

Spiritual care education: results from an EAPC survey

How are healthcare professionals trained in spiritual care? To find out, the European Association for Palliative Care (EAPC) Taskforce on Spiritual Care in Palliative Care has surveyed EAPC members. **Piret Paal, Carlo Leget** and **Andrew Goodhead** report on the results and formulate recommendations for improving spiritual care education

The European Association for Palliative Care (EAPC) White Paper on palliative care education states that, to adequately support patients and their families, 'palliative care professionals should be able to:

- Demonstrate the reflective capacity to consider the importance of spiritual and existential dimensions in their own lives
- Integrate the patients' and families' spiritual, existential and religious needs in the care plan, respecting their choice not to focus on this aspect of care if they so wish
- Provide opportunities for patients and families to express the spiritual and/or existential dimensions of their lives in a supportive and respectful manner
- Be conscious of the boundaries that may need to be respected in terms of cultural taboos, values and choices.¹

Palliative care professionals need to be trained in recognising spiritual issues and in delivering spiritual care. Every professional or volunteer working with patients, families and caregivers must be able to open a dialogue about meaning, purpose and change. The confidence to do so can be developed through training courses, which provide a space for participants to reflect on their personal understandings of spirituality, and a place where theoretical learning and skills practice come together. Training in spiritual care is a crucial component of any form of palliative care education, whether as a stand-alone course or as part of a broader programme.

Online survey

In October 2013, the education subgroup of the EAPC Task Force on Spiritual Care in Palliative Care launched an online survey of EAPC members. The initial call for responses was sent to all EAPC members and was

followed by a second call in April 2014 and a post on the EAPC Blog in July 2014.² The survey's aim was to identify spiritual care training courses currently running or planned for the near future. Ethical approval was not required, since no vulnerable groups were involved, no medical interventions were performed and no privacy issues arose.

Between October 2013 and mid-September 2014, we received responses from 14 countries around the world regarding 36 training courses. Some were stand-alone courses and some were broader programmes that included spiritual care education. A large majority of responses came from Europe, where 28 (78%) of the 36 training courses are delivered. Figure 1 shows the 14 countries and the number of training courses in each one.

Version 22 of the Statistical Package for the Social Sciences (SPSS22) was used for statistical analysis, and inductive content analysis was applied to the qualitative data gathered.

Definition of spirituality

Twenty-nine training courses (81%) used the EAPC working definition of spirituality: 'Spirituality is the dynamic dimension of

Key points

- Palliative care professionals and volunteers need to be trained in recognising spiritual issues and in delivering spiritual care.
- The education subgroup of the EAPC Task Force on Spiritual Care in Palliative Care has surveyed EAPC members to identify spiritual care training courses, current or planned. Data were gathered regarding 36 courses in 14 countries, mostly in Europe.
- The education subgroup makes recommendations regarding spiritual care training, encourages EAPC members to invest in such training, and welcomes further responses to its survey, as this will allow it to extend its database of training courses.

human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred.⁷³

For the seven remaining courses (19%), other definitions were used, or in one case no definition at all; four respondents specified that the definition used had resulted from group discussions.

Religious framework

One of the questions was whether or not the training course was set within a specific religious framework. Only one respondent replied that their course was, and the religious framework was Tibetan Buddhism. All other respondents replied 'no' to this question.

Target group

Twenty-one training courses (58%) targeted all healthcare professionals, of which seven also targeted volunteers. Ten courses (28%) were aimed at specific professional groups: three (8%) at nurses; three (8%) at psychologists; two (6%) at chaplains, pastoral counsellors and spiritual directors; one (3%) at medical students; and one (3%) at physicians. Two training courses (6%) were designed for volunteers, family members and the general public. Data were unclear or missing in the responses regarding three courses.

Duration

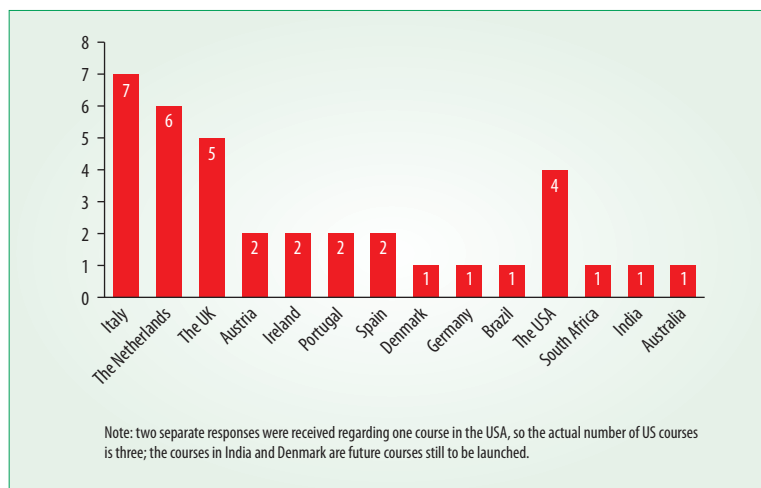
We divided the training courses into five groups according to their duration:

- Four (11%) took place over less than one day
- Six (17%) took place over the course of one day
- Eight (22%) took place over less than a week
- Eight (22%) lasted several weeks
- Three (8%) lasted several years (these were usually master programmes).

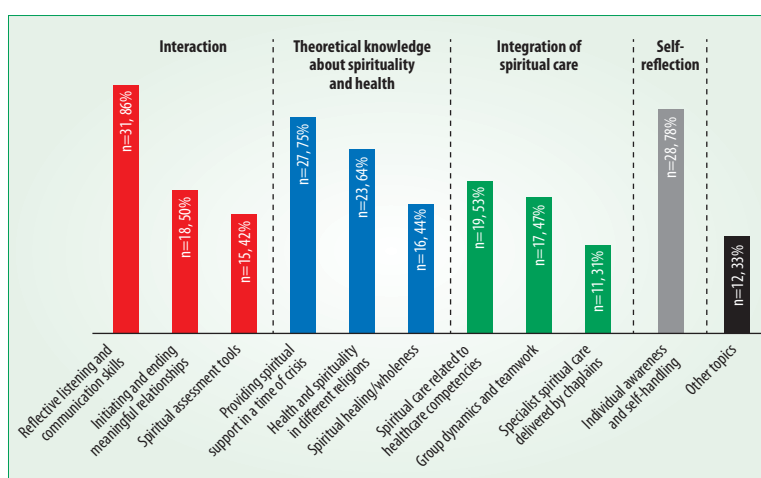
For seven courses, responses were unclear or the information had not been provided at all.

Format and setting

Twenty-eight courses (78%) provided face-to-face learning in a classroom setting; three courses (8%) combined face-to-face and online learning; only one (3%) combined face-to-face learning with some practical training; and one (3%) was entirely online. For three courses the information was missing.



■ **Figure 1.** The 14 countries from which the responses to the survey came and the number of spiritual care training courses in each country



■ **Figure 2.** The 11 pre-given core topics and to what extent they were covered in the 36 training courses

Training took place either in small groups of less than 15 participants (seven courses, 19%), in medium-size groups of between 16 and 30 participants (23 courses, 64%), or large groups of up to 150 participants (five courses, 14%). For the online-only course (3%), training took place individually.

Core topics

We asked respondents to rank the importance of 11 pre-given core topics in their particular training course. The results are presented in Figure 2. The topics were divided into four subgroups: interaction; theoretical knowledge about spirituality and health; integration of spiritual care; and self-reflection.

'Reflective listening and communication skills' (n=31, 86%), 'individual awareness and self-handling' (n=28, 78%) and 'providing spiritual support in a time of crisis' (n=27, 75%) were the most cited topics or competencies across the different courses.

Depending on the courses' aims, various other topics were cited under other relevant

Table 1. Overview of the spiritual care training courses identified by the survey

Target group	Title	Country	Duration
All healthcare professionals	Spiritual care in hospice care	Ireland	1 day
	Introduction to palliative care*	South Africa	6 days
	Opening the spiritual gate	UK	1 day face-to-face or over 4 weeks online
	Keys to opening the spiritual gate	UK	1 day
	Masterclass spirituality in palliative care	The Netherlands	5 days
	Regional palliative care training programme*	Spain	4 levels over 4 years
	Curso de tanatología ('thanatology course')	Brasil	3 times a week over 2 months
	Acompañamiento espiritual ('spiritual accompaniment')	Spain	3 days
	Lehrgang spiritual care 2012–2014 ('spiritual care studies 2012–2014')	Austria	25 days
	Curso basico de cuidados paliativos ('basic palliative care course')*	Portugal	21-hour course with 2 hours dedicated to spiritual care
	Contemplative end-of-life care certificate program	USA	15 weeks of online learning and 8 days of face-to-face training
	Master i livello in medicina palliativa: modelli organizzativi, clinica, ricerca, leadership ('master in palliative medicine: models of organisation, clinical work, research and leadership')*	Italy	2 years
	Peer coaching for the members of the palliative care network	The Netherlands	3 evenings over 3 months
	The collective soul symposium	USA	1 day
All healthcare professionals plus volunteers	How to handle spiritual needs	The Netherlands	3 afternoons
	Life and death, the same preparation	Portugal	7 days
	Spirituality and care	UK	-
	Issues in care of the spirit in palliative care	Australia	9 hours per week over 14 weeks
	Psychosocial and spiritual palliative care	Austria	19 days or 2 semesters
	Spiritual care at the end of life	UK	-
	Spirituality on the edge of life	Italy	1 day
Chaplains, pastoral counsellors and spiritual directors	Bridging the spiritual gap	UK	1 day
	Psychosocial oncology for chaplains, pastoral counselors and spiritual directors	The Netherlands	3 days
Medical students	Spiritual care in palliative care	Germany	1.5 hours
Physicians	Hope in palliative care	The Netherlands	1 morning
Nurses	Resident nurses palliative care education programme*	USA	12 hours over 4 weeks
	Master in palliative care*	Ireland	-
	Spiritual care in basic palliative care	The Netherlands	0.5 day
Psychologists	Master in psychology*	Italy	2 years
	Comprehensiveness of care: emotional awareness and spiritual experience of the operator. Relational and communicative for an appropriate spiritual support	Italy	3 days
	Pain therapy for psychologists	Italy	-
Volunteers, family members and the general public	The art of listening	Italy	-
	L'immortale diventa gioia ('the immortal becomes joy')	Italy	6 days

* In these courses, spiritual care was one element of a broader programme

Note: this table lists only 33 courses; the three remaining ones were two courses to be launched (one in India and one in Denmark) and the course in the USA entitled 'The collective soul symposium', for which information had been submitted twice

topics (n=12, 33%); these included the recording and reporting of spiritual issues, spiritual care planning, organising spiritual support for self and other staff members, mindfulness, meaning-making, compassion, bereavement care, and understanding the concepts of wholeness and transcendence.

Teaching methods

The training courses used, to varying degrees, the teaching methods outlined below.

Interactive training

Interactive training emphasises the importance of active listening and the development of compassion and presence. It also uses exercises that promote self-reflection and self-care. Meditation exercises, such as walking meditation, listening to the silence or working on visualisations, are an important element. Students learn to develop personal awareness, slow down, relax and become aware of their own breathing and voice. Interactive training may also include the demonstration of simple communication models followed by communication analysis.

Theoretical teaching

Theoretical teaching is usually delivered in a classroom setting in the form of lectures or workshops using presentations, slides and handouts. Several respondents emphasised the importance of panel discussion and working in small groups. Multifaith specialists may be involved in theoretical teaching.

Practical exercises

Skills and competencies are taught through practical exercises: role play, brainstorming sessions and other types of group activities. Exercises can focus on specific aspects; for example, care planning, reporting or working on a team vision. Practical exercises can be a good way of integrating spiritual care into daily tasks. Participants may be asked to reflect on personal and professional meanings, and launch their own spiritual care projects.

Self-reflection

Participants may be expected to share their personal insights and reflections with the group; these reflections revolve around individual experiences, expectations and fears – for example, fear of one's own death. Less commonly, self-reflection may take the shape

of written exercises. Some training courses allow participants to pursue self-reflection using music and art, or online discussion forums. After the course, participants may be expected to build on the knowledge they have acquired. Responses to the survey indicate that courses that incorporate constructive feedback promote the self-reflection process.

Assessment of students' progress

The survey included an open question regarding how students' progress was evaluated and the assessment methods used (several courses used more than one method). The results were as follows:

- Course evaluation by participants at the end of the training: 15 courses
- Final written assignment: ten courses
- Multidisciplinary conferences: five courses
- Final round of discussion: five courses
- Self-assessment by students: four courses
- Mentoring: four courses
- Specific test: three courses.
- No assessment at all: three courses
- Practical application of the competencies gained: one course
- Obtaining a job interview: one course
- Development of an individual spiritual care project: one course.

The development of adequate performance assessment tools appears to be an issue. Only three courses used a test specifically designed to evaluate participants' progress. A one-off evaluation at the end of the training, used in 15 courses, can only give a snapshot of students' progress, as opposed to the more rigorous and long-term results gained by ongoing performance assessment.

Recommendations

Teaching spiritual care requires creativity and attention, just like providing spiritual care does. The survey has shown that there is already a great variety of spiritual care education and training courses available. It has also found that many individuals and organisations are interested in launching further courses. The findings have allowed us to list a certain number of points that need to be considered when creating spiritual care training courses. Based on these findings, and considering the need for a change in culture and the development of an empirical basis for spiritual care training, we have drawn a list of recommendations, outlined below.

- Many courses are designed for all healthcare professionals. This is a good thing, as it supports the idea that providing spiritual care is a task to be shared by all within the team. But different professionals – for example, social workers or physicians – will be expected to employ their spiritual care skills in different ways and at different times. Volunteers also need training tailored to their roles. In a course designed for all members of the team, it is important to be clear about the tasks and goals of each one, so that there are no ambiguities in practice about who should be doing what.
- There is currently a marked preference for teaching in small groups. To enable more professionals and volunteers to receive training, it is essential to develop training courses for larger groups. Developing online learning platforms, information exchange and mentoring is equally important in order to extend spiritual care education.
- Education providers should also consider in what context the training course is provided: offering spiritual care training as part of a broader palliative care course will enable them to embed these core skills in palliative care practice generally, so spiritual care is not seen as an additional part of service provision to be taken up only by those who are interested.
- There is a need to develop training on core competencies in self-reflection, theory and integration into daily practice.
- The aims of the training should be clearly stated, and all theoretical and practical exercises should serve these aims. It is also crucial that a safe environment is created where participants can discuss their personal ideas about spirituality, their own spiritual needs, or their concerns about particular patient cases. All these can be challenging to share in a group.
- Ongoing performance assessment is essential and should not be replaced by simple, one-off course evaluations. Evaluations are important to provide a means of critically appraising the training delivered. However, immediately after a training course, it is not possible to measure whether the long-term training goals have been reached. Measuring the long-term effects of training courses is necessary in order to build an evidence base for spiritual care training. Reflective practice and

ongoing performance assessment are of more help in developing spiritual care skills and competencies. Ongoing performance assessment is not intended to interfere with work or contribute to appraisals, but as a personal means of improving one's practice. Briefings, check-ups and mentoring should be provided after the end of a course to help students apply the skills they have acquired.

- The use of a single, recognised definition of spiritual care would be helpful. Referring to other definitions and working on what spiritual care is in a group are both helpful, but there still needs to be a common definition shared by all. A way forward might be to compare any individual or consensus definition with the EAPC definition, in order to better understand overlaps and blind spots.

Conclusion

The education subgroup of the EAPC Task Force on Spiritual Care in Palliative Care encourages all EAPC members to review the provision of spiritual care training in their respective countries, as well as to invest in delivering classroom or online training, and ongoing support through performance assessment and reflective practice.

We are happy to receive further completed surveys. As our database of training courses grows, it will become a more useful resource for individuals and organisations to access appropriate spiritual care education, and in the long run contribute to improving the delivery of spiritual care at the end of life.

Declaration of interest

The authors declare that there are no conflicts of interest.

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