Can Spirituality be Taught to Health Care Professionals?

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Abstract Although people with life-limiting conditions report a desire to have spiritual concerns addressed, there is evidence that these issues are often avoided by health care professionals in palliative care. This study reports on the longitudinal outcomes of four workshops purpose-designed to improve the spiritual knowledge and confidence of 120 palliative care staff in Australia. Findings revealed significant increases in Spirituality, Spiritual Care, Personalised Care, and Confidence in this field immediately following the workshops. Improvements in Spiritual Care and Confidence were maintained 3 month later, with Confidence continuing to grow. These findings suggest that attendance at a custom-designed workshop can significantly improve knowledge and confidence to provide spiritual care.

Keywords Spirituality · Health care professionals · Palliative care

Introduction

Spirituality is a delicate and complex topic that is receiving increasing attention in academic and medical circles (Sulmasy 2002), with evidence of the importance of spirituality

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to both physical and emotional health (Larson and Larson 2003). Within a holistic approach to health, there is recognition of the need to address existential or spiritual issues (Sulmasy 2002), and this particularly exists in the field of palliative care (Murphy et al. 2000; Mytko and Knight 1999). Further, the need for spiritual concerns to be taken up by all disciplines, rather than just those of a religious orientation, has been recognised (Herrmann 2001; Rumbold 2003). Nevertheless, there is also evidence that these issues are often not broached or addressed by practitioners working with those facing serious health challenges, even though patients report a desire to address them (Farber et al. 2004; Hart et al. 2003).

Reasons for failure of health care professionals to address these issues include a lack of knowledge of the issues, a lack of confidence in broaching spiritual topics, and a lack of shared language of spirituality outside the confines of traditional religious terminologies (Kellehear 2000). Illustrating the challenge of providing this care, and indicative of the need for training, a survey of Australian nurses revealed that, although 97% of registered nurses believe that they should address patient’s spiritual needs, only 66% felt able to do so (Barletta and Thompson 2001). Some of the reasons identified within the literature for such discrepancies include the nurses’ perceived inability to communicate on spiritual matters (Greasley et al. 2001), pluralism resulting in nurses encountering a wide variety of ideologies, philosophies and creeds (Laukhuf and Werner 1998), and deficits in nursing education in relation to spiritual care (Catanzaro and McMullen 2001). Similar difficulties have been expressed in other professions: “Spirituality is not well understood by occupational therapists and neither do we seem to educate ourselves about it.” (Wilding 2002, p. 47).

These difficulties are exacerbated by the multidisciplinary nature of palliative care and lack of easily defined competencies in spiritual care across disciplines (Gordon and Mitchell 2004). In addition, issues arise in the perception of spiritual needs as of lesser priority, the extent of contrasting belief systems, limited staff resources, and training that fails to enhance knowledge, insight, and confidence (Culliford 2002). However, there is some evidence that training in spiritual care that focuses on spirituality as a broad concept, as opposed to religious interpretations, can improve staff attitudes to patients and families, reduce stress, and build the confidence of staff (Abrams et al. 2005; Wasner et al. 2005), as well as enhance multidisciplinary collaboration in palliative care (Oppenheimer et al. 2004).

A Training Option

In response to a perceived need, a multidisciplinary team of health and religious professionals at the University of Queensland, Australia, in consultation with people with life-limiting illness, their family members, and those employed in the clinical field, developed a set of training resources. These resources were designed to increase the knowledge and confidence of staff in the field of palliative care in terms of overcoming hesitancy and/or difficulty in knowing how to address issues of existential and spiritual care with patients. The nature of the resources was to ensure the accessibility of the information by health care practitioners regardless of geographic location or religious affiliation. The resources were designed to appeal equally to health professionals and pastoral care givers with religious and non-religious orientations. They were designed to be used as either a self-paced independent learning package or a workshop that could be delivered by a member of any profession. The Spirituality in Palliative Care training resource is available, free of charge, from Palliative Care Australia on their national website at: www.pallcare.org.au. Having undertaken this developmental task, the next aim was to evaluate the training resources.
Study Expectations

In this paper, the outcomes of four pilot workshops using the Spirituality in Palliative Care package are described. It was anticipated that participation in the workshops would result in significant gains in measures of spiritual care, spirituality, and confidence to provide spiritual care in palliative care. Furthermore, it was expected that these gains would be maintained up to 3 months after workshop attendance. Religiosity, workplace concerns, stress, anxiety, and depression, although not expected to change in response to the workshop, were also measured as control variables. In anticipation of these objectives being met, it is suggested that this training package will prove to be a valuable educational tool for health care professionals.

Methods

Participants

Participants were a self-selected sample of employees and volunteers in the field of palliative care. Approximately 120 people attended one of four workshops. Pre-workshop questionnaires were collected for 113 (94.2%) of these (23 + 26 + 28 + 36 at each of the four workshops, respectively). At the post-workshop stage, 109 questionnaires (96.5%) were returned, and 69 of the 113 participants (61.1%) completed follow-up questionnaires. As can be seen from Table 1, participants were predominantly Australian women, older than 40 years of age, who were employed permanently in the field of palliative care. A wide range of professions was represented.

Procedure

Following the development of the workshop content by the authors, promotions for the Queensland pilots were undertaken in three locations: one provincial town (Cairns), one rural town (Roma), and one metropolitan town (Brisbane). Due to the high numbers of registrants, two workshops were provided in Brisbane. Promotional material was distributed through hospital, hospice and palliative care facilities, church groups, and aged care facilities in the various locations. Participants enrolling in the workshops were sent the pre-workshop questionnaire as part of their confirmation of registration package. The majority of participants completed these measures before attendance on the day of the workshop. Those who forgot to complete their questionnaire prior to the workshop, or who neglected to bring it with them on the day, were provided with an additional questionnaire to complete prior to the commencement of the workshop. Workshops were delivered jointly by a psychologist and a nurse counsellor on the program development team. Participants completed the post-workshop questionnaire prior to leaving the workshop venue on that day. Three months following the workshop, participants were sent the follow-up questionnaire by mail and asked to return the completed questionnaire in a postage-paid envelope. Ethical clearance for this project was obtained from The University of Queensland’s Behavioral and Social Science Ethical Review Committee. Confidentiality of participants was maintained through the use of a confidentiality code—a unique six letter code generated by the participants from personal information known only to them. This code was required in order to link pre-, post- and follow-up questionnaires.
Measures

**Demographic Details**

Participants were invited to provide information regarding their gender, age, country of origin, employment status, and profession.

*The Spirituality and Spiritual Care Rating Scale (SSCRS) (McSherry et al. 2002)*

The SSCRS is a 17-item measure employing a five-point Likert scale (1 = strongly disagree, to 5 = strongly agree) that seeks to determine an individual’s understanding of
spiritual care. It produces four subscales: (1) “Spirituality”, (2) “Spiritual Care”, (3) “Religiosity”, and (4) “Personalised Care”. The Spirituality subscale reflects participants’ beliefs about what constitutes personal spirituality. An example is: “I believe spirituality is about finding meaning in the good and bad events of life”. The Spiritual Care subscale taps into the beliefs of participants with respect to who is responsible for providing spiritual care and how spiritual care can be offered e.g., “I believe we can provide spiritual care by showing kindness, concern and cheerfulness when giving care”. Religiosity reflects beliefs concerning the centrality of religious beliefs to spiritual care, as in the following example: “I believe spirituality involves only going to Church/Place of Worship”. Finally, Personalised Care reflects staff beliefs concerning the interactional nature of spiritual care, such as: “I believe spirituality involves personal friendships, relationships”.

Perception of Workplace Change Schedule (POWCS)
(Nolan et al. 1998; Schofield et al. 2005)

The POWCS is a 16-item measure employing a 5-point Likert scale (1 = decreased a lot, to 5 = increased a lot) that seeks to measure the perceptions of staff with respect to their workplace. It provides three subscales that measure: (1) perceived “Strengths” of the workplace (e.g., “My feelings of being a valued employee have…”), (2) “Concerns” held about the workplace (e.g., “The levels of stress I feel have…”), and (3) “Pressures” in terms of workplace demands (e.g., “My workload has…”). This measure was included at only the pre-workshop and follow-up phases to determine if there had been any perceived changes in the workplace that could account for any changes in outcome measures.

Knowledge and Confidence Scale (KCS) (Murray and Chan, manuscript in preparation)

This is a 15-item measure employing a seven-point Likert scale (1 = very strongly disagree, to 7 = very strongly agree) that was developed by one of the researchers in previous research looking at provision of care in bereavement and other adverse life events. It provides two subscales: (1) participant “Confidence” in their ability to provide spiritual support and (2) participant “Compassion”, reflecting the willingness on the part of staff to view providing support as their role or responsibility. A sample confidence item is: “I have skills that I can use to help a person facing death”, while a sample compassion item is: “People facing death need to talk about their situation.” Because the Cronbach’s alpha for the Compassion subscale fell below 0.7 at all three data collection stages, the Compassion scale was not utilised in this study.

Depression Anxiety Stress Scale-21 (DASS-21) (Lovibond and Lovibond 1995; Clara et al. 2001)

The DASS is a 21-item scale that comprises three scales: (1) “Stress”, (2) “Depression”, and (3) “Anxiety”, each with seven items. Questions are scored on a four-point scale (0 = did not apply to me at all, to 3 = applied to me very much or most of the time) based on the previous week. Adequate reliability, convergent and discriminant validity have been reported, internal consistency, temporal stability, and convergent and discriminant validity are excellent, and a consistent factor structure has been found (Brown et al. 1997; Clara et al. 2001; Crawford and Henry 2003; Lovibond and Lovibond 1993). Sample items include: “I found it hard to wind down” (stress), “I experienced trembling” (anxiety), and
“I couldn’t seem to experience any positive feeling at all” (depression). The scale was employed only at pre-workshop and follow-up phases of the project.

Statistical Analyses

Results were analysed using SPSS Version 15.0. Participants with missing data were excluded from some analyses, resulting in smaller numbers in some analyses. No outliers were detected. Each variable was analysed with the Kolmogorov-Sminov statistic, and results confirmed that data were normally distributed. Descriptive data for categorical demographic variables are provided in Table 1, and descriptive data for continuous variables are provided in Table 2. Due to the high number of t-tests employed in this study, a conservative level of significance was adopted ($P = 0.01$) in order to minimise the family wise error rate.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Stage of evaluation</th>
<th>Valid N</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>Range</th>
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<td>2.80</td>
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<td></td>
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<td>22.09</td>
<td>2.33</td>
<td>16–25</td>
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<tr>
<td></td>
<td>Follow-up</td>
<td>69</td>
<td>21.12</td>
<td>2.65</td>
<td>12–25</td>
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<tr>
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<td>2.56</td>
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<td>2.40</td>
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<tr>
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<td>1.54</td>
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<tr>
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<tr>
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<td>7–15</td>
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<td>5.48</td>
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<td>63</td>
<td>23.43</td>
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<td>Perception of workplace pressures</td>
<td>Pre-</td>
<td>101</td>
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<td>13.60</td>
<td>2.64</td>
<td>7–20</td>
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<tr>
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<td>4.55</td>
<td>3.34</td>
<td>0–15</td>
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<td>4.03</td>
<td>2.66</td>
<td>0–11</td>
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<td>Pre-</td>
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<td>1.96</td>
<td>2.40</td>
<td>0–11</td>
</tr>
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<td></td>
<td>Follow-up</td>
<td>67</td>
<td>1.52</td>
<td>2.54</td>
<td>0–13</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Pre-</td>
<td>108</td>
<td>1.48</td>
<td>2.15</td>
<td>0–14</td>
</tr>
<tr>
<td></td>
<td>Follow-up</td>
<td>65</td>
<td>1.62</td>
<td>2.05</td>
<td>0–8</td>
</tr>
</tbody>
</table>
Results

Comparisons Between Pre-Workshop, Post-Workshop, and Follow-Up Measures

A series of paired sample *t*-tests were conducted in order to compare changes on each of the scales between three time frames: (1) pre-workshop to post-workshop, (2) pre-workshop to follow-up, and (3) post-workshop to follow-up. The results of these analyses are summarised in Table 3.

**Pre- to Post-Workshop Comparison**

Immediately following the workshop, there was a significant increase in four of the subscales: Spirituality, Spiritual Care, Personalised Care, and Confidence. A significant change was not detected for the Spiritual Care-Religiosity subscale.

**Pre-Workshop to Follow-Up Comparison**

There was a significant change in two subscales between the pre-workshop and follow-up stages of the study: Spiritual Care and Confidence. There was *no* significant change between the pre-workshop and follow-up measures for Spirituality, Religiosity, Personalised Care, the Strengths, Concerns and Pressures subscales of the Perceptions of Workplace Changes measure, or Stress, Anxiety or Depression.

<table>
<thead>
<tr>
<th>Measure/subscale</th>
<th>Pre- to post-workshop comparison</th>
<th>Pre-workshop to follow-up comparison</th>
<th>Post-workshop to follow-up comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirituality</td>
<td><em>t</em>(103) = -5.97, <em>P</em> &lt; 0.001</td>
<td><em>t</em>(57) = -1.48, <em>P</em> = 0.14</td>
<td><em>t</em>(57) = 2.13, <em>P</em> = 0.04</td>
</tr>
<tr>
<td>Spiritual care</td>
<td><em>t</em>(103) = -4.71, <em>P</em> &lt; 0.001</td>
<td><em>t</em>(57) = -3.00, <em>P</em> = 0.004</td>
<td><em>t</em>(57) = -0.58, <em>P</em> = 0.56</td>
</tr>
<tr>
<td>Religiosity</td>
<td><em>t</em>(103) = 0.24, <em>P</em> = 0.81</td>
<td><em>t</em>(57) = 0.76, <em>P</em> = 0.45</td>
<td><em>t</em>(57) = -0.18, <em>P</em> = 0.86</td>
</tr>
<tr>
<td>Personalised care</td>
<td><em>t</em>(102) = -2.96, <em>P</em> = 0.004</td>
<td><em>t</em>(56) = -1.00, <em>P</em> = 0.32</td>
<td><em>t</em>(57) = 0.62, <em>P</em> = 0.54</td>
</tr>
<tr>
<td>Confidence</td>
<td><em>t</em>(95) = -7.08, <em>P</em> &lt; 0.001</td>
<td><em>t</em>(56) = -19.15, <em>P</em> &lt; 0.001</td>
<td><em>t</em>(54) = -17.31, <em>P</em> &lt; 0.001</td>
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<td>Perception of workplace strengths</td>
<td>Not measured</td>
<td><em>t</em>(54) = -1.27, <em>P</em> = 0.21</td>
<td>Not measured</td>
</tr>
<tr>
<td>Perception of workplace concerns</td>
<td>Not measured</td>
<td><em>t</em>(49) = -0.88, <em>P</em> = 0.38</td>
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<tr>
<td>Perception of workplace pressures</td>
<td>Not measured</td>
<td><em>t</em>(52) = 1.07, <em>P</em> = 0.29</td>
<td>Not measured</td>
</tr>
<tr>
<td>Stress</td>
<td>Not measured</td>
<td><em>t</em>(56) = 0.00, <em>P</em> = 1.00</td>
<td>Not measured</td>
</tr>
<tr>
<td>Depression</td>
<td>Not measured</td>
<td><em>t</em>(55) = 0.88, <em>P</em> = .38</td>
<td>Not measured</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Not measured</td>
<td><em>t</em>(53) = -0.73, <em>P</em> = .47</td>
<td>Not measured</td>
</tr>
</tbody>
</table>
Post-Workshop to Follow-Up Comparison

The only significant change between post-workshop and follow-up was an increase in Confidence scores. There was no significant change in the other four subscales: Spiritual Care, Spirituality, Religiosity, and Personalised Care subscales of the SSCRS.

Discussion

As identified in the literature, there is a need for health care professionals to increase their knowledge and confidence in addressing spiritual issues as part of our health care services. The overall aim of the Spiritual Care in Palliative Care Project was to develop a training program that would improve the confidence and ability of staff to provide spiritual care in a palliative care setting. The results of this study suggest that the workshops were successful in achieving this aim. Immediately following the workshop, participants significantly increased their Spiritual Care (Spirituality, Spiritual Care, and Personalised Care) and Confidence in this field. The improvement in the Spiritual care subscale was maintained at 3 months, while the Confidence subscale continued to improve beyond the post-workshop scores. Thus, over a 3-month period, the workshops contributed to ongoing improvements in the confidence of staff in providing spiritual care. As anticipated, there was no change in participants’ level of religiosity: the workshop clearly distinguished between spirituality and religiosity, and appeared to have no impact on religiosity.

At the same time as participants reported improvements in staff confidence to provide spiritual support, there were no perceived alterations to workplace demands or to staff levels of personal stress, anxiety or depression. That is, improvements in spiritual care and confidence cannot be attributed to decreases in workplace concerns or pressures, increases in workplace strengths, or to positive changes in staff mood or stress levels. Thus, it appears that identified changes are related more to the self-perceived ability of individual staff members to provide spiritual care in their everyday encounters with patients and their families.

In addition, workshop participants showed significant improvements in personal spirituality at the post-workshop phase, as indicated by the Spirituality subscale of the Spirituality and Spiritual Care Rating Scale (SSCRS). This aspect of personal spirituality enhancement appears to have had its own effects on the individual, separate from mental health, which, as previously noted, did not differ significantly over time. That both Spiritual Care and personal Spirituality improved is consistent with Toomey’s (1999, p. 198) notion that: “...by seeing our own spirituality we become better equipped to recognise spiritual things in others”.

The initial improvements in personal Spirituality and Personalised Care present immediately post-workshop decreased 3 months post-workshop to be non-significant, however. While the opportunity for staff in this field to gather together, reflect on clinical practice, and discuss spiritual matters may nurture one’s spirituality and refuel one’s capacity to provide personalised care, it appears that this effect does not last. Thus, hosting gatherings such as these workshops intermittently for staff in palliative care may confer a significant benefit. Notably, while scores in these personal aspects of spirituality returned to pre-workshop levels, improvements in spiritual care and confidence in providing support were maintained at the follow-up stage and, as noted earlier, confidence continued to improve. This is apparently not the result of the participant’s innate spirituality.

It is possible only to speculate upon the mechanisms behind the apparent success of these workshops. The positive outcomes could potentially be attributed to a combination or interaction of a range of factors, including: (a) the nature of the presenters of the
workshops, (b) the content and format of the program itself, and/or (c) the emotional and intellectual benefits of a group of like-minded people gathering collectively. The program team was comprised of professionals with a range of relevant backgrounds (medical, nursing, psychology, religion, occupational therapy) and clinical experience. Hence, potentially ethereal topics were able to be clearly presented in language relevant to everyday clinicians and situations. For example, core concepts were couched in terms of “love and fear” for clarity and acceptability by all participants, regardless of religious affiliation. Further, processes guiding workshop development included an extensive literature review (including recommendations for teaching health professionals), consultation with an expert reference group drawn from a range of professions, and wide consultation with key stakeholders. This ensured that the workshops were both comprehensive and relevant, while also informing a range of design decisions. For example, the teaching and learning concept of “different ways of knowing” was adopted by using a diversity of learning resources (poems, music, quotes, movie clips, interviews with people experiencing life-limiting illnesses and their families, a reflection journal, and photo montages).

In this way, the team demonstrated that spirituality is more than a cognitive experience—the workshops engaged sensory, emotional and experiential aspects of the participant in addition to the cognitive element. Finally, although the workshops were designed to be delivered by any health professional, training at all four of the evaluated workshops was provided by people on the project team. While each of these aspects may have contributed to the observed success, only further tailored research considering the many potential influencing factors (workshop development, content, personnel, method of delivery, group processes, and dynamics) could shed further light on this question.

There are a number of considerations that indicate a need for caution in interpreting the results. Firstly, a self-selection bias may have been introduced in several ways. The participants attending each workshop were voluntary registrants, suggesting that those interested in and open to exploring spiritual elements presented in the workshops may have been more likely to attend. In addition, although the sample of individuals attending the workshops was over 120, the rate of questionnaire return at the 3-month follow-up stage was only 61% of the initial sample. Secondly, the sessions were conducted in English, as were the evaluations. People whose primary language is not English and who may have a non-European cultural background may be under-represented, and the study is not applicable to non-European cultures. Thirdly, although workshops were delivered in a range of settings throughout Queensland, results may not be generalisable to staff and volunteers in other states of Australia, or in other countries. Finally, there was no control group, so the observed changes cannot be categorically attributed to the intervention itself. Further research would help to address these issues.

Although it is a strength of this study that longitudinal measures were obtained, time constraints on the project made only a 3-month follow-up possible. This may have been insufficient to determine long-term changes to care offered by staff or any subsequent changes to the workplace as the result of staff changes. It would be advantageous to review outcomes about 1 year after the workshop to determine longevity of change.

The measurements in this project relied on the self-report of participants. While this may have been appropriate given the goal of improving participants’ spiritual care and confidence, it may have also been valuable to consider more behavioral measures of the impact of the workshops. For example, the absence of objective measures of actual change in staff behaviors and care (as determined by colleagues or patients and their families, for example) meant that reports of change were restricted to subjective perceptions on the part of staff.
Future Directions

There is still much research to be done in relation to this training package. Replications of this training and outcome study using various samples and altering outcome measures will strengthen confidence in these findings. While there is now evidence that the workshop, delivered by the experts who were part of the program development team, has an apparent beneficial outcome for participants, it remains to be seen whether the content of the workshop will be similarly helpful for those who elect to take a self-directed study approach to the online package. Finally, there is a need to measure outcomes for participants of workshops delivered by trainers not previously involved in the development of the package.

Conclusion

As noted by Toomey (1999), the growth of one’s own spirituality involves a complex journey, yet embarking on this journey equips us to recognise the spiritual lives of those with whom we work. The aim of the Spiritual Care in Palliative Care Project was to develop and evaluate a set of staff training resources aimed at encouraging a multidisciplinary approach to spirituality and health in palliative care. In order to achieve this aim, the workshops were focused on improving the awareness, confidence, and ability of the multidisciplinary group of staff and volunteers to provide spiritual care in palliative care settings. The evidence reported in this paper suggests that this aim has been met, and that spirituality can indeed be taught to health care professionals.

Acknowledgments

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