

5-2016

# Implementation and Utilization of Alternative Interventions in Hospice

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## Recommended Citation

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# Implementation and Utilization of Alternative Interventions in Hospice

Comparing and Contrasting Nurses with Social Workers

by:

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MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work

St. Catherine University and the University of St. Thomas St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

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LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### **Acknowledgments**

This research project would not have been possible without the help of some amazing people in my life. Mike and Julie helped me attend this school and I am eternally grateful. My research chair (and research guru), Ande, taught me research, guided me through the process and encouraged me along the way. My committee members, Gretchen and Heidi, helped me reform my ideas and reminded me that I have the ability to do this. My unofficial editor (and favorite person), Jonathan, spent a lot of time reading these pages and fixing my mistakes. He also got the pleasure of putting up with me when the hours were long and my emotion regulation skills were tested. I told him, when we were teenagers, that one day I would publish something and thank him in it; here it is. My classmates commiserated with me and reminded me of our goals. To each of you and all the others who have helped me on my path: you have made my life easier, I appreciate you and could not have done any of this without you.

## **Introduction**

Merriam Webster defines hospice as “A facility or program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill” (Merriam-Webster Online, n.d.). From this definition, one can see that hospice was intended to be holistic in nature in that it was not meant to only treat the physical manifestations of the end-of-life process, but also the emotional and mental aspects of patient care. Holistic, for the purposes of this paper means, “relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts” (Merriam-Webster Online, n.d.). It is important to note that hospice, in the United States, is only available to those who have a prognosis of less than 6 months and are deemed terminal by a doctor (Bogasky, Sheingold, & Stearns, 2014). This provides a short time frame to allow a patient to cope with end-of-life issues. On the hospice team, social work’s role, in recent years, is being threatened due to a lack of financial resources and the pervasive belief that the role that social work plays can be accomplished by other disciplines, like nursing. Additionally, the medicalization of the dying process has caused some directors and stakeholders to question the value of social workers within the hospice team (Reese & Rymer, 2014).

## **Background**

For years, in our western culture, the ways that United States citizens have approached healthcare has not been health focused. It has focused, instead, on disease management and cure (Weick, 1983). Hospice emerged from this framework as a way to handle end-of-life care. Ideally, hospice embodies a holistic care model where all aspects of a person are cared for (Nebel Pederson & Emmers-Somma, 2012; Reese & Reymer, 2004; Reese, 2011). Hospice is, for many, the preferred care at end-of-life. In 2011, 1,650,000 people used hospice services and

around 44.6 percent of all U.S. deaths were within hospice care (NHPCO Facts and Figures: Hospice Care in America, 2012).

One thing that makes hospice holistic is its implementation and use of alternative interventions for things like anxiety, depression and pain. Methods such as meditation, massage, Reiki, deep breathing, mindfulness activities, acupuncture, aromatherapy, pet therapy, and music therapy can be effective while maintaining the cognitive ability of the patient. One study looked at the use of massage with Reiki, in Connecticut, among hospice patients; it found that over 90 percent of the fifty-two patients studied claimed a decrease in labored breathing and stress/anxiety as well as 76 percent asserting a reduction in pain (Vandergrift, 2013). There have been many studies that show that the use of alternative interventions in end-of-life care is a common practice. Bercovitz, Sengupta, Jones, and Harris-Kojetin (2011), noted that 41.8 percent of the 1036 hospice agencies that responded to a national survey offered some form of alternative therapy (like music, massage or pet therapy)

Hospice is then believed to be in opposition to the biomedical model, which emphasizes cure over care (Nebel Pederson & Emmers-Somma, 2012). Nebel Pederson & Emmers-Somma (2012) instead found that the comfort care patients receive in hospice is actually framed within the medical model framework. One qualitative study of ten home hospice patients noted a subtheme of medication in interviews, which they proposed signified that patients equate hospice care with pain management (Nebel Pederson & Emmers-Somma, 2012). Nebel Pederson & Emmers-Somma (2012) also found that zero patients discussed the holistic approach as a reason for electing into hospice and instead themes that revolved around the medical model emerged. These themes make it clearly evident that patients are misinformed about the services that they

have available to them when in hospice care, as well as their general needs as they near end-of-life.

### **Social Work Involvement**

One staple of hospice care is thought to be its focus on the patient and one's self-driven end-of-life goals. Patient direction in plan of care (at least for geriatric patients) has been shown to positively affect perceived outcomes (Enguidanos, Davis & Katz, 2005). Social workers advocate for patient goals and person-centered care, however, due to financial restraints, the holistic goals of hospice are being tested and reshaped in hospices throughout the country as cuts are being made to the social work staff (Mahoney, 1997; Reese & Reymmer, 2004). The truth of the matter is that increasing social work involvement in patient care actually might reduce overall costs, and increase patient and family satisfaction (Reese & Reymmer, 2004). Reese & Reymmer (2004) noted the trend that as social work services are minimized in hospice care, nursing services are increased. Lack of social work involvement in the early stages of hospice involvement might precipitate the need for their involvement due to a crisis and emergency services, which also decreases overall patient care and satisfaction (Reese & Reymmer, 2004). Because of these things, it is essential that social workers be involved in hospice patient's care.

Social workers have the ability to provide a high degree of care to the patient through alternative methods that will be less expensive and equally effective. One of the major ways in which social workers are able to intervene in hospice care is through education of patients, families and other team members. However, social workers and other health care providers tend to undervalue education (Christ & Sormanti, 1999). This is despite the fact that education of patient and family is seen as a primary role for social workers (Miller & Walsh, 1991; Hay & Johnson, 2001; Reese, 2011). Anxiety was reduced, in cancer patients, through relaxation breath

work (Kim & Kim, 2005). Anxiety was also found to be reduced, in cancer patients, through psycho-educational and social interventions (Dolce, Marsh, Sheldon, Summers, & Swanson, 2008).

One qualitative study, limited by a sample size of ten caregivers, found that most of the education on end-of-life care came from physicians and social workers but, generally, patients didn't recollect specific interactions with social workers (Csikai & Martin, 2010).

### **Limits to Existing Research**

A few limitations of this research are that few studies have been done, and those that have been done frequently involve small sample sizes of specific patient populations. Additionally, research on the challenges of implementing and using alternative interventions within a biomedical model is sparse. Evidence of improved patient satisfaction with hospice care when social workers are involved might suggest that social workers approach people and situations differently than other disciplines do (Reese & Reymer, 2004). However, faced with social work hours being cut, lack of education around alternative interventions, and the biomedical model framework, social workers appear to be fighting an uphill battle to hold on to (or possibly get back to) hospice's intended holistic approach, which is to care for all of a patient's needs. Therefore, through comparing and contrasting Minnesota hospice nurses' and hospice social workers' answers to a survey, this research aims to answer the question: How effective are hospice team members at implementing and using alternative interventions with patients? What follows is a review of current literature, a discussion of the methods and findings of research performed and a discussion of those findings.

## Literature Review

### History

For most of United States history, it was the responsibility of the family to take care of their dying; religious establishments took on the task of caring for those individuals who had no family or income (Lutz, 2011). These avenues were not predominantly focused on the end-of-life care of the patient as a whole. Eventually, these organizations started to create homes to care for these people but it was not until the Twentieth Century that hospice, as we think of it today, was created (Lutz, 2011; Noe, Smith & Younis, 2010). Cicely Saunders was a nurse and a social worker who is credited as being the driving force behind London's St. Christopher's which was the first hospice in the world to provide hospice care without religious association, class restriction and limitation on type of terminal diagnosis (Lutz, 2011; Noe, Smith & Younis, 2010). She also believed in the idea of "total pain" which defined pain as being complex, having biological and also spiritual, psychological, and social parts, which needed to be addressed (Saunders, 1986). This was a radical idea because at the time, treatment for pain was strictly oral narcotics (Saunders, 1986). Between the work of Saunders, the attention that Kubler-Ross received for her book *On Death and Dying* and various political forces of the 1970's (namely the creation of the Medicare Hospice Benefit), hospice became a fixture of the American medical system and society (Lutz, 2011). Livne (2014), states that hospice was accepted into the medical system readily because it unintentionally provided a moralized solution to a fiscal problem. The fiscal problem being that as people age, healthcare costs rise. Between then and now, hospice use has increased dramatically. In 2011, 1,650,000 people used hospice services and around 44.6 percent of all U.S. deaths were within hospice care (NHPCO Facts and Figures: Hospice Care in America, 2012). Lutz (2011), projects that in the coming years, hospice usage will escalate as



our population ages and it will necessitate improvements in end-of-life care. Seeing this trend, practitioners need to be conducting research that will maximize the quality of services provided.

### **Interventions**

Many terminal patients struggle with pain management, anxiety and depression. To address these troubling symptoms, interdisciplinary teams can integrate many different interventions into a patient's plan of care through the knowledge and experience of a social worker. In order to do this, team members must work with patients and their families to agree upon interventions to use. One complication of doing this is illustrated by one unique study which found that hospice patients usually equate their physical needs with pain management, and that despite knowledge of non-medical needs being important, patients did not believe these needs are essential to their plan of care (Nebel Pederson & Emmers-Sommer, 2012). This study's results are important because it is one in which hospice patients themselves were directly asked their thoughts on their care. This is significant because within hospice research, typically, dying patients are not the source of information in the studies.

**Hindrances.** As stated before, since the inception of modern day hospice, the primary avenue for treatment of distressing symptoms like pain was pharmacologically based. When using medications, practitioners must weigh potential benefits of these interventions with possible undesired side effects, such as lack of cognitive ability, nausea, fatigue, and decreased motor functions (Portenoy, Sibirceva, Smout, Horn, Connor, Blum, Spence & Fine, 2006). As hospice has grown and changed, viable symptom treatment options have increased. Among them are: various complementary therapies, guided meditation, and breath work. Despite the availability of these various interventions, doctors continue prescribing medications alone to address difficult symptomatology. Research has shown that there are many reasons that doctors

continue to do this, Cohen-Mansfield, Libin, Marx and Dakheel-Ali (2012), found that doctors themselves didn't feel that they had enough information on non-pharmacological interventions to make recommendations outside of medication. Probably because of this, hospice doctors choose to utilize opioid drugs with patients. In fact, one study, with 725 hospice patients, found that 89 percent of patients were on at least one opioid drug (Portenoy et al., 2006). Additionally, doctors stated the belief that other interventions take too much time, are expensive and that motivating patients to utilize them is quite hard (Seitz & Gill, 2013). Also noted in research was the possibility that time restraints due to various nursing responsibilities, low staffing, lack of education on interventions and perceived short duration of effects, might account for the lack of implementation of non-pharmacological interventions (Cohen-Mansfield, Thein, Marx & Dakheel-Ali, 2012; Janzen, Zecevic, Kloseck & Orange, 2013). It is clear that the struggle with implementing these interventions lies mostly in education (of social workers, nursing staff, doctors and patients/families) and the time it takes to utilize these interventions. Paramount to the implementation and utilization of non-medication interventions is collaboration among the hospice team.

### **Relevance**

In the United States, the first hospice program was opened in 1974; today, there are over 5,300 programs nationally (NHPCO Facts and Figures: Hospice Care in America, 2012). The roughly 1,650,000 people using hospice services today are within these programs (NHPCO Facts and Figures: Hospice Care in America, 2012). To look at this another way, in 2010, 44 percent of those covered by Medicare used the hospice benefit which shows an increase from 23 percent in 2000 (Bogasky, Sheingold, & Stearns, 2014). According to one study, the average number of days that an individual stays in hospice care is 83 however; the median number of total days is

only 19 (Bogasky, Sheingold, & Stearns, 2014). Interestingly, 33 percent of hospice patients surveyed were only on for seven days or less (Connor, Teno, Spence & Smith, 2005).

Interdisciplinary teams are serving all of these people. When looking at paid staff on these teams, 30.2 percent are nursing staff while social work only accounts for around 8.6 percent of staffing; nationally, the average caseload of a nurse case manager is 11.0, while the average caseload of a social worker is 24.9 (NHPCO Facts and Figures: Hospice Care in America, 2012).

### **Interdisciplinary teams**

Hospice's intended holistic nature provided a space for various disciplines to come together and treat the whole person at the end-of-life. Interdisciplinary teams were formed within hospices across the country. Patients who qualify for the Medicare Hospice Beneficiaries are entitled to have social work as part of this team (Lutz, 2011). Today, the hospice team can have representatives from many different disciplines including: nursing, social work, spiritual care, and volunteers (Lutz, 2011). Many hospices also include complementary therapies (like massage or music therapy, healing touch or Reiki specialists) or other disciplines (Lutz, 2011).

Unfortunately, one study found that services are either being covered through donations or that volunteer specialist in alternative therapies are providing most of these services as health insurance will not always cover them, even at end-of-life (Bercovitz, Sengupta, Jones, Harris-Kojetin, 2011). This limits options for patients overall.

On the hospice team, nurse case managers and social workers must work together to create a plan of care for the patients and families. Part of that plan of care involves coming up with strategies to address symptoms that occur during the end-of-life process (mainly, pain, anxiety and depression). The problem therein is the theoretical frameworks from which these two

disciplines function. While nursing staff are usually operating out of a medical perspective, social workers tend to start from an ecological perspective.

**Medical Model.** The medical model is the framework that is overwhelmingly used within the American medical system. This model is disease and cure-oriented which focuses on figuring out an etiology and going through some form of treatment (Weick, 1983). Engrained in this approach is a reliance on professional knowledge. As such, the professional (usually a doctor) is thought of as the “agent of change” to whom the client must come to for answers, this is defined as the “giving over process” (Weick, 1983, p.468). In this model it is not the patient who holds the knowledge about themselves, it is the doctors because the etiology is hidden from the patients (Weick, 1983). Through gaining a diagnosis, the patient can add meaning about their symptoms or illness (Weick, 1983).

**Ecological Perspective.** The ecological perspective is the one that most social workers operate out of. Within the realm of health care, this model is more health-focused and client-centered. Weick (1983), This framework proposes that if patients and healthcare providers begin to adopt this perspective, patients can then start to ascribe meaning to medical incidents themselves through self-healing and holistic approaches.

**Current medication usage versus alternative intervention.** When patients enter hospice, their medications are usually evaluated and changed. There are various symptoms that might emerge when a patient is dying including pain, depression and anxiety. The World Health Organization puts out standards by which pain should be addressed pharmacologically. The current medications used for pain at the end-of-life, for example, are usually opioid-based (Flume, Leong, Sherman, Silvestri, Turrisi & Williams, 2002). When used at the end-of-life, there are no regulations for a maximum dosage for most of these types of medications and as

such, providers usually taper up until needs are met or side effects are seen (Flume, et al., 2002). Some potential side effects are: constipation, respiratory depression, nausea, urinary retention, changed mental functioning and sleep problems (Flume, et al., 2002). Using alternative interventions, a professional could attempt to accomplish the pain management goals without pharmacological intervention thereby limiting debilitating side effects that are not congruent with comfort care.

### **Summary**

It is clear that hospice was intended to meet the needs of the whole person at the end-of-life. When creating a plan of care for a patient, the interdisciplinary team needs to consider how their interventions are affecting quality of life. One way to meet their symptom management needs is to use alternative interventions instead of medications (which can have detrimental side effects). However, through analyzing current research, there appears to be a lack of information regarding if and how hospice team members are currently managing pain, anxiety and depression outside of or in conjunction with medication interventions. Therefore, by comparing and contrasting Minnesota hospice nurses' and hospice social workers' answers to a survey, this research intends to answer the question: How effective are hospice team members at implementing and using alternative interventions with patients?

### **Conceptual Framework**

For the purposes of this research, an integrative healthcare (IH) framework is applicable. Integrative healthcare has arisen out of complementary and alternative medicine (CAM) that gained momentum in the United States through the holistic health movement of the 1970's (Baer & Coulter, 2008). Integrative healthcare highlights the use of alternative medicines within the western medical model (Boon, Verhoef, O'Hara, Findlay & Majid, 2004). Unfortunately, alternative medicines and the western medical model are seen as being at odds with each other. This division has created a struggle in categorizing the medical interventions that are not currently within the western medical model. One theory suggests that everything medical, which has been scientifically proven, falls under "orthodox medicine" and anything else becomes complementary alternative medicine (Johnson, 2009, p.706). By this logic, as various methodologies and interventions are proven to be effective they will move into the orthodox medicine realm and eventually CAM will be encompassed by integrative care (Johnson, 2009).

Integrative healthcare demands an interdisciplinary team approach in which each discipline is equally involved in the plan of care, respected for the knowledge and proficiencies they bring and working to insure greater patient care than could be done individually (Boon et al., 2004). Essentially, Boon et al. (2004), contend that integrative healthcare: is structured on a mutual relationship between the patient and team, treats the entire patient, promotes health and quality care, and ultimately creates efficient care. By bringing together various disciplines and modalities and allowing them to function both independently and interdependently with patients and other team members, the integrative healthcare framework expects to create a healthcare system that is mutually beneficial to all involved.

This framework was selected as a guide for this research project due to its inherent holistic nature, encompassment of western medicine and complementary and alternative medicine and its applicability to social work practice. It provided a lens through which hospice could be looked at and evaluated as a whole and through its fractions. It also allowed for exploration into hospice's interdisciplinary functionality. Because of these things, the integrative health framework was used in the process of developing questions for the survey that was sent out. Through careful use of this framework, questions were developed that revolved around holistic care, alternative interventions, interdisciplinary teams and effective care.

## **Methods**

### **Purpose and Design**

For the purposes of this study, a quantitative survey was sent out, via email to Minneapolis and St. Paul based hospice nurses and social workers asking them to partake in this research project through Qualtrics. The survey gathered data in an attempt to answer the question: How effective are hospice team members at implementing and using alternative interventions with patients? This exploratory study was retrospective in design as it asked nurses and social workers to think back on their experience at how alternative interventions have been handled within their agency. Given the fact that a quantitative study of this nature has not been completed within the Twin Cities, it yielded data that allowed for exploration on this topic.

### **Instruments/Measures**

A survey was developed using Qualtrics as a way to gather data from Twin Cities hospice providers. Questions on a self-complete survey were shaped in attempt to measure the research question. In order to do this a 30 question survey was created. It was sent only to professional nurses and social workers work at an agency that operates out of Minneapolis and/or St. Paul. The questions used can be found in Appendix B.

### **Sample/Participants**

Data was collected via a snowball sample. The two committee members for this research sent out the surveys sent via email starting in January 2016 and data were collected through February 19, 2016. The survey was sent out twice during this time period.

### **Human Subjects Protection**

Through the University of St. Thomas Institutional Review Board (IRB), approval to conduct research was obtained. After receiving confirmation of this approval, the researcher sent



the completed survey link to the two committee members and request them to forward it to others. Study participants received an article of informed consent when presented with the survey which included contact information for the researcher and the IRB.

### **Advantages and Limitations**

The quantitative nature of this study provided an advantage of being able to objectively and concretely measure social workers' and nurses' experiences with the use of alternative interventions within hospice. This study was limited in that it was only exploring responses from nurses and social workers. It was also only looking at hospices operating out of Minneapolis and St. Paul seven county metropolitan area. Finally, the sample size is this study's largest limitation. With a total of 18 participants, more complex statistical analysis could not be completed.

### **Data Analysis**

Once data was collected, quantitative information gathered was analyzed. Mean, mode and range numbers for descriptive questions in the survey was found. Data gathered from scale questions was examined through finding the mean and range for different questions. Finally, content analysis was done on the three open-ended questions in order to ascertain themes in professional's opinions of the implementation and utilization of alternative interventions within hospice.

### **Findings**

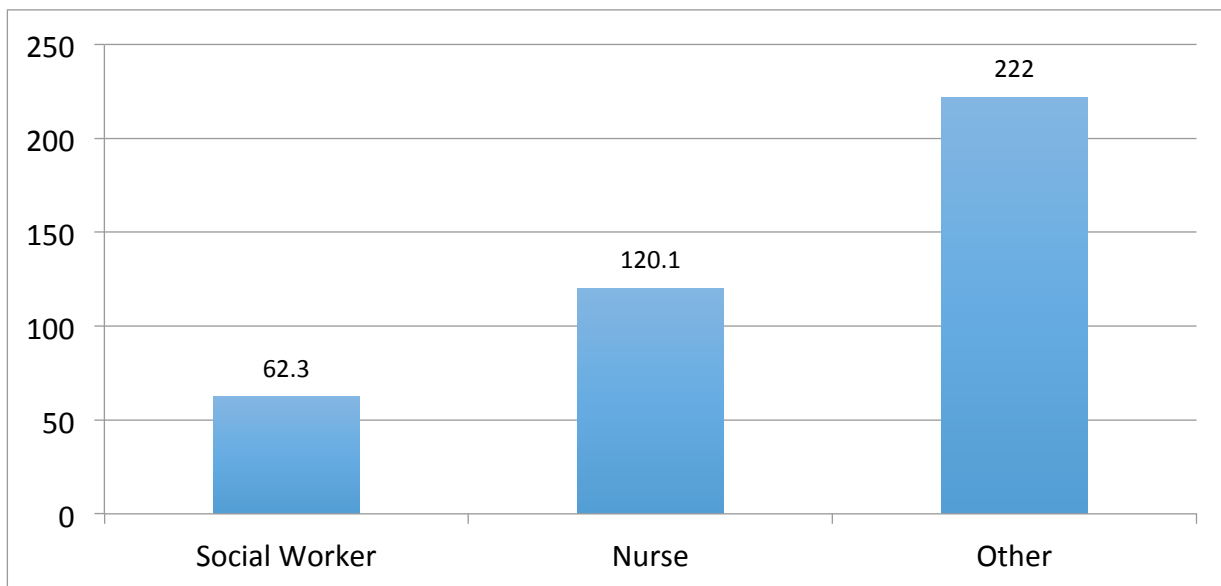
#### **Personal Demographics**

This survey included eight 21 respondents initially. After looking at the data provided, the researcher excluded three respondents. One was excluded due to being an apparent repeat as their qualitative answers were identical to another respondent. Two were excluded because they did not complete the survey past demographic questions. In the end there were 8 social workers,

8 nurses and 2 “other” respondents (n=18). The 2 “other” respondents were included due to their data being enriching.

**Degrees held.** Of the nurses, 2 had less than a bachelor’s degree and 6 held a bachelor’s degree. For social workers, 3 held a bachelor’s degree and 5 possessed a master’s degree. When looking at the “others” 1 had a bachelor’s degree and 1 held a master’s degree.

**Time in hospice.** The average amount of time spent working in hospice across all disciplines was 105.8 months (or 8.8 years). See figure 1 below. The minimum was 4 months while the maximum was 432 months (36 years). For nurses the average was 120.1 months (10 years), social workers 62.3 months (5.2 years) and “other” was 222 months (18.5 years).



**Figure 1. Average number of months in hospice by discipline**

### **Hospice Demographics**

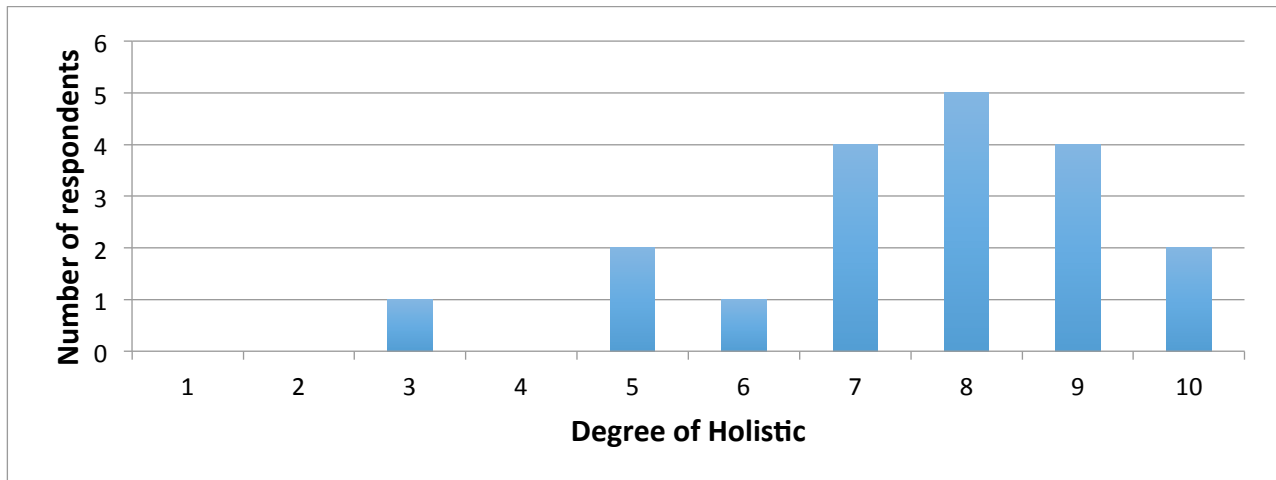
**Census.** There were 12 respondents who worked for a hospice that has an average census between 50 and 55. There was 1 respondent who was below this number (n=37), 4 respondents who had a census between 600 and 650 and 1 who claimed a census of 230. As such, the average census was 187.05

**Caseload.** The average caseload for all respondents was 18.78 with a minimum of 1 and a maximum of 37 (this excludes the 2 “other” respondents who both identified a caseload of 0). The average nurse caseload was 10.38 while the average social work caseload was 27.19. This represents a difference of 16.81 patients. In a typical month, the average amount of times a patient was seen by these two disciplines was 5.5. For nurses that average was 7 and social works it was 4.

**Disciplines Present at Intake.** All respondents (n=18) indicated that a nurse was usually present at intake. Five said that a social worker was usually present (and 1 said that a social worker was present half the time). Five listed that another discipline was present at intake (although only 2 specified that discipline, both indicated chaplain).

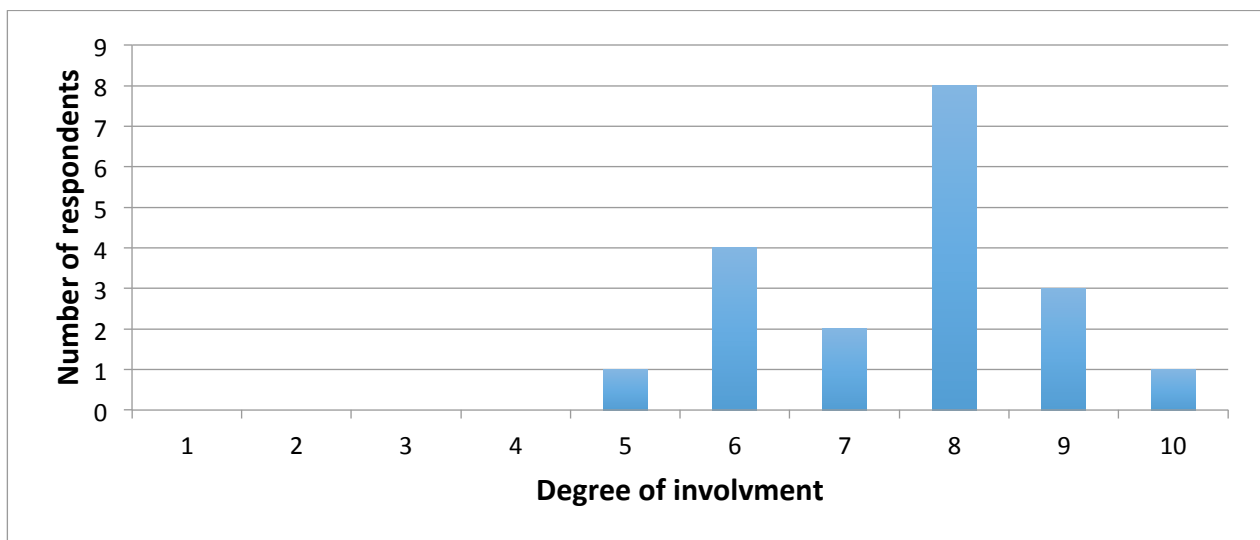
### **Perceptions of Hospice Care Provided**

**Holistic care.** Participants were presented with the scale question: “How holistic do you feel your agency is in addressing patient needs?” They were asked to rate this question on a scale from 1 to 10. See figure 2 below. The average to this question was response was 7.6. Nurses’ average response was 7.9 while social workers’ was 6.8 and “others” response was 9.5. Omitting the “others” responses, the average was brought down to 7.3 with a maximum of 10 and a minimum of 3.



**Figure 2. Perceived degree of holistic**

**Patient centered care.** When presented with the scale question (1-10 with 10 being the highest): “How actively involved are your patients when creating a plan of care?” the average response was again 7.8. See figure 3 below. Nurses’ average response was 7.4 while social workers’ was 7.8 and “others” response was 7.5. This question had a maximum response of 10 and no responded below 5.



**Figure 3. Perceived degree of patient involvement in plan of care**

### **Primary Utilizer of Interventions**

The question was asked: “For the following questions, please choose the discipline who primarily utilizes the intervention”. See Figure 4 below. Research participants were allowed to select from the following options: Nurse, social worker, “other” or not applicable.

**Medications.** All of the participants indicated that nurses are the primary utilizer of medication interventions.

**Guided Imagery.** When looking at guided imagery, 55.6 percent (n=10; 5 social workers, 4 nurses and 1 other) indicated that someone “other” than the social worker or nurse primarily used this intervention. 27.8 percent (n=5; 3 social workers, 1 nurse and 1 other) stated that social workers were the main utilizers of this intervention. 11.11 percent (n=2; 2 nurses) said that nurses used this intervention primarily. Finally, 5.6 percent (n=1; 1 nurse) of participants said that this intervention was not applicable in their hospice.

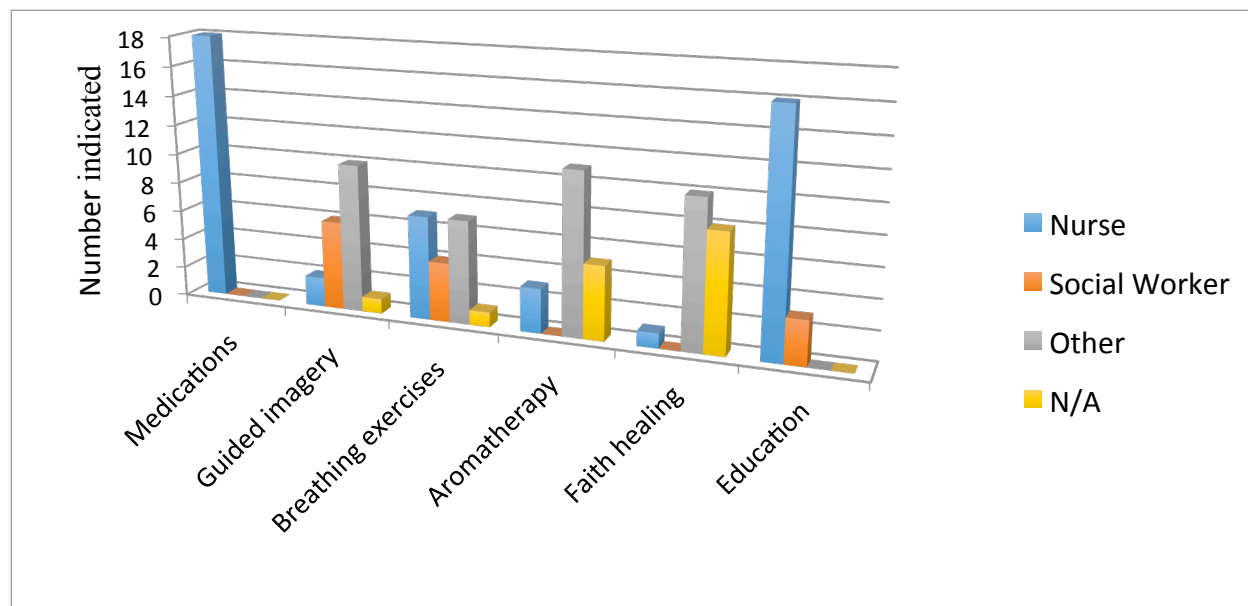
**Breathing Exercises.** Assessing breathing exercises, 38.9 percent (n=7; 3 social workers, 3 nurses and 1 other) of participants indicated that someone “other” than the nurse or social worker primarily uses this intervention with patients. 38.9 percent (n=7; 1 social worker, 5 nurses and 1 other) said that nurses are the key user of breathing exercises. 16.7 percent (n=3; 3 social workers) said that social workers are the ones who primarily use breathing exercises with patients. 5.6 percent (n=1; social worker) indicated that this intervention was not used in their hospice.

**Aromatherapy.** When looking at aromatherapy, the data showed that 61.1 percent (n=11; 5 social workers, 4 nurses, 2 other) of participants indicated that the primary individual who did aromatherapy was someone other than a social worker or nurse. 22.2 percent (n=4; 3 social workers, 1 nurse) stated that this intervention was not available at their hospice. 16.7

percent (n=3; 3 nurses), reported that nurses are the primary utilizers of this intervention. 0 percent (n=0) said that social workers used this intervention primarily.

**Faith Healing.** The data showed that 55.6 percent (n=10; 5 nurses, 4 social workers and 1 other) stated that it was someone “other” that a nurse or social worker who primarily uses this intervention at their agency. 38.9 percent (n=7; 4 social workers, 2 nurses and 1 other) indicated that this intervention was not available at their hospice employer. 5.6 percent (n=1; 1 nurse) said that the nurse is the primary user of aromatherapy with patients. 0 percent (n=0) reported that a social worker was the primary utilizer of faith healing with patients.

**Education.** When assessing education as an intervention, the data revealed that 83.3 percent (n=15; 8 nurses, 5 social workers and 2 other) stated that nurses primarily use education as an intervention with patients. 16.7 percent (n=3; 3 social workers) reported that social workers were the chief discipline to use education. 0% (n=0) indicated that “other” and 0 percent (n=0) stated that this intervention was not applicable at their agency.



**Figure 4. Primary utilizers of various interventions by discipline**

**Utilization by symptom**

The question was asked: “For the following questions, please select all of the symptoms that you have used each intervention”. Research participants were allowed to select from the following options: anxiety, depression, pain, other and not applicable. See Table 1 and Figure 5 below.

**Anxiety.** All of the nurses and 75 percent of social workers stated that they use medication as an intervention for anxiety. Sixty-two and a half percent of nurses and 87.5 percent of social workers indicated that they used guided imagery for anxiety. One hundred percent of nurses and 87.5 percent of social workers stated that they used breathing exercises for anxiety. Thirty-seven and a half percent of nurses and 50 percent of social workers indicated that aromatherapy was used to manage anxiety. Twenty-five percent of nurses and 12.5 percent of social workers indicated that faith healing as an intervention for anxiety. One hundred percent of nurses and 100 percent of social workers reported that education was an intervention they used for anxiety.

**Depression.** All of the nurses and 75 percent of social workers stated that they use medication as an intervention for depression. Thirty-seven and a half percent of nurses and 25 percent of social workers indicated that they used guided imagery for depression. No nurses and 25 percent of social workers stated that they used breathing exercises for depression. Twenty-five percent of nurses and 37.5 percent of social workers indicated that aromatherapy was used to manage depression. Thirty-seven and a half percent of nurses and 25 percent of social workers indicated that faith healing as an intervention for depression. One hundred percent of nurses and 87.5 percent of social workers reported that education was an intervention they used for depression.

**Pain.** All of the nurses and 75 percent of social workers stated that they use medication as an intervention for pain. Seventy-five percent of nurses and 37.5 percent of social workers indicated that they used guided imagery for pain. Seventy-five percent of nurses and 37.5 percent of social workers stated that they used breathing exercises for pain. Twenty-five percent of nurses and 25 percent of social workers indicated that aromatherapy was used to manage pain. Twenty-five percent of nurses and 25 percent of social workers indicated that faith healing as an intervention for pain. One hundred percent of nurses and 100 percent of social workers reported that education was an intervention they used for pain.

**Other.** The data showed that 87.5 percent of nurses and 50 percent of social workers stated that they use medication as an intervention for other symptoms. No nurses and 12.5 percent of social workers indicated that they used guided imagery for other symptoms. Twelve and a half percent of nurses and 25 percent of social workers stated that they used breathing exercises for other symptoms. Fifty percent of nurses and no social workers indicated that aromatherapy was used to manage other symptoms. Twenty-five percent of nurses and no social workers indicated that faith healing as an intervention for other symptoms. One hundred percent of nurses and 62.5 percent of social workers reported that education was an intervention they used for other symptoms.

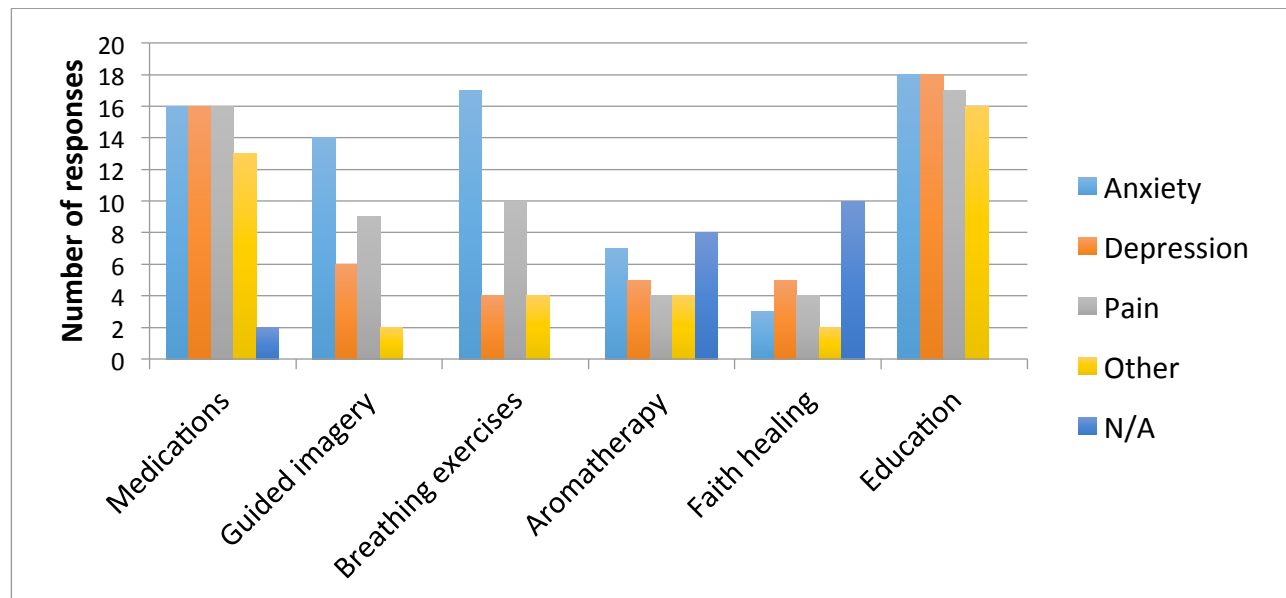
**Not Applicable.** No nurses and 12.5 percent of social workers stated that do not use medication as an intervention for symptoms. No nurses and no of social workers stated that guided imagery was not applicable to symptom intervention. No nurses and no social workers stated that breathing exercises were not applicable to symptom intervention. Thirty-seven and a half percent of nurses and 37.5 percent of social workers indicated that the use of aromatherapy for depression was not applicable. Fifty percent of nurses and 50 percent of social workers stated



that faith healing was not an applicable intervention for pain in their practice. No nurses and no social workers stated that education was not applicable to symptom intervention.

**Table 1. Total number of responses indicating utilization of interventions by symptom**

	Anxiety	Depression	Pain	Other	N/A
<b>Medications</b>	16	16	16	13	2
<b>Guided imagery</b>	14	6	9	2	0
<b>Breathing exercises</b>	17	4	10	4	0
<b>Aromatherapy</b>	7	5	4	4	8
<b>Faith healing</b>	3	5	4	2	10
<b>Education</b>	18	18	17	16	0



**Figure 5. Total number of responses indicating utilization of interventions by symptom**

**Overall.** When factoring out pharmacological interventions, the data shows a difference in utilization of interventions by symptom. See Table 2 below. For anxiety, there is almost no difference in the use of alternative interventions (65 percent of nurses verses 67.5 percent of social workers). Looking at depression there is also only a slight difference in use (40 percent for nurses verses 42.5 percent for social workers). Pain management interventions show a much larger difference (57.5 percent of nurses and 42.5 percent of social workers). For all other symptoms there is also a difference (37.5 percent of nurses and 22.5 percent of social workers).

**Table 2. Percentage of non-pharmacological interventions used by symptom and discipline**

	Anxiety	Depression	Pain	Other symptom
<b>Nurse</b>	65.00%	40%	57.50%	37.50%
<b>Social Worker</b>	67.50%	42.50%	42.50%	22.50%

### Comparing Social Work and Nursing

When grouped together, social work and nursing appear to use many alternative interventions. See Table 3 below. 95.8% of the time, education is used as an alternative intervention method. This is the most utilized tactic across all queries of the survey just ahead of medication at 88.5%. Breathing exercises, guided imagery, aromatherapy, and faith followed at 47.9%, 32.3%, 20.8%, and 14.6% respectively. However, nurses are 12.5 percent more likely to use education as an intervention and 21.8 percent more likely to use medication as an intervention for symptom management. Once pharmacological interventions are factored out, nurses and social workers are roughly as likely to use other interventions to manage anxiety and depression (nurses are 15 percent more likely to use alternative interventions for pain and other symptoms).

**Table 3. Percentages of interventions used across all symptomology**

	Social Work	Nurse	Overall
<b>Education</b>	87.5%	100%	95.8%
<b>Medication</b>	68.8%	90.6%	88.5%
<b>Breathing Exercises</b>	46.9%	46.9%	47.9%
<b>Guided Imagery</b>	40.6%	40.6%	32.3%
<b>Aromatherapy</b>	28.1%	34.4%	20.8%
<b>Faith Healing</b>	15.6%	28.1%	14.6%
<b>All</b>	47.9%	56.8%	42.3%

### Effectiveness of Interventions

Participants were asked to rate various interventions on their perceived effectiveness of each intervention. This was a scale question from 1 to 10 in which 10 was the highest possible answer. See Table 4 below.

**Medications.** A scale question was asked: “How effective would you say the following interventions are with patients?” Responses were given on a 1 to 10 scale with 10 being the highest. The mean response for medications was 8.5. The average for social workers was 8.3 while the mean for nurses was 8.5.

**Guided imagery.** Participants were asked the scale question: “How effective would you say the following interventions are with patients?” A 1 to 10 scale was used with 10 being the highest. The mean response for guided imagery was 6.33. The average for social workers was 5.71 while the average for nurses was 6.86.

**Breathing Exercises.** A scale questions was asked: “How effective would you say the following interventions are with patients?” Responses were given on a 1 to 10 scale with 10 being the highest. The mean response for breathing exercises was 7. The average for social workers was 6.4 while the mean for nurses was 7.5.

**Aromatherapy.** Respondents were presented with the scale question: “How effective would you say the following interventions are with patents?” A 1 to 10 scale was used with 10 being the highest. The average response for aromatherapy was 6.5. The mean for social workers was 6.6 while the average for nurses was 6.7.

**Faith healing.** A scale question was asked: “How effective would you say the following interventions are with patients?” Responses were given on a 1 to 10 scale with 10 being the highest. The mean response for faith healing was 6.2. The average for social workers was 8 while the average for nurses was 6.

**Education.** Participants were asked the scale question: “How effective would you say the following interventions are with patients?” A 1 to 10 scale was used with 10 being the highest. The mean response for education was 8.4. The average for social workers was 8.2 while the mean for nurses was 8.3.

**Table 4. Perceived effectiveness of various interventions**

	Total Responses	Mean
<b>Medications</b>	17	8.5
<b>Guided imagery</b>	15	6.3
<b>Faith healing</b>	12	6.2
<b>Education</b>	17	8.4
<b>Breathing exercises</b>	16	7
<b>Aromatherapy</b>	12	6.5

## Qualitative Themes

Three qualitative questions were asked in attempt to gain deeper understanding into professional's perceptions of the implementation and use of these various alternative interventions. In analyzing the data, three themes emerged: complex decisions about implementation and utilization, limited resources and the need for education on many levels.

**Complex decisions about implementation and utilization.** When deciding what intervention to use a theme on the complexity of the decision about interventions emerged. Six nurses, four social workers and one other respondent mentioned something about this in their response (this amounts to 61.1 percent of the sample). Of note, six nurses stated that inconstancy (ranging from dosing to side effects) of pharmacological interventions factored into the difficulty with medications use as an intervention. One nurse stated, "Medications do not always effect patients in the same way, or equally." Additionally, when using non-pharmacological interventions, patient buy-in is factored into decisions about implementation and use. Four nurses, four social workers and one other noted something that connected to this idea (ranging from hesitation to negative bias and lack of openness). To illustrate this, one social worker reported that an intervention is effective, "Only if the patient is unwilling to try."

**Limited resources.** The data collected points to a theme of limited resources. Five nurses, three social workers and one other discipline identified this theme either in time, personnel, or budget (this amounts to 50 percent of the sample). One nurse reported the need for, "Increased time 'at the bedside' without the distraction of feeling the pressure to move onto the next patient." A social worker highlighted budgeting as one thing that would improve the implementation and use of interventions, "I would like to see a discretionary budget...to draw

from.”

**Need for education on many levels.** The most prevalent theme among the qualitative data collected was the need for more education on all levels. Five nurses, seven social workers and one other discipline mentioned education in this part of the survey (this amounts to 72.2 percent of the sample) The first level identified was the need to better educate patients. Four nurses and two social workers talked about this need. One social worker noted that “education is critical because patients often simply aren't aware of the ways in which they can help themselves.” The second level of education need identified was within the team. Three social workers and one other discipline stated the need to increase practitioner’s knowledge on alternative interventions. The “other” discipline highlighted this when stating, “more education for staff on how and when to utilize” in response to the question of how to improve interventions in hospice. Finally one nurse identified the need for “better... documentation of clinical studies.”

## **Discussion**

### **Important Findings**

After assessing the data, patterns seemed to emerge. One can conclude that education and medication are the most frequently used and trusted interventions by hospice social workers and nurses in the seven county metro area of Minnesota. Interestingly, there appears to be a difference in the circumstances in which the likelihood that a social worker or nurse will use these interventions. Overall, nurses are more likely than social workers to use any of the interventions studied across the board of symptomology. This might be due to their higher frequency of visits (7 for nurses versus 4 for social workers). In fact, nurses are 12.5 percent more likely to use education as an intervention and 21.83 percent more likely to use medication as an intervention for symptom management. However, once pharmacological interventions are

factored out, nurses and social workers are roughly as likely to use other interventions to manage anxiety and depression (nurses are 15 percent more likely to use alternative interventions for pain and other symptoms).

Qualitative data sheds light on these findings. Respondents were able to identify a need for more education of staff, patients and within the larger research community. This might mean that current practitioners are not feeling capable of using alternative interventions. They also reflected on the reasons behind decisions on interventions used and recognized the inconsistency that pharmacological interventions can bring which was identified in the literature review for this research paper. Finally, the recognition that limited resources are a challenge points to another reason why some interventions might be used less. When resources are lacking (monetary, time or human) it is hard for a practitioner to take the time and effort that is required to get the “buy-in” of patients for the validity of alternative interventions. Relating to the research question: How effective are hospice team members at implementing and using alternative interventions with patients? It is clear that much more can be done.

### **Implications for Social Work**

The literature review conducted for this project revealed many implications for the social work profession. Overall, it seems that social workers are not being utilized to their full potential. Based on this limited sample, social workers are only involved in the initial intake 30.56 percent of the time and it would seem that often they are only involved due to a nurse not being able to complete the intake. This is important and (and coincides with the literature review) in that lack of early social worker involvement might increase overall costs. Additionally, Social workers are well equipped to provide education as an intervention. This is, interestingly, reinforced by research presented before that patients and families see this as the primary role of the social

worker. However, based on this sample, it appears that social workers are still not providing this intervention as often as one might hope for. Moreover, as presented before, there is ever mounting evidence of the legitimacy of alternative interventions for symptom management at the end of life. Social workers practicing in this field should see this as a call to get more educated on the available interventions and advocate, within their agencies, to integrate them into care plans. There is also a general need to educate patients and other team members on the implementation and utilization of alternative intervention. This task falls well on the shoulders of hospice social workers.

### **Implications for Future Research**

This research is limited in its small sample size and distinct regional confinement. As such, future research should seek to expand on this exploratory study. A larger sample size would be necessary to perform more complex statistical analysis, which could yield important quantifiable data in support of this study's findings. It would also be useful to investigate more deeply into the reasons behind each interventions use or lack of use. As more interventions become available, it is also important to continue to study each one's value, efficacy and validity through empirical research.

### **Implications for Policy**

As reported earlier, less than 50 percent of hospice agencies offer alternative therapies despite claiming to be "holistic". When looking at the definition of holistic provided at the beginning of this research paper, "relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts" (Merriam-Webster Online, n.d.) it is clear that practitioners are doing their patients a disservice (and not living up to their claimed holistic nature) by not integrating alternative interventions. Future agency level policies



should be focused on improving access to alternative interventions for both team members and patients. Additionally, hospice agencies should support practitioners in their continued education around this area (both monetarily and by increasing opportunities to learn about them). Budgets for hospice providers need to begin factoring in these (and other) alternative interventions that increase patient satisfaction through a decrease in symptomology.

### References

- Baer, H. A., & Coulter, I. (2008). Introduction--taking stock of integrative medicine: Broadening biomedicine or co-option of complementary and alternative medicine? *Health Sociology Review, 17*(4), 331.
- Bercovitz, A., Sengupta, M., Jones, A., Harris-Kojetin, L. D. (2011) Complementary and Alternative Therapies in Hospice: The National Home and Hospice Care Survey: United States, 2007. *National Health Statistics Report, 33*, 1-20.
- Bogasky, S., Sheingold, S., & Stearns, S. C. (2014). Medicare's hospice benefit: Analysis of utilization and resource use. *Medicare & Medicaid Research Review, 4*(2), E1-E14.  
doi:10.5600/mmrr.004.02.b03
- Boon, H., Verhoef, M., O'Hara, D., Findlay, B., & Majid, N. (2004). Integrative healthcare: Arriving at a working definition. *Alternative Therapies in Health and Medicine, 10*(5), 48.
- Cagle, J. G., & Kovacs, P. J. (2009). Education: A complex and empowering social work intervention at the end of life. *Health & Social Work, 34*(1), 17-28.
- Christ, G. H., & Sormanti, M. (1999). Advancing social work practice in end-of-life care. *Social Work in Health Care. 30*(2), 81-99.
- Cohen-Mansfield, J., Thein, K., Marx, M.S. & Dakheel-Ali, M. (2012). What are the barriers to performing nonpharmacological interventions for behavioral symptoms in the nursing home? *Journal of the American Medical Directors Association, 3*, 400-405.  
Doi:10.1016/jamda.2001.07.006

- Connor, S.R., Tendo, J., Spence, C., & Smith, N. (2005). Family evaluation of hospice care: Results from voluntary submission of data via website. *Journal of Pain and Symptom Management, 30*(1), 9-7. doi:10.1016/j.jpainsymman.2005.04.001
- Csikai, E., L. & Martin, S. S. (2010). Bereaved hospice caregivers' views of the transition to hospice. *Social Work in Health Care, 49*(5), 387-400. doi:10.1080/00981380903426822
- Dolce, A., Marsh, K., Sheldon, L. K., Summers, J., & Swanson, S. (2008). Putting evidence into practice[R]: evidence-based interventions for anxiety. *Clinical Journal of Oncology Nursing, 12*(5), 789+.
- Enguidanos, S. M., Davis, C., & Katz, L. (2005). Shifting the paradigm in geriatric care management: Moving from the medical model to patient-centered care. *Social Work in Health Care, 41*(1), 1-16.
- Flume, P., Leong, S.-S., Sherman, C., Silvestri, G. A., Turrisi, A., & Williams, T. (2002, September). Caring for the dying patient with lung cancer. *Chest, 122*(3), 1028+.
- Hay, A., & Johnson, S. (2001). Fundamental skills and knowledge for hospice and palliative care social workers. *Competency Based Education For Social Workers*. Arlington, VA: National Hospice and Palliative Care Organization.
- Merriam-Webster Online. (n.d.). *Holistic [Def. 2]*. In Merriam-Webster. Retrieved July 1, 2015, from <http://www.merriam-webster.com/dictionary/holistic>
- Merriam-Webster Online (n.d.). *Hopsice [Def. 2]*. In Merriam-Webster. Retrieved July 1, 2015, from <http://www.merriam-webster.com/dictionary/hospice>
- Janzen, S., Zecevic, A. A., Kloseck, M. & Orange, J.B. (2013). Managing agitation using nonpharmacological interventions for seniors with dementia. *Journal of Alzheimer's Dementia and Other Dementias, 28*, 551-561. doi: 10.117/1533317513494444

- Johnson, C. (2009). Health care transitions: A review of integrated, integrative, and integration concepts. *Journal of Manipulative and Physiological Therapeutics*, 32(9), 703-713.  
doi:<http://dx.doi.org.ezproxy.stthomas.edu/10.1016/j.jmpt.2009.11.001>
- Kim, S. D. & Kim, H.S. (2005). Effects of a relaxation breathing exercise on anxiety, depression, and leukocyte in hemopoietic stem cell transplantation patients, *Cancer Nursing*, 28(1) 79-83.
- Livne, R. (2014). Economics of dying: The moralization of economic scarcity in U.S. hospice care. *American Sociological Review*, 79(5), 888-911. doi:10.1177/0003122414547756
- Lutz, S. (2011). The history of hospice and palliative care. *Current Problems in Cancer*, 35(6), 304-309.  
doi:<http://dx.doi.org.ezproxy.stthomas.edu/10.1016/j.currproblcancer.2011.10.004>
- Mahoney, J. (1997) Hospice and managed care, *Hospice Journal*, 12, 81-84
- Miller, R. D., & Walsh, T. D. (1991). Psychological aspects of palliative care in advanced cancer. *Journal of Pain and Symptom Management*, 6, 24-29
- Nobel Pederson, S., & Emmers-Sommer, T. (2012). "I'm not trying to be cured, so there's not much he can do for me": Hospice patients' constructions of hospice's holistic care approach in a biomedical culture. *Death Studies*, 36(5), 419-446.  
doi:10.1080/07481187.2011.584024
- NHPCO Facts and Figures: Hospice Care in America*. (2012). Alexandria, VA: National Hospice and Palliative Care Organization. Retrieved from  
[http://www.nhpc.org/sites/default/files/public/Statistics\\_Research/2012\\_Facts\\_Figures.pdf](http://www.nhpc.org/sites/default/files/public/Statistics_Research/2012_Facts_Figures.pdf)

- Noe, K., Smith, P., & Younis, M. (2012). Calls for reform to the U.S. hospice system. *Ageing International*, 37(2), 228-237. doi:10.1007/s12126-010-9106-8
- Portenoy, R. K., Sibirceva, U., Smout, R., Horn, S., Connor, S., Blum, R. H., Spence, C., Fine, P. G. (2006). Opioid use and survival at the end of life: A survey of a hospice population. *Journal of Pain and Symptom Management*, 32(6), 532-540.  
doi:http://dx.doi.org.ezproxy.stthomas.edu/10.1016/j.jpainsymman.2006.08.003
- Reese, D. J. (2011). Interdisciplinary perceptions of the social work role in hospice: Building upon the classic kulys and davis study. *Journal of Social Work in End-of-Life & Palliative Care*, 7(4), 383-406. Retrieved from  
<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=83301&site=ehost-live>
- Reese, D. J., & Raymer, M. (2004). Relationships between social work involvement and hospice outcomes: Results of the national hospice social work survey. *Social Work*, 49(3), 415-422. Retrieved from <http://www.jstor.org/stable/23721078>
- Saunders, C. (1986). The nature and nurture of pain control. *Journal of Pain & Symptom Management*, 1(4), 199-201. doi: [http://dx.doi.org/10.1016/s0885-3924\(86\)80041-0](http://dx.doi.org/10.1016/s0885-3924(86)80041-0)
- Seitz, D.P. & Gill, S. S. (2013). Review: Non-pharmacological interventions delivered by family caregivers improve symptoms in people with dementia. *Evidence-Based Mental Health*, 16, 22. doi:10.1136/ed-2012-101095
- Vandergrift, A. (2013). Use of complementary therapies in hospice and palliative care. *Omega: Journal of Death & Dying*, 67(1), 227-232. doi:10.2190/OM.67.1-2.z2
- Weick, A. (1983). Issues in overturning a medical model of social work practice. *Social Work*, 28(6), 467-471. Retrieved from

<http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=10555&site=ehost-live>

**Appendix B**

1. You are a:
  - a. Social worker
  - b. Nurse
  - c. Other
2. Do you work for a hospice provider that operates out of one of these seven counties – Anoka, Hennepin, Ramsey, Washington, Carver, Scott and/or Dakota?
  - a. Yes
  - b. No
3. What is the average daily census of your hospice?
  - a. Enter a number
4. What is your average caseload?
  - a. Enter a number
5. How often do you see each patient in a typical month?
  - a. Enter a number
6. How long have you worked in hospice settings within the Twin Cities?
  - a. Enter a number of months
7. What is the highest educational level you have attained?
  - a. Less than a Bachelor's Degree
  - b. Bachelor's Degree
  - c. Master's Degree
  - d. Doctoral Degree

Definition of Holistic: “Relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts” (Merriam-Webster Online, n.d.).

8. On a scale of 1 -10 (10 being the highest) how holistic do you feel your agency is in addressing patient needs?
  - a. 1-10
9. On a scale from 1 – 10 (10 being the highest) how actively involved are your patients when creating a plan of care?
  - a. 1-10
10. What disciplines are usually present for the initial hospice intake? Check all that apply.
  - a. Nurse
  - b. Social Work
  - c. Other \_\_\_\_\_
11. Who primarily, within your agency, utilizes medications with patients?
  - a. Social worker
  - b. Nurse
  - c. Other \_\_\_\_\_
  - d. n/a
12. Who primarily, within your agency, utilizes guided imagery with patients?
  - a. Social worker
  - b. Nurse
  - c. Other \_\_\_\_\_
  - d. n/a
13. Who primarily, within your agency, utilizes breathing exercises with patients?



- a. Social worker
  - b. Nurse
  - c. Other \_\_\_\_\_
  - d. n/a
14. Who primarily, within your agency, utilizes aromatherapy with patients?
- a. Social worker
  - b. Nurse
  - c. Other \_\_\_\_\_
  - d. n/a
15. Who primarily, within your agency, utilizes faith healing with patients?
- a. Social worker
  - b. Nurse
  - c. Other \_\_\_\_\_
  - d. n/a
16. Who primarily, within your agency, utilizes education with patients?
- a. Social worker
  - b. Nurse
  - c. Other \_\_\_\_\_
  - d. n/a
17. For what purposes have you used medications with patients? Check all that apply
- a. Anxiety
  - b. Depression
  - c. Pain

d. Other \_\_\_\_\_

e. n/a

18. For what purposes have you used guided imagery with patients? Check all that apply

a. Anxiety

b. Depression

c. Pain

d. Other \_\_\_\_\_

e. n/a

19. For what purposes have you used breathing exercises with patients? Check all that apply

a. Anxiety

b. Depression

c. Pain

d. Other \_\_\_\_\_

e. n/a

20. For what purposes have you used aromatherapy with patients? Check all that apply

a. Anxiety

b. Depression

c. Pain

d. Other \_\_\_\_\_

e. n/a

21. For what purposes have you used faith healing with patients? Check all that apply

a. Anxiety

b. Depression

- c. Pain
  - d. Other \_\_\_\_\_
  - e. n/a
22. For what purposes have you used education with patients? Check all that apply
- a. Anxiety
  - b. Depression
  - c. Pain
  - d. Other \_\_\_\_\_
  - e. n/a
23. On a 1 -10 scale (10 being the highest) How effective would you say guided imagery is with patients?
- a. 1 – 10
  - b. n/a
24. On a 1 -10 scale (10 being the highest) How effective would you say breathing exercises are with patients?
- a. 1 -10
  - b. n/a
25. On a 1 -10 scale (10 being the highest) How effective would you say aromatherapy is with patients?
- a. 1 -10
  - b. n/a
26. On a 1 -10 scale (10 being the highest) How effective would you say faith healing is with patients?

- a. 1 -10
  - b. n/a
27. On a 1 -10 scale (10 being the highest) How effective would you say education is with patients?
- a. 1 -10
  - b. n/a
28. In your opinion, what are the reasons why these interventions have been effective?
- a. Open answer
29. In your opinion, what are the reasons why they have been ineffective?
- a. Open answer
30. In your opinion, how could these interventions be improved?
- a. Open answer