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Review Article

The Content, Teaching Methods and Effectiveness of Spiritual Care Training for Healthcare Professionals: A Mixed-Methods Systematic Review

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Abstract

Context. Spirituality has been demonstrated to play an important role in healthcare, yet many staff feel ill-equipped to deliver spiritual care. Spiritual care training programs have been developed to address this need.

Objective. The aim of this mixed-methods systematic review was to identify spiritual care training programs for healthcare professionals or students, and to investigate program content, teaching methods, key outcomes, and identified challenges and facilitators.

Methods. A mixed-methods systematic review was conducted. The search terms ('religio*' OR 'spiritual*' OR 'existenti*') were combined with ('educat*' OR 'train*' OR 'curricul*' OR 'program*'), AND ('care' OR 'therap*' OR 'treatment' OR 'competenc*'). Search terms were entered into the following data bases: PsycINFO, Medline, Cinahl and Web of Science. Findings were restricted to peer-reviewed studies published in English between January 2010 and February 2020.

Results. Fifty-five studies were identified. The quality of studies was mixed. Programs encompassed a range of content and teaching methods. Reported outcomes included increased levels of competency across intrapersonal spirituality, interpersonal spirituality, and spiritual assessment and interventions. Identified barriers included competing healthcare priorities, negative perceptions of spirituality and spiritual care, resistance towards focusing on one's own spirituality, staff feeling inadequate, and the need for ongoing training. Facilitators included opportunities for reflection, involvement of chaplains, application of practical tools, opportunities for practice, online training, and managerial support.

Conclusions. Positive outcomes following spiritual care training were identified. Further research is needed to identify patient-related outcomes of staff training, and to examine how the benefits of such training can be maintained over time. J Pain Symptom Manage 2021;000:1−18.

Key Words

Health personnel, spirituality, spiritual care, training

Key Message

Spiritual care training programs have been effective in increasing levels of spiritual care competency and confidence for a range of healthcare professionals. Training that incorporates clinical practice and more in-depth evaluation is required, and further research is required to consider the impact of spiritual care training over time.

Introduction

Consensus has been reached among researchers, policy makers, practitioners and patients, that spirituality is an important component of health and should be integrated at all levels of healthcare. [1−5] Such views endorse the bio-psycho-social-spiritual model.[6] In 1984 at the 37th World Health Assembly,[7] the spiritual dimension was integrated into the World Health

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Organisation Member States' strategies for health, and understood to play "a great role in motivating people's achievement in all aspects of life." (p.5-6). Adding credence to these policy shifts are research findings that reveal the important contribution spirituality may make towards positive outcomes for healthcare patients and their family members.[2] Research across a range of healthcare contexts indicates that spiritual well-being is closely associated with increased comfort, quality of life, life satisfaction, physical and mental health, resilience, and lower levels of depression and anxiety. [3, 8–10] When spiritual care has been well integrated into healthcare settings, findings suggest that there are significant benefits for patients and their family members. [11–13] However, studies have also revealed that healthcare staff often feel ill-equipped to address the spiritual needs of their patients, and that training in this area is required. [14, 15]

Spirituality is a multidimensional construct, incorporating existential challenges, value-based considerations and attitudes, and religious considerations and foundations. [16] The European Association for Palliative Care has defined spirituality as "the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred" (p.2). This definition embraces a broad view of spirituality, which indicates that a person may draw upon a wide range of different sources of spiritual connection. Likewise, spiritual care has been broadly defined. Speck explains that spiritual care "requires the caregiver to focus on, and relate to, the whole person who is before them. The essence of the encounter is the ability to create a safe space within which the person can explore such issues as personal worth and value, the possible purpose of what is being experienced, the opportunity to access strength and support to transcend the here and now experience and sustain hope for a future" (p.464).[17] This definition acknowledges that spiritual care may be appropriate in a range of situations or healthcare contexts.

Despite the value placed on spiritual care in many healthcare settings, several barriers to integrating spirituality into healthcare have been reported. [14, 15, 18–20] These include inadequate staff training, [14, 18–22] a belief that spiritual care is 'not my professional role',[19] peer pressure,[15] a perceived lack of time due to priority placed on other medical or physical concerns, [18–20] confusion between spirituality and religion, [15] and staff members' lack of comfort with, or awareness of, their own personal spirituality. [15, 23] In a study of 770 physicians and nurses from 14 Middle Eastern countries, Bar-Sela and colleagues [23] found that one of the key factors for participants who did not provide spiritual care was a low personal sense of being spiritual.

To help address these barriers, spiritual care training programs have been introduced in healthcare settings. There is a growing belief that awareness of spiritual care is important for all healthcare professionals, [24] not just those with specialist training in spiritual care. Furthermore, although often considered to be the domain of palliative or end of life care, the relevance of spiritual care for a wide range of healthcare contexts is also recognised.[14, 25, 26] In a systematic review of spiritual care training effectiveness by Paal, Helo and Frick, [27] 46 spiritual care training programs were identified. The authors found that programs were aimed at increasing sensitivity towards participants' own spirituality, clarifying the role of spiritual care in healthcare and preparing participants for spiritual encounters.

More recent studies have begun to explore what spiritual care competencies should be taught to healthcare professionals[28, 29] such as doctors and nurses. In a study with family medicine residents, Anandarajah and colleagues [29] identified spiritual care competencies which included: *knowledge* related to understanding spirituality and religion, spirituality and belief in patient care, resources, and literature; *skills* relating to both assessment and therapy, communication and listening, in compassionate presence, providing spiritual whole-person care, and negotiating differences of belief; and *attitudes* including respect, spiritual self-awareness, spiritual self-care, and spiritual centredness. Extensive work in this area has also been conducted in Europe, with undergraduate nurses and midwives.[28, 30, 31] McSherry and colleagues[32] reviewed the findings of these studies to develop the EPICC (Enhancing nurses' and midwives' competence in Providing spiritual care through Innovative education and Compassionate Care) Spiritual Care Education Standard. The standard is underpinned by four key competencies: (1) intrapersonal spirituality (awareness of the importance of spirituality on health and well-being); (2) interpersonal spirituality (engages with persons' spirituality, acknowledging their unique spiritual and cultural worldviews, beliefs and practices); (3) spiritual care: assessment and planning (assesses spiritual needs and resources using appropriate formal or informal approaches, and plans spiritual care, maintaining confidentiality and obtaining informed consent); and (4) spiritual care: intervention and evaluation (responds to spiritual needs and resources within a caring, compassionate relationship).

This mixed-methods systematic review sought to identify spiritual care training programs conducted with trainee and practising healthcare professionals within the last ten years. Both quantitative and

qualitative studies were included. The study aimed to consider the following questions:

1. What content has been taught in spiritual care training programs?
2. How has this content been delivered?
3. What key outcomes have been reported after spiritual care training, and:
4. What challenges and facilitators have been associated with the implementation of spiritual care training?

Methods

Search strategy

A systematic search was conducted in February 2020 to identify studies which detailed and evaluated spiritual care training with healthcare practitioners or students (study protocol is available at: https://www.crd.york.ac.uk/PROSPERO/display_record.php?RecordID=167140). The search terms ('religio*' OR 'spiritual*' OR 'existenti*') were combined with ('educat*' OR 'train*' OR 'curricul*' OR 'program*'), AND ('care' OR 'therap*' OR 'treatment' OR 'competenc*'). Searches were conducted in the following databases: PsycINFO, Medline, Cinahl and Web of Science. Inclusion criteria were as follows: studies which outlined a spiritual care training program for healthcare practitioners working in inpatient or outpatient hospital care, disability services, aged care, or mental health services; studies which recruited students training to work in the above healthcare contexts. Findings were restricted to peer-reviewed studies reporting original research and published in English between January 2010 and February 2020. Studies were excluded if: they focused solely on the spiritual well-being of staff; they reported on programs for patients only; no description of the training program was provided or available; or the program was not formally evaluated. As we were interested in spiritual care training that addressed the needs of healthcare practitioners who had no previous training in spiritual care, studies with cohorts of spiritual care practitioners alone were also excluded.

Title and abstract searches were conducted independently by two of the researchers (KJ, XS) with 35% of the citations reviewed by both researchers. The full texts of all articles which met the inclusion criteria were reviewed by at least two of the four researchers. For any studies where there was uncertainty about whether they met inclusion criteria, all four researchers discussed the matter until consensus was achieved.

Analysis strategy

Fig. 1 outlines the overall analysis strategy used for this mixed-methods systematic review. All methodology is reported according to PRISMA [33] and ENTREQ [34] guidelines. The quality of all the studies was assessed with the QualSyst [35] systematic review tool. The first 20% of studies were assessed by three authors (KJ, MB, XS) and the remaining 80% assessed by the first author (KJ).

Due to the heterogeneity of the quantitative studies, a meta-analysis was not possible. Quantitative data relevant to each objective were identified and summarised from the Results sections of the papers. Kirkpatrick's triangle, [36] a framework used to classify the level of evaluation of educational interventions, was applied to each quantitative study. Within this framework, levels progress from Level 1 "measuring learner reactions"; to Level 2, "measuring learning as indicated by change in attitudes, knowledge and/or skills"; to Level 3, "measuring changes in learner behaviours"; and Level 4 "measuring the intervention's impact on society", such as healthcare outcomes.[36]

The Results sections of the qualitative papers were subjected to an inductive thematic synthesis [37] by two of the authors (KJ, MB), using line-by-line coding. Descriptive themes were identified, and analytical themes generated. The qualitative and quantitative results were then combined and reported using the four-item competency framework provided in the EPICC Spiritual Care Education Standard. [32] No ethics approval was required.

Results

From 14817 preliminary hits, 55 studies were identified for final review (see Fig. 2). Thirty-three of the studies were quantitative. 11 quantitative studies included a control group, 12 collected follow-up data and seven of the studies were conducted as randomised [38–42] or cluster [43, 44] controlled trials. The remainder using either qualitative (n=12) or mixed methods (n=10) approaches. Eleven quantitative studies included a control group, and 13 collected follow-up data. Follow up data was typically collected between three and 12 months after training, but in one case was collected after eight years [45] (see Table 1 for further details). Over 75% of studies were conducted in the USA (n=33) or Europe (n=10). Nursing students or nurse practitioners comprised the sample population for just under half of the studies (n=27). Medical students and practitioners were also well represented, with the remainder of the studies recruiting participants from a range of disciplines, including social work and other allied health fields. The total number of participants who engaged in spiritual care training across the studies was 3674, with an additional 510 participants from control groups. Further details relating to the identified studies are reported in Table 1.

The quality of the studies ranged widely, however no papers were excluded because of quality. When ranked using the QualSyst tool, [35] 25 (45%) of the studies

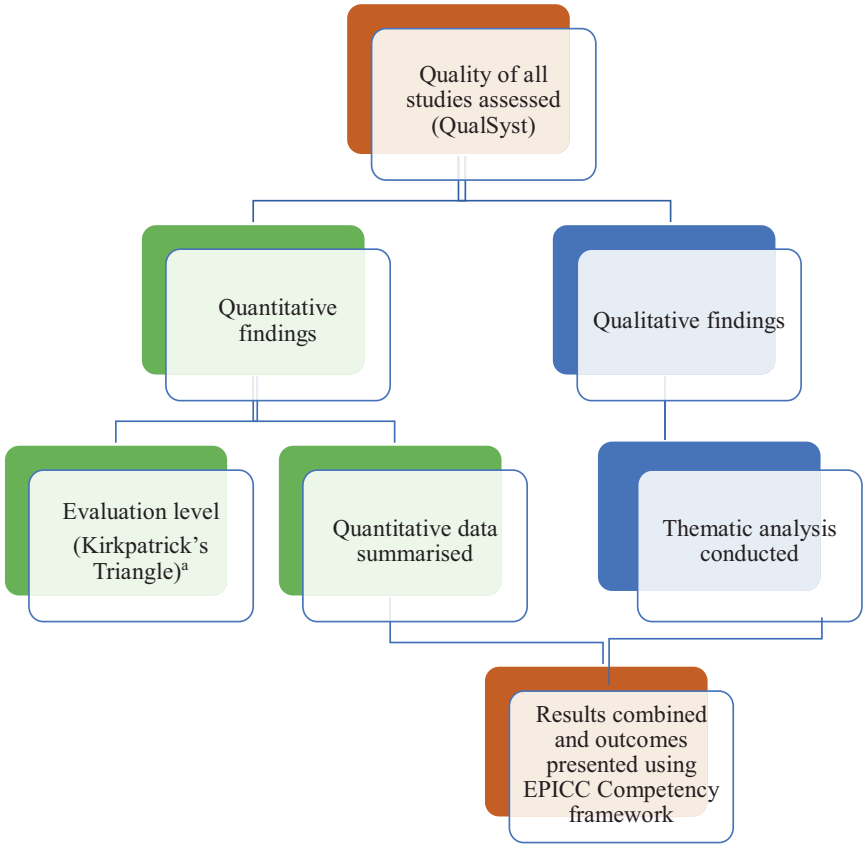

Fig. 1. Data analysis plan.
Note. [a]See Table 1

scored 90% or over and eight (16%) scored 60% or less (see Table 1). On the basis of the evaluation system provided by Kirkpatrick, [37] only four quantitative studies were assessed as Level 4. [43, 46–48] The remainder of the quantitative studies were assessed as Level 2.

The findings of the review have been organized into four overarching categories: 1) content and delivery of the spiritual care training programs; 2) reported outcomes of spiritual care training; 3) identified challenges encountered in the integration of spiritual care into healthcare; and 4) identified facilitators of spiritual care training.

Content of spiritual care training programs and how this content was delivered

A wide range of content and teaching methods were utilized to deliver spiritual care training to healthcare professionals (see Supplementary Table). Fifteen program topics were identified: spiritual screening (n=30), whole person care (n=29), definitions of spirituality or spiritual care (n=24), spiritual care encounters (n=26), understanding suffering and spiritual distress (n=25), role of spiritual care specialists (n=21), awareness of personal spirituality (n=19), communication skills (n=16), comparative religious study (n=14), spiritual care research findings (n=11), ethics of spiritual care (n=7), negative religious coping (n=5), barriers to spiritual care (n=4), self-care (n=4), and documentation (n=5). In some cases, only one topic was focused on, such as a program which focused on teaching participants how to manage spiritual care encounters via a simulation exercise. [49] Other programs covered a range of topics. For instance, a study which integrated spirituality into substance-use prevention training for social workers [50] covered 11 of the 15 topics listed above, alongside information and training on substance use.

The most common teaching method among the spiritual care programs was didactic teaching (n=36). Most often this training was conducted in person, however three programs utilized online training. [50–52] Group (n=26) or personal reflection (n=14) often accompanied the didactic teaching and was usually based on case studies or practical exercises, such as role-plays. Teaching on spiritual care screening or assessment was incorporated in over half (n=30) the programs. Six programs included training on use of the FICA (Faith Importance Community Address)[53] spiritual history tool.[43, 54–58] The pictorial Spiritual Life Map was introduced in another.[59] Two studies [60, 61] utilized spiritual history taking models drawn from other research.

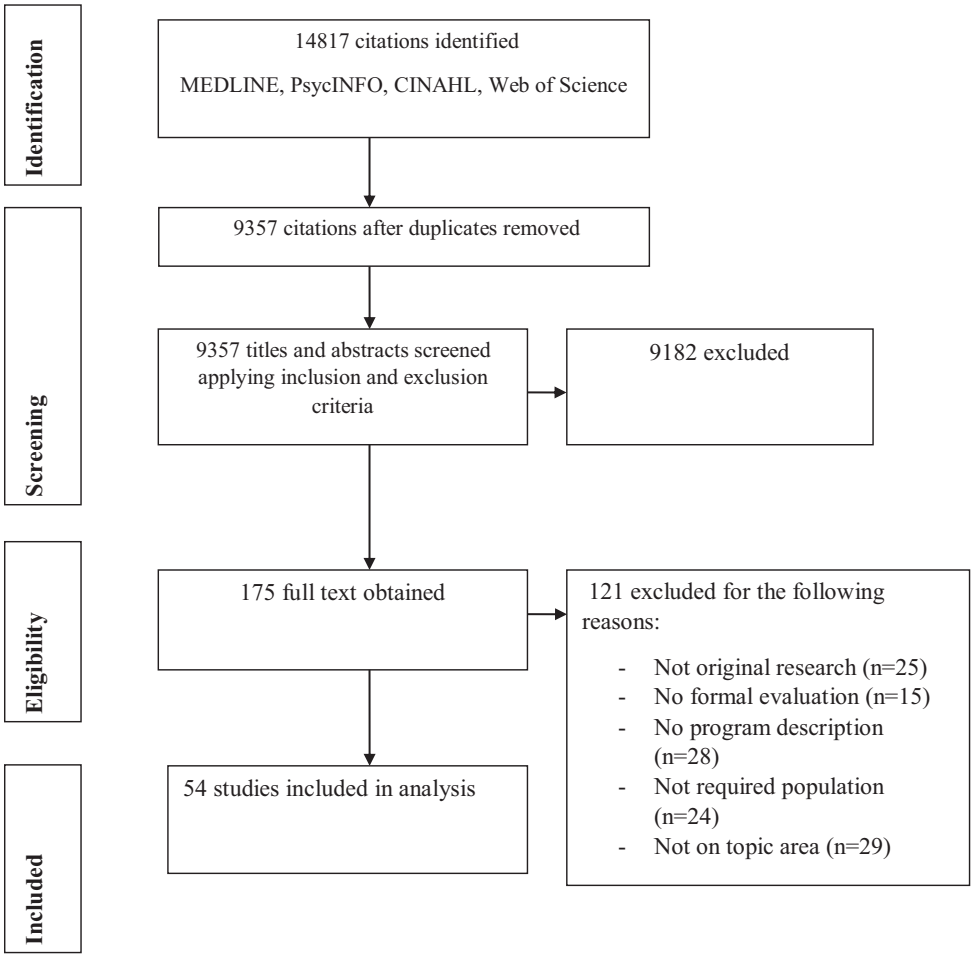

Fig. 2. Database search.

Koenig and colleagues [60] adopted a screening approach which consisted of three questions: Do you have a faith-based support system to help you in times of need? Do you have any religious beliefs that might influence your medical decisions? and Do you have any other spiritual concerns that you would like someone to address?

Practical exercises were incorporated into over half of the programs. Simulated learning with a standardized patient or professional actor was adopted as a teaching method in ten programs.[49, 57, 58, 62–68] Other examples of practice-based learning included shadowing chaplains, which was utilized in four programs,[69–72] and practical application of the spiritual care tools mentioned above.[54, 58, 59] Only five programs directly incorporated clinical contact with patients.[54, 57, 72–74]

Several programs utilized a variety of teaching methods. A one-day workshop with practitioners working in aged care incorporated didactic teaching, simulated learning with professional actors, video content, and demonstrations. [62] Another, [57] included a brief lecture followed by a role-play exercise, debrief, and spiritual assessment with a patient during clinical rotation.

Most of the programs were held over a short period of time ranging from 30-minute lectures to whole day workshops. About a third of the programs were held over a period of weeks or throughout a year, and three programs were conducted for more than one year. Nine studies did not report the duration of the program. While most of the programs were stand-alone courses, a few were included as a component of another training program or degree. These included a program by Anandarajah and colleagues [72] run as part of a 3-year residency curriculum for physicians, an adapted course for social workers on substance-use prevention which included elements addressing faith and spirituality,[50] and three studies which reported on the effects of integrated spiritual care training for undergraduate nurses.[74–76]

Reported outcomes of spiritual care training

Increasing participants' competency in spiritual care delivery was a key aim of many of the studies. Findings

Table 1
Study Characteristics

Authors	Country	Methods	Data collection time-points	RCT?	Sample	Field	Evaluation tool	Quality (%)	Evaluation Level (Kirkpatrick's Triangle)
Anandarajah (2016)	USA	Qual, long, interviews	Pre-post-FU	NA	Physicians n=26 (13 intervention, 13 comparison)	General medicine	NA	95	NA
Atkinson (2018)	USA	MM, long, interviews	Post-FU	N	Student physicians, n=165	School of medicine	Researcher developed	81	2
Attard (2014)	Malta	Quant, c-s	Post only	N	Nurses and midwives, n=163 (106 intervention, 57 comparison)	Faculty of Health Sciences	SCCS	68	2
Awaad (2015)	USA	MM, long	Pre-post	N	Student physicians, n=20	Outpatient clinics	Researcher developed	59	2
Baldacchino (2011)	Malta	Qual, c-s, survey	Post only	NA	Nurses, n=103	General hospital	NA	85	NA
Bandini (2019)	USA	Quant, long	Pre-post-FU	N	Multidisciplinary, n=68	Aged Care	Researcher developed	95	2
Beese (2018)	USA	Quant, long	Pre-post	N	Multidisciplinary, n=5	Mental health	Researcher developed	50	4
Bell (2010)	UK	Qual, c-s, survey	Post only	NA	Student physicians, n=52	Palliative care	NA	45	NA
Bremault-Phillips (2015)	Canada	MM, c-s, focus groups	Post only	NA	Multidisciplinary, n=9	Inpatient units	NA	70	2
Briggs (2014)	USA	MM, c-s, survey	Post only	NA	Student nurses, n=75	Tertiary institution	Researcher developed	50	2
Burkhart (2012)	USA	Quant, long	Pre-post	Y	Student nurses, n=59	Nursing school	SCI, SCIP, SWBS	88	2
Buser (2013)	USA	Qual, c-s, survey	Post only	NA	Student counsellors, n=39	Tertiary institution	NA	90	NA
Connors (2017)	USA	Quant, long	Pre-post	N	Student nurses, n=26	Community college	Researcher developed	77	2
Cooper (2016)	Australia	Qual, c-s, interviews	Post-only	NA	Student nurses, n=6	Tertiary institution	NA	70	NA
Costello (2012)	USA	Quant, long	Pre-post	N	Student nurses, n=52	Maternal-child health	SCCS	77	2
Daudt (2019)	Canada	Qual, c-s, interviews	Post only	NA	Multidisciplinary, n=19	Palliative care	NA	90	NA
Desmond (2018)	USA	Quant, long	Pre-post	N	Nurses, n=40	Health care	SCI	95	2
Dezorzi (2019)	Brazil	Quant, long	Pre-post	N	Multidisciplinary, n=52	Palliative care	SCCS	91	2
Fink (2014)	USA	Quant, long	Pre-post	N	Student nurses, n=54 (30 intervention, 24 control)	Nursing school	Researcher developed	83	2
Galloway (2017)	USA	MM, long, survey	Pre-post	N	Student nurses, n=74	Nursing school	SSCRS	65	2
Gomez (2020)	USA	MM, c-s, focus groups	Post only	N	Student physicians, n=100	School of medicine	Researcher developed	90	2
Hall (2013)	USA	Quant, long	Pre-post	N	Multidisciplinary, n=33	Palliative care	Researcher developed	50	2
Hemming (2016)	USA	Qual, c-s, focus groups	Post-only	NA	Multidisciplinary, n=30	Medical centre	NA	90	NA

Henoch (2013)	Sweden	Quant, long	Pre-post-FU	Y	Nurses, n=102 (60 intervention, 42 control)	Oncology, palliative care	SOC-13, ATCPFMS, FATCOD	100	2
Hu (2019)	China	Quant, c-s	Pre-post	Y	Nurses, n=92 (45 intervention, 47 control)	Oncology	SCCS, Spiritual Health Scale	96	2
Hubbell (2017)	USA	Quant, long	Pre-post	N	Nurses, n=12	Pulmonary/ infectious diseases	SSPS, NSCPS	68	2
Huehn (2019)	USA	Qual, c-s, interviews	Post only	NA	Student nurses, n=16	Tertiary institution	NA	55	NA
Hvidt (2018)	Denmark	MM, long, interviews	Pre-post	N	Physicians, n=20	General medicine	Researcher developed	91	2
Koenig (2017)	USA	Quant, long	Pre-post-FU	N	Physicians, n=520	Outpatient clinics	Researcher developed	95	2
Ledford (2014)	USA	Qual, long, interviews	Post-FU	NA	Physicians, n=27	Community hospital	NA	85	NA
Ledger (2013)	UK	Quant, long	Post-FU	N	Multidisciplinary, n=134	Mental health	Researcher developed	45	2
Lennon-Dearing (2012)	USA	MM, c-s, survey	Post only	N	Multidisciplinary (students), n=53	Tertiary institution	Researcher developed	56	2
Lind (2011)	USA	Quant, long	Post-only	N	Nurses, n=37, patients (not reported)	Cardiovascular health	Avatar Patient Satisfaction	57	4
Meredith (2012)	Australia	Quant, long	Pre-post-FU	N	Multidisciplinary, n=113	Palliative care	SSCRS, POWCS, DASS	86	2
Moale (2019)	USA	Quant, long	Pre-post	N	Multidisciplinary, n=73	General hospital	Researcher developed	95	2
Morita (2014)	Japan	Quant, long	Pre-post	Y	Nurses, n=84 (42 intervention, 42 control)	Palliative care	FACIT-Sp meaning subscale, Maslach burnout scale	96	2
Murray (2017)	USA	Quant, long	Pre-post	N	Nurses, n=49	General hospital	SSCRS	91	2
O'Brien (2019)	UK	Qual, c-s, interviews	Post only	NA	Multidisciplinary, n=21	Multiple health sites	NA	65	NA
O'Shea (2011)	USA	Quant, long	Pre-post	N	Nurses, n=41	Paediatric Hospital	SCPS-R, SPS	91	2
Osorio (2017)	Brazil	Quant, c-s	Post only	Y	Multidisciplinary, n=49 (25 intervention, 24 control)	Tertiary institution	DUREL, Researcher developed,	92	2
Pearce (2019)	USA	Quant, long	Pre-post	N	Multidisciplinary, n=169	Mental health	RSIPAS, Researcher developed	95	2
Petersen (2017)	USA	Quant, long	Pre-post-FU	N	Nurses, n=112	Paediatric Hospital	SCCS, SSCRS	95	2
Rawlings (2019)	USA	Quant, long	Pre-post-FU	N	Student social workers, n=251	Tertiary institution	Researcher developed	95	2
Riahi (2018)	Iran	Quant, long	Pre-post-FU	Y	Nurses, n=82 (40 intervention, 42 control)	Critical care units	SANCSC, King's Spiritual Intelligence Scale	96	2
Robinson (2016	USA	Quant, long	Pre-post-FU	N	Multidisciplinary, n=115	Paediatric Hospital	Researcher developed	86	2
Smothers (2019)	USA	Quant, long	Pre-post	N	Student physicians, n=123 (71 intervention, 52 control)	Academic medical centre	Researcher developed	92	2

(*Continued*)

Table 1
Continued

Authors	Country	Methods	Data collection time-points	RCT?	Sample	Field	Evaluation tool	Quality (%)	Evaluation Level (Kirkpatrick's Triangle)
So (2011)	Korea	Qual, c-s, interviews	Post only	NA	Student nurses, n=12	Tertiary institution	NA	65	NA
Strand (2017)	Norway	Qual, c-s, focus groups	Post only	NA	Student nurses, n=18	Tertiary institution	NA	85	NA
Taylor (2014)	USA	MM, c-s, survey	Post only	N	Student nurses, n=113	Nursing school	Researcher developed	60	2
Udo (2014)	Sweden	MM, long, interview	Pre-post-FU	Y	Nurses, n=42 (21 intervention, 21 control)	Surgical wards	ATCPFM	71	2
Vlasblom (2011)	The Netherlands	Quant, long	Pre-post	N	Nurses and patients, n=44	Hospital	Flemis Lucas questionnaire on spiritual care giving	92	4
White (2017)	USA	Quant, long	Pre-post	N	Student nurses, n=69	Tertiary institution	SCCS	86	2
Yang (2017)	Singapore	Quant, long	Pre-post	Y	Patients, n=144 (intervention 70, control 74)	Palliative care	FACIT-Sp; FACT-G	100	4
Yilmaz (2014)	Turkey	Quant, c-s	Post only	N	Student nurses, n=130 (58 intervention, 72 control)	Tertiary institution	SSCRS	91	2
Zollfrank (2015)	USA	Quant, long	Pre-post	N	Multidisciplinary, n=50	Range of healthcare settings	Researcher developed	86	2

Note. Quant=Quantitative; Qual=Qualitative; MM=mixed methods; long=longitudinal; c-s=cross-sectional; SCCS= Spiritual Care Competency Scale; [93] SCI=Spiritual Care Inventory; [89] SCIP=Spiritual Care in Practice Survey; SWBS=Spiritual Well-being Scale; [112] SSCRS=Spirituality and Spiritual Care Rating Scale; [85] SOC-13=Sense of Coherence Scale; [113] ATCPFMS=Attitudes Towards Caring For Patients Feeling Meaningless Scale; [114] FATCOD=-Frommelt Attitude Towards Care for the Dying; [115] SPS=Spiritual Perspective Scale; [116] NSCPS=Nursing Spiritual Care Perspective Scale; [117] POWCS=Perception of Work Change Schedule; [118] DASS=Depression and Anxiety Stress Scales; [119] SCPS-R= Spiritual Care Perspectives Scale; [117] SPS= Spiritual Perspectives Scale; [91] DUREL=Duke University Religion Index; [120] RSIPAS= Religious/Spiritually Integrated Practice Assessment Scale; [88] SANCSC=Scale for Assessment of the Nurses' professional Competence in Spiritual Care; FACIT-Sp=Functional Assessment of Chronic Illness Therapy-Spiritual wellbeing scale; [121] FACT-G=Functional Assessment of Cancer Therapy-General; [122] NA= Not applicable; RCT=Randomised Controlled Trial

Table 2
Identified Barriers and Facilitators Regarding Spiritual Care in Healthcare

Challenges	Facilitators
i) Spiritual care is not viewed as a healthcare priority	i) Opportunities for self and group reflection
ii) Spirituality may be considered a taboo topic by patients and staff	ii) Including chaplains to model spiritual care
iii) Examination of one's own spirituality may be a struggle	iii) Practical tools to incorporate spirituality
iv) Staff can feel inadequate to deliver spiritual care	iv) Practising skills through clinical experience
v) Interdisciplinary communication may be inconsistent	v) The provision of learning via an online format
vi) Ongoing training and incorporation of learning into practice may be required for outcomes to be maintained	vi) Training being supported by management.

relating to participants' level of competency have been grouped under the four core spiritual competencies identified by the EPICC group: [32] interpersonal spirituality (being aware of the importance of spirituality on health and well-being); interpersonal spirituality (engages with persons' spirituality, acknowledging their unique spiritual and cultural worldviews, beliefs and practices); spiritual care − assessment and planning (assesses spiritual needs and resources using formal or informal approaches, and plans spiritual care, maintaining confidentiality and obtaining informed consent); and spiritual care − intervention and evaluation (responds to spiritual needs and resources within a caring, compassionate relationship).

Intrapersonal Spirituality (EPICC Spiritual Care Education Standard, Item 1). Analysis of the qualitative data identified five key areas where participants developed skills in intrapersonal spirituality: 1) understanding the concept of spirituality; 2) recognizing the importance of the spiritual dimension in patient care; 3) gaining awareness of the importance of understanding one's own spirituality before addressing the spiritual needs of others; 4) valuing the importance of self-care, and 5) an increasing ability to self-reflect.

A range of studies reported how programs broadened participants' existing understanding of spirituality. The qualitative data revealed that spiritual care training assisted participants to distinguish spirituality from religion, [61, 77–81] to realize that spirituality is about more than just death, [38, 78] and to understand that spirituality can be a positive resource [51, 79] as well as a potential source of distress or struggle. [51, 82] Spirituality was broadened to being relevant during other times of life than just end-of-life, and associated with meaning and freedom. [38] Consequently, spiritual care was also understood to be more than religious care, encompassing compassion and kindness, respect, and finding out what matters most to an individual patient. [80] In some cases, participants expressed surprise as they gained this new understanding of spirituality and spiritual care. [64]

Studies also reported a change in participants' recognition of the importance of the spiritual dimension in patient care, and appreciation of its value to patient well-being. [38, 54, 57, 68, 70, 72, 75, 80] Holistic patient care was seen to encompass more than just physical care, with participants encouraged to adopt a bio-psycho-social-spiritual model. [68, 72, 77]

Alongside this growing understanding of spirituality and its importance in healthcare, was recognition that to address the spiritual needs of others it was important to understand one's own spirituality. Several programs provided participants with specific opportunities to reflect upon their own spiritual beliefs, [57, 59, 69, 73, 79, 82, 83] which were generally well received. In one study however, some participants found personal spiritual exercises very uncomfortable. [82]

The personal impact of providing spiritual care was highlighted in a few programs, leading to an emphasis on self-care. In one study, the consequences of healthcare professionals not knowing how to provide self-care, including burnout and vicarious suffering, were highlighted.[54] Daudt and colleagues [82] observed that providing spiritual care could bring about moral or spiritual distress for healthcare providers, and therefore, self-care was a professional responsibility. In another study, one participant observed "you will be a better healer and better caretaker by taking care of yourself" [72] (p.868). The inclusion of a self-care retreat for the participants in that program was greatly valued.

Lastly, the qualitative data revealed that training increased the ability of participants to self-reflect.[51, 68, 73, 84] This raised awareness of internal barriers towards providing spiritual care,[68] the potential for transference and countertransference of patient issues,[61] and the importance of debriefing. [38] One way in which self-awareness was encouraged was through the use of journaling.[64, 70]

The quantitative studies consolidated these findings on intrapersonal spirituality. The Spirituality and Spiritual Care Rating Scale (SSCRS), [85] a scale designed to measure participants' perspectives of spirituality and spiritual care, was administered in five studies. Four of these were conducted with nurses or nursing students. [52, 57, 74, 86] Across the studies, significant increases in the sub-scales of spirituality and spiritual care were reported after training, though two studies found there was no significance increase on the religiosity subscale. [52, 74] A fifth program, a one-day workshop held with multidisciplinary healthcare professionals, [87] also reported significant increases in the SSCRS sub-scales

of spirituality, spiritual care, and personalized care, but not religiosity. However, only the increase in the subscale of spiritual care was maintained at 3-months' follow-up. In addition to the SSCRS, other measures of changes in participant perception or attitude were administered. In a mixed methods study, Pearce and colleagues, [51] reported changes in the attitude and knowledge of participants after eight weeks of online training using the Religious and/or Spiritually-Integrated Practice Assessment Scale (RSIPAS). [88] Highlighting the value of conducting a simulation exercise alone, Desmond et al., [63] found that there was a significant change in participants' total scores, and two of the three subscale scores (meaning-making, spiritual intervention) of the Spiritual Care Inventory.[89]

A few quantitative studies also sought to measure the impact of participants' own spirituality. In a study with paediatric nurses, O'Shea and colleagues [90] observed a positive relationship between perception of participants' own spirituality (measured by the Spiritual Perspective Scale [91]) and their perspective towards providing spiritual care. In several programs participants reported that a focus on spiritual self-awareness enabled them to integrate spiritual self-care strategies into their own lives. [45, 75, 82] This allowed them to manage personal discomfort, [82] become more aware of their own spirituality, [38, 92] gain greater ability to self-reflect [68] and place an emphasis on spiritual growth. [73]

Interpersonal Spirituality (EPICC Spiritual Care Education Standard, Item 2). The analysis of the qualitative data identified two important ways that spiritual care training facilitated the development of interpersonal spirituality. These were: by 1) helping participants to acknowledge individual patient spirituality as part of holistic care; and 2) increasing participants' understanding of diverse cultures and beliefs.

An aim of many of the spiritual care training programs was to assist participants to acknowledge individual patient spirituality as part of holistic care. [54, 57, 83] Enquiring about a patient's spirituality was seen to be a way to get to know patients.[54, 73, 77] It was increasingly understood that all members of the multidisciplinary team could address spiritual needs, [54] and that spiritual conversations could happen at any time. [78] Participants observed that patients were more likely to open up when asked about their spiritual needs, [73] and appreciated being asked about their spirituality. [54]

A heightened awareness of cultural and religious diversity was reported by participants in several programs.[77, 80, 82, 83] Such awareness included specific training in understanding different cultural and religious sensitivities, such as how to care for a body after death [77] and addressing general prejudice about different cultures and faiths. [80] Participants were also encouraged to examine their own biases. [51]

Spiritual Care: Assessment and Planning (EPICC Spiritual Care Education Standard, Item 3). The EPICC competency of "Spiritual care: assessment and planning" was demonstrated by participants in four areas: an increased ability to recognize spiritual cues; being present with the patient; increased spiritual screening and documentation; and an increased use of chaplaincy services.

According to several studies, participants increased their ability to recognize spiritual cues. This included examples of participants' better understanding spiritual distress,[77, 79] picking up on verbal references, [78] and observing items in a patient's room to prompt conversation. [71] In other studies, emphasis was placed on identifying patients' sources of spiritual strength. [54]

Being present with patients was identified as another way that participants developed skills in spiritual assessment and planning. Assessing a patient's spiritual needs involved placing value on silence, [71, 77] developing better listening skills,[54, 73, 78, 82] and feeling at ease with not having all the answers.[77] Being present also helped participants to build a trust relationship with patients. [80]

Positive qualitative feedback was received from participants regarding the incorporation of a spiritual assessment tool. [54, 59, 61, 78, 84] This was complemented by quantitative data, which in one study revealed an increase in patient spiritual screening levels.[60] Koenig et al.,[60] observed that clinicians who placed a high importance on religion were more likely to conduct a screening spiritual history. Another study [58] recorded self-reported increases across all skills associated with spiritual screening and care plans, making referrals to a chaplain, and discussing patients' spiritual strengths or distress with the care team. These increases which were maintained at 3-months follow-up.

Chaplains were included in spiritual care training via shadowing programs, [69–72] teaching and modelling,[58, 65, 66, 72] or collaboration on medical teams. [71] Although some participants expressed initial apprehension regarding the inclusion of chaplains in training, [66] many found that the training assisted them to understand the role of chaplains on the interdisciplinary team better.[69] Observing chaplains helped participants to know how they too might engage patients in difficult conversations,[69] but to feel comfortable to refer to chaplains when required. [61] One quantitative study reported an increase in chaplaincy referrals after training.[46]

Spiritual Care: Intervention and Evaluation (EPICC Spiritual Care Education Standard, Item 4). Few studies measured the effectiveness of spiritual care training on spiritual care interventions or evaluated these interventions. One such study [48] reported that after spiritual care training the number of spiritually based

interventions charted by staff rose from 0.4 to 1.1 per visit. Only three of the 54 studies incorporated patient feedback in their evaluation of the staff training.[43, 46, 47] The results were mixed. While Yang and colleagues [43] found that the spiritual well-being of patients treated by spiritually trained staff was not significantly different to those who were untrained, Vlasblom et al.,[46] observed that after training, patients experienced more receptiveness and support from staff on spiritual matters and the number of referrals to chaplains increased. Greater patient satisfaction with spiritual care after staff training was reported by Lind, Sendelbach and Steen.[47]

The effectiveness of staff training to improve staff competency in delivering spiritual interventions was mainly assessed by the administration of self-report measures. The main quantitative measure to evaluate self-reported competency was the Spiritual Care Competency Scale (SCCS), [93] used in six of the quantitative studies. This measure evaluates self-reported spiritual care competency across six domains: 1) assessment and implementation of spiritual care; 2) professionalisation and improving the quality of spiritual care: 3) personal support and patient counselling; 4) referral to professionals; 5) attitude towards patients' spirituality, and 6) communication. The majority of these programs observed significant increases in spiritual care competency post-program, [49, 52, 76, 94, 95] despite variety in their length and teaching methods. One study, however, did not observe significant changes in competency levels.[31]

Increasing levels of self-reported competency were paralleled by increasing levels of participant confidence to deliver spiritual care intervention, as reported in the qualitative data. [68, 73, 75, 77, 78, 82] Participants were more likely to feel confident to conduct difficult conversations, [69, 72, 77] to integrate spirituality into clinical practice, [61] and to pray with patients [73, 75] Increases in confidence to deliver spiritual care were also reported in many of the quantitative studies. [38–40, 42, 46, 62, 67, 87, 96]

Identified barriers to integrating spiritual care into healthcare

The qualitative findings of the studies included in this review highlighted six challenges regarding the integration of spiritual care into healthcare (see Table 2).

Spiritual Care is not Viewed as a Healthcare Priority. In three studies,[54, 72, 82] participants raised the challenge of competing healthcare priorities. It was perceived that spiritual care was not deemed a healthcare priority due to a focus on physical issues during hospitalization and pressure on staff to deliver healthcare outcomes.[54] This consequently led to a lack of time and other structural barriers, making it difficult for staff to address issues of spirituality with patients.[72]

Spirituality may be Considered a Taboo Topic by Patients and Staff. In four studies, participants expressed initial discomfort about spirituality and were reluctant to integrate it into their practice. [59, 73, 78, 82] In most cases this initial discomfort was overcome, and the training assisted participants to feel more confident and at ease to discuss spirituality with patients. However, it was acknowledged that this initial discomfort was also something that some patients experienced too. [54, 73]

Examination of One's Own Spirituality may be a Struggle. This barrier was highlighted in a study by Daudt et al.,[82]. Although participants reported several benefits from the training, some found the focus on personal spirituality in that program to be overwhelming. In another study, it was noted that caring for dying patients can raise personal anxiety about death. [38] The impact of spiritual care training upon the emotions of participants was considered in several studies, with participants provided with time to debrief and discuss their own feelings. [38, 57, 72] This was considered helpful by participants.

Staff Can Feel Inadequate to Provide Spiritual Care. Although much of the training was aimed at building participants' levels of competency in delivering spiritual care, there were lingering concerns that staff may still not be able to adequately address patients' spiritual needs. Particular issues raised by participants included: feeling like they might not have the answers; [73] uncertainty about how to finish the spiritual dialogue; [38] concerns that discussing spirituality could create expectations of intimacy in relationship that they were unable to meet [54] and; how to manage a patient's discharge if a close relationship had been established. [54]

Interdisciplinary Communication may be Inconsistent. Involving chaplains in spiritual care training led to the identification of some challenges regarding interdisciplinary communication on the wards. In one study, participants felt that expectations about roles needed to be clearer when chaplains were present on medical rounds.[71] In another, [54] concerns were raised about the consistency of communication on spiritual matters between team members, and whether healthcare professionals would respect professional boundaries relating to spiritual care as easily as spiritual care practitioners might.

Ongoing Training and Incorporation of Learning Into Practice is Required For Outcomes to Be Maintained. At the completion of training, many participants across the different studies suggested further training was

required. Participants requested more opportunities to train with chaplains,[69] more opportunities to practice,[57, 61, 81] more information on other faiths,[70, 72] reminders or prompts to integrate learning,[84] and a greater emphasis on skills and integrating spiritual care in practice.[54, 64]

Identified facilitators of spiritual care training

Participant feedback revealed that several aspects of the spiritual care training they attended were particularly helpful (see Table 2).

Opportunities for Self and Group Reflection. Many participants enjoyed undertaking reflective exercises during training. In some situations, these were facilitated through self-reflection or journaling.[64, 70] Reflection was also encouraged in small groups. Participants valued discussing their learning with others,[81] building self-awareness,[82] and developing strategies for managing spiritual or religious conversations.[64]

Including Chaplains to Model Spiritual Care. Participants valued the opportunity to shadow chaplains and to observe how they addressed patients' spiritual needs.[58, 69, 71, 72] The chaplains modelled how to talk to patients about spirituality,[58, 71] how to be present during suffering,[69] and how to manage sensitive situations.[69] Involving a chaplain in simulated learning was also well-received.[66]

Practical Tools to Incorporate Spirituality. Having a spiritual assessment guide, such as the FICA or the Spiritual Life Map, was helpful to participants,[59, 78, 84] and provided them with greater confidence to incorporate spiritual care into practice.[54]

Practising Skills through Clinical Experience. The opportunity to practice skills through clinical experience was not often available to participants during training, however when it was, it was highly valued.[64, 75] In some cases, skills were developed later, over time. For instance, a longitudinal study with physicians observed that years of practice assisted participants to apply what they had learnt.[72]

The Provision of Learning via an Online Format. Online training was valued by participants for being self-paced, well-organized and allowing a variety of learning formats.[51] However, it was noted that some participants would have liked opportunities to experience in-person follow-up training for hands-on practice and to ask questions.[51]

Training being Supported by Management. Spiritual care training indicated to some participants that the organization they worked or studied with valued spirituality and spiritual care.[72, 82] The support from those organizations with an existing mission focus was appreciated.[54]

Discussion

The aim of this systematic review was to identify spiritual care training programs in healthcare and to investigate: the content of spiritual care training programs; how this content has been delivered; the reported outcomes of spiritual care training; and challenges and facilitators associated with implementing spiritual care training. The review identified 55 papers outlining spiritual care training programs conducted with healthcare professionals or students. These programs encompassed a broad range of content and teaching methods and were conducted across a variety of contexts. While some only involved a 1-hour lecture, others addressed spiritual care training over the course of a tertiary degree. Following spiritual care training, increased levels of competency across intrapersonal spirituality, interpersonal spirituality, spiritual care (assessment and planning), and spiritual care (intervention and evaluation) were reported. Barriers to integrating spiritual care into healthcare, and features which facilitated training were identified.

The content of spiritual care training programs was wide-ranging. Topics aligned with much of the existing literature.[28, 32] Attard, Ross and Weeks [28] identified seven domains of spiritual care competency: 1) body of knowledge in spiritual care; 2) self-awareness and use of self; 3) communication and interpersonal relationship in spiritual care; 4) ethical and legal issues in spiritual care; 5) quality assurance in spiritual care; 6) assessment and implementation of spiritual care; and vii) informatics in spiritual care. Many of the programs identified in this review addressed the first five domains listed here. Less represented were topics which corresponded with ethical and legal issues in spiritual care and informatics in spiritual care. Ethical and legal issues were present in comprehensive programs.[72, 75] Informatics, or the use of information technology as a resource for learning about spiritual care, was only evident in training provided online, and only examined in depth by Pearce and colleagues.[51] Since the onset of the COVID-19 (novel severe acute respiratory syndrome coronavirus 2 − SARS - CoV2) global epidemic in 2020, there has been greater focus on the opportunities provided by technology in the field of spiritual care[97, 98] and more emphasis may be placed on this in the future.

A range of teaching methods were employed by the spiritual care training programs and included didactic teaching, group discussion, self-reflection, and the opportunity to practise clinical skills via role-play or simulation. However, few courses provided participants

with opportunities to practice their skills in a clinical context, and no studies assessed changes in participants' behaviour after training (Level 3, Kirkpatrick's triangle). Paal et.al., [99] advise that acquiring skills in spiritual history taking involves time, and that the process of building a meaningful relationship with a patient, involving "listening, understanding, and responding to their individual needs is often disregarded" (p.23). Although it is known that adult learning is facilitated by *doing*, [100] it is not yet established whether the use of simulated patients is more effective than less expensive options such as role-plays. [101] Both were integrated into these studies and may be beneficial to incorporate in future studies.

Increased levels of competency in spiritual care delivery were reported across both qualitative and quantitative studies. In line with the EPICC spiritual care education standards, [32] outcomes could be grouped according to intrapersonal spirituality, interpersonal spirituality, spiritual care assessment, and spiritual care interventions. Most reported outcomes comprised changes in intrapersonal spirituality, interpersonal spirituality, and spiritual care assessment.

One of the notable findings across both qualitative, quantitative and mixed-methods studies regarding intrapersonal spirituality was participants' broadening understanding of the concept. In most training programs, spirituality was taught to be a broad, inclusive dimension, that was not restricted to religion alone. This understanding was reflected in the results of the SSCRS. [85] Although increases were reported in the SSCRS sub-scales of 'spirituality' and 'spiritual care', it was consistently reported that no increases were noted on the 'religiosity' sub-scale. This is an understandable outcome as the sub-scale measures participants' views that spirituality is only about religious beliefs, and most of the programs emphasized that spirituality is much more than just religion. This finding has been replicated in more recent research [102] with rehabilitation professionals.

Another theme which was identified across many of the studies, was participants' realization that in order to provide spiritual care to others, they needed to understand their own spirituality first. This association was highlighted in the systematic review by Paal and colleagues, [27] and has been explored in several studies with various findings reported. [13, 23, 98] Interestingly, in a study of nursing students, low levels of spiritual well-being were associated with a high level of self-reported spiritual care competency. [98] However Bar-Sela et al. [23] observed that a low sense of being spirituality was associated among nurses and doctors who valued spiritual care but did not provide it. The practice context may be significant. For instance, the importance of understanding and being secure with one's own spirituality, and comfortable with one's own mortality, was demonstrated in a study of physicians caring for patients with advanced cancer. [13] These studies suggest that although participants may value and feel confident to deliver spiritual care, this may be difficult to implement in practice if their own level of spiritual well-being is low. These findings support the value of incorporating self-reflection in spiritual care training and allowing time for attendees to examine their own beliefs and feelings.

Interpersonal spirituality was addressed in many of the programs, however a focus on comparative religions was only included in a few. Those that did, addressed how different beliefs may impact upon particular situations such as end-of-life. [77] Most studies emphasised the importance of respecting a patient's individual spirituality, which was accompanied by good listening skills, being present, and tailoring spiritual care in response to the patients' wishes. Such emphasis underpins a growing trend in healthcare towards individualised, person-centred care rather than knowledge of religious traditions.[103]

Training in the competency of spiritual care intervention was brief in most cases, mainly focused on spiritual care assessment, and often relied on participants continuing to practice skills outside of the program. Only four programs included direct patient contact. Where practitioners were able to practice skills, positive feedback was received. Such findings give support to the principle that training which includes opportunities to practice skills in real-life scenarios is appreciated. [104]

It is noteworthy that even short courses had a reported impact on the confidence and comfort levels of staff to deliver spiritual care, which suggests that training may not need to be time-consuming. Shorter courses would make training accessible for a larger group of healthcare professionals, which is important as lack of training is one of the most significant barriers to provision of spiritual care in healthcare. [14, 20, 105] However, some caution would need to be exercised to ensure that appropriate guidelines are in place to protect patients from healthcare practitioners who are not sufficiently trained, [99] and that opportunities for ongoing training and review are provided. Furthermore, follow-up data is needed to ensure that short courses are effective over time. Not many of the studies represented in this review collected such data.

Several studies captured participants' initial concerns regarding the integration of spiritual care into healthcare. Identified barriers including competing healthcare priorities, negative perceptions of spirituality and spiritual care, resistance towards a focus upon one's own spirituality, staff feeling inadequate, interdisciplinary communication, and the need for ongoing training. In most cases, spiritual care training led to change in participants' perspectives, and most were positive about the impact of the training on their

practice. These findings suggest that previously identified barriers such as inadequate staff training, [14, 18–22] confusion about roles, [19] peer pressure, [15] a perceived lack of time, [18–20] confusion between spirituality and religion, [15] and a lack of awareness of personal spirituality, [15, 23] may be overcome with training which enhances staff awareness and skills. Features which facilitated training were the inclusion of chaplains, opportunities for practice and reflection, application of spiritual care assessment tool, online training, and having the support of management.

One of the underlying assumptions of all of these studies is that spiritual care can be delivered, to some extent, by all healthcare professionals. Nurses, doctors, social workers, occupational therapists and other healthcare professionals participated in training. This message has been reiterated in more recent training with a team of rehabilitation professionals. Participants' increased understanding that "spirituality is everybody's business" [24] was one of the overarching themes of the study. Interdisciplinary education in spiritual care delivery has been promoted through the interprofessional model of spiritual care.[106, 107] Although this model suggests that specific spiritual interventions are usually the domain of the chaplain,[107] a chaplain may not always be available or appropriately trained to work in the healthcare context, such as in the case of visiting clergy.[16] Many opportunities exist for other healthcare staff to identify spiritual needs[108–110] and to foster spiritual strengths such as meaning, connection, agency, hope and faith. [111] The inclusion of chaplains in such generalist spiritual care training appears to have multiple positive outcomes, including increased awareness of their role, and increased numbers of referrals.

Overall, the findings of this review suggest that spiritual care training is effective in building staff competency in spiritual care delivery. However, the results should be treated with some caution. Firstly, the quality of the studies was inconsistent. Relatively few quantitative studies incorporated a control group, administered validated evaluation tools, or included a follow-up evaluation with participants. Therefore little is known about the long term impact of training upon participants, and how often it may need to be repeated. Furthermore, the effect of spiritual care training on actual staff behaviours or outcomes for patients was rarely considered, resulting in most studies evaluated as Level 2 on Kirkpatrick's triangle. Lastly, it is possible that many of the study samples were biased towards participants from religious backgrounds, due either to their interest in spirituality or the interests of the faith-based institutions conducting the training. These findings replicate those of Paal et al.,[27] and indicate that more work is needed in this area so that a deeper understanding of the effectiveness and impact of training can be evaluated.[36]

Limitations

This review had several limitations. Spirituality is, in many respects, a concept that is deeply personal, often viewed as intangible, and something difficult to capture with empirical measures. Broadening definitions and usage mean that increasing numbers of search terms are needed to capture studies relating to spirituality and spiritual care, and therefore some relevant papers may have been missed in this study. Furthermore, this review only included formally evaluated spiritual care programs for healthcare professionals. There may be other approaches and programs that were not formally evaluated or were designed for groups other than healthcare professionals, which may have contributed to this topic but were excluded.

Conclusion

This study provides an insight into spiritual care training that has been conducted over the last ten years. While studies vary in approach to the content, teaching methods, and duration of programs, clear positive outcomes can be identified. Increases in spiritual care competency were evident, particularly regarding participants understanding of spirituality and spiritual care and confidence to assess the spiritual needs of their patients. Further research is needed to identify patient-related outcomes when staff are trained in spiritual care, and to examine how the benefits of such training can be maintained and evaluated over time. This will enable spiritual care to be integrated as a standard component of healthcare practice, benefitting both staff and patients.

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Supplementary materials

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