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Effects of spiritual care training for palliative care professionals

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Little is known about the effects of spiritual care training for professionals in palliative medicine. We therefore investigated prospectively the effects of such training over a six-month period. All 63 participants of the three and a half-day training were asked to fill out three questionnaires: before and after the training, as well as six months later. The questionnaires included demographic data, numeric rating scales about general attitudes towards the work in palliative care, the Self-Transcendence Scale (STS), the spiritual subscale of the Functional Assessment of Chronic Illness Therapy (FACIT-Sp) and the Idler Index of Religiosity (IIR). Forty-eight participants (76%) completed all three questionnaires (91% women, median age 49 years; 51% nurses, 16% hospice volunteers, 14% physicians).

Significant and sustained improvements were found in self-perceived compassion for the dying (after the training: $P=0.002$; 6 months later: $P=0.025$), compassion for oneself ($P<0.001$; $P=0.013$), attitude towards one's family ($P=0.001$; $P=0.031$), satisfaction with work ($P<0.001$; $P=0.039$), reduction in work-related stress ($P<0.001$; $P=0.033$), and attitude towards colleagues ($P=0.039$; $P=0.040$), as well as in the FACIT-Sp ($P<0.001$; $P=0.040$). Our results suggest that the spiritual care training had a positive influence on the spiritual well-being and the attitudes of the participating palliative care professionals which was preserved over a six-month period. *Palliative Medicine* 2005; **19:** 99–104

Key words: palliative care; professional attitude; religion; self-care; spirituality; quality of life

Introduction

Palliative care is committed to holistic care – that is physical, social, psychological and spiritual care of patients and families facing incurable, progressive disease.[1] For patients at the end of life, increased emotional and spiritual anguish often exacerbates the perception of pain, anxiety, restlessness and other distressing symptoms of dying. Surveys suggest that religious involvement and spirituality are associated with positive health outcomes,[2] including better coping skills, better (health-related) quality of life, less anxiety and depression,[3,4] even during terminal illness.[5]

Comprehensive palliative care ought to address the patients' spiritual needs and concerns as well as their physical distress. However, medical professionals working in this field often have little preparation or training for responding to patients who are struggling to find meaning in life. Power and Sharp found that inadequate preparation to meet these emotional and spiritual demands of patients and their families are significant stressors for hospice nurses.[6] To be able to recognize another person's spiritual and religious values and beliefs, it is necessary to have some awareness of one's own beliefs, and of how they affect the provision of care; this seems especially true at the end of life.[7] Personal work with meditation and exploring one's own spirituality may be helpful for professionals who want to get in touch with their 'deeper selves' as a way of maintaining their own psychological and spiritual health and of enhancing their ability to reach out to others.[8]

The aim of this study was to evaluate the effects of a spiritual care program for Palliative Care professionals. We asked whether professional carers may gain benefits from this training such as positive changes of their attitudes, better spiritual well-being and lower levels of work-related stress, and whether the effects are sustained over a six month period.

What is 'Spirituality'?

There is still little agreement on the definition of spirituality or on the most appropriate ways to measure it. Historically, before the 1970s, spirituality was usually identified with religiosity. Due to political and social changes in Western societies in the 1970s and 1980s

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there is now a growing proportion of people who regard themselves as spiritual, but not religious (for a review, see Ref. 9).

The word *religion* comes from the Latin *religare*, which means 'to bind together'. A religion organizes the collective spiritual experiences of a group of people into a system of beliefs and practices. Thus, religiosity has been defined as 'participation in the particular beliefs, rituals and activities of traditional religion'.[10] In contrast, the word 'spiritual' is derived from the Latin *spiritus*, spirit, something which is within the body providing the life force, and refers to the domain of human existence which lies beyond the material – the aspects of life which give a sense of meaning, connection, integrity and hope.

Kellehear[11] developed a model of spiritual needs of palliative care patients which includes situational, moral, biographical and religious needs. Murata[12] used a philosophical approach to construct a conceptual framework for spiritual pain: spiritual pain of palliative care patients is described as loss of meaning in life, loss of identity, and loss of autonomy. Wright[13] employed a phenomenological approach to investigate the spiritual essence of palliative care in the lived experience. His results, obtained through semi-structured interviews, show that spiritual care responds to religious and humanistic needs by meeting both a requirement for faith and the desire for another human being to be 'there'. Thus, spiritual care seeks to affirm the value of each and every person based on non-judgmental love.

The Association of Hospice & Palliative Care Chaplains of the UK uses the following working definition: 'Spirituality concerns all that makes for an individual's existence as a person with all that implies of our capacity as human beings for self-transcendence, relationship, love, desire and creativity, altruism, self-sacrifice, faith and belief: it is the dynamic of integration towards a person's unique identity and integrity'.[14] Following this definition, the place in society, life circumstances, the rituals and patterns of living, loving and working contribute to one's spiritual development.

Thus, spirituality appears to be an individualized construct within multicultural and multifaith contexts. The spiritual domain includes religion, but those who are not affiliated with an institutionalized religion still experience spiritual needs which are universal, e.g., the wish to find meaning in life and the need to feel a genuine connection to others.

'Wisdom and compassion in care for the dying'

Based on Tibetan Buddhist traditions, but with a non-denominational scope, Sogyal Rinpoche, a Buddhist teacher and author of 'The Tibetan Book of Living and Dying',[15] founded the Spiritual Care Program with the aim to demonstrate practical ways in which the wisdom and compassion of the Buddhist teachings can be of benefit to those facing illness or death and also to their families and caregivers. The philosophy behind this program is that people who work with the dying have the opportunity to learn an enormous amount from them and to come close to the innermost essence of their being.

The three and a half-day training 'Wisdom and Compassion in Care for the Dying' was designed by Christine Longaker for those working as professionals or volunteers in medical or social support fields from diverse cultural and religious backgrounds. The aim of the training is to enable the participants to recognize the different facets of suffering of the dying persons and their relatives and to respond effectively. A precondition for this is in-depth reflection on one's own fear of death, learning firsthand both the needs and the hopes in dying. The participants learn techniques of active and compassionate listening, and how to recognize and address the causes of emotional and spiritual suffering. Practical exercises are presented to enable the participants to connect with disturbed or cognitively impaired patients, to learn how to deal with unfinished business and be able to support mourners. Furthermore, non-denominational spiritual practices such as contemplation and meditation are introduced, which can help the participants apply and experience the benefits of spiritual care for themselves, and learn how to integrate these techniques for calming the mind and deepening compassion in their professional work.

Sample and methods

Sample

The course 'Wisdom and Compassion in Care for the Dying' took place in Munich from 7–10 October 2002. All 63 participants were asked to fill out anonymously three questionnaires: before and immediately after the training, and six months later. They were informed about the extent and aim of the study at the beginning. The questionnaires comprised demographic data, numeric rating scales about general attitudes towards the work in palliative care, the spiritual subscale of the Functional Assessment of Chronic Illness Therapy (FACIT-Sp), the Self-Transcendence Scale (STS) and the Idler Index of Religiosity (IIR). The measurements were performed at all three points of investigation, except for the IIR which was performed at baseline and six months after the course.

In addition, in the second questionnaire the participants were asked to name their main problems in the handling with death and dying, to describe the changes as a result of the course and to rate the single course contents on a 4-point scale ranging from 0 (unhelpful) to 3 (very helpful). Before the training and six months later, the participants were asked to quote the number of days they had been ill in the last six months.

All participants were professionals involved in Palliative Care who took voluntarily part in the study. Anonymity of the data analysis was guaranteed. According to the Institutional Review Board (IRB) of the Munich University Hospital, a formal IRB approval was not required.

Instruments

Functional Assessment of Chronic Illness Therapy – Spiritual Well-being (FACIT-Sp). This scale was developed as a subscale of the FACIT with the input of cancer patients, psychotherapists, and religious/spiritual experts. It was designed to measure important aspects of spirituality, such as a sense of meaning in one's life, harmony, peacefulness, and a sense of strength and comfort from one's beliefs, and is well validated.[16,17] Spirituality is defined as 'the way in which people understand and live their lives in view of their ultimate meaning and value',[10] and therefore is seen as being more basic than religiosity. Responses are based upon a 5-point response scale ranging from 0 (not at all) to 4 (very much), higher values reflecting a higher level of spiritual well-being.

Self-Transcendence Scale (STS). Self-transcendence is defined here as 'the expansion of one's conceptual boundaries inwardly through introspective activities, outwardly through concerns about others' welfare, and temporally by integrating perceptions of one's past and future to enhance its present'. The key assumption is that a sense of connectedness within the self and with one's environment is an essential characteristic of humanness.[18] Reed developed this measure of self-transcendence using a 15 item self-report questionnaire. Typical questions regard 'helping younger people or others in some way', and 'finding meaning in my spiritual beliefs'. In a study with older adults the test – retest reliability was 0.95, and the internal consistency range was 0.80 to 0.93.[18] Responses are based upon a 4-point scale ranging from 1 (not at all) to 4 (very much). The final score reflects the overall level of self-transcendence.

Idler Index of Religiosity (IIR). The IIR contains two 2-item scales, one that sums attendance at religious services and number of other congregation members known to the respondent (public religiousness) and the other that sums self-reports of religiousness and receiving strength and comfort from religion (private religiousness). The overall score, ranging from 4 (least religious) to 17 (most religious) represents the level of religiosity in general.[19]

Numeric rating scales (NRS). In all questionnaires, 10 numeric rating scales ranging from 0 (not at all) to 10 (very much) were used to test general attitudes towards the work in palliative care. Specifically, we asked the participants to rate the following items: quality of life, compassion with severely ill and dying persons, compassion with oneself, attitude towards one's family, fear of the dying process and of death, contentment with the job, meaningfulness of the job, attitude towards colleagues and perception of work-related stress. In addition, a composite attitudinal score was obtained by summing up the ratings from all NRS.

Data analysis

Since the data did not follow a normal distribution, the tests used to check significant differences and to examine correlations included the Wilcoxon rank sum test for paired data, as well as Spearman's correlation coefficient. All P-values were corrected for multiple comparisons (Bonferroni correction) except for those obtained from the analyses of the NRS. The significance level was set at $P < 0.05$. The Statistical Package for the Social Sciences (SPSS 11.5 for Microsoft Windows) was used.

Results

Demographics (Table 1)

Fifty-nine participants (94%) filled out the first questionnaire, 58 (92%) the second and 55 (87%) the third; 48 completed all three questionnaires (76%). Thirteen percent of the participants had previously taken part in training by Christine Longaker.

Main problems identified and rating of the course contents

Before the course started, the participants identified the following as their main problems in the care of the dying person and his/her family: own uncertainty

Table 1 Demographics ($n = 63$)

Sex	91% women
	9% men
Age (median)	49 years (range: 26–70)
Profession	51% nurses
	16% hospice volunteers
	14% physicians
	5% social workers
	5% pastoral counselling
	9% other
Religious affiliation	71% Christians
	10% Buddhists
	19% no religious affiliation
Regular spiritual practice	56% prayer
	54% meditation
	27% reading sacred texts
	22% contemplation
Severely ill participants	6%
Participants with a severely ill family member or friend	35%
Participants in a bereavement process	25%

(45%), communication difficulties (31%), the handling of difficult family members (27%) and own emotions (25%). Overall, 77% of the respondents (percentage of participants with a rating 8 or higher on an NRS from 0 to 10) thought that their coping with these issues had been improved through the training.

Thirty-five per cent of the participants reported to have one of their loved ones with a severe illness, and their ability to cope with this was rated significantly better six months later ($P = 0.03$). Twenty-five percent of them reported to be in a bereavement process, the coping with which was also rated better after the training ($P < 0.01$), but this effect was not preserved over a six-month period ($P = 0.26$).

On a scale from 0 (not helpful) to 3 (very helpful), the overall course contents were judged as helpful (average rating: 2.7; range: 2.6–2.9).

Changes in attitudes towards work in palliative care

Significant and sustained improvements were found in single attitudes towards work in palliative care, as well as in the overall attitudinal score (Table 2 – these results should be regarded as indications, because they are not Bonferroni-corrected).

The number of sick leave days in the last six months remained quite stable (average before the training: 488 days; after 6 months: 2.41; $P = 0.868$).

Changes in the validated instruments

The FACIT-Sp was increased directly after the training and still after six months. The STS increased as well; after Bonferroni correction it was statistically significant directly after the training, but not after six months. The IIR did not change significantly over time (Table 3).

Table 2 Changes in attitudes towards work in palliative care

	Before the training (mean ± SD)	After the training (mean ± SD)	Six months later (mean ± SD)
Quality of life	7.1 ± 1.7	7.7 ± 1.3*	7.4 ± 1.4 (ns)
Compassion for the dying	7.4 ± 1.4	7.9 ± 1.2**	7.9 ± 1.3*
Compassion for oneself	6.2 ± 1.6	7.1 ± 1.5**	6.9 ± 1.4**
Attitude towards one's family	7.2 ± 1.5	7.9 ± 1.3**	7.7 ± 1.4*
Fear of dying	6.6 ± 2.1	7.2 ± 1.6*	6.8 ± 1.7*
Fear of death	7.3 ± 2.4	8.0 ± 1.9**	7.6 ± 1.8 (ns)
Satisfaction with work	7.2 ± 1.6	7.9 ± 1.4**	7.7 ± 1.5*
Work meaningful	8.5 ± 1.5	8.9 ± 1.2**	8.8 ± 1.3(ns)
Attitude towards colleagues	7.5 ± 1.4	7.9 ± 1.3*	7.9 ± 1.1*
Work-related stress	6.6 ± 2.3	7.9 ± 1.7**	7.4 ± 1.9*
Overall NRS score	71.8 ± 10.6	78.4 ± 9.4**	76.0 ± 9.1**

Higher scores always reflect more positive attitudes (e.g., higher compassion for oneself, less fear of death).
* $P < 0.05$; ** $P < 0.01$; ns = not significant.
SD = standard deviation.

Table 3 Group scores: FACIT-Sp, STS and IIR

Instrument	Maximal range	Before the training [range]	After the training [range]	Six months later [range]
FACIT-Sp	0–40	25.5 [15–34]	27.5 [19–33]**	26.3 [18–33]*
STS	15–60	48.5 [34–57]	50.4 [36–59]**	49.3 [38–58] ns
IIR	4–17	11.5 [6–16]		11.1 [5–15] ns

* $P < 0.05$; ** $P < 0.01$; ns = not significant.
All P-values are Bonferroni-corrected.

Correlations

The results of the FACIT-Sp and of the STS were strongly correlated at all time points. The IIR was correlated with the FACIT-Sp before and after the training, but at no point of investigation with the STS. The overall attitudinal score was correlated with the FACIT-Sp and the STS at all points of investigation, but at no point of investigation with the IIR (Table 4).

The nurses' group was compared with the other professional groups at all points of investigation, but no significant differences were found. The other professions could not be compared with each other due to the small number of individuals.

Discussion

Palliative care work can be rewarding, but also stressful. Constant confrontation with the deaths of others may result for caregivers in repeated re-evaluations of their own mortality and re-examination of the meaning of their lives. One key issue in this area is coping with the emotional effects of the patients' suffering; this is felt by both those who suffer and those who want to help. In the face of suffering, the key to sustaining in the area of palliative care is to learn how to feel compassion while maintaining the delicate boundary that keeps the carers from being burned out by their work.[20] In recent years, medical schools in the USA have started teaching courses on spirituality and medicine.[21] Our data suggest that the

Table 4 Spearman's correlations: FACIT-Sp, STS, IIR and composite score of the NRS (attitudinal score)

	Before the training (*r*-values)	After the training (*r*-values)	Six months later (*r*-values)
FACIT-Sp-STS	0.491**	0.581**	0.651**
FACIT-Sp–IIR	0.575**		0.315*
FACIT-Sp-NRS	0.323*	0.547**	0.439**
STS–NRS	0.764**	0.581**	0.523**
STS–IIR	0.289 (ns)		0.176 (ns)
NRS–IIR	0.203 (ns)		0.036 (ns)

* $P < 0.05$; ** $P < 0.01$; ns = not significant.
All P-values are Bonferroni-corrected.

spiritual care training had a positive influence on the participating palliative care professionals which was preserved over a six-month period: The FACIT-Sp, reflecting spiritual well-being, increased significantly. The STS was increased after the course, but not six months later. On the other hand, no change in the IIR was noted. This is not surprising if one thinks of the quite stable construct of religiosity ('participation in particular beliefs and activities of traditional religion') underlying the IIR. We assume that the STS and the FACIT-Sp measure similar constructs and that self-transcendence is one aspect of spirituality. This assumption is confirmed by the strong correlations between the two scales at all points of investigation. In contrast, religiosity is not correlated with self-transcendence.

There were significant improvements in self-perceived compassion for the dying, but also in compassion for oneself. Furthermore, the attitude towards one's family and the attitude towards colleagues improved, satisfaction with the work increased due to the training, and work-related stress decreased. We did not specifically validate the NRS used in this study. However, numeric rating scales are often used for the assessment of attitudes and have been found to be valid and reliable.[22] In addition, the correlations between the FACIT-Sp, the STS and the overall NRS score support the informational value of these results.

Some of the measurements were increased immediately after the training, but the effect was not preserved over six months – perhaps due to the routine effect of everyday working conditions. Some of the participants commented that it would be quite helpful to have regular meetings close by or a refresher training every six months.

This study has several limitations: First, every attempt to measure a highly subjective concept such as spiritual well-being will fall short to some extent. In addition, the use of self-report measures always carries a risk of bias; no statement is possible beyond the period of six months; and the number of physicians was too low to allow for a subgroup analysis.

These limitations notwithstanding, the results of this study indicate that a training in spiritual care can be helpful for palliative care professionals, and may contribute to reduce work-related stress and to improve the working atmosphere. Further research is needed to evaluate various spiritual care trainings (contents, structures, time frame), and to improve the existing courses. In addition, there is a need for prospective studies including qualitative data which address the role of spirituality and religion in palliative care and how they affect the burnout rate, the quality of life and the quality of the work of palliative care professionals.

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