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"Spirituality is everybody's business": An exploration of the impact of spiritual care training upon the perceptions and practice of rehabilitation professionals

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"Spirituality is everybody's business": An exploration of the impact of spiritual care training upon the perceptions and practice of rehabilitation professionals

Running title: Spiritual care training with rehabilitation staff

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Declaration of interest

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Abstract

Purpose: This study explored the impact of a brief spiritual care training program upon the perceptions and self-reported practice of rehabilitation professionals working in traumatic injury.

Methodology and methods: A qualitative study. Semi-structured interviews were held with staff from a rehabilitation hospital in Sydney, Australia, between six and eight weeks after participation in spiritual care training. A thematic analysis was conducted.

Results: Of the 41 rehabilitation professionals who attended the training (1 hour online, 1.5 hours face to face), 16 agreed to be interviewed. The majority worked in spinal cord injury and were female. Half reported holding a Christian affiliation. One overarching theme and six sub-themes were identified from the qualitative data. The overarching theme was "spirituality is everybody's business". The six sub-themes were: i) increased awareness of the nature of spirituality, ii) realisation of the importance of spirituality to clients, iii) a desire to keep spirituality on the radar, iv) identifying barriers to providing spiritual care v) incorporating spirituality into practice, and, vi) recognising spirituality as personally meaningful.

Conclusions: A brief spiritual care training program can impact positively upon perceptions and practice of rehabilitation professionals. Ongoing training is needed to ensure that staff retain what was learnt.

Keywords: Spirituality, spiritual care, training, evaluation, health professionals, spinal cord injury, traumatic brain injury, rehabilitation

Introduction

There is a growing awareness that to address all the needs of a person who receives services from a healthcare provider, a bio-psycho-social-spiritual model of care is required [1,2]. Such awareness is informed by research which has demonstrated strong associations between spirituality and positive health outcomes, such as quality of life, resilience, positive mental health, and life satisfaction [3-5]. However, it is also known that many healthcare professionals do not feel confident or comfortable addressing the spiritual needs of healthcare recipients in their everyday work [6,7]. The most frequent factors attributed to this lack of confidence and comfort are insufficient training in spiritual care and lack of time [6,8,9].

Spirituality has been defined in a range of ways in healthcare, with different emphasis upon its association with religion [2]. The definition of spirituality adopted for this study was agreed to at a consensus conference of spirituality care experts in palliative care. They defined spirituality as 'the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred'[10] (p.887). This broad definition acknowledges that a person may draw upon a range of different sources of meaning and connection, of which religious faith may be one [11]. Other identified sources of spirituality include the natural world, other people, music, art, and oneself [12]. Spiritual care, also broadly defined, has been described as "person centred care which seeks to help people (re)discover hope, resilience and inner strength in times of illness, injury, transition and loss" [13].

Spinal cord injury (SCI) and traumatic brain injury (TBI) are devastating injuries which often have a lifelong impact upon the injured individual and their family. A SCI may impact upon mobility, sensation, continence, sexual function, and pain levels [14,15]. A TBI may impact upon all these areas and additionally affect memory, cognition, and

behaviour[16-18]. Such physical injuries can have far-reaching consequences upon psychological well-being for both the injured person and their family members [19-23]. Although there are many costs associated with these consequences, increasingly research has focused upon the resources which assist patients and their families to draw on strength and resilience, adapting and moving forward after such an injury [24-27]. Spirituality has been identified as one such resource. Research has indicated the important role spirituality may play in contributing towards the adaptation and resilience of patients after both SCI and TBI [4,12,28-30]. Quantitative studies have reported strong positive associations between spirituality and post-traumatic growth, resilience and life satisfaction after TBI and SCI [4,5]. One research study among family caregivers of patients with TBI or SCI found that spirituality had a direct positive association with hope, which in turn was positively linked with resilience [30]. Furthermore, a direct inverse association between spirituality and depression was reported in that study, suggesting that spirituality may act as a protective factor in relation to negative outcomes. Qualitative research has expanded upon these findings, suggesting spirituality may contribute towards resilience by facilitating hope, meaningful connections and gratitude after SCI [12,31,32].

The period of rehabilitation may be a pivotal time for patients and family members as they adjust to a traumatic injury [15,28]. Rehabilitation professionals are in a unique position to address the spiritual needs of this population. However the findings of a recent study showed that although rehabilitation professionals felt that spirituality was an important component of rehabilitation, they did not feel well-equipped to address spirituality with their patients [6]. A systematic review of spiritual care training programs conducted by Paal, Helo and Frick [33] revealed that although staff training programs in spiritual care are emerging, many of the existing programs have been conducted within palliative care settings where issues pertaining to end-of-life are at the forefront for patients. Recent programs developed

within a palliative care setting highlight the importance of this training, both in undergraduate and clinical settings [34-37]. However, Johnstone et al. [38] have suggested that addressing the spiritual needs of rehabilitation patients may be just as important as for those who are receiving end of life care. Such patients often have many years of meaning-making ahead of them as they adjust to their new circumstances [38].

To the best of our knowledge, no spiritual care programs have been developed for health care professionals working in rehabilitation. This qualitative study explored the experience of rehabilitation professionals who attended a brief spiritual care training program. The main objective of this study was to explore the most significant changes in either participants' perceptions of spirituality or self-reports of spiritual care practice after attending the training.

Methods

Ethical approval was obtained from Northern Sydney Local Health District Human Research Ethics Committee (LNR AU/1/5688313). A letter of invitation to participate in a brief spiritual care training program was emailed to all healthcare professionals working at Royal Rehab, a specialised rehabilitation centre in Sydney, Australia. Information on the training program was provided to interested participants, and written consent was obtained from those who wished to attend. An additional option to participate in a 30-minute interview, six to eight weeks after the training, was included in this consent form. Training participants indicated their agreement to being interviewed by selecting a tick box on the consent form prior to attending the program and were contacted a month after the training to confirm they were still interested. The training was held between February and July 2019, and participants from all four groups were invited to participate in the interviews.

Patients are usually admitted to Royal Rehab from an acute hospital and undertake a program of rehabilitation prior to returning home. The centre offers a number of publicly-funded rehabilitation programs, including two inpatient services (Brain Injury Uni, Spinal Injury Unit) and two community services (Brain Injury Community Rehabilitation Team, Spinal Outreach Service). These four services are staffed by multidisciplinary teams, which can include representatives from medical, nursing, physiotherapy, occupational therapy, speech therapy, dietetics, vocational consultancy, case management, recreational therapy, psychology and social work. Study participants were recruited from these four services.

The spiritual care training required participants to attend a training program that consists of two modules, the first a self-study module (one hour) and the second a face to face workshop (1.5 hours). All training was conducted at Royal Rehab. The training included didactic content, video footage, role plays and self-reflection. Material for the training was developed by the research team (3 social workers and 1 nurse, all with extensive clinical experience in rehabilitation following SCI and/or TBI) from interviews with former clients, and a review of existing tools and resources in the literature [33,39,40]. Due to the small number of staff available to participate in the training, a pilot was not conducted. The training was run on four separate occasions and open to staff from both inpatient and community settings.

The first training module was provided to staff as a downloadable file and completed by them in their own time. The module addressed the importance of spirituality in healthcare practice and aimed to increase participants' awareness of different sources of spiritual strength. Spirituality was introduced as a broad construct which encompasses religious faith as well as other sources of spiritual strength, such as the natural world, meaningful connections with others, art and music. Examples of how different spirituality has been important for patients undergoing rehabilitation were provided through the inclusion of a

range of interviews (via pre-recorded videos) with former rehabilitation clients and their family members. These interviews explored different sources of spiritual strength (for example, the natural world, music, religious faith) that were personally meaningful to those interviewed, during and after their experience of rehabilitation.

The second module aimed to increase participant knowledge, skills, comfort and confidence in addressing spiritual care with patients. The module comprised a face-to-face workshop, which included three sections addressing a definition of spiritual care, introduction to a training tool to assist staff to discuss and document spirituality with patients, and opportunity to practise using this tool via case scenarios and role play. The spiritual care training tool was developed by the research team after a review of other existing tools such as FICA [40] and HOPE [41], but with a greater emphasis on sources of spiritual strength and practical ways rehabilitation professionals can incorporate sources of spiritual strength into rehabilitation. Time was provided for participants to reflect upon personal sources of spiritual strength. The face-to-face training was facilitated by the lead author (KJ) with supporting material (role play videos) provided by two other authors (JP, CC).

Demographic data were collected for each participant who attended the training, and included discipline, place of work, age group, gender, ethnicity and religious affiliation (if any). Participants were also invited to respond to the question “I am a spiritual person” on a scale from 0 to 10. A semi-structured interview [42] conducted by the first author (KJ) was held with each participant and lasted approximately 30 minutes (see Appendix 1). During this interview participants were invited to reflect upon the most significant change in their thinking or practice they had noticed in the six to eight weeks since attending the training. Each interview was audio recorded and transcribed verbatim.

A thematic analysis of the interview transcripts was conducted by two of the authors (KJ, JP) according to the guidelines provided by Braun and Clarke [43]: familiarisation with

the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report. The first phase was achieved through the transcription of the data by the author (KJ) who conducted all the interviews. During the second phase, preliminary codes were generated from the transcripts using line-by-line analysis. These initial codes were independently generated by the two researchers (KJ, JP), and considered to hold significance regarding the healthcare professional experience of the training and changes in awareness or practice. Following this the two researchers met to compare codes and explore potential themes. Emerging themes were reviewed, defined and named and then recorded in a report.

All excerpts of data included here have been de-identified to protect participant confidentiality. Discipline identifiers for each participant have been provided in accordance with the following broad groupings: medical or nursing; functional/leisure therapist (physiotherapist, occupational therapist, recreation therapist, vocational therapist or case manager); psychosocial therapist (social worker or psychologist). Information on whether the participant identified with a religious affiliation has been included. A study enrolment number for each participant has also been included. The term "client" instead of "patient" has been adopted here, as the term "client" is used by the rehabilitation professionals themselves.

Results

Of the 41 rehabilitation professionals who attended the training, 20 consented before the training to participate in a follow-up interview. Sixteen of these 20 were available to be interviewed six to eight weeks after the training. The 16 interviews were conducted between April and September 2019. Demographic details are reported in Table 1. Interview participants were from a range of disciplines, with most working in the field of SCI. The

majority of participants were female and half identified their religious affiliation to be Christianity. Participants had worked in the traumatic injury field between two and 31 years (M=12.88, SD=7.68). Responses to the question "Do you consider yourself a spiritual person from 0 (not at all spiritual) to 10 (very spiritual)?" ranged from 3 to 10 (M=6.56, SD =2.25).

Insert Table 1

The thematic analysis of the interview data identified one overarching theme and six sub-themes which depicted the journey participants embarked upon after the training (see Table 2). The overarching theme was "spirituality is everybody's business". This was evident in the mix of disciplines in the cohort of study participants which was reflective of the group who attended the spiritual care training. It was also evident across the six sub-themes: i) increased awareness of the nature of spirituality, ii) realisation of the importance of spirituality to clients, iii) a desire to keep spirituality on the radar, iv) identifying barriers to providing spiritual care, v)incorporating spirituality into practice, and vi) recognising spirituality as personally meaningful.

Insert Table 2

Overarching theme: Spirituality is everybody's business.

The journey healthcare professionals embarked upon following the spiritual care training demonstrated that they had incorporated the idea that "spirituality is everybody's business" into their own understanding of spirituality: *"everyone can have some input into a client's spiritual well-being"* (7, psychosocial therapist, no religious affiliation). This understanding was explained by another participant who commented that spirituality is *"everyone's business because it's, you know, human nature for everyone. You know everyone finds purpose, everyone finds meaning, everyone to some degree is spiritual … everyone then*

should be responsible for looking at it" (1, functional/leisure therapist, no religious affiliation).

More specifically, learning about spiritual care meant that any discipline could have a conversation with a client before they referred them to another discipline. While some recognised nursing and social work as disciplines where spirituality might come up more often, others felt that spirituality might come up anytime clients felt they could open up.

> *You think oh it's not my role, it's social work's role, I need to go and get the priest, pastor, chaplain or whatever. It [the training] just made me stop and go, you know what, you can stop and sit in this moment with the client. Cause often I just want to fix things. Or get the right person. And I just thought, no you can sit in this, it's okay* (3, functional/leisure therapist, religious affiliation).

One participant felt that they would take a very particular message for nursing from the training: *"encourage those opportunities to share that kind of information and explore those … little plans. Don't squash them, don't run away. Don't walk away … do something with that information"* (16, medical or nursing, religious affiliation). Another participant reflected that as their client assessments already considered physical, recreational, vocational, and social aspects of rehabilitation, considering *"spirituality as part of that framework"* may be something to think about (4, medical or nursing, religious affiliation). Furthermore, they might be less likely to *"open up"* to one staff member rather than another (5, functional/leisure therapist, no religious affiliation). Overall, there was shared agreement, *"my take home message would be don't buck pass it on to someone else"* (1, functional/leisure therapist, no religious affiliation). In at least one case the training had already "*really encouraged everyone on our team to speak more about it and again just*

increasing that language and awareness in everyday practice" (12, psychosocial therapist, no religious affiliation).

Future training and service delivery was considered to involve the whole team, not only one or a few disciplines. This was reiterated by a participant who commented how helpful it was for the whole team to attend the training, so that a *"whole team focus"* could be adopted (8, psychosocial therapist, religious affiliation).One participant even suggested that it might be appropriate for hospital administrators to attend training in the future (9, medical or nursing, no religious affiliation), because spirituality training was relevant for everyone in the organisation. One participant reflected that *"everyone is involved then, in some way, to then get to the holy grail of purpose. It's just that everyone needs to think about it in that way"* (1, functional/leisure therapist, religious affiliation). One participant (6, psychosocial therapist, religious affiliation) commented that with everyone attending training, *"if I'm going to talk about this ... everybody else is and I think that will be of huge benefit to the client".*

Sub-themes

i) Increased awareness of the nature of spirituality

Many of the participants reported that the training changed how they perceived spirituality and increased their awareness of what the word 'spirituality' could mean. Three closely related aspects of this increasing awareness were identified. First, participants described moving away from the idea that spirituality was only about religion. Second, this led to a broadened understanding of spirituality. Third, this broadened understanding led participants to new insights about different ways spirituality might look.

According to several participants, the assumption they held prior to the training was that spirituality was about religion alone. One participant (10, medical or nursing, no religious affiliation) explained how they had thought of spirituality *"more in a religious*

sense … in practising whatever religion you have and I guess more of a god focus, that was how I would have defined spirituality". Another (11, psychosocial therapist, no religious affiliation) reported that *"I did have this mistaken view about it [spirituality] being about people's religious beliefs …"*. According to one participant (4, medical or nursing, religious affiliation), the perception that spirituality was about religion meant that they had previously thought that spirituality only applied to those with religious beliefs. This belief had since shifted to *"everyone has some form of spirituality whether they are religious or not".*

The training challenged perceptions that spirituality was only about religion by introducing a much broader definition of spirituality, based on meaning and connectedness. This broader understanding was evident in the ways participants described their new understanding of spirituality, such as *"anything that can help someone through"* (5, functional/leisure therapist, no religious affiliation), *"this all-encompassing thing that you know transcends everything else"* (1, functional/leisure therapist, no religious affiliation), *"at the core of what makes that person tick"* (9, medical or nursing, no religious affiliation), *"support for your soul, for your being"* (10, medical or nursing, religious affiliation), and *"what makes them feel like life is worth living"* (13, medical or nursing, religious affiliation).

Broadening the definition of spirituality to incorporate meaning and connectedness meant that participants recognised that spiritual expression might take different forms. One participant reflected how she now understood that spirituality *"just doesn't have to be religion there are a lot of other parts of spirituality that can be meaningful and important"* (7, psychosocial therapist, no religious affiliation). Music, art and nature were all mentioned as now recognised under the heading of 'spirituality'. One participant commented that the videos of former patients had helped them to realise that clients might access more than one form of spirituality, *"they were religious but they were also, well, she also liked being outside*

and being around nature" (8, psychosocial therapist, religious affiliation). However, adopting a broader perspective on spirituality was not easy for every participant. One spoke of how they were still trying to *"work it out"* (4, medical or nursing, religious affiliation).

> *I really still don't know exactly the non-religious spirituality … it can be, you know, just going out and listening to the wildlife or the birds or going to some place that they like to go to or listening to certain music … I need to just get an idea about what is it that is spirituality and not religious.*

ii) Realisation of the importance of spirituality to clients

Becoming more aware of the broader definition and scope of spirituality led to a greater appreciation by rehabilitation professionals of how important spirituality may be to clients, new awareness that incorporating meaningful, patient-centred practice may assist clients achieve their rehabilitation goals, and a realisation that clients may want to talk about it.

A participant spoke of how after the training they were more aware *"how important it [spirituality] is to people, that it is a huge part of their lives…"* (7, psychosocial therapist, no religious affiliation). According to this participant, hearing former clients share their own experiences of spirituality (via video footage) had particularly increased their understanding of the important role spirituality may play during adjustment. Another described how previously spirituality had been included as an item on the demographic profile during assessments, but they now realised how it was of *"deeper significance"* and something which could be explored (12, psychosocial therapist, no religious affiliation). For one participant the training had *"given me a bit more of an idea as to why these things might be important to someone and why they need that, and it's a need rather than just a want"* (14, functional/leisure therapist, religious affiliation).

One of the ways spirituality was seen to be most important in a rehabilitation context was how it could potentially help staff to incorporate meaningful, patient-centred practice into rehabilitation. This was of particular interest to two participants who sometimes found it difficult to engage clients in achieving their physical rehabilitation goals. One commented, *"I do feel it's helpful to think about things that are really important and meaningful for the person … and whether that will be a motivating factor to get them to do the things that will help them exercise"* (15, functional/leisure therapist, religious affiliation). Likewise, another participant was keen for interventions that supported clients *"in their spirit"*, because *"they're going to be better supported, they're going to be more engaged and motivated"* (16, medical or nursing, religious affiliation). Others spoke of how spirituality could be incorporated into clients' rehabilitation plans to *"tap into what's really important"* to them (111, psychosocial therapist, no religious affiliation). An example of this was provided by one participant (2, functional/leisure therapist, no religious affiliation), who described how after the training they had met with a client who found meaning in music.

> *And so we kind of got in the discussion you know about how music makes her feel and does it uplift her and that kind of thing and she said 'yeah' you know she's loved singing and it was something that she really enjoyed.*

This participant hoped to continue exploring the importance of music with this client in future sessions, incorporating it into her goal planning as appropriate.

A new realisation of the importance of spirituality led several participants to express surprise that talking about spirituality was enjoyable. Some reported that prior to the training they had assumed that clients did not want to talk about spirituality. Since the training they had found clients to be *"open and comfortable"* with *"telling their story"* (12, psychosocial therapist, no religious affiliation), that clients had responded well and wanted to talk about it,

and that talking about things that were meaningful was *"like a breath of fresh air"* (6, PST, religious affiliation). For one participant (7, psychosocial therapist, no religious affiliation), realising that spirituality was important to clients and that they wanted to talk about it helped her to feel more comfortable asking about it.

iii) A desire to keep spirituality on the radar

A new awareness of the breadth of spirituality and realisation of its importance resulted in a desire from participants to 'keep spirituality on the radar'. Among participants was a strong desire to continue their newfound awareness of spirituality to *"more actively look for it"* (1, functional/leisure therapist, no religious affiliation) and by prioritising it in their work. One explained:

> *they're not going to come to you with a placard that says 'I'm a spiritual person' and I think that's probably been of the biggest challenges for me is just to … be more aware that that can come onto the radar* (1, functional/leisure therapist, no religious affiliation).

It was observed by another (11, psychosocial therapist, no religious affiliation) that work involved constantly juggling priorities and therefore it was easy for things to *"fall off the radar",* so *"I think for me anything that's going to help me keep it on my radar"* would be a help. Suggested strategies to prioritise spirituality included discussing spirituality in disciplinary meetings or during supervision. It was suggested that just keeping it in the minds of rehabilitation professionals *"whether you're waiting for it intentionally or seek it"* would assist them to address spiritual needs with clients (16, medical or nursing, religious affiliation).

iv) Identifying barriers to providing spiritual care

The spiritual care training led participants to reflect upon their own clinical experiences and to identify some of the barriers to spiritual care they had encountered in the past. This theme comprised three barriers or challenges: the primary focus for many patients upon the physical nature of rehabilitation, how a previous practice of incorporating spirituality had been forgotten due to the physical focus of rehabilitation, and a need to better understand the label 'spirituality'.

The physical focus of rehabilitation was a recurring challenge for participants as they sought to consider how spirituality might be incorporated into their work. A participant (7, psychosocial therapist, no religious affiliation) explained that *"I kind of still get the feeling that the physical side is people's focus and so I probably got sucked in a little bit to that thinking that it's physical"*. Another participant (10, medical or nursing, religious affiliation) suggested that the clients' focus on the physical was due to it being an aspect of care they could focus on in the *"here and now…their sole focus is physical … you know … I want to walk again, I want to get as good as I can again"*. For others, the focus might be on just surviving and so the patient might not see the value in *"the possibility of engaging in a more sort of significant conversation"* (12, psychosocial therapist, no religious affiliation).

Second, for some participants the training reminded them that spiritual care was something they had provided in the past, but due to a focus on physical outcomes had forgotten. For instance, one explained how on the ward it was easy to forget *"about the little things that can mean so much"* (6, psychosocial therapist, religious affiliation). Another (3, functional/leisure therapist, religious affiliation) reflected how the training had reminded them that the activities they supported clients with *"are spiritual in a way for some people and I'd forgotten that side of it. I'd got so clinically minded, impairment based that it was actually refreshing to hear"*. During the interview one participant recalled providing spiritual

care in their previous job in a palliative care setting. Once they moved to rehabilitation *"it kind of just dropped off my radar a bit, which is crazy because it lends itself so well to a rehab context"* (11, psychosocial therapist, no religious affiliation). For these participants, the training was a reminder of why they had entered into their profession in the first place.

Lastly, other participants commented how, prior to the training, they had not recognised spiritual care in their work due to a lack of understanding around the label 'spirituality'. After their understanding of spirituality expanded, they were encouraged to realise the amount of spiritual care they were already providing. One participant felt reassured they were providing spiritual care indirectly by listening to a client's concerns (5, functional/leisure therapist, no religious affiliation) as they had not previously thought of this as spiritual care. Another (14, functional/leisure therapist, religious affiliation) reported how they had *"always kind of really prioritised trying to find what it is for those people that sort of helps them"*. Attending the training reaffirmed to this participant that their approach was appropriate. For participants providing counselling the spiritual care training provided a label for the work they were already doing.

> *I think the change is … for me the label spirituality I think it's something that I've been doing in my practice in terms of so what gives you meaning, how are you getting through this, what's important to you … yes this is spirituality"* (6, psychosocial therapist, religious affiliation).

v) Incorporating spirituality into practice

Reflection upon some of the barriers encountered in previous practice led participants to consider ways that spirituality could be better incorporated into practice. These reflections incorporated three key strategies: making subtle changes in language to add depth to

questions asked, establishing ongoing training, and improving service delivery around spiritual care.

One of the outcomes from the staff training was greater awareness about language and how questions about spirituality might be asked. Many participants spoke of the challenges around use of the terms 'spirituality' and 'spiritual care'. Spirituality itself was perceived to be a misunderstood term because *"absolutely everybody thinks its religion"* (9, medical or nursing, no religious affiliation). This misunderstanding was considered to deter clients from wanting to talk about it. One participant described how patients *"just shut it down and go 'nup, nup, nup, not interested in any of this'"* (8, psychosocial therapist, religious affiliation). One strategy identified by participants was to pitch their language to the client, something highlighted in the training:

> *I do ask very generally open ended questions, I don't think I've actually used the word "spirituality" with people um and that's just something I'm very mindful of; it's trying to pitch the language to the client or to the family member in a way that they're not kind of put off* (11, psychosocial therapist, no religious affiliation).

When asked what alternatives they might use, this participant suggested a few questions, such *as "How are you making sense of what's happening? … What's really important to you? What do you love doing? What really motivates you and moves you?*" (11, psychosocial therapist, no religious affiliation). One participant reported that they used the word 'spirituality', but pre-empted discussion with clients by explaining to them: *"I'm going to use the word "spirituality", but it can mean this* [indicates a large amount with hands] *many things"* (8, psychosocial therapist, religious affiliation). One participant mentioned that when they conducted psychosocial assessments now *"it's more than just finding out, it's sort of going to a deeper level in that conversation with the client"* (12, psychosocial therapist, no

religious affiliation). And another observed that they had been getting *"a better understanding about the person, yeah going into things a little bit more"* (7, psychosocial therapist , no religious affiliation).

Ongoing training was highlighted as a key strategy to better incorporate spirituality into clinical practice. *"I don't think it's kind of like a one-stop shop training that you get trained and then you're done,"* said one participant (1, functional/leisure therapist, no religious affiliation). Several others adopted a similar position and commented how it would be easy to slip back into old practices and forget what they had learnt. One participant observed:

> *It's like that with all other courses we do. You know, you get excited and you think you can implement some of those strategies in your practice, but without regular refreshers or prompts, it might just take a step back again"* (15, functional/leisure therapist, religious affiliation).

Another also spoke of the challenge to remember what they had learnt*: "we just get so stuck in the ward and you know that you forget about all these things"* (6, psychosocial therapist , religious affiliation). A few participants suggested that some refresher training might be useful for people who had attended the training *"to share experiences and see how they've changed"* (15, functional/leisure therapist, religious affiliation).

Various changes to service delivery were proposed by participants during the interviews. These comprised four possible approaches: i) adding spirituality into assessment forms or meeting agendas, ii) increasing the range of spiritual resources for rehabilitation professionals to refer to, iii) incorporating peers into a program for clients and iv) increasing client access to spiritual spaces. Like the training, these strategies were considered to help

rehabilitation professionals remember to incorporate spirituality into their work and remember what they had learnt.

vi) Recognising spirituality as personally meaningful

For a few participants, the nature of the training had a profound impact on their understanding of the role of spirituality in their own lives. Firstly, listening to stories of others helped participants recognise sources of spirituality for themselves. Secondly, this helped participants to then recognise spirituality in others.

According to participants, a particularly powerful aspect of the training was listening to the interviews with former patients sharing their own perspectives of spirituality. The love of trees described by one former client in a video resonated with a participant who also loved the natural world (14, functional/leisure therapist, religious affiliation). For another participant, finding out that spirituality did not have to be just about religion *"that it's all of these other things, is definitely comforting"* (9, medical or nursing, no religious affiliation).

Participants identifying themselves as spiritual helped identify spirituality in patients. One participant described how "*now that spirituality is sort of in me, I sort of see it more*" in others (12, psychosocial therapist, no religious affiliation). She provided the illustration of a pregnant woman who suddenly notices other pregnant women. And another reported:

> *"I've not considered myself probably a deeply spiritual person but then some of the examples that were brought to us, I could really identify with them and so it makes me think about what, what my spirituality is … it makes me feel that I can relate to people in a different way in terms of spirituality than I had before"* (15, functional/leisure therapist, religious affiliation).

Discussion

This study explored the experiences of rehabilitation professionals who had attended a brief spiritual care training program. The findings revealed that the training impacted upon participants' perceptions of spirituality both professionally and personally. Understanding that "spirituality is everybody's business" led to important changes in thinking and practice across disciplines, and a desire to better incorporate spiritual care in the future. The initial step for many participants was an increased awareness of the broad nature of spirituality, followed by a realisation of its importance to clients. This increased awareness resulted in many participants desiring to keep spirituality 'on their radar'. Reflection on these issues assisted participants to identify barriers to providing spiritual care in the past and consider how spirituality could be better incorporated in practice. For several participants, the training impacted upon them personally, changing how they perceived the role of spirituality in their own lives and the lives of others.

In their systematic review, Paal, Helo and Frick [33] reported that spiritual care training increased awareness of spirituality among training participants and drew attention to the importance of the spiritual dimension in providing care. Among the studies in their systematic review, Paal et al. [33] found that participants better acknowledged the role of listening in providing spiritual care. They were more likely to relate more meaningfully with patients after the training and felt more confident to do so. These findings were also reflected in this study.

In this study, participants were introduced to a broad definition of spirituality [10] which raised awareness that spirituality was not limited to religion alone but encompassed a wide range of different sources of meaning and connectedness. Confusion between spirituality and religion has been a reported barrier for healthcare staff to incorporate spiritual

care into practice [44]. One study with rehabilitation professionals in SCI, found that staff experienced discomfort when patients raised issues of faith and considered religious beliefs to, at times, be a hindrance during rehabilitation [45]. The results of a number of studies have indicated that awareness of spirituality as a construct which embodies more than just religion is a key component of effective training in spiritual care [33,34].

The inclusion of patient stories (via pre-recorded videos) appeared to be a particularly effective way to increase participants' awareness of the importance of the spiritual dimension in their provision of care. Hearing how different patients and their family members accessed different sources of spiritual strength led to participants identifying with the patients, and recognising spirituality both in themselves and coming to the realisation that the topic of spirituality is for "everybody". For several participants, these stories served as a reminder of the meaningful, patient-centred care they had trained for, but forgotten.

In addition to raised awareness of spirituality and the importance of the spiritual dimension in care, the spiritual care training provided staff with practical strategies for incorporating spiritual care. The introduction of a tool and the opportunity to practice using this tool were valued components of the training. Six to eight weeks after the training several participants could refer to instances where they had changed the way that they discussed issues with clients. This was true of rehabilitation professionals from both disciplines of a more physical nature and those where the focus was more on counselling. In other studies participants have welcomed such practical components of spiritual care training. Pearce, Pargament, Oxhandler, Vieten and Wong [46] reported that participants who attended an online spiritual care training course appreciated being given tools, assessment questions and language to use, understood the benefits of integrating religion or spirituality into their practice, and planned to change their practice. Such results, together with the findings of this

study, indicate how effective a short spiritual care training program can be to instigate changes in awareness and practice.

For some participants, engaging in the spiritual care training meant their journey culminated in an increased recognition of spirituality in their own life. As one participant commented, although they had not considered themselves a “deeply spiritual person”, they had been able to identify with the stories from the videos and this had brought them to reflect upon their own spirituality. The personal impact of spiritual care training has also been identified in other studies [9,33]. Recognising one’s own spirituality has been deemed an important factor in the provision of spiritual care generally [47].

One of the key messages highlighted in this study was the need for ongoing spiritual care training for rehabilitation professionals. Keeping spirituality ‘on the radar’ meant prioritising it, talking about it and learning about it. The physical focus of rehabilitation was perceived to at times be a barrier to incorporating spiritual care, because it led to staff forgetting “about the little things that can mean so much”. Incorporating ongoing training and awareness may require system changes that support such training and acknowledge the importance of holistic, person-centred care, that addresses the needs of the whole person.

There are a number of limitations that need to be taken into account. Firstly, participants who were more likely to be interested in spirituality may have attended the training. This may have included those who were more likely to identify with spirituality due to religious faith (half the participants identified their religious affiliation to be Christian), or due to interest fostered through awareness of previous SCI and spirituality research conducted by one of the authors (KJ). The higher numbers of staff working with SCI clients participating in the study may also be attributed to by the higher number of clinicians working in these services compared to the TBI services. Lastly, the proportion of training

attendees who participated in the interviews was small (39%), and their perspectives may not have been reflective of the whole group.

This program was designed as an introductory course to spirituality within the context of rehabilitation. Future training could explore the topic in more depth, considering other aspects of spirituality after traumatic injury, such as forgiveness [48] and gratitude [49]. It is also important to note that there was no evaluation of the impact of the training upon outcomes other than those reported by the participants. Further research which explores the direct impact of spiritual care training upon patients and their family members would be beneficial[50]. Longitudinal studies which demonstrate the impact of spiritual care training over a longer period of time, and deeper exploration of the spiritual care needs of rehabilitation patients and their family members to inform future training is also warranted. In addition, the relevance of the training for rehabilitation professionals working with other groups of patients beyond TBI and SCI warrants exploration.

No other rehabilitation studies we are aware of have conducted spiritual care training with a multidisciplinary team and explored both the personal and professional impact of the training upon participants. While training programs have focused upon the training needs of one discipline, such as nursing [51-53], or considered spirituality within the context of end of life care [34,35], this training emphasised the need for all rehabilitation professionals to feel comfortable providing spiritual care within a rehabilitation setting. That members from each discipline attended the training underscored the message that spirituality is for everybody, and not just one discipline such as nursing, medicine or social work. This whole-of-team approach to training is likely to be necessary for rehabilitation services to move forward with integrating spirituality into rehabilitation programs.

Conclusion

This study demonstrated that a brief spiritual care training program had a significant impact upon both the perspectives and practices of rehabilitation professionals from a wide variety of disciplines regarding spirituality and spiritual care. Most important was the shift in understanding that spirituality refers to more than just religion, that spirituality is important to rehabilitation clients and their families, and that the provision of spiritual care is the responsibility of all disciplines. Ongoing training and integration of spiritual care into rehabilitation systems and processes is required to sustain these changes.

Implications for Rehabilitation

- Brief spiritual care training can impact positively upon rehabilitation professionals' perceptions of spirituality and lead to practice change in the delivery of spiritual care across many clinical disciplines
- The stories of patients and family members are powerful staff education tools in spiritual care training
- Client spirituality is an under recognised resource that staff can draw upon in supporting and enhancing the rehabilitation process

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Table 1: *Demographic details of interview participants*

Demographic Item	Interviewees (N=16) N (%)	Training attendees (N=41) N (%)
Discipline		
Nursing	4 (25)	12 (29.3)
Social Work	4 (25)	8 (41.2)
Physiotherapy	2 (12.5)	4 (9.8)
Medicine	1 (6.3)	1 (2.4)
Psychology	1 (6.3)	3 (7.3)
Occupational Therapy	1 (6.3)	4 (9.8)
Recreational Therapy	1 (6.3)	3 (7.3)
Vocational Rehabilitation	1 (6.3)	3 (7.3)
Case Management	1 (6.3)	1 (2.4)
Dietician	0 (0)	1 (2.4)
Speech pathologist	0 (0)	1 (2.4)
Place of work		
Spinal Injury Unit	10 (62.5)	23 (56.1)
Spinal Outreach Service	3 (18.8)	7 (17.1)
Brain Injury Unit	2 (12.5)	10 (24.3)
Brain Injury Community Rehabilitation Team	1 (6.3)	1 (2.4)
Gender		
Female	13 (81.3)	33 (80.5)
Male	3 (18.8)	8 (19.5)
Age		
21-29	3 (18.8)	8 (19.5)
30-39	4 (25)	10 (24.4)
40-49	4 (25)	13 (31.7)
50-59	4 (25)	10 (24.4)
60 and over	1 (6.3)	
Ethnicity		

Australian	13 (81.3)	27 (65.9)
Other*	3 (18.7%)	14 (34.2)
Religious affiliation		
Christian	8 (50.0)	26 (63.4)
None	7 (43.8)	11 (26.8)
Other	1 (6.3)	2 (4.9)

Note. Other ethnicity: Southern/Central Asian, European, South African. Other religious affiliation not specified for participant confidentiality.

Table 2.

Identified themes: Rehabilitation professional experience after training

Overarching theme	Spirituality is everybody's business
Sub-themes	1. Increased awareness of the nature of spirituality i) moving away from idea that spirituality is only about religion. ii) a broadened understanding of spirituality iii) new insights about different ways spirituality might look. 2. Realisation of the importance of spirituality to clients i) greater appreciation of the importance of spirituality to clients ii) new awareness that incorporating meaningful, patient-centred practice may assist clients achieve their rehabilitation goals iii) realisation that clients may want to talk about it 3. A desire to keep spirituality on the radar i) actively looking for it ii) prioritising spirituality in rehabilitation processes 4. Identifying barriers to providing spiritual care i) the focus for patients upon the physical nature of rehabilitation, ii) forgetting to incorporate spirituality due to the physical focus of rehabilitation iii) better understanding the label 'spirituality' 5. Incorporating spirituality into future practice i) making subtle changes in language to add depth to questions asked ii) establishing ongoing training iii) improving service delivery around spiritual care 6. Recognising spirituality as personally meaningful i) Hearing stories of others which resonated ii) Recognising spirituality in others

Appendix 1. Semi-structured interview questions.

1. What is the most significant change in your *thinking or understanding* around spirituality as a result of the training?
2. What is the most significant change in your *practice* around spiritual care as a result of the training?
3. What is helping you/enabling you to implement changes in your practice following the training?
4. What challenges or barriers can you identify to you implementing changes in your practice following the training?
5. What take home message do you have for other clinicians about addressing patients' spiritual care needs in rehabilitation?