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Original Articles

Efficacy of Training Interprofessional Spiritual Care Generalists

Mary R. Robinson, MA, MDiv,[1] Mary Martha Thiel, MDiv,[2] Kezia Shirkey, PhD,[3] David Zurakowski, PhD,[6,7] and Elaine C. Meyer, PhD, RN[4,5]

Abstract

Background: Provision of spiritual/religious (S/R) care has been associated with improvements in patient care, patient–provider relationships, and resource utilization. Clinicians identify a lack of training in S/R care as the primary impediment. The purpose of the study was to evaluate the effectiveness of one-day, simulation-based workshops to prepare interprofessional clinicians to function as capable, confident, and ethical spiritual care generalists.

Methods: Interprofessional practitioners (physicians, nurses, social workers, psychologists, child life specialists) in a quaternary care academic pediatric hospital participated in daylong Spiritual Generalist workshops utilizing professional actors to learn requisite spiritual generalist skills. Participants completed pre- and postworkshop questionnaires on the day of the workshop, and three-month follow-up self-report questionnaires that included 1–5-point Likert scale items focused on 15 spiritual generalist skills.

Results: One hundred fifteen interprofessional staff members completed pre- and postquestionnaires and three-month follow-up surveys. Analysis revealed significant mean improvement in all 15 spiritual generalist skills targeted for developing mastery within each of three broad domains: Spiritual Screen and Care Plan, Provision of Spiritual Care, and Professional Development. Although the initial degree of improvement tended to be greater immediately postworkshop, 14 of the 15 spiritual generalist skills remained significantly higher at three months compared to preworkshop.

Conclusions: This daylong workshop of concentrated instruction, including didactics, visual slideshow, simulation of clinical scenarios, and debriefing/discussion components, was efficient and effective in training clinicians from varied disciplines to learn basic generalist-level spiritual care skills and to collaborate more effectively with chaplains, the spiritual specialists.

Introduction

Most Americans describe themselves as spiritual and/or religious. Religion is usually understood as a formal set of beliefs, practices, and rituals based upon a commonly accepted authoritative text and tradition. Religion is typically experienced in the context of a worshipping community with a common definition of the sacred and leaders with designated authority. Religion is a subset of spirituality. There is little agreement on a precise definition of spirituality or its measurement, due to its varied, subjective, and intangible nature. Spirituality is experienced in the context of a person's relationship with something that is greater than one's self that is perceived as ultimately trustworthy and a source of ultimate meaning or value. Spirituality can be a source of inspiration and hope, comfort and courage. Foci of spirituality often include such things as nature, one's family, mindfulness of the present moment, empirical research, artistic expression, or the vocation to which one is devoting one's life. Variations abound, and persons typically have more than one foci of spiritual inspiration. Spirituality can be religious, but need not have any reference to the divine.

[1]Department of Chaplaincy, Boston Children's Hospital, Boston, Massachusetts.
[2]Department of Religious and Chaplainy Services, Hebrew Senior Life/Hebrew Rehabilitation Center, Boston, Massachusetts.
[3]Department of Psychology, North Park University, Chicago, Illinois.
[4]Department of Psychology, Harvard Medical School, Boston, Massachusetts.
[5]Institute for Professionalism and Ethical Practice, Boston, Massachusetts.
[6]Department of Anesthesia, Boston Children's Hospital, Boston, Massachusetts.
[7]Department of Anesthesia, Harvard Medical School, Boston, Massachusetts.
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According to a 2012 Pew Research poll, 58% of Americans report that religion is very important in their lives. Of the 20% of Americans who are without religious affiliation, 68% report belief in God or a higher power, 37% describe themselves as ''spiritual'' and 21% report praying every day.[1] Prayers for one's own health and the health of others are the two most commonly described complementary therapies.[2]

From patient and family perspectives, both spiritual and religious (S/R) concerns rise to greater importance during times of chronic or life-threatening illness,[3,4] suffering, and end of life,[5–8] Several studies indicate that S/R beliefs influence medical decisions.[9–11]

Effective S/R coping has been positively associated with improved quality of life in terminal illness,[12–17] recovery from psychiatric illness,[18] guidance for medical decision making,[11,19] reduction of depression and anxiety,[20,21] as well as improved coping with physical symptoms[22] and disability.[23] Conversely, negative S/R coping and spiritual distress have been associated with poorer quality of life[24] and higher morbidity.[25] Spiritual distress, referred to as existential suffering in secular language, can be of greater concern to patients than pain and physical symptoms.[4,16]

Effective S/R care has been documented to improve patient satisfaction ratings,[26,27] strengthen the patient–provider relationship,[28] as well as family satisfaction with end-of-life decisions.[29] S/R support by the healthcare team, rather than by the community clergy, has been associated with earlier referral to and increased utilization of hospice[30] and significantly lower medical costs in the last week of life.[31] For all of these reasons, comprehensive palliative care should include effective and integrated S/R care.[32]

Yet, patients and families rarely report receiving adequate S/R care in the context of illness and medical care[9,27,29,33] despite guidelines to the contrary.[34] Fewer patients are religiously affiliated, and among those who were, only 58% in one study reported that their spiritual needs during hospitalization were met by their faith communities.[11] Increasingly, patients and families rely on in-hospital resources for S/R support in time of a medical crisis.

The strongest predictor of S/R care by nurses and physicians was having completed prior S/R training, and few had received it.[35] Additional obstacles to clinicians providing spiritual support included ''uncertainty of role responsibility,'' ''confusion between the terms religious and spiritual,'' ''unfamiliarity with screening tools,'' ''lack of secular terminology to address nonreligious spiritual needs,'' and ''lack of comfort or uncertainty with one's own spirituality.''[36]

The generalist/specialist medical model is increasingly accepted as a useful approach to providing spiritual care in the hospital setting.[37] All members of the healthcare team can learn to screen for spiritual strengths and spiritual distress and incorporate basic spiritual resources into the patient care plan.

The critical importance of spiritual care training for palliative care professionals has been widely noted.[38,39] Clinicians establishing new palliative care programs may find themselves providing basic spiritual care until funds for a chaplain can be obtained. While some palliative care teams have board-certified chaplains, this may not be so in community hospital settings, outpatient clinics, and satellite facilities of larger teaching hospitals. Of note, spiritual care training has been shown to provide direct benefit to palliative care providers themselves. In one study, the clinician's spiritual well-being, compassion for oneself, and satisfaction with work increased, and work-related stress decreased following spiritual care training.[40]

Participants and Methods

The study was conducted between October 2011 and April 2013 at Boston Children's Hospital. A total of 115 interprofessional clinicians voluntarily enrolled in Spiritual Generalist workshops. Participants included physicians, nurses, social workers, psychologists, and child life specialists who focused on mastering 15 basic skills needed to function in the role of spiritual generalist. (Training for chaplains, in contrast, typically requires four years.[41])

The study was reviewed by the Institutional Review Board of Boston Children's Hospital and determined to meet exemption criteria for research conducted in established educational settings involving normal educational practices. Each participant signed a voluntary consent form granting permission for questionnaires to be used for educational and research purposes.

Enrollment in the workshops was voluntary. Practitioners learned of the educational opportunity through promotional flyers e-mailed to clinicians providing direct patient care. While the training was designed for nonchaplains, a board-certified staff chaplain (spiritual specialist) attended each workshop to participate in the final simulation and to enhance interdisciplinary learning.

Spiritual Care Generalist Workshop Model

Workshops were developed based on the pedagogy and demonstrated efficacy of the Program to Enhance Relational and Communication Skills (PERCS) of the Institute for Professionalism and Ethical Practice. The PERCS workshops offer interprofessional, experiential simulation-based learning focused on a range of challenging conversations across healthcare, including neonatal and pediatric critical care, anesthesiology, radiology, ophthalmology, and the aftermath of adverse medical outcomes.[42–45] Pedagogical principals that guide PERCS workshops include the following: creating a safe learning environment; emphasizing the moral and relational dimensions of healthcare; suspending healthcare hierarchy; valuing reflection and self-awareness; and honoring multiple interprofessional perspectives.[42] In PERCS workshops, realistic case simulations with professional actors provide clinicians an opportunity to practice and observe communication and relational skills.

Each workshop provided a full day of instruction for 20–30 interprofessional learners (Supplementary Data 1; Supplementary Data are available online at www.liebertpub.com/jpm). The curriculum included brief, focused didactic presentations (Table 1), a slideshow of photographs taken within the hospital setting to highlight S/R environmental cues to cultivate increased awareness and observational skills, and brief educational videos demonstrating the use of the Puchalski Faith and Belief, Importance, Community, Address (FICA) spiritual screening tool,[46–48] A written case allowed participants to practice use of the FICA tool in pairs. Three realistic simulated case enactments with professional actors as patients or family members followed (Supplementary Data 2).

Table 1. Didactic Components of Spiritual Care Generalist Workshop

Inclusive definition of spirituality (religious and secular modalities)
Changing demographics of spirituality in the United States
Current research on positive impact of S/R care on healing, patient satisfaction, resource utilization, and resilience
Hospitality and respect for all S/R traditions in patient-centered care
FICA spiritual screening tool
Making the transition into an S/R inquiry
Documentation in the medical record
Spiritual distress expressed in both religious and secular language
Ethical guidelines for providing S/R care
Appropriate boundaries
Responses to patient requests for prayer, or personal information
The training and role of board-certified chaplains
The difference between community clergy versus board-certified chaplains
Indicators for a chaplaincy referral
How to make a chaplaincy referral

FICA, Faith and Belief, Importance, Community, Address; S/R, spiritual/religious.

In two of the realistic enactments, participant volunteers practiced spiritual generalist skills. The third enactment provided participants an opportunity to witness spiritual care being offered at a spiritual specialist's level by a professional chaplain.

Before each realistic enactment, the participants read aloud the case scenario and asked questions for clarification. The facilitators recruited volunteers to participate as the clinicians in the simulations. They were instructed to maintain their usual clinical roles, but to incorporate spiritual screening into their typical psychosocial, nursing, or medical interview. The use of a small simulation room outfitted as a family interview room enabled volunteer participants to meet with the actors privately, while other learners simultaneously viewed the enactments via live video feed.

Two enactments were designed for the generalist level of spiritual care competence. The first case enactment illustrated a highly religious mother whose son was living with a difficult-to-control seizure disorder and developmental disabilities. The second case enactment depicted an anxious and guilt-ridden father without religious affiliation. His newborn son had recently been born very prematurely and was hospitalized in the neonatal intensive care unit. The third enactment offered participants the rare opportunity to observe a chaplain at work in a more complex case involving S/R conflict between a young adult patient with cystic fibrosis and her mother regarding aggressive versus palliative goals of care. This scenario was chosen to demonstrate a situation beyond the clinical scope of a spiritual generalist and for which a referral to the chaplain is appropriate. These three scenarios mirror some of the ethnic and religious diversity of this particular hospital: Caucasian, Afro-American, Haitian, Roman Catholic, Evangelical Protestant, Jewish, ''spiritual but not religious,'' as well as the variety of perspectives within the same religious tradition.

Supportive and interactive debriefings were facilitated immediately after each simulation. Participant volunteers reflected on their comfort in the spiritual generalist role. Opportunities to discuss the enacted spiritual generalist screening and proposed care plan, to pose questions and share perspectives, and to receive additional coaching from the chaplain faculty members were provided. Interdisciplinary conversation and collaboration were encouraged.

Two of the workshop faculty were highly skilled spiritual care specialists: a board-certified pediatric chaplain with 30 years of clinical experience (M.R.R.) and a clinical pastoral education supervisor and board-certified chaplain who has previously trained healthcare providers in providing spiritual generalist care (M.M.T.).[49,50] The third faculty member, both an RN and clinical psychologist, specialized in facilitating interprofessional experiential learning in the healthcare setting (E.C.M.). The final faculty member was a parent who had spent many months at the NICU bedside of her critically ill infant, and who could articulate how her spirituality impacted her coping and decision making, as well as how the illness of her child impacted her spirituality.

Measures/Instruments

Each participant completed self-report pre- and post-questionnaires on the day of the workshop, and an on-line follow-up questionnaire three months after training. Questionnaire demographic inquiry included professional role, gender, age, and years of experience. In addition, participants rated their degrees of religiosity, spirituality, and agnosticism/skepticism/atheism on five-point Likert scales (1 = Not At All, 5 = Very). All three questionnaires (pre, post, follow-up) included 15 five-point Likert scale items to rate essential spiritual generalist skills (1 = Not At All Able, 5 = Highly Able) that were adapted from the work of Puchalski (July 16, 2010, pers. comm.) (Table 2).

Statistical Analysis

Descriptive statistics were utilized to analyze the participants' demographic characteristics. The 15 skills comprising the Spiritual Care Generalist questionnaire were analyzed

Table 2. Demographic Characteristics of the Workshop Participants

Age of participants, years (range)	49 ± 12 (22–76)
Years of experience, years (range)	22 ± 12 (0–45)
Ethnicity, *n* (%)	
Caucasian	108 (93)
African American	3 (3)
Asian	3 (3)
Multiracial	1 (1)
Gender, *n* (%)	
Female	101 (88)
Male	14 (12)
Discipline, *n* (%)	
Physician	14 (12)
Nurse	58 (50)
Social worker	20 (17)
Psychologist	11 (10)
Child life specialist	5 (4)
Other	7 (6)

using analysis of variance (ANOVA) to determine effectiveness of the workshop. By considering six covariates in the multivariable linear regression analysis (demographics, including age, gender, ethnicity, discipline, years of experience, and baseline level of spirituality), variables associated with the amount of improvement in the Total Ability Score were identified.[51]

Total Ability Score (summary score of all 15 Spiritual Care Generalist skill items), after participation in the PERCS Spiritual Generalist Care workshops, was obtained by repeated-measures ANOVA, paired *t* tests, and the F-test used to test significance.[52]

Statistical analysis was performed using IBM SPSS Statistics (version 21.0; IBM, Armonk, NY). Two-tailed values of $p < 0.05$ with Bonferroni adjustment were considered statistically significant. Power analysis indicated that a sample size of at least 75 participants in the PERCS Spiritual Care Generalist workshop provided 80% power to detect a minimum 10-point improvement in the Total Ability Score as well as 80% power to detect a 1-point change for each of the 15 spiritual generalist skills (1–5 Likert scale) using ANOVA for assessing mean changes in these abilities.

Results

A total of 115 interprofessional participants enrolled in a Spiritual Care Generalist workshop, and 79 (68.6%) completed all three pre, post, and three-month follow-up questionnaires. Demographic characteristics of the participants are presented in Table 3. Female nurses were the largest group of participants, although many disciplines were represented. Participants who did not complete the three-month questionnaire were excluded from these findings. However, there were no significant differences (selection or nonresponse biases) between those who completed the three questionnaires and those who did not (Table 4).

Participants showed significant mean improvement in their overall Total Ability Score as a spiritual generalist immediately postworkshop ($p < 0.001$) and at 3 months ($p < 0.001$) (Fig. 1). Multivariable stepwise linear regression identified two variables with independent influence on the amount of postworkshop improvement: gender ($p = 0.015$) and baseline level of self-perceived spirituality ($p = 0.014$). Female participants on average improved by 15 points in the total score (standard deviation [SD] = 8) compared to male participants who improved by 10 points (SD = 8) and this gender difference was significant by multivariable analysis. In addition, participants with less self-perceived spirituality increased by a significantly larger amount in the Total Ability Score postworkshop compared to those with a high level of spirituality (20 ± 4 vs. 13 ± 8 points).

Repeated-measures ANOVA revealed significant mean improvement in each of the 15 spiritual care generalist skills, which were clustered into three broad domains: Spiritual Screen and Care Plan (Fig. 2A), Provision of Spiritual Care (Fig. 2B), and Professional Development (Fig. 2C). Although

Table 3. Demographic Characteristics of Workshop Participants ($N = 115$)

Age of participants, years (range)	49 ± 12 (22–76)
Years of experience, years (range)	22 ± 12 (0–45)
Ethnicity, *n* (%)	
Caucasian	108 (93)
African American	3 (3)
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Gender, *n* (%)	
Female	101 (88)
Male	14 (12)
Discipline, *n* (%)	
Physician	14 (12)
Nurse	58 (50)
Social worker	20 (17)
Psychologist	11 (10)
Child life specialist	5 (4)
Other[a]	7 (6)

Error bars note standard deviations.
[a]Other includes medical interpreters, researchers, educators.

Table 4. Demographic Characteristics of Participants Who Did and Did Not Complete the Questionnaire at 3 Months

Variable	*Completed questionnaire* (n = *74*)	*Did not complete questionnaire* (n = *41*)	p[a]
Age, years	49 ± 11	50 ± 14	0.79
Gender (F/M)	63/11	38/3	0.37
Experience, years	25 (12–31)	23 (11–31)	0.75
Spiritual level (quite/very), %	72	69	0.48
Preability total score, points	52 ± 9	51 ± 9	0.46

Plus–minus data for age and total score are mean and standard deviation with groups compared by the Student's *t* test; experience is described in terms of median (interquartile range) due to skewness and assessed using the Mann–Whitney *U* test. Gender and spiritual levels are compared by Fisher's exact test for proportions.
[a]No significant group differences, indicating no selection bias or nonresponse bias.

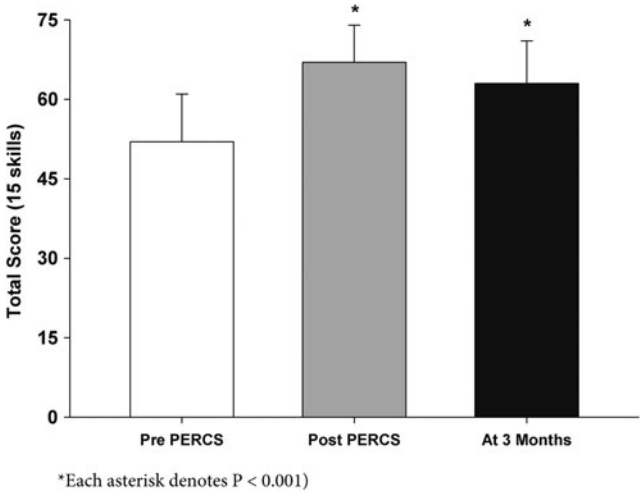
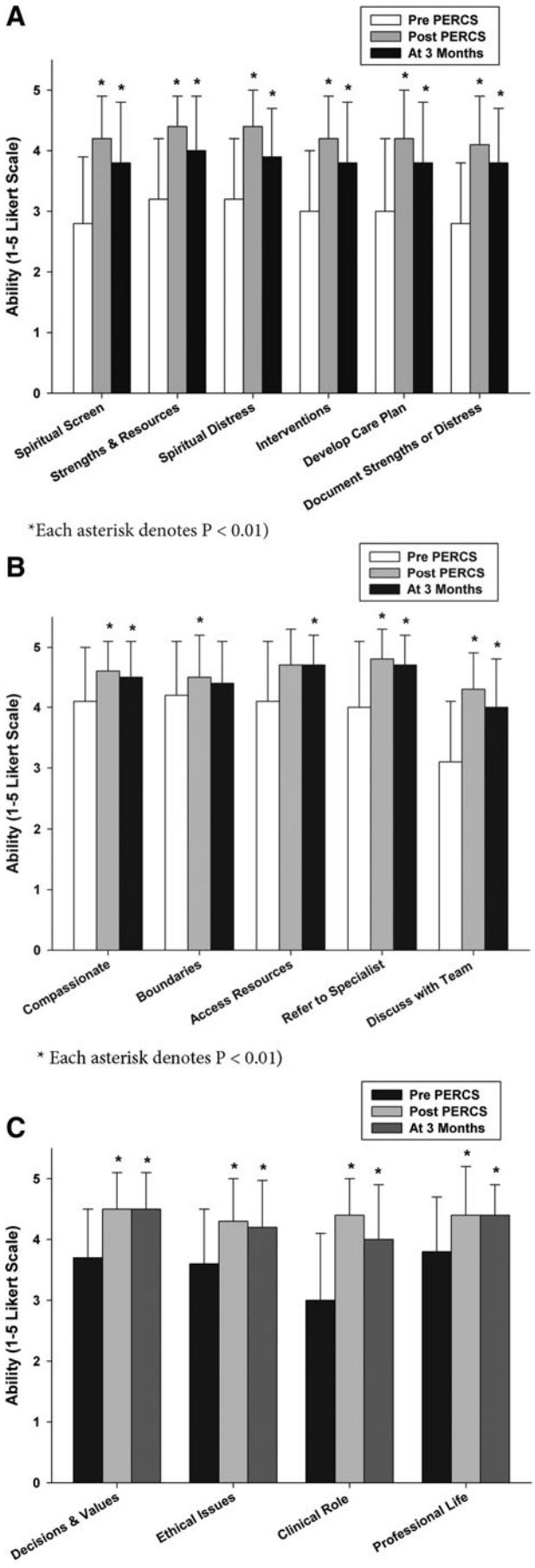


FIG. 1. Improvement in overall self-reported ability as a spiritual generalist.



the initial degree of improvement tended to be larger immediately postworkshop, 14 out of 15 skills remained significantly higher at three months compared to preworkshop. The largest improvements included all six skills in the domain of Spiritual Screen and Care Plan (Fig. 2A), referring to a specialist, discussing patient/family spiritual strengths or distress with the care team (Fig. 2B), recognizing how spirituality affects patient's healthcare decisions and values, and feeling comfortable as a spiritual generalist within one's own clinical role (Fig. 2C).

The postworkshop survey completed on the day of the workshop revealed that 98.6% of respondents would recommend the workshop to others in the same clinical role.

Discussion

This study demonstrates the effectiveness of interprofessional Spiritual Care Generalist workshops in a pediatric hospital setting. This workshop yielded significant and sustained improvement in skills critical to effective S/R care at the generalist level. The workshop was effective regardless of participant age, gender, ethnicity, self-perceived level of spirituality/religiosity, professional discipline, or years of clinical experience. The workshops had a heightened learning effect on female clinicians and those who perceived their personal level of spirituality to be low.

The largest and most sustained improvements were demonstrated in the cluster of skills needed to conduct spiritual screening and develop basic spiritual care plans. Effective spiritual screening can identify and support the patient/family's existing S/R coping mechanisms, sources of community support, and postdischarge resources, as well noting spiritual/existential distress that requires a specialist's care. The screening enables the generalist to provide care in secular or religious modalities, according to the patient's own framework. The rate of improvement in this area compares favorably to comparable interprofessional curricula.[53]

The interprofessional enrollment of the PERCS Spiritual Care Generalist workshops mirrors the wide range of clinicians who are involved in palliative care. When clinicians learn how to inquire skillfully about the patient/family's S/R values and beliefs, they are better positioned to offer compatible care options. In cases involving spiritual distress or value-based objections to the proposed care plan, clinicians learn how to utilize the specialized skills of the chaplain.

FIG. 2. **(A)** Spiritual screen and care plan skills measured in pre-, post, follow-up questionnaires. 1. Do spiritual screen (FICA); 2. identify spiritual strengths and resources; 3. identify spiritual distress; 4. identify appropriate interventions in care setting and community; 5. develop care plan with customized spiritual support; 6. document spiritual strengths and/or distress in chart. **(B)** Provision of spiritual care skills measured in pre, post, follow-up questionnaires. 1. Practice compassionate and respectful presence; 2. establish appropriate boundaries; 3. access chaplaincy resources; 4. refer to spiritual specialist; 5. discuss spiritual strengths and/or distress with team. FICA, Faith and Belief, Importance, Community, Address. **(C)** Professional development. 1. Recognize how spirituality affects patients' health care decisions and values; 2. identify ethical issues in interprofessional spiritual care; 3. feel comfortable as a spiritual generalist in your clinical role; 4. understand role of spirituality in one's own professional life.

Participants with less self-perceived spirituality showed a significantly greater increase in their Total Ability Score postworkshop compared to those who began with a higher self-perceived level of spirituality. This suggests that clinicians need not be spiritual or religious to learn effective, generalist-level, patient-centered spiritual care.

This workshop curriculum was also shown to be efficient, achieving significant results in six hours of learning, and is a practical alternative to programs requiring as many as 100 hours of instruction.[50] Finally, this curriculum provided explicit ethical guidelines for patient-centered spiritual care, often lacking in other workshops.[53–56]

Our strategic goal for this training was to educate a variety of front-line clinicians to function as spiritual care generalists throughout the hospital. Board-certified chaplains are typically a scarce hospital resource. Freed from routine spiritual screening, chaplains can be utilized more judiciously for the complex or high-risk cases involving spiritual distress, palliative and end-of-life care, or belief-based opposition to the medical treatment plan.

Participants frequently reported gaining a better understanding of the role of chaplaincy, as well as how and when to make referrals. A consistent theme in postworkshop evaluations was the discovery that spirituality need not be religious and that spiritual issues can be expressed and responded to in secular or religious language. Clinicians were eager to learn how to match the spiritual language used by those in their care and to inquire with respectful curiosity when terms or practices were unfamiliar. Some participants discovered that many of the clinical skills already in their professional repertoire—such as good listening, visual observation skills, and a compassionate presence—are essential ingredients of a generalist's spiritual caregiving repertoire. Also, frequently cited was the discovery that one need not be a religious or spiritual person to respect and skillfully support the spirituality of another.

Study limitations include self-selection of participants, who may have been more motivated to learn about the provision of S/R care than a typical group of healthcare providers. The majority of participants were women, and persons from non-European backgrounds were underrepresented. The study relied exclusively on self-reported measures. In addition, participants were almost exclusively from one quaternary pediatric teaching hospital in New England that serves a sizeable number of international patients and thus a great religious diversity. This hospital may not be typical. Finally, funding for these workshops was provided by grants as well as direct hospital budgetary support. The long-term financial sustainability of these workshops remains a challenge.

Future spiritual generalist trainings might use observational behavioral measures in addition to self-report outcome measures. Actual patient/family ratings of their caregiver's spiritual care competencies, before and after training, would also be useful. The cumulative effect of an increasing number of spiritual generalists in the hospital is yet to be measured.

Conclusion

This study demonstrated that one day of concentrated instruction, including didactics, simulation, visual slideshows, debriefing, and discussion components, is both efficient and effective in training clinicians from across disciplines to learn basic-level spiritual care skills. Spiritual generalist training has the potential to address issues of inadequate spiritual care delivery due to lack of staff training and confidence, as well as to enhance the quality of spiritual care provided by all members of the palliative health care team.

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Author Disclosure Statement

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Address correspondence to:
Mary R. Robinson, MA, MDiv
Department of Chaplaincy
Boston Children's Hospital
300 Longwood Avenue
Boston, MA 02115

E-mail: mary.robinson@childrens.harvard.edu