$ 48 (81.4) 39 (35.8)	$p < 0.001$ 50 (84.7) 48 (44.0)	$p = 0.56$ 52 (88.1) 91 (83.5)	$p = 0.28$ 57 (96.6) 99 (90.8)	

the social worker, quite often with the psychologist, and only occasionally with the spiritual caregiver. Aiding in communication and being part of the decision-making at key junctures is one of the key roles that needs to be filled by a psycho-social-spiritual professional (Jeuland et al. 2017; Russell and Quaack 2021), though the question of who fills that role may vary by country or even by type of hospital.

The topic of changes was the most commonly reported content area, including as it does 1 or more items that come up frequently with all 3 professions, such as losses, anxiety, depression, despair, and clarifying what is important to patients so long as they are still alive. The diagnosis of a life-threatening disease can be perceived as a significant crisis in a person's life, forcing adjustments in various personal, occupational, and social aspects of life. This may be highly challenging, especially given the abrupt nature of the crisis and the sense of loss of control and certainty (Isenberg 1996).

The linkage between changes and medical coping may be explained by the relationship between change-induced anxiety and frustration with the medical system. Alternatively, major life changes open the door to reconsidering and clarifying key goals and values so that they can guide medical decision-making, a process that can be assisted by the development and adoption of patient decision aids (You et al. 2022).

These 2, medical coping and changes, were the topics that by far most commonly arose with the social worker, perhaps reflecting the key role social workers play in forming a bridge between the strictly medical approach and seeing patients as a whole person, navigating new waters in their medical treatment and in their changing psychological and social worlds (Buller et al. 2021; Rothman 2010). Our findings regarding the content of palliative social work conversations largely replicate professionals' self-described perception of their role including aiding in communication and in facilitating manageable transitions (Buller et al. 2021; Glajchen et al. 2018; Middleton et al. 2018; Thiel et al. 2021).

We can now turn to the cluster of "reflective" topics that were much more prominent within the conversations with the spiritual

caregiver and the psychologist, and which may play a key role in coping.

The topic that most commonly arose with the spiritual caregiver, labeled here "resources," included faith, calmness, meaning of life, key values, hope, and prayer. Though these topics certainly do arise with psychologists and social workers as well, it would seem that this group of items can be described as core to spiritual care and best-suited to describing its unique contribution, as is also seen elsewhere (Berkhout 2020; Cooper et al. 2010; Damen et al. 2019; Massey et al. 2015).

Speaking about relationships included talking about the current status of family relationships, including disagreements within the family about what comes next, questions of forgiveness, and helping patients express their love. This came up frequently with spiritual caregivers and psychologists, as is seen elsewhere (Adelson et al. 2019; Massey et al. 2015; Saracino et al. 2019). It can be helpful for patients to remind themselves of the support they are receiving, or alternatively to speak about the tensions they are experiencing within the family. Our relationships are also an opportunity to go beyond our personal needs, and speaking about them strengthens this inner resource.

Looking back over the past is an important end-of-life intervention, sometimes more open-ended and sometimes more structured (Ng et al. 2022), though the fact that it often did not happen in this study may reflect a need for a certain degree of time and calmness for this kind of conversation to happen. Speaking about one's past even correlates with reduced aggressive care at the very end of life, perhaps because of that greater degree of calmness (Schultz et al. 2023). Discussing one's past can also be part of the mourning process, remembering things that will not return, as one processes the upcoming end of life.

Surprisingly, given that all the study participants had terminal cancer, the end of life came up less than half the time with each of the professions. This was less often than spiritual caregivers elsewhere (Pagis et al. 2017), even those working in palliative care (Jeuland et al. 2017), perceived themselves to be speaking with

patients about end of life. Our finding may reflect how hard it is for patients and family members to speak about the painful existential truth of their mortality and upcoming loss (Yalom 2009).

### Study limitations

It is important to approach the results of this work with caution due to several limitations. First, it was conducted in a single medical center in Israel, so the ability to extrapolate it to other populations is limited. In addition, in an alternate setting such as home hospice, where social workers are under less time pressure, these findings might vary substantially and merit further study. Furthermore, we examined these 6 key content areas, but of course they are not comprehensive nor do they fully capture the nature of the many interventions done by each profession. Additionally, though all professionals received the same orientation for recording the data, the possibility remains that there were some differences in how each profession or how individual professionals parsed the meaning of each content area. Finally, given the research format, we cannot compare patients' own perceptions of their conversations with the different professionals.

### Conclusion and clinical implications

These findings help shed light on the differences, in practice, between patients' conversations with social workers, psychologists, and spiritual caregivers. Each of these professions makes a substantial contribution to patient well-being at the end of life (Balboni 2010; Chochinov *et al.* 2011; Jones *et al.* 2014), yet as this study suggests, each does so in different, complementary ways, varying in their approaches, interventions, and in what they are listening for. Patients, too, have their own sense of what each profession has to offer and raise different topics accordingly with each profession. Spiritual caregivers and psychologists may be seen as facilitating more reflective conversations as part of the coping process, while social workers may contribute especially to bridging between the medical aspects of care and seeing patients as a whole person, navigating their new physical, psychological, and social worlds.

This study, by revealing possible differences in content, may assist in formulating individualized care plans, as the team assesses the needs of patients and family members and considers which professionals to involve.

**Data availability statement.** The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

**Author contributions.** Conceptualization: Michael Schultz, Gil Bar-Sela; Data curation: Michael Schultz, Svetlana Baziliansky, Inbal Mitnik, Nirit Ulitzur, Daniela Zalman; Formal analysis: Salvatore Campisi-Pinto, Simon Givoli; Funding acquisition: Michael Schultz, Gil Bar-Sela; Project administration: Michael Schultz, Daniela Zalman; Writing – original draft: Michael Schultz, Svetlana Baziliansky, Inbal Mitnik, Salvatore Campisi-Pinto, Daniela Zalman; Writing – review and editing: Gil Bar-Sela, Simon Givoli, Nirit Ulitzur. Gil Bar-Sela and Daniela Zalman should be considered joint senior authors.

**Funding.** This study was funded by a grant from the Joint Distribution Committee – Eshel and the Government of Israel's Ministry of Health, as part of the National Program for Palliative Care.

**Competing interests.** The authors declare none.

**Ethical approval.** This study was approved by Rambam Health Care Campus' Helsinki committee, request # 0556-17-RMB, on January 4, 2018. The study was

performed in accordance with the Declaration of Helsinki. All study participants received and signed a written consent form explaining the nature of the study. No individual person's data are presented in this manuscript.

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